TAB 16

PROSPECT MEDICAL HOLDINGS, INC.

Consolidated Financial Statements

As of and for the Years Ended
September 30, 2017 and 2016

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.

BDO

Prospect Medical Holdings, Inc.

Contents

	Page
Independent Auditor's Report	3
Consolidated Financial Statements:	
Consolidated Balance Sheets	4 - 5
Consolidated Statements of Operations	6
Consolidated Statements of Comprehensive Income (Loss)	7
Consolidated Statements of Stockholder's Equity	8
Consolidated Statements of Cash Flows	9 - 10
Notes to Consolidated Financial Statements	11 - 60

BDO

Tel: 714-957-3200
Fax: 714-957-1080
www.bdo.com

600 Anton Blvd., Suite 500
Costa Mesa, CA 92626

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, 2017 and 2016, and the related consolidated statements of operations, statements of comprehensive income (loss), statements of stockholder's equity, 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, 2017 and 2016, 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 30, 2017

Prospect Medical Holdings, Inc.

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

September 30,	2017	2016
Assets		
Current assets		
Cash and cash equivalents	$ 27,109	$ 29,587
Restricted cash	30,761	6,117
Restricted investments	15,810	4,568
Patient accounts receivable, net of allowance for doubtful accounts of $141,775 and $91,723 at September 30, 2017 and 2016, respectively	358,914	262,497
Due from government payers	51,152	38,806
Other receivables, prepaid expenses and other current assets	191,190	99,228
Income taxes receivable, net	-	24,731
Inventories	36,967	25,590
Hospital fee program receivable	59,209	43,039
Current assets held for sale	-	10,494
Total current assets	771,112	544,657
Property, improvements and equipment, net	576,933	441,352
Deferred income taxes, net	104,323	25,294
Goodwill	310,695	341,488
Intangible assets, net	40,794	41,897
Other assets	58,543	42,560
Long-term assets held for sale	-	2,384
Total assets	$ 1,862,400	$ 1,439,632

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,	2017	2016
Liabilities and Stockholder's Equity		
Current liabilities:		
Accrued medical claims and other healthcare costs payable	$ 55,485	$ 52,761
Accounts payable and other accrued liabilities	320,246	205,946
Accrued salaries, wages and benefits	144,287	108,795
Hospital fee program liability	1,968	18,684
Due to government payers	23,754	23,002
Income taxes payable, net	42,793	-
Revolving line of credit, net	113,061	55,000
Current portion of capital leases	11,315	6,894
Current portion of long-term debt	12,509	6,951
Other current liabilities	17,762	10,293
Current liabilities held for sale	-	2,630
Total current liabilities	743,180	490,956
Long-term debt, net of current portion	625,719	613,005
Malpractice reserves	60,722	34,757
Capital leases, net of current portion	37,612	33,334
Asset retirement obligations	6,022	5,056
Other long-term liabilities	21,377	22,235
Pension obligations	300,364	209,658
Long-term liabilities held for sale	-	787
Total liabilities	1,794,996	1,409,788
Commitments, contingencies and subsequent events		
Stockholder's equity:		
Common stock, $0.01 par value; 100 shares authorized, issued and outstanding at September 30, 2017 and 2016	1	1
Additional paid-in capital	22,398	21,277
Accumulated other comprehensive income	8,148	11,338
Retained earnings (accumulated deficit)	24,253	(9,999)
Total stockholder's equity attributable to Prospect Medical Holdings, Inc.	54,800	22,617
Non-controlling interests	12,604	7,227
Total stockholder's equity	67,404	29,844
Total liabilities and stockholder's equity	$ 1,862,400	$ 1,439,632

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Operations
(in thousands)

For the Years Ended September 30,	2017	2016
Revenues:		
Net Hospital Services revenues	$ 2,538,695	$ 1,273,038
Provision for bad debts	(91,203)	(41,427)
Net Hospital Services revenues less provision for bad debts	2,447,492	1,231,611
Medical Group revenues	391,120	369,730
Net Global Risk Management revenues	20,752	19,635
Other revenues	55,133	9,582
Total net revenues	2,914,497	1,630,558
Operating Expenses:		
Hospital operating expenses	2,003,706	990,385
Medical Group cost of revenues	274,639	248,063
Global Risk Management cost of revenues	10,396	17,661
General and administrative	454,576	270,988
Depreciation and amortization	104,348	47,106
Total operating expenses	2,847,665	1,574,203
Operating income (loss) from unconsolidated joint ventures	5,388	(931)
Operating income	72,220	55,424
Other (income) expense:		
Interest expense and amortization of deferred financing costs, net	73,190	48,616
Loss on debt extinguishment	-	26,561
Bargain purchase gain	(30,010)	-
Other (income) expense, net	(1,861)	(315)
Total other expense, net	41,319	74,862
Income (loss) before income taxes	30,901	(19,438)
Income tax provision (benefit)	554	(4,750)
Net income (loss) from continuing operations	30,347	(14,688)
Income (loss) from discontinued operations:		
Income (loss) from discontinued operations	7,738	(8,277)
Income tax provision (benefit)	2,966	(3,373)
Income (loss) on discontinued operations, net of taxes	4,772	(4,904)
Net income (loss) income before allocation to non-controlling interests	35,119	(19,592)
Net income (loss) attributable to non-controlling interests	867	(3,435)
Net income (loss) attributable to Prospect Medical Holdings, Inc.	$ 34,252	$ (16,157)

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Comprehensive Income (Loss)
(in thousands)

For the Years Ended September 30,	2017	2016
Net income (loss) attributable to Prospect Medical Holdings, Inc.	$ 34,252	$ (16,157)
Other comprehensive income, net of tax:		
Pension obligation and other post-retirement benefits adjustment (net of $(1,794) and $7,797 tax)	(3,646)	11,332
Debt and equity securities, unrealized gain	456	6
Total other comprehensive (loss) income, net of tax	(3,190)	11,338
Total comprehensive income (loss)	$ 31,062	$ (4,819)

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

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

	Number of Common Shares	Common Stock	Additional Paid-in Capital	Accumulated Other Comprehensive Income	Retained Earnings (Accumulated Deficit)	Prospect Medical Holdings, Inc. Stockholder's Equity	Non-controlling Interests	Total Stockholder's Equity
Balance at October 1, 2015	100	$ 1	$ 20,037	$ -	$ 6,158	$ 26,196	$ 10,244	$ 36,440
Options exercised	-	-	121	-	-	121	-	121
Stock-based compensation	-	-	1,119	-	-	1,119	-	1,119
Non-controlling interest attributed to PCC Seller	-	-	-	-	-	-	418	418
Net loss	-	-	-	-	(16,157)	(16,157)	(3,435)	(19,592)
Other comprehensive income, net of tax	-	-	-	11,338	-	11,338	-	11,338
Balance at September 30, 2016	100	1	21,277	11,338	(9,999)	22,617	7,227	29,844
Options exercised	-	-	3	-	-	3	-	3
Stock-based compensation	-	-	1,118	-	-	1,118	-	1,118
Non-controlling interest attributed to minority shareholders	-	-	-	-	-	-	4,510	4,510
Net income	-	-	-	-	34,252	34,252	867	35,119
Other comprehensive income, net of tax	-	-	-	(3,190)	-	(3,190)	-	(3,190)
Balance at September 30, 2017	100	$ 1	$ 22,398	$ 8,148	$ 24,253	$ 54,800	$ 12,604	$ 67,404

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,	2017	2016
Operating activities		
Net income (loss)	$ 35,119	$ (19,592)
Adjustments to reconcile net income (loss) to net cash and cash equivalents provided by (used in) operating activities:		
Depreciation and amortization	104,348	47,106
Amortization of deferred financing costs, net	2,090	2,245
Gain on outlier settlement	-	(5,741)
Write-off of deferred financing costs	-	5,587
Amortization of original issue discount and premium, net	1,909	1,200
Write-off of asset retirement obligation	(272)	-
Write-off of original issue discount and premium	-	3,030
Provision for bad debts	91,203	41,427
Pension obligation net periodic benefit cost (credit)	13,688	(1,356)
Deferred income taxes, net	(50,248)	20,863
Stock-based compensation	1,118	1,119
Undistributed earnings from equity method investments	(5,552)	(4)
Gain on sale of equity method investment	(2,974)	-
Gain on disposal of assets	(2,870)	-
Bargain purchase gain	(30,010)	-
Changes in operating assets and liabilities, net of business combinations:		
Patient accounts receivable	(147,130)	(68,660)
Due to/from government payers, net	(14,063)	(9,942)
Other receivables, prepaid expenses and other current assets	(76,754)	(20,946)
Hospital fee program receivable	(16,170)	(10,754)
Inventories	(2,489)	(2,095)
Hospital fee program liability and deferred revenue	(16,716)	3,662
Income taxes payable/receivable, net	67,523	(39,841)
Deposits and other assets	19,593	(8,293)
Accrued medical claims and other healthcare costs payable	2,980	(769)
Accounts payable and other accrued liabilities	83,713	47,215
Pension obligation	(7,174)	(100,000)
Net cash and cash equivalents used in operating activities from discontinued operations	(623)	(583)
Net cash and cash equivalents provided by (used in) operating activities	50,239	(115,122)
Investing activities		
Purchases of property, improvements and equipment	(56,807)	(38,642)
Purchases of long-term investments	(991)	-
Proceeds from sale of equity method investment	4,334	-
Cash paid for acquisitions, net of cash received and working capital adjustments	(18,373)	(72,259)
Cash in escrow for acquisitions	-	(22,854)
Change in restricted cash for acquisitions	(21,562)	-
Proceeds from sale of property and improvements	7,840	-
Change in note receivable (net)	-	42
Increase in restricted investments	(10,786)	(3,302)
Net cash and cash equivalents used in investing activities from discontinued operations	5,884	(150)
Net cash and cash equivalents used in investing activities	(90,461)	(137,165)

Prospect Medical Holdings, Inc.

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

For the Years Ended September 30,		2017		2016
Financing activities				
Borrowings on Senior Secured Notes, net of original issue discount		-		615,625
Repayments on Senior Secured Notes		(6,250)		(1,563)
Repayment of Retired Senior Secured Notes		-		(425,000)
Borrowings on line of credit, net		59,515		55,000
Promissory note		3,500		-
Repayments on retired line of credit, net		-		(20,000)
Proceeds of other long-term debt		1,413		-
Repayments of long-term debt		(1,179)		(1,634)
Proceeds from financing leases, net		9,646		17,072
Repayment of financing leases		(683)		-
Repayments of capital leases		(12,313)		(4,350)
Proceeds from exercise of stock options		3		121
Cash paid for deferred financing costs		(2,990)		(12,251)
Change in restricted cash		(3,082)		(1,532)
Repayments of insurance premium financing		(9,836)		(5,513)
Net cash and cash equivalents provided by financing activities		37,744		215,975
Decrease in cash and cash equivalents		(2,478)		(36,312)
Cash and cash equivalents, beginning of year		29,587		65,899
Cash and cash equivalents, end of year, continuing operations	$	27,109	$	29,587
Supplemental disclosure of cash flow information				
Interest paid (including cash paid on debt extinguishment)	$	52,593	$	54,688
Income taxes paid, net	$	13,739	$	12,255
Schedule of non-cash investing and financing activities				
Equipment acquired under capital leases	$	12,959	$	11,575
Insurance premium financed	$	9,836	$	5,513
Partial satisfaction of long-term liability assumed from acquisition of PCC	$	1,537	$	418

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.

Hospital Services Segment

As of September 30, 2017, the Company owns 20 acute care and behavioral hospitals and multi-level elder care facilities in Southern California, Texas, Rhode Island, New Jersey, Pennsylvania and Connecticut with approximately 3,800 licensed beds, and a network of specialty and primary care clinics, through its subsidiaries. The Hospital Services segment subsidiaries are wholly-owned by Prospect, except for the facilities in Rhode Island, in which Prospect has an 85% interest in the subsidiary that owns such facilities. The Hospital Services segment has a captive insurance company based in the Cayman Islands, Connecticut Healthcare Insurance Company ("CHIC"), which provides hospital and physician professional and general liability coverage to the Company's hospitals and affiliated subsidiaries in Connecticut.

Admitting physicians are primarily practitioners in the local area. The hospitals have payment arrangements with Medicare, Medicaid 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 ("Capitation"). 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 California network consists of various physician organizations that are generally wholly-owned by Prospect Medical Group, Inc. ("PMG") and managed by the two medical management company subsidiaries that are wholly-owned by Prospect. PMG is owned by a nominee physician shareholder pursuant to an assignable option agreement, under which 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.

Most of the physician organizations have entered into Management Service Agreements ("MSA") with Prospect Medical Systems Inc., ("PMS"), and have agreed to pay a management fee to PMS, which is based in part on the costs to the management company and on a percentage of revenues. In return for payment of the management fee, PMS 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, PMS 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 fluctuates based on the profitability of each physician organization.

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

Prospect consolidates the revenues and expenses of all the physician organizations (except for one entity that is a 50/50 joint venture, which is accounted for under the equity method) from the respective dates of execution of the Management Agreements. All significant inter-entity balances have been eliminated in consolidation. In the case of the joint venture, 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 the joint venture for managing the other owners' share of the joint venture operations.

Prospect has also entered into management services 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. These management services agreements are terminable in accordance with the agreements.

The affiliated physician organizations provided medical services to a combined total of approximately 355,000 and 307,000 enrollees as of September 30, 2017 and 2016, respectively. The enrollees include approximately 159,000 and 109,000 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, 2017 and 2016, respectively. The total paid member months including managed enrollees, for the fiscal years ended September 30, 2017 and 2016 was approximately 3,991,000 and 3,600,500, respectively.

Global Risk Management Segment

The Global Risk Management segment has 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 Services and Medical Group segments.

Corporate Segment

The Corporate segment primarily 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 established a captive insurance company, Prospect Medical Holding Risk Retention Group, Inc. ("RRG") on June 20, 2016 in the state of Vermont. RRG was formed to provide primary insurance coverage for hospital and physician professional and general liability risks for the Company's subsidiary health care organizations. RRG is a wholly owned subsidiary of the Company with all intercompany balances and transactions being eliminated upon consolidation. The Company does not allocate interest expense related to acquisition debt or income taxes to the other reporting segments.

2. Significant Accounting Policies

Principles of Consolidations and 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 Inc. and Ivy Intermediate Holding Inc. The Company has a variable interest in various entities under the Medical Group segment 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 physician organizations under the Medical Group segment which allows the Company to direct the activities of such physician organizations that most significantly impact their economic performance, retain the right to receive expected residual returns and assume the obligation to absorb losses. Accordingly, the Company is considered to be the primary beneficiary and these entities are consolidated within the accompanying consolidated financial statements.

Operating results for acquisitions are consolidated with the Company's financial statements from their acquisition dates. All significant intercompany balances and transactions have been eliminated in consolidation. Non-controlling interests in less-than-wholly-owned consolidated subsidiaries of the Company are presented as a component of total equity to distinguish between the interests of the Company and the interests of the non-controlling owners.

The consolidation of these entities does not change any legal ownership, and does not change the assets or the liabilities and equity of the Parent Entity as a stand-alone entity. These entities had total revenues of approximately $356,533,000 and $352,657,000 and total net income of approximately $21,886,000 and $23,327,000 for the years ended September 30, 2017 and 2016, respectively.

The assets and liabilities of the variable interest entities are as follows (in thousands):

September 30,	2017	2016
Assets		
Total current assets	$ 151,729	$ 131,541
Total non-current assets	20,631	16,625
Total assets	$ 172,360	$ 148,166
Liabilities		
Total current liabilities	$ 52,548	$ 43,294
Total long-term liabilities	700	700
Total liabilities	$ 53,248	$ 43,994

Revenues

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

For the Years Ended September 30,	2017	2016
Net Hospital Services		
Inpatient	$ 1,423,273	$ 826,128
Outpatient	955,543	332,243
Capitation	110,330	94,232
Other	49,549	20,435
Total Hospital Services revenues	2,538,695	1,273,038
Less: Provision for bad debts	(91,203)	(41,427)
Total net Hospital Services revenues less provision for bad debts	2,447,492	1,231,611
Medical Group		
Capitation	369,185	335,542
Management fees	7,977	10,760
Other	13,958	23,428
Total Medical Group revenues	391,120	369,730
Global Risk Management		
Capitation	13,097	19,635
Other	7,655	-
Total Global Risk Management revenue	20,752	19,635
Other revenues	55,133	9,582
Total net revenues	$ 2,914,497	$ 1,630,558

The revenues of acquisitions have been included in the accompanying consolidated financial statements for the period from their respective acquisition dates. These revenues also exclude revenues from discontinued operations.

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, 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 and exclude revenues from discontinued operations (in thousands):

Years ended September 30,	2017	2016
Medicare	$ 848,221	$ 410,147
Medicaid	699,340	437,968
Managed Care	607,362	231,146
Self-Pay/Other	223,893	79,110
Capitation	110,330	94,232
Other	49,549	20,435
Total patient service revenue	$ 2,538,695	$ 1,273,038

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 persons with end-stage renal disease and certain other beneficiary categories, including eligible disabled person. Most inpatient hospital services rendered to Medicare program beneficiaries are paid on a fee-for-service basis at prospectively determined rates per discharge, according to a patient classification system based on clinical, diagnostic, and other factors. Most outpatient services also are paid on a fee-for-service basis generally using prospectively determined rates. The Company is also reimbursed, as appropriate, for Medicare disproportionate share hospital and bad debt payments at tentative rates, with final settlement determined after submission of the annual Medicare cost report and audit thereof by the Medicare Administrative Contractor. The Company also receives Medicare outlier payments on an ongoing basis during the year for cases that are unusually costly, and under certain circumstances these payments may be reconciled to more closely reflect the costs in excess of outlier thresholds after the submission and audit of the annual Medicare cost report. Normal estimation differences between filed settlements and amounts accrued are reflected in net patient service revenue.

The Company is reimbursed by Medicare for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare Administrative Contractor. The estimated amounts due to or from the program are reviewed and adjusted annually based on the status of such audits and any subsequent appeals. Differences between final settlements and amounts accrued in previous years are reported as adjustments to net patient service revenue in the year that examination is substantially completed.

Although services for most Medicare beneficiaries are paid by the Federal government on a fee-for-service basis, approximately one-third of Medicare beneficiaries are enrolled in a "Medicare Advantage" plan, which is a type of Medicare health plan offered by a health plan that contracts with Medicare to provide hospital and medical benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-For-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. For Medicare beneficiaries enrolled in a

CIIH16-000637

Medicare Advantage plan, most Medicare services are covered by the plan and are not paid for under fee-for-service Medicare. Certain Medicare Advantage plans make capitation payment using a "Risk Adjustment model," which compensates providers based on the health status (acuity) of each enrollee. Providers with higher acuity enrollees generally will receive more and those with healthier enrollees will receive less.

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 programs in each state in which it operates at prospectively determined rates for inpatient services and a mixture of fee schedules and cost reimbursement methodologies for outpatient services depending on the specific state regulations. Cost report settlements are recorded based upon as-filed cost reports (if required by the respective facility's state) and adjusted for tentative and final settlements, if any.

The various states in which the Company operates have additional programs in which certain of the Company's facilities participate in, related to medical facilities serving a disproportionate number of low-income patients. The following table shows the revenues generated by these programs during the years ended September 30, 2017 and 2016 (in thousands), which are reflected in Net Hospital Services revenues in the accompanying consolidated statements of operations:

For the years ended September 30,	2017	2016
California Medi-Cal Disproportional Share ("CA DSH") *(a)*	$ 21,460	$ 19,926
Texas Section 1115 Waiver - UCC Pool *(b)*	10,492	12,368
Texas Section 1115 Waiver - DSRIP Pool *(b)*	12,712	11,356
Rhode Island DSH and UPL *(c)*	24,402	20,496
New Jersey Health Care Subsidy Funds *(d)*	9,040	8,569
Pennsylvania State Programs *(e)*	30,719	24,257
Connecticut Medicaid DSH revenue *(f)*	14,301	-
	$ 123,126	$ 96,972

(a) Revenues are accrued based on the expected total annual awards. Differences between the estimated and the actual awards are recorded in the period they become known, and are subject to retrospective revision prior to finalization, which could lead to material retractions. The Company records retrospective retractions when they are estimable and probable. Retrospective additional revenues are recorded when the amounts are received.

(b) Under the Section 1115 Waiver that was recently extended by the Center for Medicare and Medicaid Services ("CMS") to September 30, 2022, payments to hospitals 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. The most recent Section 1115 Waiver extension provides for changes to both pools, including the future revision of the UCC disbursement methodology, to align the methodology with nationally applied federal policies, and a phase out of federal funding for DSRIP by the year 2022. For DSRIP, there will be level funding over the next two years.

(c) Rhode Island hospitals receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low income patients. 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 Company recorded $20,137,000 and $16,199,000 of expense during the years ended September 30, 2017 and 2016, respectively, as a result of the license fee.

(d) The New Jersey Health Care Reform Act of 1992 established Health Care Subsidy Funds to provide certain hospitals in New Jersey with funds necessary to provide charity care and other forms of uncompensated care.

(e) The Pennsylvania Act 49 of 2010 ("Act 49") imposes a statewide hospital assessment, Medicaid Modernization Assessment ("MMA"), on net inpatient revenue of Pennsylvania licensed acute for the periods July 1, 2010 through June 30, 2016. It has been extended through June 30, 2018 by Act 92 of 2015. The assessments have enabled the Commonwealth of Pennsylvania to maintain the updated inpatient payment system, make changes to existing disproportionate share/supplemental payments, and to create new payments where applicable. The Company has also recognized revenues from the Pennsylvania Community Access Fund ("CAF") for the year ended September 30, 2017 and the period from July 1, 2016 (inception) through September 30, 2016.

(f) Connecticut's Disproportionate Share Hospital ("DSH") and supplemental payments provide hospitals with additional reimbursement for treating a disproportionate share of low income patients.

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.

Laws and regulations governing the third-party payor arrangements are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Normal estimation differences between subsequent cash collections on patient accounts receivable and net patient accounts receivable estimated in the prior year are reported as adjustments to net patient service revenue in the current period (See Note 12).

The following is a summary of due from and due to governmental payers at September 30, 2017 and 2016 (in thousands):

September 30,	2017	2016
Due from government payers:		
Medicaid Disproportionate Share (DSH)	$ 20,414	$ 12,146
Medicare cost report settlements	7,707	5,686
Medicaid Section 1115 receivable	23,031	20,974
	$ 51,152	$ 38,806
Due to government payers:		
Medicare cost report settlements	$ 17,712	$ 21,238
Medicaid cost report settlements	6,042	1,764
	$ 23,754	$ 23,002

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.

California Hospital Fee Program

The Company recognizes revenues related to supplemental Medi-Cal payments under California provider fee programs. These programs are funded by quality assurance fees paid by participating hospitals and matching federal funds.

Based on formulas contained in the legislation as well as modeling done by the California Hospital Association, the Company recognized supplemental payments, included in net patient service revenue, and quality assurance fee expense, included in general and administrative expenses in the accompanying consolidated statements of operations and comprehensive income (loss) as follows (in thousands):

Years Ended September 30,	2017	2016
Hospital services revenues	$ 70,620	$ 91,929
General and administrative expenses	46,127	60,376
Net pre-tax impact	$ 24,493	$ 31,553

As of September 30, 2017 and 2016, the Company had a receivable related to the California Hospital Fee Program of $59,209,000 and $43,039,000, respectively, in the accompanying consolidated balance sheets. As of September 30, 2017 and 2016, the Company had a liability related to the California Hospital Fee Program of $1,968,000 and $18,684,000, respectively, in the accompanying consolidated balance sheets.

Legislation approved by the State of California in October 2013 created the framework for the hospital fee program to continue in perpetuity without requiring further legislation from the State. In November 2016, California voters approved Proposition 52, which made the hospital fee program permanent and prohibits lawmakers from diverting Medi-Cal funds to pay for anything other than their intended purpose. In December 2017, CMS approved the fee for service inpatient and outpatient payments and taxes for the period from January 1, 2017 to June 30, 2019 (see Note 15).

Charity Care

The Company provides charity care to patients who lack financial resources and are deemed to be medically indigent based on criteria established under the Company's charity care policy. This care is provided without charge or at amounts less than the Company's established rates. Because the Company does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The direct and indirect costs related to this care totaled approximately $10,653,000 and $2,645,000 for the years ended September 30, 2017 and 2016, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. In addition, the Company provides services to other medically indigent patients under various state Medicaid programs. Such programs pay amounts that are less than the cost of the services provided to the recipients. The Company has not changed its charity care or uninsured discount policies during the years ended September 30, 2017 or 2016.

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 was 28% and 26% at September 30, 2017 and September 30, 2016, respectively. The allowance for doubtful accounts was $141,775,000 and $91,723,000 as of September 30, 2017 and 2016, respectively.

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.

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 physician organizations 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 returned and recognized as a reduction in revenue, approximately $13,105,000 as a result of the final Hierarchical Condition Category ("HCC") reconciliation during the year ended September 30, 2017. The Company received and recorded as additional revenue, approximately $13,601,000 in positive capitation risk adjustments for the Medical Group segment during the year ended September 30, 2016.

HMO contracts also include provisions to share in the risk for hospitalization, whereby the physician organization 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, 2017 and 2016, Medical Group revenues included approximately $73,454,000 and $11,827,000, respectively, of additional revenues due to favorable settlements on prior year risk-sharing arrangements. At September 30, 2017 and 2016, contingent liabilities for carry-forward risk-pool deficits expected to be forgiven, or offset against future surpluses were approximately $30,543,000 and $7,953,000, 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, 2017 and 2016, the Company recognized $1,100,000 and $3,560,000, respectively, related to a shared savings incentive program with one health plan. Pay-for-performance revenues recorded during the years ended September 30, 2017 and 2016 were $2,682,000 and $6,263,000, 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, 2017 and 2016 were $7,977,000 and $10,760,000, 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 period. See Note 13 for changes in claims estimates during the years ended September 30, 2017 and 2016.

The Company has contractual reimbursement payment to providers and discretionary incentive payment to physicians. These payments are in large part predicated on the pay-for-performance, shared risk revenues, and favorable senior capitation risk adjustment payments received by the Company from the health plans. 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. During this period, the Company also finalizes the physician discretionary incentive. For the years ended September 30, 2017 and 2016, the Company recorded physician incentives expense totaling approximately $41,807,965 and $16,311,000, respectively. As of September 30, 2017 and 2016, physician incentive accruals of approximately $31,193,000 and $9,665,000, respectively, were included in accounts payable and other accrued liabilities in the accompanying consolidated financial statements.

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. There were no such premium deficiencies recorded at September 30, 2017 and 2016, respectively.

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 the Hospital Services 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. During the years ended September 30, 2017 and 2016, the Global Risk Management Segment recognized capitation risk adjustments of $3,234,000 and $2,108,000.

Global Risk Management Cost of Revenues

The cost of health care services consists primarily of the transfer of capitation revenue to the Hospital Services 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. There were no such premium deficiencies recorded at September 30, 2017 or 2016.

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 5 to 40 years, buildings are depreciated over 5 to 40 years, equipment is depreciated over 2 to 15 years and furniture and fixtures are depreciated over 2 to 20 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 12, 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

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.

The Company tests for goodwill impairment as of September 30 each year, at the reporting unit level, by comparing the reporting unit's carrying amount, including goodwill, to the fair value of the reporting unit. The fair value of the reporting units are estimated. 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 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. If the estimated fair value of the reporting unit is less than its carrying value, this indicates that goodwill may be impaired and a second step is performed to measure the amount of the impairment, if any. The Company recorded goodwill impairment related to the closure of a facility in Texas and classification as discontinued operations effective September 30, 2016 (see Note 5). The Company's impairment test related to goodwill during the years ended September 30, 2017 and 2016, resulted in no additional impairment charges.

Intangible Assets

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, 2017 and 2016.

Insurance Reserves

Medical Malpractice Liability Insurance

The individual physicians who contract with the physician organizations 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. The Company's hospitals have a consolidated policy for professional and general liability insurance with separate retentions for each entity. The Pennsylvania MCARE fund provides the $500,000 in excess of $500,000 RRG malpractice coverage for Crozer.

For the current fiscal year, the RRG provided primary malpractice insurance ($500,000 per occurrence and $2,500,000 in the aggregate) and general liability ($1,000,000 per occurrence and $2,000,000 in the aggregate). In addition, the RRG provided coverage for losses of $4,000,000 in excess of $1,000,000 for each hospital professional liability claim with no aggregate limit. The RRG also provides additional layers of excess coverage over $5,000,000 up to $20,000,000, which are 100% reinsured by third party insurance carriers through multiple layers. The excess coverage provided for general liability is over $10,000,000 up to $50,000,000, which is also 100% reinsured by third party carriers.

CHIC provides malpractice ($3,000,000 per occurrence and $9,000,000 in the aggregate) and general liability ($1,000,000 per occurrence and $3,000,000 in the aggregate) coverage for ECHN and Waterbury for the year ended September 30, 2017. CHIC also provided an excess healthcare professional liability and umbrella liability insurance policy on a claims-made basis covering healthcare professional liability, general care liability, automobile liability, employers' liability, helipad liability and non-owned aircraft liability. The limit provided was $30,000,000 for each loss event and in the annual aggregate excess of the primary coverage layers described above. This coverage was fully reinsured by third party carriers.

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, 2017 and 2016, the total gross claims liability, was $60,722,000 and $34,757,000 and reinsurance recoverable on unpaid losses were $9,059,000 and $4,107,000, respectively, included in other assets on the accompanying consolidated balance sheets, and were estimated using a discount factor of 4%.

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 Companies' entities located in California. The facilities in Texas have opted out of the Texas Workers' Compensation system as a non-subscriber, and provide their employees with benefits for occupational injury or disease through an ERISA plan, and have an Employer's Excess Indemnity policy with a $25,000 deductible with limits of $10,000,000 per occurrence and $25,000,000 aggregate. The facilities in Rhode Island were fully insured for workers' compensation claims with no deductible. East Orange was fully insured for workers' compensation claims with no deductible from March 1, 2016 through September 30, 2016. Crozer has a workers' compensation policy with a $500,000 deductible, with limits of $1,000,000 per occurrence and aggregate. At September 30, 2017 and 2016, included in accrued salaries, wages and benefits are accruals for uninsured claims and claims incurred but not reported of approximately $28,329,000 and $17,675,000 and reinsurance recoverable on unpaid losses were $7,246,000 and $5,829,000, respectively, included in other assets on the accompanying consolidated balance sheets. The amounts are estimated based upon an actuarial valuation of their claims experience, using a discount factor of 4%.

Reserve Methodology

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 the medical malpractice and workers' compensation 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.

Stock Options

Ivy Holdings has a stock option plan (the "Ivy Plan"), which is administered by the Compensation Committee of the Ivy Holdings Board. The 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 plan. These options granted under the Ivy Plan are exercisable into Ivy Holdings stock and vest based on a number of criteria.

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

The Company's certain cash are restricted for various purposes including research, regulatory requirements and letters of credit. In addition, as of September 30, 2017, approximately $22 million of internally restricted cash was held related to arbitration with the seller of Crozer. Such funds were disbursed to the seller in December 2017.

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 and are classified as a deduction from the carrying amount of the related debt.

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, 2017 and 2016, the Company incurred $960,000 and $225,000 of interest and penalties related to income taxes, respectively.

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, New Genesis Medical Associates, Inc., ("NGMA") and Nuestra Familia Medical Group Inc., ("Nuestra"), which file their own federal tax returns. The Company files separate state tax returns for California, Texas, Rhode Island, Pennsylvania, Connecticut, New Jersey and Florida. The Company's filed tax returns are generally subject to examination by the IRS and state tax boards for 3 to 4 years.

Sale-Leaseback Transactions

The Company evaluates sale-leaseback transactions by determining whether the transaction meets the qualifying criteria to be recognized as a sale-leaseback, including the transfer of risk and rewards of ownership as well as the absence of continuing involvement of the Company. When the qualifying criteria for a sale-leaseback transaction are not met, the Company accounts for the transaction as a financing, see Note 9.

Comprehensive Income (Loss)

Comprehensive income consists of net income and other gains and losses affecting stockholder's equity that, under generally accepted accounting principles, are excluded from net income (loss) attributable to the Company. For the Company, such items consist primarily of unrealized gains or losses on debt and equity securities as well as changes related to pension and other postretirement liabilities that are not recognized immediately in net periodic benefit costs (see Note 11).

Fair Value of Financial Instruments

Financial instruments consist primarily of cash and cash equivalents, restricted cash, restricted 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, 2017				
Certificates of deposit	$ 850	$ 850	$ -	$ -
Mutual funds	14,960	14,960	-	-
Total	$ 15,810	$ 15,810	$ -	$ -
As of September 30, 2016				
Certificates of deposit	$ 1,302	$ 1,302	$ -	$ -
Mutual funds	3,266	3,266	-	-
Total	$ 4,568	$ 4,568	$ -	$ -

The Company's investments are classified within Level 1 of the fair value hierarchy because they are valued using quoted market prices. The Company's defined benefit pension plan assets are also measured at fair value (see Note 11).

The Company's carrying amount of long-term debt approximated fair value as of September 30, 2017 and 2016, respectively.

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 intangible assets when there are indications of impairment.

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, 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 segment and from the Medicare and Medicaid 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.

For the years ended September 30, 2017 and 2016, the Hospital Services segment received a total of 61% and 66% of its net patient revenues from Medicare and Medicaid programs, respectively, and the Medical Group segment received a total of 64% and 65% for the years ended September 30, 2017 and 2016, respectively, of their capitation revenues from its five largest HMOs, as follows (in thousands):

Years Ended September 30,	2017	% of Total Revenue		2016	% of Total Revenue
Hospital Services:					
Government Payers:					
Medicare	$ 848,221	33%		$ 410,147	32%
Medicaid	699,340	28%		437,968	34%
Total	$ 1,547,561	61%		$ 848,115	66%
Medical Group:					
HMO A	$ 61,624	21%	HMO A	64,346	20%
HMO F	34,950	12%	HMO B	42,417	13%
HMO B	32,923	11%	HMO F	37,137	12%
HMO D	29,617	10%	HMO C	35,300	11%
HMO C	28,585	10%	HMO E	27,898	9%
Total	$ 187,699	64%		$ 207,098	65%

The Global Risk Management segment received all of their revenues from seven and four health plans during the years ended September 30, 2017 and 2016, respectively.

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 pension obligations and other postretirement benefit reserves, reserves for outcome of legislation and valuation allowances against deferred tax assets.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued ASU 2014-09, "Revenue from Contracts with Customers (Topic 606)" which defers the effective date of the revenue standard 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. October 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 2014-15, "Presentation of Financial Statements - Going Concern: Disclosures of Uncertainties about an Entity's Ability to Continue as a Going Concern (Subtopic 205-40)" 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 has early adopted this guidance and such adoption did not have a material impact on its consolidated financial statements.

In September 2015, the FASB issued ASU 2015-16, "Business Combinations (Topic 805): Simplifying the Accounting for Measurement-Period Adjustment". ASU 2015-16 requires that an acquirer recognize adjustments to provisional amounts that are identified during the measurement period in the reporting period in which the adjustment amounts are determined. Prior to the issuance of the standard, entities were required to retrospectively apply adjustments made to provisional amounts recognized in a business combination. The standard will be effective for fiscal years, and interim periods within those years, beginning after December 15, 2016. Early adoption is permitted, and the Company adopted this standard in the current fiscal year. The adoption of this guidance did not have a material impact on the Company's consolidated financial position, results of operations or cash flows.

In January 2016, the FASB issued ASU 2016-01, "Financial Instruments (Subtopic 825-10)". ASU 2016-01 requires all equity investments to be measured at fair value with changes in fair value recognized through net income (other than those accounted for under equity method of accounting or those that result in consolidation of the investee). ASU 2016-01 also requires an entity to present separately in other comprehensive income the portion of the total change in the fair value of a liability resulting from a change in the instrument-specific credit risk when the entity has elected to measure the liability at fair value in accordance with the fair value option for financial instruments. In addition, ASU 2016-01 eliminates the requirement to disclose the fair value of financial instruments measured at amortized cost for entities that are not public business entities. ASU 2016-01 is effective for annual and interim periods beginning after December 15, 2017. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)". The core principle of ASU 2016-02 is that a lessee should recognize the assets and liabilities that arise from leases, including operating leases. Under the new requirements, a lessee will recognize in the statement of financial position a liability to make lease payments (the lease liability) and the right-of-use asset representing the right to the underlying asset for the lease term. For leases with a term of 12 months or less, the lessee is permitted to make an accounting policy election by class of underlying asset not to recognize lease assets and lease liabilities. The recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee have not significantly changed from previous GAAP. The standard is effective for nonpublic entities for fiscal years beginning after December 15, 2019. Early application of the amendment is permitted. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

In March 2016, the FASB issued ASU 2016-07, "Investments - Equity Method and Joint Ventures (Topic 323)". ASC 2016-07 eliminates the requirement for an entity to retroactively adopt the equity method of accounting if an investment qualifies for use of the equity method as a result of an increase in the level of ownership or degree of influence. Rather, ASU 2016-07 requires that the equity method investor add the cost of acquiring the additional interest in the investee to the current basis of the investor's previously held interest and adopt the equity method of accounting as of the date the investment becomes qualified for equity method accounting on a prospective basis upon adoption. The standard is effective for fiscal years beginning after December 15, 2016, including interim periods within those fiscal years. Early application of the amendment is permitted. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

In March 2016, the FASB issued ASU 2016-09, "Compensation - Stock Compensation (Topic 718)". The updated standard simplifies several aspects of the accounting for employee share-based payment transactions, including the accounting for income taxes, forfeitures, and statutory tax withholding requirements, as well as classification in the statement of cash flows. ASU 2016-09 is effective for non-public business entities for annual reporting periods beginning after December 15, 2017, including interim periods within those annual reporting periods. Early adoption is permitted. The Company is currently evaluating the impact of its pending adoption of the new standard on its consolidated financial statements.

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230)". The updated standard addresses eight specific cash flow issues with the objective of reducing diversity in practice. ASU 2016-15 is effective for non-public business entities for annual reporting periods beginning after December 15, 2018, including interim periods within those annual reporting periods. Early adoption is permitted. The Company is assessing the impact of the adoption of ASU 2016-15 on its consolidated financial statements.

In January 2017, the FASB issued ASU 2017-01, "Business Combinations (Topic 805): Clarifying the Definition of a Business." These amendments clarify the definition of a business. The amendments affect all companies and other reporting organizations that must determine whether they have acquired or sold a business. The definition of a business affects many areas of accounting including acquisitions, disposals, goodwill, and consolidation. The amendments are intended to help companies and other organizations evaluate whether transactions should be accounted for as acquisitions (or disposals) of assets or businesses. This update is effective for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2018. Early adoption is permitted under certain circumstances. The amendments should be applied prospectively as of the beginning of the period of adoption. The Company is evaluating the effect that this update will have on its consolidated financial statements and related disclosures.

In January 2017, the FASB issued ASU 2017-04, "Intangibles-Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment)". The new guidance is effective for fiscal years beginning after December 15, 2019 and interim periods within those fiscal years, and should be applied on a prospective basis. Early adoption is permitted for interim or annual goodwill impairment tests performed on testing dates after January 1, 2017, and the Company will adopt this standard effective for the year ending September 30, 2018. The new guidance simplifies the current two-step goodwill impairment test by eliminating Step 2 of the test. The new guidance requires a one-step impairment test in which an entity compares the fair value of a reporting unit with its carrying amount and recognizes an impairment charge for the amount by which the carrying amount exceeds the reporting unit's fair value, if any. The Company is currently evaluating the impact of this guidance on its consolidated financial statements.

In March 2017, the FASB issued ASU 2017-07, "Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost. The ASU amends ASC Topic 715, Compensation — Retirement Benefits, to require employers that present a measure of operating income in their statements of income to include only the service cost component of net periodic pension costs and net periodic postretirement benefit cost in operating expenses. The ASU also stipulates that only the service cost component of net benefit cost is eligible for capitalization. This guidance is effective for fiscal years beginning after December 15, 2018. Early adoption is permitted as of the beginning of an annual period for which financial statements have not been issued or made available for issuance. Disclosures of the nature of and reason for the change in accounting principle are required in the first interim and annual periods of adoption. The Company is currently evaluating the provisions of ASU 2017-07 and its impact on the Company's consolidated financial position, results of operations and cash flows.

In May 2017, the FASB issued ASU 2017-09, "Modification Accounting for Share-Based Payment Arrangements (Topic 718)", which identifies and provides guidance on the types of changes to share-based payment awards that an entity would be required to apply modification accounting under ASU 2016-09, Stock Compensation (Topic 718). Specifically, an entity would not apply modification accounting if the fair value, vesting conditions and classification of the awards are the same immediately before and after the modification. ASU 2017-09 is effective for annual periods beginning after December 15, 2017 and will be applied prospectively to awards modified on or after the effective date. The Company is currently evaluating the provisions of ASU 2017-09 and its impact on the Company's consolidated financial position, results of operations and cash flows.

The remainder of this page intentionally left blank.

3. Property, Improvements and Equipment

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

September 30,	2017	2016
Property, improvements and equipment:		
Land and land improvements	$ 86,214	$ 58,881
Buildings and improvements	352,194	283,269
Leasehold improvements	26,641	21,482
Equipment	274,577	144,413
Furniture and fixtures	5,184	4,715
	744,810	512,760
Less: accumulated depreciation	(219,093)	(123,755)
	525,717	389,005
Construction in Progress	51,216	52,347
Property, improvements and equipment, net	$ 576,933	$ 441,352

At September 30, 2017 and 2016, the Company had assets under capitalized leases of approximately $33,013,000 and $33,118,000, respectively, and related accumulated depreciation of $22,960,000 and $21,766,000, respectively.

Depreciation expense was approximately $96,143,000 and $40,128,000 for the years ended September 30, 2017 and 2016, respectively.

4. Acquisitions

Hospitals

For the years ended September 30, 2017 and 2016, the Company entered into the following material acquisitions. All business combinations were consistent with the Company's strategic growth plan and were accounted for using the acquisition method of accounting. Operating results for each of the acquisitions have been included in the accompanying consolidated financial statements from the date of acquisition. Goodwill arising is primarily attributable to the synergies expected to arise after the acquisitions, and is expected to be deductible for tax purposes for entities that were asset acquisitions.

All assets acquired and liabilities assumed were at fair value with the exception of the defined benefit pension liabilities and other post retirement employee benefits, which allows for an exception to fair value accounting for business combinations in accordance with GAAP. The recognized tax bases (the amount that is attributable for tax purposes) of the assets and liabilities are compared to the financial reporting values of the acquired assets and assumed liabilities (book bases) to determine the appropriate temporary differences. The Company identified temporary differences related to assumed pension liabilities, due primarily to differences in tax law regarding when a liability is or is not assumed in an asset acquisition; this difference in the treatment of the pension liabilities resulted in the recording of deferred tax assets which are reflected in the acquisition accounting and noted in the tables below.

The Company incurred approximately $3.1 million and $7.0 million transaction costs during the years ended September 30, 2017 and 2016, respectively which are included in General and Administrative expenses in the accompanying consolidated statements of operations.

2017 acquisitions

On October 1, 2016, the Company acquired substantially all of the assets, and certain liabilities, of Eastern Connecticut Health Network, Inc. and certain of its subsidiaries (collectively, "ECHN") in exchange for cash consideration of $105 million (subject to certain adjustments). The acquired assets include a network of hospitals, outpatient service centers and providers and specialists serving eastern Connecticut. The acquired hospitals are The Manchester Memorial Hospital and The Rockville General Hospital.

On October 1, 2016, the Company acquired substantially all of the assets, and certain liabilities, of Greater Waterbury Health Network, Inc. and certain of its subsidiaries (collectively, "Waterbury") in exchange for cash consideration of $31.8 million (subject to certain adjustments). The acquired assets include Waterbury Hospital, an acute-care hospital with 357 licensed beds, and a network of outpatient centers and affiliated physicians. Waterbury Hospital provides a comprehensive range of inpatient, outpatient and ancillary services for residents of Waterbury, Connecticut, and its surrounding community.

The following table summarizes the assets acquired and liabilities assumed in connection with each of the acquisitions in 2017 (in thousands):

	ECHN	Waterbury
Cash and cash equivalents	$ 5,292	$ 3,010
Patient accounts receivable and other receivables	31,238	23,442
Prepaid expenses and other current assets	8,893	4,100
Property, improvements and equipment	100,002	46,298
Intangible assets	3,440	2,870
Other assets	24,071	6,108
Accounts payable and other current liabilities	(39,122)	(24,639)
Capital leases and long term debt	(15,307)	(3,646)
Other long-term liabilities	(15,286)	(7,354)
Deferred tax liabilities ("DTL")	(5,474)	(13,360)
Pension obligations	(66,902)	(11,850)
Noncontrolling interests	(421)	(2,504)
Bargain gains, net of DTL of $5,474 and $13,360, respectively	(8,722)	(21,288)
Consideration	$ 21,702	$ 1,187

In connection with the acquisitions of ECHN and Waterbury, the Company recorded bargain gains (net of deferred tax liabilities) of $30,010,000 which are included in gain on bargain purchase in the accompanying consolidated statements of operations. The bargain gains arose primarily because of the future capital commitment requirements associated with the acquisitions.

On May 1, 2017, the Company's wholly-owned subsidiary, Prospect Blackstone Valley Surgicare, LLC ("Prospect Blackstone"), completed an asset acquisition of a freestanding ambulatory surgery center located near the CharterCARE facilities in Rhode Island, in exchange for cash consideration of $1.5 million, of which $100,000 is subject to a one-year indemnification escrow hold-back.

2016 acquisitions

On March 1, 2016, the Company acquired substantially all of the assets and associated real estate of East Orange General Hospital ("East Orange"), located in East Orange, New Jersey in exchange for cash consideration of $22.7 million (subject to certain adjustments). The following table summarizes the assets acquired and liabilities assumed in connection with this acquisition (in thousands):

	East Orange (Final)
Patient accounts receivable and other receivables	$ 9,631
Prepaid expenses and other current assets	2,602
Property, improvements and equipment	38,851
Intangible assets	2,423
Other assets	20
Accounts payable and other current liabilities	(26,150)
Capital leases	(1,691)
Other long-term liabilities	(7,550)
Goodwill	4,572
Consideration	$ 22,708

During the year ended September 30, 2017 the purchase price allocation was finalized. This led to an increase in goodwill of approximately $1.0 million, a decrease in receivables of approximately $0.4 million and an increase in liabilities of approximately $0.6 million.

On July 1, 2016, the Company acquired certain assets and assumed certain liabilities of Crozer-Keystone Health System ("Crozer"), located in Delaware County, Pennsylvania and the surrounding areas in exchange for cash consideration of $56.4 million (subject to certain adjustments). During the year ended September 30, 2017, the purchase price allocation was finalized and in December 2017, the Company paid an additional $22 million as a working capital adjustment and added to the consideration paid. The table below gives effect to the finalization of the purchase price for Crozer.

The remainder of this page intentionally left blank.

The following table summarizes the assets acquired and liabilities assumed in connection with this acquisition (in thousands):

	(Preliminary)	(Final)
Patient accounts receivable and other receivables	$ 89,901	$ 75,361
Prepaid expenses and other current assets	57,147	57,147
Property, improvements and equipment	153,785	176,110
Deferred tax assets	40,746	86,566
Intangible assets	17,620	17,620
Other assets	1,272	1,272
Accounts payable and other current liabilities	(102,162)	(102,162)
Capital leases	(19,116)	(19,746)
Other long-term liabilities	(25,158)	(22,658)
Pension obligation	(330,331)	(330,331)
Goodwill	172,744	138,831
Consideration	$ 56,448	$ 78,010

Medical Groups

Effective December 1, 2015, NGMA entered into a Stock Purchase Agreement pursuant to which it simultaneously closed its acquisition of 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. The purchase price consisted of cash consideration less certain liabilities and adjustments as specified in the Stock Purchase Agreement. Included within the purchase price is $1,080,000 of future consideration which was paid during the year ended September 30, 2017. The Company elected to treat the stock acquisition as a taxable asset acquisition under Internal Revenue Code Section 338. Of the cash consideration of $5.4 million, $5.1 million was allocated to goodwill and the remainder to property, improvements and equipment and other assets.

5. Discontinued Operations

During the year ended September 30, 2016, the Company determined the operations of Prospect CharterCARE Elmhurst Extended Care LLC (dba Elmhurst Extended Care), Nix Community General Hospital LLC ("Nix CGH") and CA ACO, LLC ("CA ACO") would be discontinued. Elmhurst Extended Care and Nix CGH are reported in the Hospital Services segment and the CA ACO is reported in the Global Risk Management segment. During the year ended September 30, 2017, Elmhurst Extended Care was sold (effective December 22, 2016) and Nix CGH ceased operations (effective October 1, 2016). The Company closed and sold the Elmhurst Extended Care business for proceeds of $13,722,000. Effective April 1, 2017, the Company made a decision to no longer discontinue operations of CA ACO and its onward activities are classified as part of the continuing operations on the consolidated financial statements. The Company's decision to discontinue the operations of each of the entities was based on the Company's management's strategy in their respective markets and financial results.

Summarized financial information for discontinued operations is included below (in thousands):

September 30,	2017	2016
Cash	$ -	$ 910
Restricted cash	-	4,296
Patient accounts receivable, net of allowance for doubtful accounts and other receivables	-	3,039
Due from government payors	-	1,894
Other current assets	-	355
Total current assets	-	10,494
Property, plant and equipment, net	-	1,985
Other assets	-	399
Total assets of the disposal groups classified as held for sale in the consolidated balance sheets	$ -	$ 12,878
Accounts payable and other accrued liabilities	$ -	$ 2,630
Long-term liabilities	-	787
Total liabilities of the disposal groups classified as held for sale in the consolidated balance sheets	$ -	$ 3,417

For the Year Ended September 30,	2017	2016
Net Hospital Services revenues	$ 10,178	$ 22,520
Operating expenses	(6,941)	(28,009)
Depreciation and amortization	(80)	(276)
Loss on write-off of goodwill	-	(2,475)
Interest expense	(24)	(37)
Income (loss) on discontinued operations before income taxes	3,133	(8,277)
Gain from sale of discontinued operations	4,605	-
Income tax provision (benefit)	2,966	(3,373)
Income (loss) on discontinued operations	$ 4,772	$ (4,904)

The Company's consolidated financial statements and notes to consolidated financial statements have been retrospectively reclassified for discontinued operations as of and for the year ended September 30, 2016.

The remainder of this page intentionally left blank.

6. Goodwill and Intangible Assets

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

September 30,	2017	2016
Southern California Hospitals	$ 130,912	$ 130,912
Nix Health	3,138	3,138
CharterCARE	5,822	3,775
California Medical Groups	27,420	27,388
East Orange	4,572	3,531
Crozer	138,831	172,744
Total	$ 310,695	$ 341,488

The changes in the carrying amount of goodwill for the years ended September 30 are as follows (amounts in thousands):

September 30,	2017	2016
Balance, beginning of year	$ 341,488	$ 159,821
Acquisitions	2,047	181,667
Adjustments to prior year acquisitions	(32,840)	-
Balance, end of year	$ 310,695	$ 341,488

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

September 30,	Useful lives	2017	2016
HMO membership	14 years	$ 25,200	$ 25,200
Trade names, net of impairment	3 - 20 years	52,583	51,373
Physician guarantees	2 to 3 years	723	547
Customer relationships	7 years	350	350
Other	5 - 6 years	117	117
Gross carrying value		78,973	77,587
Accumulated amortization		(38,179)	(35,690)
Intangible assets, net		$ 40,794	$ 41,897

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, 2017 and 2016 was $8,205,000, and $6,978,000, respectively.

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

Years ending September 30,		
2018		
2019	$	7,389
2020		6,734
2021		5,564
2022		5,545
Thereafter		3,755
		11,807
	$	40,794

The weighted-average remaining useful life for the intangible assets was approximately 8 years as of September 30, 2017.

7. 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 Upland Medical Group, a Professional Medical Group and Pomona Valley Medical Group, Inc (collectively "ProMed Entities"), has ownership interests in physician medical groups that provide medical services to ProMed members, including Chaparral Medical Group, Inc., (in which the Company beneficially owns a 12.99% interest). For the years ended September 30, 2017 and 2016, the ProMed Entities paid these groups approximately $17,216,000 and $17,125,000, respectively. As of September 30, 2017 and 2016, the Company had accounts payable and other accrued liabilities due to these related parties of $473,000 and $392,000, 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, 2017 or 2016.

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. Under this agreement, the Company received refunds (net of payments) of $26,378,000 for the year ended September 30, 2017 and the Company made payments (net of refunds) of $7,460,000 for the year ended September 30, 2016.

8. Income Taxes

The components of the income tax (benefit) provision for continuing operations are as follows (in thousands):

For the years ended September 30,	2017	2016
Current:		
Federal	$ 42,836	$ (23,645)
State	8,057	(1,968)
	50,893	(25,613)
Deferred:		
Federal	(41,809)	18,897
State	(8,529)	1,966
	(50,338)	20,863
Total:		
Federal	1,026	(4,748)
State	(472)	(2)
	$ 554	$ (4,750)

The remainder of this page intentionally left blank.

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

September 30,	2017	2016
Deferred tax assets:		
Allowances for bad debts	$ 29,057	$ 21,294
Vacation accrual and other	10,530	9,693
Workers compensation	7,803	4,956
Accrued bonuses	13,829	3,783
Malpractice reserves	9,819	6,014
Deferred rent	335	125
Tax credits	2,458	2,002
Net operating losses	10,180	2,615
Partnership outside basis difference	10,548	6,310
Transaction Cost	6,576	4,519
Claims Payable	3,609	688
Accrued Insurance	920	-
Pension Deduction	145,824	-
Deferred Revenue	3,061	113
Other	531	116
Deferred tax assets	255,080	62,228
Valuation allowance	(15,859)	(742)
Net deferred tax assets	239,221	61,486
Deferred tax liabilities:		
Intangible assets	(14,572)	(5,998)
Fixed assets	(96,833)	(16,873)
OCI-Pension liability	(6,464)	(8,389)
State tax	(4,162)	(3,552)
Capital Lease	(8,917)	-
Prepaid Expense	(3,858)	(1,290)
Other	(92)	(90)
Deferred tax liabilities	(134,898)	(36,192)
Net deferred tax assets (liabilities)	$ 104,323	$ 25,294

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.

During fiscal 2016, 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. Additionally, the Company received a notice from the Internal Revenue Service in connection with the examination of fiscal year 2015 federal tax return.

Generally, the Company's tax years 2012 through 2015 are open for federal and state tax examination. As of September 30, 2017, 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 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,	2017	2016
Tax provision at statutory rate	35%	35 %
State taxes, net of federal benefit	(1)%	0 %
Non-controlling interest	-	(6)%
Bargain Purchase Gain	(34)%	-
Other	2%	(4)%
	2%	25 %

9. Long-Term Debt

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

September 30,	2017	2016
Senior secured notes (net of discount of $7,374 and $8,984)	$ 609,813	$ 614,454
Other debt *(1)*	38,321	17,151
Less: Deferred financing costs, net ("DFC")	(9,906)	(11,649)
Total Debt, net of discount, premium and DFC	638,228	619,956
Less: current maturities	(12,509)	(6,951)
Long-term debt, net of current maturities	$ 625,719	$ 613,005

(1) Other debt includes financing obligations related to sales-leaseback transactions. The financing obligations related to sales-leaseback transactions were $26,027,000 and $17,151,000 for years ended September 30, 2017 and 2016 respectively.

Senior Secured Notes

On June 30, 2016, the Company entered into a six-year $625 million senior secured term loan B (the "Term Loan"), the proceeds of which were used to repay $425 million for PMH's existing 8.375% senior secured notes due during 2019; to repay $60 million for borrowings under the Company's existing revolving credit facility (the "Replaced Revolver"); to fund acquisitions, including the acquisition of Crozer; and to finance transaction fees and expenses. The Term Loan bears interest at LIBOR (subject to a 1.0% floor) plus 6.0%, and the effective interest rate was 7.0% as of September 30, 2017. The Term Loan was issued with an original discount of 1.5%, or $9,375,000.

Additionally, the Company refinanced the Replaced Revolver with a new $100 million asset-based revolving credit facility ("ABL Facility" and together with the Term Loan, the "New Senior Secured Credit Facilities"). The Company has capitalized an additional $785,000 for deferred financing costs in connection with the amendment of ABL facility. Pursuant to amendments dated August 23, 2016, August 21, 2017 and October 6, 2017, the loan limit under the ABL facility was increased to $115 million,

$155 million and then $175 million. The ABL Facility bears interest at a variable base rate plus an applicable spread, contingent on the Company's ABL Facility availability, as defined in the ABL Facility credit agreement. The ABL Facility effective interest rate was 3.25% as of September 30, 2017 and 2016, respectively. The ABL Facility balance as of September 30, 2017 and 2016 was $115,300,000 and $55,000,000 respectively, net of deferred finance charges. As of September 30, 2017, the Company had used letters of credit of $9,800,000, which offset the Company's ability to borrow additional funds, and the ABL Facility had unused lender commitments of $29,900,000 as of September 30, 2017.

The maturity date for the ABL Facility is June 30, 2021, and the maturity date for the Term Loan is June 30, 2022. As of September 30, 2017, the Company was in compliance with the financial covenants of the New Senior Secured Credit Facilities.

The New Senior Secured Credit Facilities are guaranteed on a senior secured basis by all assets of the Company and its subsidiaries ("Guarantors") except Prospect Health Plan, Inc., AMVI/Prospect Medical Group, Nuestra Familia Medical Group, Inc., Prospect Medical Holding Risk Retention Group, Inc., CHIC and certain immaterial subsidiaries. The ABL Facility has a first priority security interest on the working capital assets of the Company and the Guarantors and a second priority security interest on their fixed assets. The Term Loan has a first priority security interest on fixed assets and a second priority security interest on working capital assets. The New Senior Secured Credit Facilities are effectively senior to all of the Company's existing and future indebtedness.

Capitalized deferred financing costs of $14,882,000 related to the New Senior Secured Credit Facilities are being amortized over the term of the related debt using the effective interest method.

Retired 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"). 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. 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.

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. In conjunction with the repayment of the PMH 2019 Notes, Additional 2019 Notes, and the PMH Senior Secured Credit facility, the Company recognized a loss on debt extinguishment of $26,561,000. The loss on debt extinguishment included $17,799,000 of bond redemption costs, $3,030,000 of unamortized debt discount and premium, and $5,732,000 of unamortized debt financing costs, which are included within loss on debt extinguishment in the accompanying consolidated statements of operations for the year ended September 30, 2016.

Demand Notes

The Company has a commitment from a bank for a $15 million equipment leasing facility to finance various equipment at the Company's hospital facilities. As of September 30, 2017 and 2016, draws under the facility 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. As of September 30, 2017, approximately $12.5 million had been drawn under the line.

Scheduled payments under the Company's current and long-term debt as of September 30, 2017 are as follows (in thousands):

Years ending September 30,		
2018	$	12,509
2019		9,020
2020		8,990
2021		8,528
2022		594,228
Thereafter		22,233
Total scheduled payments		655,508
Less: Senior Secured Notes discount, net		(7,374)
Less: Deferred financing costs, net		(9,906)
Total long-term debt	$	638,228

10. Stockholder's Equity

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 year ended September 30, 2015, the Compensation Committee of the Board of Directors of Ivy Holdings ("Compensation Committee") granted 37,814 options 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, and on June 30, 2015 the stockholders of Ivy Holdings also approved the First Amendment, pursuant to which the Compensation Committee of the Board of Directors of Ivy Holdings authorized the issuance of options exercisable for an additional 13,972 shares of common stock of Ivy Holdings ("New Options") to employees effective May 18, 2017, the Ivy Plan was further amended, pursuant to which the aggregate number of shares which may be issued upon exercise of options was increased by an additional 33,554 shares to 202,636 shares.

Following such amendments, the Compensation Committee granted 13,972 options, 635 options and 28,319 options, on June 30, 2015, November 4, 2016 and June 23 2017, respectively, to certain members of the Company's management, employees and an independent member of the board of directors of Ivy Holdings' subsidiary. 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, 2017 and 2016 no compensation cost has been recorded in the Company's consolidated financial statements for the years then ended.

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, 2017 and 2016 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 October 1, 2015	150,562	$ 91.42	$ 436.51	$ 88.2
Granted	-	-	–	–
Exercised	(4,063)	30.00	–	–
Canceled/Forfeited	(3,300)	104.37	–	–
Outstanding as of September 30, 2016	143,199	92.94	445.06	76.2
Granted	28,954	568.55	–	–
Exercised	(100)	70.00	–	–
Canceled/Forfeited	(4,214)	162.35	–	–
Outstanding as of September 30, 2017	167,839	$ 173.28	$ 664.72	$ 64.1

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, 2017, the aggregate intrinsic value of outstanding shares was approximately $111,600,000. As of September 30, 2017, there were 118,396 options that are exercisable at a weighted average exercise price of 64.94.

A summary of Ivy Holdings non-vested options and the changes during the fiscal years ended September 30, 2017 and 2016 is presented as follows for the Initial Options and New Options:

	Shares	Weighted Average Grant Date Fair Value
Ivy Holdings Stock Options:		
Nonvested at October 1, 2015	44,746	$ 94.22
Vested	(15,022)	89.03
Canceled/Forfeited	(3,300)	93.29
Nonvested at September 30, 2016	26,424	97.55
Granted	28,954	299.00
Vested	(16,940)	164.82
Canceled/Forfeited	(4,214)	195.21
Nonvested at September 30, 2017	34,224	$ 224.79

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 year ended September 30, 2017 was estimated with the following assumptions for Ivy Holdings (no options were granted during the year ended September 30, 2016):

For the year ended September 30,	2017
Weighted average fair value of option grants	$ 299.00
Estimated fair market value of the Company's common stock on the date of grant	$ 568.55
Weighted average expected life of the options	10 years
Risk-free interest rate	1.79%
Weighted average expected volatility	43.8%
Dividend yield	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, 2017 and 2016 was $1,118,000 and $1,119,000, respectively. At September 30, 2017, there were 34,224 unvested options, which could potentially vest over the next nine 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 $932,000. 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, 2017 and 2016.

11. Retirement Benefits

In conjunction with the acquisitions of Crozer on July 1, 2016 and ECHN and Waterbury on October 1, 2016, the Company became the sponsor of various employee non-contributory, defined benefit pension plans covering certain full-time employees of the respective facilities.

Upon acquisition, Crozer agreed to pay out of the purchase price $100 million into an escrow, which funds were subsequently used by the Company upon becoming the sponsor of the plan pursuant to IRS rules and regulations to fund in part the underfunded Plan liability then outstanding. Additionally, within five years after acquisition and subject to applicable filing and authorization by the applicable Government Entity, the Company shall adopt a plan amendment to terminate the plan effective within such five year period and shall liquidate, fully fund and satisfy, and pay all benefits owed to participants and beneficiaries of the plan by providing lump sum distributions to participants, purchasing annuities for participants who do not elect a lump sum distribution.

In connection with the acquisition the plan was frozen with all benefit accruals ceased as of July 1, 2016. With respect to each Represented Employee who is a member of the Laborers' International Union of North America, the Monthly Compensation (as defined), the Credited Service (as defined), the Eligibility Service (as defined) and the accrued benefit was frozen and determined as of July 1, 2016. No benefits accrue since that date. Additionally, the plan was amended to provide that for purposes of determining Vesting Service (as defined) for employees who were employed with the Company before

July 1, 2016, years of service shall include all periods of employment completed on and after July 1, 2016, subject to the Break in Service rules (as defined).

On September 3, 2016, the DB Plan was further amended to provide certain Qualifying Participants (as defined) the right to make a Special Benefit Election (as defined) during "2016 Lump Sum Option Window" period from October 15, 2016 through November 30, 2016 to receive or commence receiving his or her vested Accrued Benefit as of December 1, 2016 in accordance with procedures adopted by the Committee.

In conjunction with the acquisition the Company also became the sponsor and assumed CKHS postretirement benefit program (the "OPEB Plan") which is an unfunded medical care and life insurance benefit program, and a supplemental executive retirement plan (the "SERP Plan") which is an unfunded retirement plan that covers a group of current and former executives. These plans were frozen with all benefit accruals ceased as of July 1, 2016. No benefits will accrue since that date. With respect to each Represented Employee who is a member of the Laborers' International Union of North America, benefits will continue to accrue until a settlement of an ongoing union contract negotiation is reached.

ECHN has a defined benefit pension plan that covered substantially all of its employees. The benefits were based upon years of service and compensation for the five highest years during the employee's last 10 years of service. Effective December 31, 2013, ECHN froze the defined-benefit for all remaining participants. During September 2013, the Board passed a resolution to freeze all benefits related to the Defined benefit pension plan. On December 31, 2008, ECHN implemented a soft freeze on the defined benefit pension plan. All qualified employees were eligible to enter into the defined contribution plan, ECHN contributed 3% of eligible employees' salaries. This contribution was non-guaranteed for all employees, except certain union workers covered under a collective bargaining agreement.

ECHN also sponsors a postretirement benefit plan that provides health care benefits to those employees who retired. The criteria to receive this benefit is to be vested in the pension plan, attain age 55 or older and start collecting under the defined benefit plan described above once retired. The retiree must be enrolled into the medical plan on the date of retirement to be eligible for the continuation. Full-time registered nurse retirees from ECHN's Manchester facility (retired prior to October 1, 2005 and were eligible per the collective bargaining agreement) were grandfathered and required to pay at least 50% of the total cost of the medical and dental coverage they elect for themselves under the plan.

Waterbury has a noncontributory defined benefit cash balance plan. It is Waterbury's policy to make contributions to the plan sufficient to meet the minimum funding requirements of applicable laws and regulations. The plan was frozen to non-union participants effective June 30, 2015. Participants who are part of the Connecticut Healthcare Associates Technical Unit remain active in the plan. Non-union employees no longer accrue additional employer contribution credits in the plan. These participants will continue to receive interest credits based on their account balances in accordance with the terms of the plan. They will be entitled to their account balance (the retirement benefit they have earned up to June 30, 2015) plus applicable interest credits after the Plan were frozen.

The activity of the pension plans for the year ended September 30, 2017 and the period from July 1, 2016 (acquisition of Crozer) through September 30, 2016 are as follows (in thousands):

		2017		2016
Changes in benefit obligations				
Projected benefit obligations, beginning of period	$	953,983	$	687,612
Service cost		292		20
Interest cost		33,193		5,624
Plan participant contributions		367		-
Actuarial (gain) loss		(31,788)		(3,498)
Benefits paid		(91,045)		(5,995)
Plan changes		(709)		-
Projected benefit obligation, end of year	$	864,293	$	683,763
Changes in plan assets				
Fair value of plan assets, beginning of year	$	656,074	$	350,393
Actual return on plan assets		(15,980)		22,630
Contributions by plan sponsor		7,174		100,236
Plan participant contributions		367		-
Benefits paid		(91,045)		(5,995)
Fair value of plan assets, end of year	$	556,590	$	467,264
Funded status of the plan, end of year	$	(307,703)	$	(216,499)
Accumulated benefit obligation, end of year	$	(307,703)	$	(216,499)

The funded status of the pension plans as of September 30, 2017 and 2016 is as follows (in thousands), split between the pension plans and the post retirement plans:

	2017 Pensions	2017 OPEBs	2016 Pensions	2016 OPEBs
Amounts recognized in the consolidated balance sheets consist of:				
Current liability	$ -	$ 820	$ -	$ 1,050
Non-current liability	300,364	6,519	209,658	5,791
Amount recognized, end of year	$ 300,364	$ 7,339	$ 209,658	$ 6,841

The components of net periodic benefit cost for the year ended September 30, 2017 and the period from July 1, 2016 (Crozer acquisition) through September 30, 2016 were as follows (in thousands):

	2017	2016
Components of net periodic benefit cost:		
Service cost	$ 292	$ 20
Interest cost	33,193	5,624
Expected return on plan assets	(19,477)	(7,000)
Effect of settlement	(2,479)	-
Total net periodic benefit cost (credit)	$ 11,529	$ (1,356)
Other change in benefit obligations recognized in accumulated other comprehensive income:		
Liability (gain) loss due to assumption change	$ (23,922)	$ 2,116
Liability (gain) loss due to participant experience	(7,865)	(5,615)
Asset return (gain) loss	35,456	(15,630)
Prior service cost (credit)	(708)	-
Amount recognized due to settlement	2,479	-
Total recognized in other comprehensive loss (income) and accumulated other comprehensive loss (income)	$ 5,440	$ (19,129)

The assumptions used in determining the actuarial present value of the projected benefit obligations for pension plans as of September 30, 2017 and 2016 and for the year ended September 30, 2017 and the period from July 1, 2016 (Crozer acquisition) through September 30,2016 are as follows:

	2017	2016
Weighted average assumptions used to determine benefit obligations at end of period		
Discount rate	3.23-3.68 %	3.27-3.68 %
Rate of compensation increase	0.00-2.00 %	0.00-2.00 %
Weighted average assumptions used to determine net periodic benefit cost for the period ended		
Discount rate	3.18-4.01 %	3.38 %
Rate of compensation increase	0.00-2.00 %	0.00 %
Expected return on the plan assets	0.00-5.00 %	0.00-6.5%

Assumed health care cost trend rates for the next period used to measure the expected cost of benefits covered by the plan are as follows:

	2017	2016
Health care trend rate assumed for next year	7.0%	7.0%
Rate to which the cost trend is assumed to decline (the ultimate rate)	4.5%	4.5%
Year that the rate reaches the ultimate trend rate	2025	2025

Assumed health care cost trend rates have a significant effect on amounts reported for other postretirement benefit programs. A one-percentage-point change in assumed health care cost trends would have the following effects (in thousands):

	1% Increase	1% Decrease
Effect on other postretirement benefit obligations	$ 7,512	$ 7,181
Effect on total of service and interest cost components	$ 251	$ 237

The asset allocation percentage by major asset class for the plans and the target allocation for 2017 follows:

	Target	2017
Asset class:		
Cash and cash equivalents	0% - 20%	-
Fixed income	10% - 100%	95.3 %
Domestic equity	0% - 100%	-
International equity	0% - 40%	-
Real estate	0% - 30%	4.2 %
Alternative investments and hedge funds	0% - 30%	-
Annuity Contact		0.5 %
		100 %

The investment objectives of the plans are to invest consistently with the fiduciary standards of ERISA, to provide for the funding and anticipated withdrawals on an ongoing basis, conserve and enhance the capital value of the plans in real terms while maintaining a moderate risk profile, to minimize principal fluctuations over the investment cycle, and achieve a long-term level of return commensurate with contemporary economic conditions. The expected long-term rate of return with respect to the plans is based on an aggregate of expected capital market returns within each asset category.

The remainder of this page intentionally left blank.

The following tables set forth the assets in the plans measured at fair value, by input level (in thousands):

September 30, 2017	Level 1	Level 2	Level 3	Net asset value	Total
Fixed income securities:					
Short-Term Duration	$ -	$ 37,637	$ -	$ -	$ 37,637
Extended Duration	-	163,537	-	-	163,537
Interim Duration	-	53,703	-	-	53,703
Long-Term Duration	-	277,720	-	-	277,720
Real estate	-	-	5,098	-	5,098
Alternative investments	-	-	16,035	-	16,035
Hedge funds	-	-	-	-	-
Cash and cash equivalents	-	-	-	2,860	2,860
Total	$ -	$ 532,597	$ 21,133	$ 2,860	$ 556,590

September 30, 2016	Level 1	Level 2	Level 3	Total
Fixed income securities:				
Short-Term Duration	$ -	$ 7,533	$ -	$ 7,533
Extended Duration	-	135,880	-	135,880
Interim Duration	-	31,614	-	31,614
Long-Term Duration	-	229,541	-	229,541
Collective trust funds:				
Real estate	-	-	8,898	8,898
Alternative investments	-	-	31,203	31,203
Hedge funds	-	-	22,295	22,295
Cash and cash equivalents	300	-	-	300
Total	$ 300	$ 404,568	$ 62,696	$ 467,264

Pension plan assets classified as Level 3 in the fair value hierarchy represent investments in which the trustee has used significant unobservable inputs in the valuation model. The hedge funds consist of equity/long/short funds and multi-strategy funds in which fair values have been estimated using the net asset value per share of the investment. The alternative investments primarily consist of investments in limited partnerships that invest in the Public-Private Investment Program which fair values have been estimated using the net asset value per share of the investment.

On an annual basis, the Company assesses the valuation hierarchy for pension assets recorded at fair value. From time to time, assets will be transferred within the fair value hierarchy as a result of changes in, among other things, inputs used, liquidity, or valuation methodologies. During the fiscal year 2017 and the period from July 1, 2016 (Crozer acquisition) through September 30, 2016, there were no transfers in classification within the fair value hierarchy.

The following table is a rollforward of the plans' assets classified within Level 3 of the fair value hierarchy (in thousands):

September 30,	2017	2016
Balance, beginning of year	$ 62,396	$ 69,528 *(1)*
Actual return on plan assets:		
Realized gain (loss)	(445)	282
Unrealized gain (loss)	2,283	1,366
Purchases	5,734	-
Sales	(48,835)	(8,780)
Balance, end of year	$ 21,133	$ 62,396

(1) Start of period is July 1, 2016, the date of acquisition of Crozer.

The expected long-term future benefit payments to retirees with respect to the plans and are as follows (in thousands):

2018	$ 55,960
2019	54,920
2020	54,400
2021	53,390
2022	53,820
2023 - 2027	259,270
	$ 531,760

Waterbury participates in multi-employer pension plans that cover substantially all union employees. Contributions to the plans are based upon a percentage of each participant's total salary. The risks of participating in these multi-employer plans are different from single employer plans in the following aspects:

- Assets contributed to the multi-employer plan by one employer may be used to provide benefits to employees of another participating employer.
- If a participating employer stops contributing to the plan, the unfunded obligation of the plan may be borne by the remaining participating employers.
- If Waterbury chose to stop participating in the multi-employer plans, Waterbury may be required to pay those plans an amount based on the underfunded status of the plans, referred to as a withdrawal liability.

The following table presents Waterbury's participation in these plans as of and for the year ended September 30, 2017.

Pension Trust Fund	Pension Plan Employer Identification Number	Pension Protection Act ("PPA") Certified Zone Status (1)	FIP / RP Status Pending Implemented (2)	Contributions	Surcharge Imposed	Expiration Date of Collective Bargaining Agreement (3)
Connecticut Health Care Associates Pension Fund	06-1313462	Green	NA	$ 2,018,000	No	9/30/17
New England Health Care Employees Pension Fund	22-3071963	Green	NA	$ 939,000	No	2/28/17
Total contributions				$ 2,957,000		

(1) The most recent PPA zone status available in 2017 is for the plan's year-ending during 2016. The zone status is based on information received from the plan and is certified by the plan's actuary. Among other factors, plans in the red zone are generally less than 65 percent funded, plans in the orange zone are less than 80 percent funded and have an accumulated funding deficiency in the current year or projected in the next six years, plans in the yellow zone are less than 80 percent funded, and plans in the green zone are at least 80 percent funded.
(2) The "FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan ("FIP") or a rehabilitation plan ("RP") is either pending or has been implemented.
(3) These agreements are under negotiations.

During the year ended September 30, 2017, Waterbury's contributions to the Connecticut Health Care Associates Pension Plan and the New England Health Care Employees Pension Plan represented 98.3% and 2.38% of the total contributions made to the plans by all participating employers, respectively.

Governmental regulations impose certain requirements relative to union-sponsored pension plans. In the event of plan termination or employer withdrawal, an employer may be liable for a portion of the plan's unfunded vested benefits. As of September 30, 2017, Waterbury has not recorded any liabilities for future withdrawal obligations related to the multi-employer plans.

Defined contribution plans

The Company also sponsors four 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 certain facilities in Texas, Rhode Island, Pennsylvania, for which the expense for the employer match was $18,088,000 and $3,417,000 for the years ended September 30, 2017 and 2016, respectively.

12. 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 2030. 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 of $2,133,000) required under leases in effect at September 30, 2017, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2018	$ 13,897	$ 26,450
2019	11,963	22,119
2020	5,982	20,064
2021	3,095	17,439
2022	3,324	14,973
Thereafter	26,820	57,587
Total minimum lease payments	65,081	$ 158,632
Less: amounts representing interest	(16,154)	
	48,927	
Less: current portion	(11,315)	
	$ 37,612	

Rent expense for the years ended September 30, 2017 and 2016 was approximately $49,965,000 and $22,481,000, respectively. Sublease rental income was not material to the consolidated financial statements for the years ended September 30, 2017 and 2016.

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.

Seismic Standards

The Company's California Hospitals (with the exception of Bellflower, which currently only provides psychiatric services) are required to comply with laws that regulate the seismic performance of all aspects of hospital facilities in California and 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. These laws and 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 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 Southern California Hospitals at Culver City ("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. In addition, such modifications to the hospital facilities could potentially result in environmental remediation liabilities which may be material to the Company.

The Office of Statewide Health Planning and Development ("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 Southern California Hospital at Hollywood ("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. 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.

SCH Culver City and Los Angeles Community Hospital both applied for the extension from OSHPD. Two of the multi-story buildings owned by SCH Culver City were granted extensions until January 1, 2019 or July 1, 2019. An additional single-story building is classified as SPC-2. Los Angeles Community Hospital received an extension until January 1, 2019. Also, SCH Hollywood received an extension until January 1, 2030 and is currently classified as SPC-2.

The Company is in the process of pursuing Non-Structural Performance Category ("NPC") 2 classification and SB 499 Item 2 extensions of the compliance deadlines that would result for Foothill.

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") has made significant changes to the United States health care system. The legislation impacted multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Under this legislation, 32 states have expanded their Medicaid programs to cover previously uninsured childless adults. In addition, many uninsured individuals have had the opportunity to purchase health insurance via state-based marketplaces, state-based marketplaces using a federal platform, state-partnership marketplaces or the federally-facilitated marketplace. PPACA also implemented a number of health insurance market reforms, such as allowing children to remain an their parents' health insurance until age 26 or prohibiting certain plans from denying coverage based on pre-existing conditions. Nationally, these reforms have reduced number of uninsured.

In light of the transition to a new presidential administration, it is unclear what changes may be made to PPACA. The Tax Cuts and Jobs Act ("TCJA"), passed in December 2017, eliminates the individual mandate under PPACA, effective January 1, 2019. The individual mandate was included in PPACA to address concerns that other market reforms expanding access to coverage might produce adverse selection and higher premiums. The extent to which the repeal of the individual mandate will impact the uninsured rate and 2019 premiums is unclear at this juncture. Future changes to PPACA and in other federal and state legislation could have a material impact on the operations of the Company. The Company is continuing to monitor the legislative environment for risks and uncertainties.

Collective Bargaining Agreements

As of September 30, 2017, the Company had approximately 22,000 employees, of whom approximately 5,300 employees or 24% are represented by various labor organizations. Of those, approximately 1,700 employees or 8% of the Company's employees are employed under union contracts that have expired or will expire before September 30, 2018.

Tangible Net Equity ("TNE") Requirement

The Company's affiliated physician organizations and Prospect Health Plan, Inc. ("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"). TNE is defined as net assets, less intangibles and amounts due from affiliates, plus subordinated obligations. As of September 30, 2017, the Company's affiliated physician organizations and PHP were in compliance with these regulatory requirements.

Employee Health Plans

The Company offers self-insured EPO/HMO and PPO plans to 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 $750,000 for Crozer, $160,000 for East Orange, $275,000 for CharterCARE, $225,000 for ECHN, $350,000 for Waterbury, $250,000 for all other hospitals and $175,000 for the Medical Group and Corporate segments. An actuarially and internally-estimated liability of approximately $10,985,000 and $4,157,000 for incurred but not reported claims has been included in accrued salaries, wages, and benefits as of September 30, 2017 and 2016, 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.

The remainder of this page intentionally left blank.

13. 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, 2017 and 2016 (in thousands):

September 30,	2017	2016
IBNR as of beginning of year	$ 52,761	$ 53,531
Claim expenses incurred during the year:		
Related to current year	246,409	226,431
Related to prior year	2,899	2,715
Total incurred	249,308	229,146
Claims paid during the year:		
Related to current year	(205,735)	(179,457)
Related to prior year	(40,849)	(50,459)
Total paid	(246,584)	(229,916)
IBNR as of end of year	$ 55,485	$ 52,761

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,	2017	2016
Capitation expense	$ 94,141	$ 100,673
Fee-for-service claims expense	137,860	142,674
Other physician compensation	45,173	20,436
Other cost of revenues	7,861	1,941
Total cost of revenues	$ 285,035	$ 265,724

14. Joint Ventures and Unconsolidated Equity Investments

The Company has invested in several joint ventures with unrelated third parties, which are accounted for under the equity method of accounting. As of September 30, 2017, Roger Williams Medical Center owned 20% of Roger Williams Radiation Therapy and 20% of Southern New England Regional Cancer Center, LLC. ECHN owned 50% of Northeast Regional Radiation Oncology Network, Inc., 50% of Aetna Ambulance Service, Inc., 50% of Ambulance Service of Manchester, LLC, and 50% of Evergreen Endoscopy Center, LLC. Waterbury owned 50% of Harold Leever Regional Cancer Center Inc. These joint ventures under the equity method are included in the other assets in the accompanying consolidated balance sheets as of September 30, 2017 and 2016 are $17,371,000 and $4,281,000, respectively. For the years ended September 30, 2017 and 2016, the Company received $1,636,000 and $1,081,000 respectively in distributions.

Summarized combined unaudited financial information for the Company's joint ventures as of September 30, 2017 and 2016 for the years then ended is as follows (in thousands):

September 30,	2017	2016
Cash	$ 15,750	$ 2,567
Receivables	7,304	1,265
Other current assets	1,613	271
Total current assets	24,667	4,103
Property, improvements and equipment, net	29,979	6,495
Goodwill	7,142	7,142
Intangible assets	882	912
Other long-term assets	2,905	1,641
Total assets	$ 65,575	$ 20,293
Accounts payable and accrued liabilities	$ 4,894	$ 1,251
Other long-term liabilities	1,781	378
Equity	58,900	18,664
Total liabilities and partner's capital	$ 65,575	$ 20,293

Years ended September 30,	2017	2016
Revenues	$ 62,397	$ 15,007
Net income	$ 6,219	$ 1,927
PMH's income from equity method investments	$ 2,145	$ 448

15. Subsequent Event (Unaudited)

The Company has evaluated subsequent events through December 30, 2017, the date the Company's consolidated financial statements were available for issuance.

In December 2017, New University Medical Group LLC ("New UMG") entered into a Second Closing to acquire the remaining assets of University Medical Group ("UMG") that were not acquired in the initial acquisition in December 2014. As consideration for the acquisition, New UMG has assumed certain designated liabilities of the practice. As part of the transaction, New UMG has assigned all assets acquired from UMG to New UMG's parent company, Prospect CharterCARE Physicians, LLC, dba CharterCARE Medical Associates ("CCMA"). CCMA entered into a Post Closing Administrative Services Agreement pursuant to which CCMA and its affiliates provide services to the seller of the practice in connection with its termination of all operations and the wind up its affairs and operations.

In December 2017, CMS approved the fee for service inpatient and outpatient payments and taxes for the period from January 1, 2017 to June 30, 2019 for the California Hospital Fee Program. The managed care piece of the program has not yet been approved.

Prospect CharterCARE, LLC

Consolidated Financial Statements
As of and for the Years Ended
September 30, 2017 and 2016

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.

BDO

Prospect CharterCARE, LLC

Consolidated Financial Statements

As of and for the Years Ended September 30, 2017 and 2016

Prospect CharterCARE, LLC

Contents

	Page
Independent Auditor's Report	3
Consolidated Financial Statements	
Consolidated Balance Sheets	4 - 5
Consolidated Statements of Operations	6
Consolidated Statements of Members' Equity	7
Consolidated Statements of Cash Flows	8
Notes to Consolidated Financial Statements	9 - 29

BDO

Tel: 714-957-3200
Fax: 714-957-1080
www.bdo.com

600 Anton Blvd., Suite 500
Costa Mesa, CA 92626

Independent Auditor's Report

Board of Directors
Prospect CharterCARE, LLC
Los Angeles, California

We have audited the accompanying consolidated financial statements of Prospect CharterCARE, LLC, which comprise the consolidated balance sheets as of September 30, 2017 and 2016, and the related consolidated statements of operations, members' equity, 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 audit 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 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 CharterCARE, LLC and its subsidiaries as of September 30, 2017 and 2016, 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.

Emphasis of Matter

As discussed in Note 1, the Company is financially dependent on its parent company which has agreed to provide the financial support necessary for the operations of the Company. The accompanying financial statements do not reflect any adjustments or disclosures that would be required should the parent company discontinue its financial support.

BDO USA, LLP

February 28, 2018

Prospect CharterCARE, LLC

Consolidated Balance Sheets
(in thousands)

As of September 30,		2017		2016
Assets				
Current assets				
Cash and cash equivalents	$	-	$	4,091
Restricted cash		3,028		2,198
Patient accounts receivable, less allowance for doubtful accounts of $7,245 and $8,587		42,427		38,511
Other receivables		12,295		8,883
Due from government payers		5,143		785
Inventories		5,805		6,196
Prepaid expenses and other current assets		3,286		3,372
Current assets held for sale		-		3,887
Total current assets		71,984		67,923
Property, improvements and equipment, net		53,850		55,592
Goodwill		5,822		3,774
Intangible assets, net		2,854		4,499
Equity method investments		4,357		4,611
Other assets		1,473		1,205
Total assets	$	140,340	$	137,604

See accompanying notes to consolidated financial statements.

Prospect CharterCARE, LLC

Consolidated Balance Sheets
(in thousands)

As of September 30,		2017		2016
Liabilities and Members' Equity				
Current liabilities				
Accounts payable and other accrued liabilities	$	26,881	$	26,297
Accrued salaries, wages and benefits		16,589		14,849
Deferred revenue		170		-
Due to government payers		4,505		125
Due to affiliated companies, net		20,056		28,006
Current portion of capital leases		1,475		1,439
Current liabilities held for sale		-		7,205
Total current liabilities		69,676		77,921
Capital leases, net of current portion		895		2,012
Asset retirement obligations		2,438		4,943
Deferred revenue, net of current portion		2,891		-
Other long-term liabilities		10,673		5,451
Total liabilities		86,573		90,327
Commitments, contingencies, and subsequent events				
Members' equity:				
Member contributions		82,261		71,645
Accumulated deficit		(28,494)		(24,368)
Total members' equity		53,767		47,277
Total liabilities and members' equity	$	140,340	$	137,604

See accompanying notes to consolidated financial statements.

Prospect CharterCARE, LLC

Consolidated Statements of Operations
(in thousands)

For the Years Ended September 30,	2017	2016
Revenues:		
Net patient service revenues	$ 343,050	$ 338,440
Provision for bad debts	(11,936)	(15,264)
Net patient service revenues less provision for bad debts	331,114	323,176
Other revenues	7,678	6,357
Total net revenues	338,792	329,533
Operating Expenses:		
Salaries, wages and benefits	186,382	189,529
Supplies	60,005	59,152
Taxes and licenses	25,581	20,459
Purchased services	21,542	19,629
Depreciation and amortization	13,843	12,376
Professional fees	10,535	11,774
Other	7,277	9,750
Insurance	5,659	8,141
Management fees	7,033	6,888
Utilities	3,993	4,506
Lease and rental	4,792	3,615
Research grant expense	2,231	2,424
Repairs and maintenance	2,315	1,624
Registry	713	788
Total operating expenses	351,901	350,655
Operating income from unconsolidated equity method investments	605	512
Operating loss	(12,504)	(20,610)
Interest expense	1,131	82
Other expense (income), net	(98)	-
Net loss from continuing operations	(13,537)	(20,692)
Income (loss) from discontinued operations	9,411	(2,280)
Net loss	$ (4,126)	$ (22,972)

See accompanying notes to consolidated financial statements.

Prospect CharterCARE, LLC

Consolidated Statements of Members' Equity
(in thousands)

	Member Contributions	Accumulated Deficit	Total Members' Equity
Balance at October 1, 2015	$ 68,856	$ (1,396)	$ 67,460
Member contributions	2,789	-	2,789
Net loss	-	(22,972)	(22,972)
Balance at September 30, 2016	71,645	(24,368)	47,277
Member contributions	10,616	-	10,616
Net loss	-	(4,126)	(4,126)
Balance at September 30, 2017	$ 82,261	$ (28,494)	$ 53,767

See accompanying notes to consolidated financial statements.

Prospect CharterCARE, LLC

Consolidated Statements of Cash Flows
(in thousands)

For the Years Ended September 30,	2017	2016
Operating activities		
Net loss	$ (4,126)	$ (22,972)
Adjustments to reconcile net loss to net cash used in operating activities:		
Depreciation and amortization	13,843	12,376
Provision for bad debts	11,936	15,264
Accretion of interest for asset retirement obligations	158	360
Operating income from equity method investments, net of distributions	254	(64)
Gain on sale of property, improvements and equipment	(2,891)	-
Write-off of asset retirement obligation	(272)	-
Changes in operating assets and liabilities, net of business combinations:		
Change in restricted cash	(830)	(921)
Patient accounts receivable and other receivables	(15,852)	(19,580)
Due to/from government payers, net	22	(136)
Inventories	765	(57)
Prepaid expenses and other current assets	(3,324)	(1,204)
Other assets	(268)	522
Accounts payable and other accrued liabilities	8,401	8,576
Net cash and cash equivalents (used in) provided by operating activities from discontinued operations	(10,967)	573
Net cash used in operating activities	(3,151)	(7,263)
Investing activities		
Purchases of property, improvements and equipment	(13,507)	(10,324)
Cash paid for acquisitions	(2,268)	(374)
Proceeds from sale of property, improvements and equipment	6,498	-
Net cash and cash equivalents provided by (used in) investing activities from discontinued operations	5,882	(146)
Net cash used in investing activities	(3,394)	(10,844)
Financing activities		
Member contributions	10,616	2,789
(Decrease) increase in due to affiliated companies, net	(7,950)	3,892
Repayments of capital leases	(2,036)	(796)
Proceeds from financing hospital facility	1,824	-
Net cash and cash equivalents provided by financing activities from discontinued operations	-	3,025
Net cash provided by financing activities	2,454	8,910
Decrease in cash and cash equivalents	(4,091)	(9,197)
Cash and cash equivalents, beginning of year	4,091	13,288
Cash and cash equivalents, end of year	$ -	$ 4,091
Supplemental disclosure of cash flow information:		
Interest paid	$ 975	$ 82
Schedule of non-cash investing and financing activities:		
Equipment acquired under capital lease	$ 366	$ 3,252

See accompanying notes to consolidated financial statements.

1. Organization

Prospect CharterCARE, LLC ("PCC" or the "Company") was formed on August 21, 2013 and is owned 85% by a wholly-owned subsidiary of Prospect Medical Holdings, Inc. ("Prospect") and 15% by CharterCARE Community Board.

PCC's operating subsidiaries include Prospect CharterCARE RWMC, LLC ("RWMC", dba Roger Williams Medical Center), Prospect CharterCARE SJHSRI, LLC ("SJHSRI", dba St. Joseph Health Center and Our Lady of Fatima Hospital), Prospect CharterCARE Elmhurst, LLC ("Elmhurst Extended Care"), Prospect CharterCARE Physicians, LLC ("CharterCARE Physicians"), Prospect CharterCARE Ancillary Services, Inc., and New University Medical Group, LLC ("New UMG"), which collectively consist of hospitals, medical centers and a skilled nursing facility located in Rhode Island with 785 licensed beds. The Company provides a comprehensive range of services at Roger Williams Medical Center, St. Joseph's Health Center, and Our Lady of Fatima Hospital 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 and other third party payers, including commercial insurance carriers, health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs").

The Company is dependent on Prospect to fund ongoing operations. As of September 30, 2017 and 2016, the Company had a liability of $20,056,000 and $28,006,000, respectively, due to Prospect and its subsidiaries, which is payable on demand, does not bear interest, and is included in due to affiliated companies, net in the accompanying consolidated balance sheets. Prospect does not intend to have the Company repay the liability in a manner which would impair the Company's ability to maintain sufficient liquidity to sustain ongoing operations.

2. Acquisitions

On May 1, 2017, the Company's wholly-owned subsidiary, Prospect Blackstone Valley Surgicare, LLC ("Prospect Blackstone"), completed an asset acquisition of a freestanding ambulatory surgery center located near the CharterCARE facilities in Rhode Island, in exchange for cash consideration of $1.6 million, of which $100,000 is subject to a one-year indemnification escrow hold-back.

During the year ended September 30, 2017, CharterCARE Physicians entered into asset purchase agreements to acquire two medical practices with primary care physicians. Total cash consideration for the medical practices was $1.1 million.

During the year ended September 30, 2016, CharterCARE Physicians entered into asset purchase agreements to acquire two medical practices with primary care physicians as well as a practice specializing in surgical services. Total cash consideration for the medical practices was $374,000.

The acquisitions of the medical practices were accounted for as business combinations using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values. As asset purchases, goodwill acquired is expected to be deductible for tax purposes.

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

For the Years Ended September 30,		2017		2016
Inventories	$	374	$	11
Improvements and equipment		813		21
Goodwill		2,048		342
Capital leases		(588)		-
Remaining purchase consideration due to seller		(379)		-
Net cash consideration	$	2,268	$	374

3. Discontinued Operations

During December 2016, the Company sold assets related to Elmhurst Extended Care. The Company's decision to discontinue the operations of each of the entities was based on the Company's management's strategy in their respective markets and financial results. Elmhurst Extended Care's assets and liabilities are classified as held for sale as of September 30, 2016 in the accompanying consolidated balance sheets, and the results of Elmhurst Extended Care's operations are included within loss from discontinued operations in the accompanying consolidated statements of operations.

Summarized financial information for discontinued operations is included below (in thousands):

September 30,		2017		2016
Carrying amounts of major classes of assets included as part of discontinued operations				
Cash	$	-	$	(129)
Restricted cash		-		22
Patient accounts receivable, net of allowance for doubtful accounts		-		2,555
Other current assets		-		301
Total current assets		-		2,749
Property, plant and equipment, net		-		739
Long-term assets		-		399
Total assets of the disposal groups classified as held for sale in the consolidated balance sheets	$	-	$	3,887
Carrying amounts of major classes of liabilities included as part of discontinued operations				
Accounts payable and other accrued liabilities	$	-	$	1,103
Due to affiliated companies, net		-		5,315
Long-term liabilities		-		787
Total liabilities of the disposal groups classified as held for sale in the consolidated balance sheets	$	-	$	7,205

CIIH16-000693

For the Years Ended September 30,	2017	2016
Major line items constituting pretax loss of discontinued operations		
Net revenues	$ 4,324	$ 19,590
Operating expenses	5,403	21,870
Loss on discontinued operation	(1,079)	(2,280)
Gain from sale of discontinued operations	10,490	-
Income (loss) on discontinued operations	$ 9,411	$ (2,280)

4. Significant Accounting Policies

Principles of Consolidation and 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 wholly-owned subsidiaries, but do not include the accounts of the parent companies, Prospect or CharterCARE Community Board.

Operating results for the Company's subsidiaries are consolidated with the Company's financial statements from their acquisition dates. All significant intercompany balances and transactions have been eliminated in consolidation.

Revenues

Net Patient Service Revenues

Operating revenue consists primarily of net patient service revenues. The Company reports net patient service revenues 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, 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 doubtful accounts and exclude revenues for discontinued operations (in thousands):

For the Years Ended September 30,	2017	2016
Medicare	$ 152,240	$ 151,015
Medicaid	72,948	74,216
Managed Care	74,920	82,109
Self-Pay/Other	42,942	31,100
Total	$ 343,050	$ 338,440

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 persons with end-stage renal disease and certain other beneficiary categories, including eligible disabled person. Most inpatient hospital services rendered to Medicare program beneficiaries are paid on a fee-for-service basis at prospectively determined rates per discharge, according to a patient classification system based on clinical, diagnostic, and other factors. Most outpatient services also are paid on a fee-for-service basis generally using prospectively determined rates. The Company is also reimbursed, as appropriate, for Medicare disproportionate share hospital and bad debt payments at tentative rates, with final settlement determined after submission of the annual Medicare cost report and audit thereof by the Medicare Administrative Contractor. The Company also receives Medicare outlier payments on an ongoing basis during the year for cases that are unusually costly, and under certain circumstances these payments may be reconciled to more closely reflect the costs in excess of outlier thresholds after the submission and audit of the annual Medicare cost report. Normal estimation differences between filed settlements and amounts accrued are reflected in net patient service revenue.

The Company is reimbursed by Medicare for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare Administrative Contractor. The estimated amounts due to or from the program are reviewed and adjusted annually based on the status of such audits and any subsequent appeals. Differences between final settlements and amounts accrued in previous years are reported as adjustments to net patient service revenue in the year that examination is substantially completed.

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 2014, which are used in determining disproportionate share payments, were issued on July 19, 2016. To date, the Company has not received any final NPRs since inception on June 20, 2014.

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. Similar to Medicare, cost report settlements are recorded based upon as-filed cost reports and adjusted for tentative and final settlements, if any.

RWMC and SJHSRI are participants in the State of Rhode Island's Disproportionate Share Hospital ("DSH") program, which assists hospitals that provide a disproportionate amount of uncompensated care. Under the program, Rhode Island hospitals, including RWMC and SJHSRI, receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low income patients. RWMC and SJHSRI recognized revenue related to DSH and Upper Payment Limit ("UPL") reimbursement of $24,402,000 and $20,496,000 for the years ended September 30, 2017 and 2016, respectively. DSH and UPL payments received were $20,249,451 and $20,496,000 for the years ended September 30, 2017 and 2016, 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. RWMC and SJHSRI recorded license fee expenses of $20,137,000 and $16,199,000 for the years ended September 30, 2017 and 2016, respectively, which is included within taxes and licenses expense within the accompanying consolidated statements of operations.

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.

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.

Laws and regulations governing the third-party payor arrangements are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Normal estimation differences between subsequent cash collections on patient accounts receivable and net patient accounts receivable estimated in the prior year are reported as adjustments to net patient service revenue in the current period.

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 who lack financial resources and are deemed to be medically indigent based on criteria established under the Company's charity care policy. This care is provided without charge or at amounts less than the Company's established rates. Because the Company does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The direct and indirect costs related to this care totaled approximately $833,000 and $1,225,000 for the years ended September 30, 2017 and 2016, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. In addition, the Company provides services to other medically indigent patients under various state Medicaid programs. Such programs pay amounts that are less than the cost of the services provided to the recipients. The Company has not changed its charity care or uninsured discount policies during the years ended September 30, 2017 or 2016.

Provisions for Contractual Allowances and Doubtful Accounts

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 was 15% and 18% of gross accounts receivable as of September 30, 2017 and 2016, respectively. The decrease was due to a self-pay discount which took effect during the year ended September 30, 2017, resulting in a decrease in the bad debt allowance required as of September 30, 2017.

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.

Other Revenues

Other revenues totaled $7,678,000 and $6,357,000 for the years ended September 30, 2017 and 2016, respectively. A summary of the principal components of other revenues is as follows:

Tuition Revenue: Tuition revenues include student fees and outside course reimbursement and are recognized ratably during the approximately seven months of instruction provided per year. The Company recorded tuition revenues of $2,002,000 and $1,727,000 for the years ended September 30, 2017 and 2016, respectively.

Grant Revenue: The Company receives grant revenue for direct research from the federal government, other institutions and other sources for a range of research areas including oncology, cardiology, HIV and diabetes. The Company recorded grant revenue of $1,841,000 and $1,479,000 for the years ended September 30, 2017 and 2016, respectively.

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. The Company recorded rental revenues of $704,000 and $670,000 for the years ended September 30, 2017 and 2016, respectively.

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. Building improvements are generally depreciated over seven years, buildings are depreciated over 10 years, equipment is depreciated over three to seven years and furniture and fixtures are depreciated over five 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.

Goodwill

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 consists of one reporting unit.

The Company tests for goodwill impairment as of September 30 each year, at the reporting unit level, by comparing the reporting unit's carrying amount, including goodwill, to the fair value of the reporting unit. The fair value of the reporting units are estimated. 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 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. If the estimated fair value of the reporting unit is less than its carrying value, this indicates that goodwill may be impaired and a second step is performed to measure the amount of the impairment, if any. There were no impairments recorded for the years ended September 30, 2017 or 2016.

Intangible Assets

Intangible assets include trade names. 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, 2017 and 2016.

Insurance Reserves

Medical Malpractice Liability Insurance

The Company carries professional and general liability insurance to cover medical malpractice claims. The General Liability coverage is occurrence coverage and the Professional Liability coverage is claims-made coverage. Under the Professional Liability coverage, insurance premiums cover only those claims actually reported during the policy term. Should the Professional Liability 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. CharterCARE was included in Prospect's consolidated medical malpractice insurance policy effective June 20, 2014 (inception). Assets and liabilities related to malpractice insurance related to events prior to June 20, 2014 (inception) were not assumed by the Company.

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 recognizes 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. The Company's gross claims liability was $7,591,000 and $5,083,000 as of September 30, 2017 and 2016, respectively, and insurance receivables were $1,316,000 and $806,000 as of September 30, 2017 and 2016, respectively. The gross claims liability and insurance receivables were estimated using a discount factor of 4% and are included within long-term assets and long-term liabilities, respectively, in the accompanying consolidated balance sheets.

Workers' Compensation Insurance

The Company was fully insured for workers' compensation claims with no deductible during the years ended September 30, 2017 and 2016. Assets and liabilities related to workers' compensation insurance related to events prior to June 20, 2014 (inception) were not assumed by the Company.

Reserve Methodology

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.

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 statements of operations. The Company has accrued $2,438,000 and $4,943,000 related to asbestos remediation as of September 30, 2017 and 2016, respectively. The liability was estimated using a discount factor which ranged from 7% - 9%.

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

The Company held restricted cash of $3,028,000 and $2,198,000 as of September 30, 2017 and 2016, respectively, which was restricted for research at the Company's hospitals as well as for School of Nursing grants.

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.

Income Taxes

For tax reporting purposes, the Company is treated as a Partnership. PCC and its wholly-owned subsidiaries are pass-through entities. Therefore, no provision is made in the accompanying consolidated financial statements for liabilities for federal, state or local income taxes since such liabilities are the responsibility of the Company's parent companies. The Company periodically evaluates its tax positions, including its status as a pass-through entity, to evaluate whether it is more likely than not that such positions would be sustained upon examination by a tax authority for all open tax years, as defined by the statute of limitations, based on its technical merits.

As of September 30, 2017, the Company has not established a liability for uncertain tax positions. The Company files income tax returns in the U.S. federal jurisdiction and the state of Rhode Island. Generally, the Company is subject to examination by U.S. federal (or state and local) income tax authorities for three to four years from the filing of a tax return.

Fair Value of Financial Instruments

Financial instruments consist primarily of cash and cash equivalents, restricted cash, patient and other accounts receivables, accounts payable and accrued expenses, accrued salaries and benefits, amounts due from/to government payers, capital lease obligations, 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.

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 and Medicaid. The Company received revenues from Medicare and Medicaid as follows (excluding revenues for discontinued operations, in thousands):

	For the Year Ended September 30, 2017	% of Net Patient Service Revenues	For the Year Ended September 30, 2016	% of Net Patient Service Revenues
Medicare	$ 152,240	44 %	$ 151,015	45%
Medicaid	72,948	21 %	74,216	22%
Total	$ 225,188	65 %	$ 225,231	67%

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 amounts due from/to government payers, allowances for contractual discounts and doubtful accounts, professional and general liability claims, long-lived assets, intangible assets and asset retirement obligations.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued ASU 2014-09, "Revenue from Contracts with Customers (Topic 606)" which defers the effective date of the revenue standard 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. October 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 understa8nd 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 2014-15, "Presentation of Financial Statements - Going Concern: Disclosures of Uncertainties about an Entity's Ability to Continue as a Going Concern (Subtopic 205-40)" 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 has early adopted this guidance and such adoption did not have a material impact on its consolidated financial statements.

In September 2015, the FASB issued ASU 2015-16, "Business Combinations (Topic 805): Simplifying the Accounting for Measurement-Period Adjustment". ASU 2015-16 requires that an acquirer recognize adjustments to provisional amounts that are identified during the measurement period in the reporting period in which the adjustment amounts are determined. Prior to the issuance of the standard, entities were required to retrospectively apply adjustments made to provisional amounts recognized in a business combination. The standard will be effective for fiscal years, and interim periods within those years, beginning after December 15, 2016. Early adoption is permitted, and the Company adopted this standard in the current fiscal year. The adoption of this guidance did not have a material impact on the Company's consolidated financial position, results of operations or cash flows.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)". The core principle of ASU 2016-02 is that a lessee should recognize the assets and liabilities that arise from leases, including operating leases. Under the new requirements, a lessee will recognize in the statement of financial position a liability to make lease payments (the lease liability) and the right-of-use asset representing the right to the underlying asset for the lease term. For leases with a term of 12 months or less, the lessee is permitted to make an accounting policy election by class of underlying asset not to recognize lease assets and lease liabilities. The recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee have not significantly changed from previous GAAP. The standard is effective for nonpublic entities for fiscal years beginning after December 15, 2019. Early application of the amendment is permitted. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230)". The updated standard addresses eight specific cash flow issues with the objective of reducing diversity in practice. ASU 2016-15 is effective for non-public business entities for annual reporting periods beginning after December 15, 2018, including interim periods within those annual reporting periods. Early adoption is permitted. The Company is assessing the impact of the adoption of ASU 2016-15 on its consolidated financial statements.

In January 2017, the FASB issued ASU 2017-01, "Business Combinations (Topic 805): Clarifying the Definition of a Business." These amendments clarify the definition of a business. The amendments affect all companies and other reporting organizations that must determine whether they have acquired or sold a business. The definition of a business affects many areas of accounting including acquisitions, disposals, goodwill, and consolidation. The amendments are intended to help companies and other organizations evaluate whether transactions should be accounted for as acquisitions (or disposals) of assets or businesses. This update is effective for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2018. Early adoption is permitted under certain circumstances. The amendments should be applied prospectively as of the beginning of the period of adoption. The Company is evaluating the effect that this update will have on its consolidated financial statements and related disclosures.

In January 2017, the FASB issued ASU 2017-04, "Intangibles-Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment)". The new guidance is effective for fiscal years beginning after December 15, 2019 and interim periods within those fiscal years, and should be applied on a prospective basis. Early adoption is permitted for interim or annual goodwill impairment tests performed on testing dates after January 1, 2017, and the Company will adopt this standard effective for the year ending September 30, 2018. The new guidance simplifies the current two-step goodwill impairment test by eliminating Step 2 of the test. The new guidance requires a one-step impairment test in which an entity compares the fair value of a reporting unit with its carrying amount and recognizes an impairment charge for the amount by which the carrying amount exceeds the reporting unit's fair value, if any. The Company is currently evaluating the impact of this guidance on its consolidated financial statements.

5. Property, Improvements and Equipment

Property, improvements and equipment, excluding assets held for sale, consisted of the following (in thousands):

September 30,	2017	2016
Property, improvements and equipment:		
Land and land improvements	$ 7,468	$ 7,868
Buildings and improvements	35,598	32,313
Leasehold improvements	3,394	3,280
Equipment	35,541	27,412
	82,001	70,837
Less: accumulated depreciation	(32,035)	(21,865)
	49,966	48,972
Construction in Progress	3,884	6,620
Property, improvements and equipment, net	$ 53,850	$ 55,592

At September 30, 2017 and 2016, the Company had assets under capitalized leases of approximately $4,697,000 and $4,095,000, respectively, and related accumulated depreciation of $1,792,000 and $610,000, respectively.

Depreciation expense, excluding discontinued operations, was $12,200,000 and $10,730,000 for the years ended September 30, 2017 and 2016, respectively.

6. Goodwill and Intangible Assets

Goodwill and intangible assets relate to the Prospect CharterCARE and CharterCARE Physicians medical practices acquisitions. The following is a roll-forward of goodwill from October 1, 2015 to September 30, 2017 (in thousands):

	Amount
Balance, October 1, 2015	$ 3,432
Acquisitions	342
Balance, September 30, 2016	3,774
Acquisitions	2,048
Balance, September 30, 2017	$ 5,822

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

	Amortization Period	September 30, 2017	September 30, 2016
Trade names	5 years	$ 8,130	$ 8,130
Other	5 years	97	97
Total acquisition cost of intangible assets		8,227	8,227
Less accumulated amortization		(5,373)	(3,728)
Intangible assets, net		$ 2,854	$ 4,449

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives. Amortization expense was $1,643,000 and $1,646,000 for the years ended September 30, 2017 and 2016, respectively.

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

Years ended September 30,	
2018	$ 1,642
2019	1,192
2020	19
Total	$ 2,854

The weighted-average remaining useful life for the intangible assets was approximately 2 years as of September 30, 2017.

7. Members' Equity

In accordance with the Amended & Restated Limited Liability Company Agreement of PCC ("LLC Agreement"), the profit or loss of PCC is to be allocated to the members based on their Adjusted Capital Contribution, as defined in the LLC Agreement. As a result of the acquisition of PCC as of June 20, 2014 (inception), the Company recorded a bargain gain of $3,975,000, which was allocated only to Prospect's capital account as the purchaser. The Company's earnings, with the exception of the bargain gain, have been allocated 85% to Prospect and 15% to CharterCARE Community Board, consistent with their ownership percentages.

The remainder of this page intentionally left blank.

Total member contributions were $10,616,000 and $2,789,000 for the years ended September 30, 2017 and 2016, respectively. In accordance with the LLC Agreement, the contributions were accounted for as additional member contributions and allocated 85% to Prospect and 15% to CharterCARE Community Board, consistent with their ownership percentages. The following is a summary of the members' capital accounts (in thousands):

	Prospect	CharterCARE Community Board	Total
Balance at October 1, 2015	$ 57,341	$ 10,119	$ 67,460
Member contributions	2,370	419	2,789
Net loss	(19,526)	(3,446)	(22,972)
Balance at September 30, 2016	40,185	7,092	47,277
Member contributions	9,024	1,592	10,616
Net loss	(3,507)	(619)	(4,126)
Balance at September 30, 2017	$ 55,494	$ 9,413	$ 53,767

8. Related Party Transactions

The Company and Prospect East Hospital Advisory Services, LLC ("PEHAS"), a wholly-owned subsidiary of Prospect, entered into a Management Services Agreement ("MSA") as of June 20, 2014, under which PEHAS provides certain administrative and management services to PCC and its Subsidiaries. Management fees due to PEHAS under the MSA consist of 2% of net revenues monthly. The Company recognized management fees of $7,033,000 and $6,888,000 for the years ended September 30, 2017 and 2016, respectively, which is included within management fees expense in the accompanying consolidated statements of operations. As of September 30, 2017 and 2016, the Company does not have a liability related to the MSA due PEHAS.

9. 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 September 2020. Capital leases bear interest at rates ranging from 3.0% to 8.0% per annum.

The future minimum annual lease payments (net of anticipated sublease income) required under leases in effect at September 30, 2017, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2018	$ 1,561	$ 760
2019	824	419
2020	49	415
2021	44	359
2022	-	344
Total minimum lease payments	2,478	$ 2,297
Less: amounts representing interest	(108)	
	2,370	
Less: current portion	(1,475)	
	$ 895	

Lease and rental expense was $4,792,000 and $3,615,000 for the years ended September 30, 2017 and 2016, respectively.

Contingent Liability for Borrowings by Prospect

PCC and its Subsidiaries are contingently liable as a guarantor among others for amounts borrowed by Prospect on senior secured borrowings and credit facilities as of September 30, 2017 and 2016. The obligations and related interest expense related to these credit facilities are not reflected in the Company's consolidated financial statements as of September 30, 2017 and 2016, as the borrowings are reflected in the separate consolidated financial statements of Prospect.

Total borrowings outstanding as of September 30, 2017 and 2016, reflected in the consolidated financial statements of Prospect, but for which the Company is contingently liable as a guarantor, were (in thousands):

September 30,	2017	2016
Senior secured notes (net of discount of $7,374 and $8,984)	$ 609,813	$ 614,454
Less: deferred financing costs, net	(9,906)	(11,649)
	$ 599,907	$ 602,805

On June 30, 2016, Prospect entered into a six-year $625 million senior secured term loan B (the "Term Loan"), the proceeds of which were used to repay $425 million for Holdings' existing 8.375% senior secured notes due during 2019; to repay $60 million for borrowings under Holdings' existing revolving credit facility (the "Replaced Revolver"); to fund acquisitions; and to finance transaction fees and expenses. The Term Loan bears interest at LIBOR (subject to a 1.0% floor) plus 6.0%, and the effective interest rate was 7.00% as of September 30, 2017. The Term Loan was issued with an original discount of 1.5%, or $9,375,000.

Additionally, Prospect refinanced the Replaced Revolver with a new $100 million asset-based revolving credit facility ("ABL Facility" and together with the Term Loan, the "New Senior Secured Credit Facilities"). The ABL facility was amended in August 2016 to $115 million, August 2017 to $155 million and October 2017 to $175 million. The ABL Facility bears interest at a variable base rate plus an applicable spread, contingent on Prospect's ABL Facility availability, as defined in the ABL Facility credit agreement. The ABL Facility effective interest rate was 3.25% as of September 30, 2017. The ABL Facility balance as of September 30, 2017 was $115,300,000. As of September 30, 2017, Prospect had unused letters of credit of $9,800,000, which offset Prospect's ability to borrow additional funds, and the ABL Facility had unused lender commitments of $29,900,000 as of September 30, 2017. The maturity date for the ABL facility is June 30, 2021, and the maturity date for the Term Loan is June 30, 2022. As of September 30, 2017, Prospect was in compliance with the financial covenants of the New Senior Secured Credit Facilities. Subsequent to year end, Prospect refinanced the Term Loan and amended the ABL Facility, see Note 12.

Letter of Credit

As of September 30, 2017, Prospect secured an irrevocable letter of credit for $584,000 on behalf of SJHSRI for its School of Nursing ("School") as required by the U.S. Department of Education. The purpose of the letter of credit is to (i) pay refunds of charges owed on behalf of current or former students, whether or not the School remains open; (ii) to provide for the "teach-out" of currently enrolled students if the School closes; and (iii) to pay any liabilities owed to the U.S. Department of Education.

Other Commitments

The Company has additional commitments for reagents that are based on tests performed. They are non-cancelable agreements but the future dollar commitments are not quantifiable as they are volume-driven.

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.

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") has made significant changes to the United States health care system. The legislation impacted multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Under this legislation, 32 states have expanded their Medicaid programs to cover previously uninsured childless adults. In addition, many uninsured individuals have had the opportunity to purchase health insurance via state-based marketplaces, state-based marketplaces using a federal platform, state-partnership marketplaces or the federally-facilitated marketplace. PPACA also implemented a number of health insurance market reforms, such as allowing children to remain an their parents' health insurance until age 26 or prohibiting certain plans from denying coverage based on pre-existing conditions. Nationally, these reforms have reduced number of uninsured.

In light of the transition to a new presidential administration, it is unclear what changes may be made to PPACA. The Tax Cuts and Jobs Act ("TCJA"), passed in December 2017, eliminates the individual mandate under PPACA, effective January 1, 2019. The individual mandate was included in PPACA to address concerns that other market reforms expanding access to coverage might produce adverse selection and higher premiums. The extent to which the repeal of the individual mandate will impact the uninsured rate and 2019 premiums is unclear at this juncture. Future changes to PPACA and in other federal and state legislation could have a material impact on the operations of the Company. The Company is continuing to monitor the legislative environment for risks and uncertainties.

Collective Bargaining Agreements

Approximately 422 employees at SJHSRI are subject to a collective bargaining agreement with United Nurses and Allied Professionals ("UNAP"), which will expire July 2019. The parties are currently negotiating a new collective bargaining agreement. During April 2015, a hospital unit consisting of approximately 400 service employees of Fatima elected to be represented by UNAP. The parties entered into a new collective bargaining agreement which expires October 2018. A small number of employees are subject to a collective bargaining agreement with the Federation of Nurses and Health Professionals ("FNHP"), which expires April, 2018.

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.

10. Defined Contribution Plan

The Company sponsors a defined contribution plan (the "Plan") covering substantially all employees who meet certain eligibility requirements. Under the Plan, employees can contribute up to 100% of their compensation up to the IRS deferred annual maximum. The Company may make discretionary matching contributions to the Plan. Employer contributions to the Plan were $839,000 and $2,797,000 for the years ended September 30, 2017 and 2016, respectively.

11. Equity Method Investments

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. 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, 2017 and 2016, the Company's investments in RWRT, SNERCC, and other minor investments under the equity method were approximately $4,358,000 and $4,611,000, respectively, and are included in equity method investments in the accompanying consolidated balance sheets. For the years ended September 30, 2017 and 2016, the Company recognized approximately $605,000 and $512,000, respectively, as its share of the financial results of RWRT, SNERCC, and other minor investments and received $836,000 and $448,000, respectively, in distributions.

The remainder of this page intentionally left blank.

Summarized combined unaudited financial information for RWRT and SNERCC as of and for the years ended September 30, 2017 and 2016 is as follows (in thousands):

September 30,		2017		2016
Cash	$	1,549	$	2,567
Receivables and other current assets		2,121		1,536
Total current assets		3,670		4,103
Property, improvements and equipment, net		6,104		6,495
Goodwill		7,142		7,142
Intangible assets		882		912
Other long-term assets		1,603		1,641
Total assets	$	19,401	$	20,293
Accounts payable and accrued liabilities	$	1,201	$	1,251
Other long-term liabilities		400		378
Equity		17,800		18,664
Total liabilities and partner's capital	$	19,401	$	20,293

For the Years Ended September 30,		2017		2016
Revenues	$	16,387	$	15,007
Net income	$	2,841	$	1,927
RWMC's income from equity method investments	$	507	$	384

12. Subsequent Events (Unaudited)

The Company has evaluated subsequent events through February 28, 2018, the date the Company's consolidated financial statements were available for issuance.

In December 2017, New University Medical Group LLC ("New UMG") entered into a Second Closing to acquire the remaining assets of University Medical Group ("UMG") that were not acquired in the initial acquisition in December 2014. As consideration for the acquisition, New UMG has assumed certain designated liabilities of the practice. As part of the transaction, New UMG has assigned all assets acquired from UMG to New UMG's parent company, Prospect CharterCARE Physicians, LLC, dba CharterCARE Medical Associates ("CCMA"). CCMA entered into a Post Closing Administrative Services Agreement pursuant to which CCMA and its affiliates provide services to the seller of the practice in connection with its termination of all operations and the wind up its affairs and operations.

On February 22, 2018, Prospect entered into an Amended and Restated Term Loan Credit Agreement. Under this agreement, the Term Loan is replaced by a new Term B-1 Loan and Additional Term B-1 Commitment ("Term B-1 Loans"). The total maximum borrowing under the Term B-1 Loans is $1,120 million and such loans bear interest at LIBOR (subject to a 1.0% floor) plus 5.5%, and were issued with an original discount of 2%, and matures on February 24, 2024. Additionally on February 22, 2018, Prospect entered into an Amended and Restated ABL Guarantee And Security Agreement. Under this agreement, the maximum borrowing is $250 million, and the facility bears interest at a variable base rate plus an applicable spread, contingent on the Prospect's ABL Facility availability, as defined in the agreement. The facility matures on February 22, 2023.

Prospect CharterCARE SJHSRI, LLC

Financial Statements

As of and for the Years Ended
September 30, 2017 and 2016

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.

BDO

CIIH16-000713

Prospect ChaterCARE SJHSRI, LLC

Financial Statements
As of and for the Years Ended September 30, 2017 and 2016

Prospect CharterCARE SJHSRI, LLC

Contents

	Page
Independent Auditor's Report	4 - 5
Balance Sheets	6 - 7
Statements of Operations	8
Statements of Member's Equity	8
Statements of Cash Flows	10
Notes to the Financial Statements	11 - 27
Supplemental Report and Schedule	
Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*	29 - 30
Schedule of Findings and Disposition of Prior Year Findings	31 - 32

BDO

Tel: 714-957-3200
Fax: 714-957-1080
www.bdo.com

600 Anton Blvd., Suite 500
Costa Mesa, CA 92626

Independent Auditor's Report

Board of Directors
Prospect CharterCARE SJHSRI, LLC
Los Angeles, California

Report on the Financial Statements

We have audited the accompanying financial statements of Prospect CharterCARE SJHSRI, LLC (the "Company"), which comprise the balance sheets as of September 30, 2017 and 2016, and the related statements of operations, member's equity, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these 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 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 financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the 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 Company'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 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 financial statements referred to above present fairly, in all material respects, the financial position of the Company as of September 30, 2017 and 2016, and the results its operations and its cash flows for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

BDO

Emphasis of Matter

As discussed in Note 1, the Company is financially dependent on its parent companies which have agreed to provide the financial support necessary for the operations of the Company. The accompanying financial statements do not reflect any adjustments or disclosures that would be required should the parent companies discontinue their financial support.

Other Matters

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying Note 9 of the Company's calculation of its Title IV 90/10 revenue test ("Note 9 - Title IV 90/10") and Note 6 on related party transactions are required by the U.S. Department of Education and is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the Note 9 - Title IV 90/10 information and Note 6 on related party transactions are fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated March 27, 2018 on our consideration of the Company's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Company's internal control over financial reporting and compliance.

BDO USA, LLP

March 27, 2018

Prospect CharterCARE SJHSRI, LLC

Balance Sheets
(in thousands)

September 30,	2017	2016
Assets		
Current assets		
Cash and cash equivalents	$ -	$ -
Restricted cash	659	462
Patient accounts receivable, less allowance for doubtful accounts of $3,633 and $3,811	17,399	16,321
Other receivables	969	821
Due from government payers	439	350
Inventories	1,751	1,971
Prepaid expenses and other current assets	922	1,073
Total current assets	22,139	20,998
Property, improvements and equipment, net	23,152	24,763
Intangible assets, net	1,235	1,953
Other assets	576	583
Total assets	$ 47,102	$ 48,297

See accompanying notes to financial statements.

Prospect CharterCARE SJHSRI, LLC

Balance Sheets
(in thousands)

September 30,		2017		2016
Liabilities and Member's Equity				
Current liabilities				
Accrued medical claims and other healthcare costs payable	$	673	$	653
Accounts payable and other accrued liabilities		9,299		8,847
Accrued salaries, wages and benefits		4,483		4,276
Deferred revenue		971		-
Due to government payers		36		6
Due to affiliated companies, net		744		4,484
Current portion of capital leases		750		718
Total current liabilities		16,956		18,984
Capital leases, net of current portion		408		969
Deferred revenue, net of current portion		1,701		-
Asset retirement obligations		1,945		4,188
Other long-term liabilities		4,983		2,115
Total liabilities		25,993		26,256
Commitments, contingencies, and subsequent event				
Member's equity:				
Member's contributions		28,535		28,535
Accumulated deficit		(7,426)		(6,494)
Total member's equity		21,109		22,041
Total liabilities and member's equity	$	47,102	$	48,297

See accompanying notes to financial statements.

Prospect CharterCARE SJHSRI, LLC

Statements of Operations
(in thousands)

For the Years Ended September 30,		2017		2016
Revenues:				
Net patient service revenues	$	144,498	$	144,754
Provision for bad debts		(5,819)		(6,913)
Net patient service revenues less provision for bad debts		138,679		137,841
Other revenues		2,159		1,679
Tuition revenues		2,002		1,727
Total net revenues		142,840		141,247
Operating Expenses:				
Salaries, wages and benefits		80,979		82,417
Supplies		19,948		20,707
Taxes and licenses		9,355		9,544
Purchased services		7,476		7,260
Depreciation and amortization		7,248		6,784
Professional fees		4,075		4,849
Other		3,957		4,369
Management fees		2,981		2,915
Utilities		1,862		2,227
Lease and rental		1,577		1,957
Insurance		2,142		3,287
Repairs and maintenance		1,247		783
Registry		89		222
Total operating expenses		142,936		147,321
Operating income from unconsolidated equity method investments		61		64
Operating income (loss)		(35)		(6,010)
Other (income) expense:				
Interest expense		995		55
Other (income) expense		(98)		-
Total other expense		897		55
Net loss	$	(932)	$	(6,065)

See accompanying notes to financial statements.

Prospect CharterCARE SJHSRI, LLC

Statements of Member's Equity
(in thousands)

	Member's Contributions	Accumulated Deficit	Total Member's Equity
Balance at October 1, 2015	$ 28,535	$ (429)	$ 28,106
Net loss	-	(6,065)	(6,065)
Balance at September 30, 2016	28,535	(6,494)	22,041
Net loss	-	(932)	(932)
Balance at September 30, 2017	$ 28,535	$ (7,426)	$ 21,109

See accompanying notes to financial statements.

Prospect CharterCARE SJHSRI, LLC

Statements of Cash Flows
(in thousands)

For the Years Ended September 30,	2017	2016
Operating activities		
Net loss	$ (932)	$ (6,065)
Adjustments to reconcile net loss to net cash and cash equivalents provided by operating activities:		
Depreciation and amortization	7,248	6,784
Provision for bad debts	5,819	6,913
Accretion of interest for asset retirement obligations	149	305
Gain on sale of property, improvements and equipment	(167)	-
Changes in operating assets and liabilities		
Change in restricted cash	(197)	(154)
Patient accounts receivable and other receivables	(7,045)	(6,461)
Due to/from government payers, net	(58)	55
Inventories	220	(118)
Prepaid expenses and other current assets	151	(570)
Other assets	7	62
Accrued medical claims and other healthcare costs	20	(186)
Accounts payable and other accrued liabilities	1,159	1,477
Deferred revenue	2,672	-
Net cash and cash equivalents provided by operating activities	9,046	2,042
Investing activities		
Purchases of property, improvements and equipment	(4,862)	(3,148)
Proceeds from sale of property, improvements and equipment	483	-
Net cash and cash equivalents used in investing activities	(4,379)	(3,148)
Financing activities		
Change in due to affiliated companies, net	(3,740)	1,527
Repayments of capital leases	(927)	(432)
Net cash and cash equivalents (used in) provided by financing activities	(4,667)	1,095
Change in cash and cash equivalents	-	(11)
Cash and cash equivalents, beginning of year	-	11
Cash and cash equivalents, end of year	$ -	$ -
Supplemental disclosure of cash flow information		
Interest paid	$ 756	$ 55
Schedule of non-cash investing activities		
Transfer of ARO to long-term liabilities	$ 2,391	$ -
Equipment acquired under capital lease	$ 408	$ 1,885

See accompanying notes to financial statements.

1. Organization

Prospect CharterCARE SJHSRI, LLC ("SJHSRI" or the "Company" dba St. Joseph Health Center and our Lady of Fatima Hospital) is a wholly-owned subsidiary of Prospect CharterCARE, LLC ("PCC"). PCC is owned 85% by Prospect Medical Holdings, Inc. ("Prospect") and 15% by CharterCARE Community Board. SJHSRI operates a 359-bed acute care general hospital which provides healthcare services in North Providence, Rhode Island and surrounding communities. Additionally, SJHSRI operates the St. Joseph School of Nursing and an integrated network of primary care and specialty clinics serving an economically challenged and ethnically diverse population in Providence, Rhode Island.

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

The Company is dependent on its parent companies to fund ongoing operations. As of September 30, 2017, the Company had a net liability of $744,000 due to Prospect and to PCC and its subsidiaries, which is payable on demand, does not bear interest, and is included in due to affiliated companies, net in the accompanying balance sheets. Prospect and PCC do not intend to have the Company repay the liability in a manner which would impair the Company's ability to maintain sufficient liquidity to sustain ongoing operations.

2. Significant Accounting Policies

Basis of Presentation

The financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP").

Revenues

Net Patient Service Revenues

Operating revenue consists primarily of net patient service revenues. The Company reports net patient service revenues 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, 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 balance sheets.

CIIH16-000723

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

For the Years Ended September 30,	2017	2016
Medicare	$ 63,629	$ 61,762
Medicaid	31,842	36,447
Managed Care	30,132	33,124
Self-Pay/Other	18,895	13,421
Total	$ 144,498	$ 144,754

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. Most 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 generally paid based on 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. The Company also receives Medicare outlier payments on an ongoing basis during the year for cases that are unusually costly, and under certain circumstances these payments may be reconciled to more closely reflect the costs in excess of outlier thresholds after the submission and audit of the annual Medicare cost report. 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 Supplemental Security Income ("SSI") ratios for 2014, which are used in determining disproportionate share payments, were issued on July 19, 2016. To date, the Company has not received any final NPRs since inception on June 20, 2014.

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. Similar to Medicare, cost report settlements are recorded based upon as-filed cost reports and adjusted for tentative and final settlements, if any.

SJHSRI is a participant in the State of Rhode Island's Disproportionate Share Hospital ("DSH") program, which assists hospitals that provide a disproportionate amount of uncompensated care. Under the program, Rhode Island hospitals, including SJHSRI, receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low income patients. SJHSRI recognized revenue related to DSH and Upper Payment Limit ("UPL") reimbursement of $10,819,000 and $9,476,000 for the years ended September 30, 2017 and 2016, respectively. DSH and UPL payments received were $9,935,000 and $9,476,000 for the years ended September 30, 2017 and 2016, 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. SJHSRI recorded license fee expenses of $7,284,000 and $7,527,000, respectively, which is included within taxes and licenses expense within the accompanying statements of operations.

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.

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 indigent and charity care policy.

Laws and regulations governing the third-party payor arrangements are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Normal estimation differences between subsequent cash collections on patient accounts receivable and net patient accounts receivable estimated in the prior year are reported as adjustments to net patient service revenue in the current period.

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 financial statements.

Charity Care

The Company provides charity care to patients who lack financial resources and are deemed to be medically indigent based on criteria established under the Company's charity care policy. This care is provided without charge or at amounts less than the Company's established rates. Because the Company does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The direct and indirect costs related to this care totaled approximately $286,000 and $682,000 for the years ended September 30, 2017 and 2016, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. In addition, the Company provides services to other medically indigent patients under various state Medicaid programs. Such programs pay amounts that are less than the cost of the services provided to the recipients. The Company has not changed its charity care or uninsured discount policies during the years ended September 30, 2017 or 2016.

Provisions for Contractual Allowances and Doubtful Accounts

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 was 17% and 19% of gross accounts receivable as of September 30, 2017 and 2016, respectively. The decrease was due to a self-pay discount which took effect during the year ended September 30, 2017, resulting in a decrease in the bad debt allowance required as of September 30, 2017.

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 financial statements.

Other Revenues

Other revenues totaled $2,159,000 and $1,679,000 for the years ended September 30, 2017 and 2016, respectively. A summary of the primary components of other revenues is as follows:

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 rent is recorded on the straight-line method over the terms of the related lease agreements. The Company recorded rental revenues of $380,000 and $441,000 for the years ended September 30, 2017 and 2016, respectively.

Tuition Revenues

Tuition revenues include student fees and outside course reimbursement and are recognized ratably during the approximately 7 months of instruction provided per year. The Company recorded tuition revenues of $2,002,000 and $1,727,000 for the years ended September 30, 2017 and 2016, respectively. Amounts receivable related to tuition revenues were $268,000 and $462,000 as of September 30, 2017 and 2016, respectively, which is included within other receivables in the accompanying balance sheets. The tuition receivable is net of an allowance for uncollectible tuition of $226,000 and $199,000 as of September 30, 2017 and 2016, respectively. The receivable for tuition is included in other receivables in the accompanying balance sheets.

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. Building improvements are generally depreciated over seven years, buildings are depreciated over 10 years, equipment is depreciated over three to seven years and furniture and fixtures are depreciated over five 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.

Long-Lived Assets and Amortizable Intangibles

Intangible assets include trade names. 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, 2017 and 2016.

Insurance Reserves

Medical Malpractice Liability Insurance

The Company carries professional and general liability insurance to cover medical malpractice claims. The General Liability coverage is occurrence coverage and the Professional Liability coverage is claims-made coverage. Under the Professional Liability policy, insurance premiums cover only those claims actually reported during the policy term. Should the Professional Liability 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. The Company was included in Prospect's consolidated medical malpractice insurance policy effective June 20, 2014 (inception). Assets and liabilities related to malpractice insurance related to events prior to June 20, 2014 (inception) were not assumed by the Company.

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 recognizes 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. The Company's gross claims liability was $2,535,000 and $2,096,000 as of September 30, 2017 and 2016, respectively, and insurance receivables were $522,000 and $409,000 as of September 30, 2017, and 2016, respectively. The gross claims liability and insurance receivables were estimated using a discount factor of 4% and are included within long-term assets and long-term liabilities, respectively, in the accompanying balance sheets.

Workers' Compensation Insurance

The Company was fully insured for workers' compensation claims with no deductible for the years ended September 30, 2017 and 2016. Assets and liabilities related to workers' compensation insurance related to events prior to June 20, 2014 (inception) were not assumed by the Company.

Reserve Methodology

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 financial position, results of operations or cash flows.

Employee Health Plans

The Company maintains 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. Commercial insurance policies cover per occurrence losses in excess of $350,000. An actuarially estimated liability of approximately $673,000 and $653,000 for incurred but not reported claims as of September 30, 2017 and 2016, respectively.

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 statements of operations. The Company has accrued $1,945,000 and $4,188,000 related to asbestos remediation as of September 30, 2017 and 2016, respectively. The Company recorded $149,000 of accretion of the asset retirement obligation during the year ended September 30, 2017. The remainder of the change is a reclassification to other long term liabilities as part of a sale-leaseback transaction (see Note 5).

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

The Company held restricted cash of $659,000 and $462,000 as of September 30, 2017 and 2016, respectively, which is restricted for grants for the Company's School of Nursing.

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.

Sale-Leaseback Transactions

The Company evaluates sale-leaseback transactions by determining whether the transaction meets the qualifying criteria to be recognized as a sale-leaseback, including the transfer of risk and rewards of ownership as well as the absence of continuing involvement of the Company. When the qualifying criteria for a sale-leaseback transaction are not met, the Company accounts for the transaction as a financing.

Income Taxes

For tax reporting purposes, the Company is treated as a Partnership and is a pass-through entity. Therefore, no provision is made in the accompanying financial statements for liabilities for federal, state or local income taxes since such liabilities are the responsibility of the Company's parent companies. The Company periodically evaluates its tax positions, including its status as a pass-through entity, to evaluate whether it is more likely than not that such positions would be sustained upon examination by a tax authority for all open tax years, as defined by the statute of limitations, based on its technical merits.

As of September 30, 2017, the Company has not established a liability for uncertain tax positions. The Company files income tax returns in the U.S. federal jurisdiction and the state of Rhode Island. Generally, the Company is subject to examination by U.S. federal (or state and local) income tax authorities for three to four years from the filing of a tax return.

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 and Medicaid. The Company received revenues from Medicare and Medicaid as follows (in thousands):

	For the Year Ended September 30, 2017	% of Net Patient Services Revenues	For the Year Ended September 30, 2016	% of Net Patient Services Revenues
Medicare	$ 63,629	44%	$ 61,762	43 %
Medicaid	31,842	22%	36,447	25 %
Total	$ 95,471	66%	$ 98,209	68 %

Use of Estimates

The preparation of 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 financial statements are prepared. Actual results could materially differ from those estimates. Principal areas requiring the use of estimates include amounts due from/to government payers, allowances for contractual discounts and doubtful accounts, professional and general liability claims, employee health benefit claims, long-lived assets, intangible assets and asset retirement obligations.

New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued ASU 2014-09, "Revenue from Contracts with Customers (Topic 606)" which defers the effective date of the revenue standard 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. October 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 financial statements.

In August 2014, the FASB issued ASU 2014-15, "Presentation of Financial Statements - Going Concern: Disclosures of Uncertainties about an Entity's Ability to Continue as a Going Concern (Subtopic 205-40)" 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 has early adopted this guidance and such adoption did not have a material impact on its financial statements.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)". The core principle of ASU 2016-02 is that a lessee should recognize the assets and liabilities that arise from leases, including operating leases. Under the new requirements, a lessee will recognize in the statement of financial position a liability to make lease payments (the lease liability) and the right-of-use asset representing the right to the underlying asset for the lease term. For leases with a term of 12 months or less, the lessee is permitted to make an accounting policy election by class of underlying asset not to recognize lease assets and lease liabilities. The recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee have not significantly changed from previous GAAP. The standard is effective for nonpublic entities for fiscal years beginning after December 15, 2019. Early application of the amendment is permitted. The Company is currently evaluating the standard and the impact on its financial statements and footnote disclosures.

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230)". The updated standard addresses eight specific cash flow issues with the objective of reducing diversity in practice. ASU 2016-15 is effective for non-public business entities for annual reporting periods beginning after December 15, 2018, including interim periods within those annual reporting periods. Early adoption is permitted. The Company is assessing the impact of the adoption of ASU 2016-15 on its financial statements.

In November 2016, the FASB issued ASU 2016-18, "Statement of Cash Flows (Topic 230): Restricted Cash." The updated standard requires that a statement of cash flows explain the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. As a result, amounts generally described as restricted cash and restricted cash equivalents should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts shown on the statement of cash flows. The standard is effective for fiscal years beginning after December 15, 2017, including interim periods within those fiscal years, with early adoption permitted. The amendments should be applied using a retrospective transition method to each period presented. The Company is evaluating the impact of the adoption of ASU 2016-18 on its financial statements.

Reclassifications

Certain reclassifications were made to the prior year financial statements in order to conform to the current year presentation.

3. Property, Improvements and Equipment

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

September 30,	2017	2016
Property, improvements and equipment:		
Land and land improvements	$ 4,692	$ 4,931
Buildings and improvements	16,956	14,349
Leasehold improvements	3,292	3,280
Equipment	14,817	12,239
	39,757	34,799
Less: accumulated depreciation	(17,709)	(11,665)
	22,048	23,134
Construction in Progress	1,104	1,629
Property, improvements and equipment, net	$ 23,152	$ 24,763

As of September 30, 2017 and 2016, the Company had assets under capitalized leases of $2,410,000 and $2,217,000, respectively, and related accumulated depreciation of $884,000 and $359,000, respectively.

Depreciation expense was $6,530,000 and $6,066,000 for the years ended September 30, 2017 and 2016, respectively.

4. Intangible Assets

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

	Amortization Period	September 30, 2017	September 30, 2016
Trade names	5 years	$ 3,590	$ 3,590
Total acquisition cost of intangible assets		3,590	3,590
Less accumulated amortization		(2,355)	(1,637)
Intangible assets, net		$ 1,235	$ 1,953

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives. Amortization expense was $718,000 and $715,000 for the years ended September 30, 2017 and 2016, respectively.

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

Years ended September 30,		
2018	$	718
2019		517
Total	$	1,235

The weighted-average remaining useful life for the intangible assets was approximately 2 years as of September 30, 2017.

5. Sale-Leaseback Liability and Deferred Revenue

In October 2016, the Company entered into an agreement under which it granted and conveyed an exclusive easement to a water tower utilized for telecommunications purposes for a 99 year term to an unrelated third party. The agreement also assigned certain of the Company's telecommunications leases. The purchase price was approximately $2,057,000. The income derived from this transaction has been deferred and is being recognized on a straight line basis over the remaining term of the leases, through 2028.

In December 2016, the Company entered into a transaction to sell the former St. Joseph Hospital Campus for $100,000 to an unrelated third party. The purchaser has agreed to make certain required capital improvements as part of this transaction. In connection with this transaction, the Company also entered into a separate agreement to lease back a portion of the facility for 7 years, with options to renew for three 7 year periods, for an initial base rent of $80,000 per month. The lease also provides for the payment of a portion of the property taxes for the facility, consisting of $120,000 per year through 2020 and a pro rata portion of property taxes based on the Company's leased space after 2020. This transaction does not qualify for sale leaseback accounting because of the Company's deemed continuing involvement with the buyer-lessor, including the guarantee by PCC and because the term of the lease agreement is longer than the economic age of the facility. These are considered a form of contingent collateral and results in the transaction being recorded under the financing method. The sale-leaseback liability was $2,419,000 at September 30, 2017, which consists of the purchase consideration and the transfer of the ARO balance, and is presented within other long-term liabilities in the accompanying balance sheets.

6. Related Party Transactions

PCC and its Subsidiaries and Prospect East Hospital Advisory Services, LLC ("PEHAS"), a wholly-owned subsidiary of Prospect, entered into a Management Services Agreement ("MSA") as of June 20, 2014, under which PEHAS provides certain administrative and management services to PCC and its Subsidiaries. Management fees due to PEHAS under the MSA consist of 2% of net revenues monthly. The Company recognized management fees of $2,981,000 and $2,915,000 for the years ended September 30, 2017 and 2016, respectively, which is included within management fee expense in the accompanying statements of operations. As of September 30, 2017 and 2016, $9,599,000 and $6,617,000, respectively, due pursuant to the MSA, is included in due to affiliates, net, in the accompanying balance sheets.

7. 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 2022. Capital leases bear interest at rates ranging from 4% to 8% per annum.

The future minimum annual lease payments (net of anticipated sublease income) required under leases in effect at September 30, 2017, are as follows (in thousands):

For the Years ending September 30,		Capital Leases		Operating Leases
2018	$	843	$	362
2019		384		286
2020		38		286
2021		-		286
2022		-		271
Total minimum lease payments		1,265	$	1,491
Less: amounts representing interest		(62)		
		1,203		
Less: current portion		(750)		
	$	453		

Lease and rental expense was $1,577,000 and $1,957,000 for the years ended September 30, 2017 and 2016, respectively.

Contingent Liability for Borrowings by Prospect

The Company is contingently liable as a guarantor among others for amounts borrowed by Prospect on senior secured borrowings and credit facilities at September 30, 2017 and 2016. The obligations and related interest expense related to these credit facilities are not reflected in the Company's financial statements as of September 30, 2017 and 2016, as the borrowings are reflected in the separate consolidated financial statements of Prospect.

Total borrowings outstanding as of September 30, 2017 and 2016, reflected in the consolidated financial statements of Prospect, but for which the Company is contingently liable as a guarantor, were (in thousands):

September 30,		2017		2016
Senior secured term loan (net of discount of $7,374 and $8,984)	$	609,813	$	623,438
Less: original issue discount, net		(9,906)		(8,984)
	$	599,907	$	614,454

On June 30, 2016, Prospect entered into a six-year $625 million senior secured term loan B (the "Term Loan"), the proceeds of which were used to repay $425 million for Holdings' existing 8.375% senior secured notes due during 2019; to repay $60 million for borrowings under Holdings' existing revolving credit facility (the "Replaced Revolver"); to fund acquisitions; and to finance transaction fees and expenses. The Term Loan bears interest at LIBOR (subject to a 1.0% floor) plus 6.0%, and the effective interest rate was 7.00% as of September 30, 2017. The Term Loan was issued with an original discount of 1.5%, or $9,375,000.

Additionally, Prospect refinanced the Replaced Revolver with a new $100 million asset-based revolving credit facility ("ABL Facility" and together with the Term Loan, the "New Senior Secured Credit Facilities"). The ABL facility was amended in August 2016 to $115 million, August 2017 to $155 million and October 2017 to $175 million. The ABL Facility bears interest at a variable base rate plus an applicable spread, contingent on Prospect's ABL Facility availability, as defined in the ABL Facility credit agreement. The ABL Facility effective interest rate was 3.25% as of September 30, 2017. The ABL Facility balance as of September 30, 2017 was $115,300,000. As of September 30, 2017, Prospect had unused letters of credit of $9,800,000, which offset Prospect's ability to borrow additional funds, and the ABL Facility had unused lender commitments of $29,900,000 as of September 30, 2017. The maturity date for the ABL facility is June 30, 2021, and the maturity date for the Term Loan is June 30, 2022. As of September 30, 2017, Prospect was in compliance with the financial covenants of the New Senior Secured Credit Facilities. Subsequent to year end, Prospect refinanced the Term Loan and amended the ABL Facility, see Note 9.

Letter of Credit

As of September 30, 2017, Prospect secured an irrevocable letter of credit for $584,000 on behalf of the Company for its School of Nursing ("School") as required by the U.S. Department of Education. The purpose of the letter of credit is to (i) pay refunds of charges owed on behalf of current or former students, whether or not the School remains open; (ii) to provide for the "teach-out" of currently enrolled students if the School closes; and (iii) to pay any liabilities owed to the U.S. Department of Education.

Other Commitments

The Company has additional commitments for reagents that are based on tests performed. They are non-cancelable agreements but the future dollar commitments are not quantifiable as they are volume-driven.

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 financial position, results of operations and cash flows for the period in which the effect becomes probable and reasonably estimable.

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") has made significant changes to the United States health care system. The legislation impacted multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Under this legislation, 32 states have expanded their Medicaid programs to cover previously uninsured childless adults. In addition, many uninsured individuals have had the opportunity to purchase health insurance via state-based marketplaces, state-based marketplaces using a federal platform, state-partnership marketplaces or the federally-facilitated marketplace. PPACA also implemented a number of health insurance market reforms, such as allowing children to remain an their parents' health insurance until age 26 or prohibiting certain plans from denying coverage based on pre-existing conditions. Nationally, these reforms have reduced number of uninsured.

In light of the transition to a new presidential administration, it is unclear what changes may be made to PPACA. The Tax Cuts and Jobs Act ("TCJA"), passed in December 2017, eliminates the individual mandate under PPACA, effective January 1, 2019. The individual mandate was included in PPACA to address concerns that other market reforms expanding access to coverage might produce adverse selection and higher premiums. The extent to which the repeal of the individual mandate will impact the uninsured rate and 2019 premiums is unclear at this juncture. Future changes to PPACA and in other federal and state legislation could have a material impact on the operations of the Company. The Company is continuing to monitor the legislative environment for risks and uncertainties.

Collective Bargaining Agreements

The Company has 422 employees that are subject to a collective bargaining agreement with United Nurses and Allied Professionals ("UNAP"), which was effective beginning September 2016 and expires July 2019. During April 2015, a hospital unit consisting of approximately 400 service employees of Fatima elected to be represented by UNAP. The parties entered into a new collective bargaining agreement which expires October 2018. A small number of employees are subject to a collective bargaining agreement with the Federation of Nurses and Health Professionals ("FNHP"), which expires on April 30, 2018.

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.

8. Defined Contribution Plan

PCC sponsors a defined contribution plan (the "Plan") covering substantially all employees of the Company who meet certain eligibility requirements. Under the Plan, employees can contribute up to 100% of their compensation up to the IRS deferred annual maximum. The Company may make discretionary matching contributions to the Plan. The Company's contributions to the Plan were $1,101,000 and $1,894,000 for the years ended September 30, 2017 and 2016, respectively.

9. Regulatory

General

The Company participates in Student Financial Aid ("SFA") under the Federal Title IV programs administered by the Department of Education ("ED") pursuant to the Higher Education Act of 1965, as amended ("HEA"). The Company must comply with the regulations promulgated under HEA.

Financial Responsibility

All institutions participating in the Title IV Programs must satisfy specific standards of financial responsibility as promulgated by the ED. The ED evaluates institutions for compliance with these standards each year, based on the institution's annual audited financial statements. Compliance with the financial responsibility standards are determined through the calculation of a composite score based upon certain financial ratios as defined in the regulations. Institutions receiving a composite score of 1.5 or greater are considered fully financially responsible. Institutions receiving a composite score between 1.0 and 1.4 are subject to additional monitoring and institutions receiving a composite score below 1.0 are required to submit financial guarantees in order to continue participation in the Title IV programs. As of September 30, 2017, and for the year then ended, the Company's composite score was 1.6.

Compliance with 90/10 Cash Basis Revenue Regulations

The Company derives a portion of its tuition revenues from SFA received by its students under the Title IV programs administered by the ED pursuant to the HEA. To continue to participate in the SFA programs the Company must comply with the regulations promulgated under HEA. The regulations restrict the proportion of cash receipts for tuition and fees from eligible programs to not more than 90 percent from the Title IV programs. In July 2008, modifications to the regulations were made with respect to amounts to be included in the 90 percent calculations including temporary provisions related to certain Title IV funds received and institutional loans made to students. The modifications also allow for the inclusion of funds received for certain qualifying non-Title IV programs. In addition, the modifications included provisions for institutions that do not comply with the 90 percent rule for a single fiscal year, whereby such institutions would be placed on provisional certification status for a period of two years. Institutions that do not comply with the 90 percent rule for two consecutive fiscal years are subject to the loss of their ability to participate in the SFA programs.

In October 2009, HEA amended the regulations with respect to the disclosure requirements to the 90 percent calculations and allowed institutions to implement the new and amended provisions. The amended provisions require an institution to disclose the dollar amount of the numerator and denominator of its 90 percent calculation as well as the individual revenue amounts by fund source received by the institution.

For the years ended September 30, 2017 and 2016, the Company's 90/10 cash basis revenue test percentages were computed as follows:

(in thousands)	2017	2016
Revenue by Source		
Student Title IV cash basis revenue		
Subsidized loan	$ 474	$ 340
Unsubsidized loan	696	509
Plus loan	50	34
Federal Pell grant	245	273
	$ 1,465	$ 1,156
Student Non-Title IV revenue		
Funds provided from private loans	$ 182	$ 91
State loans	193	76
Scholarships	47	27
Student payments	400	422
	$ 822	$ 616
Student Title IV cash basis revenue	$ 1,465	$ 1,156
Student title IV cash basis revenue + Student Non-Title IV cash basis revenue	$ 2,287	$ 1,772
	64%	65%

Student Default Rate

For each fiscal year, the ED calculates a rate of student defaults for each educational institution which is known as a "cohort default rate." An institution may lose its eligibility to participate in some or all Title IV programs if, for each of the three most recent federal fiscal years for which information is available, 30% or more of its students who became subject to a repayment obligation in that federal fiscal year defaulted on such obligation by the end of the following federal fiscal year. In addition, an institution may lose its eligibility to participate in some or all Title IV programs if its cohort default rate exceeds 40% in the most recent federal fiscal year for which default rates have been calculated by the ED. The Company's 3-Year cohort default rate for the 2017 federal fiscal year was 0.0%. Federal fiscal year 2017 is the most recent year for which this information is available.

10. Subsequent Event

The Company has evaluated subsequent events through March 27, 2018, the date the Company's financial statements were available for issuance.

On February 22, 2018, Prospect entered into an Amended and Restated Term Loan Credit Agreement. Under this agreement, the Term Loan is replaced by a new Term B-1 Loan and Additional Term B-1 Commitment ("Term B-1 Loans"). The total maximum borrowing under the Term B-1 Loans is $1,120 million and such loans bear interest at LIBOR (subject to a 1.0% floor) plus 5.5%, and were issued with an original discount of 2%, and mature on February 24, 2024. Additionally on February 22, 2018, Prospect entered into an Amended and Restated ABL Guarantee And Security Agreement. Under this agreement, the maximum borrowing is $250 million, and the facility bears interest at a variable base rate plus an applicable spread, contingent on the Prospect's ABL Facility availability, as defined in the agreement. The facility matures on February 22, 2023.

Supplemental Report and Schedule

BDO

Tel: 714-957-3200
Fax: 714-957-1080
www.bdo.com

600 Anton Blvd., Suite 500
Costa Mesa, CA 92626

Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

Board of Directors
Prospect CharterCARE SJHSRI, LLC
Los Angeles, California

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Prospect CharterCARE SJHSRI, LLC (the "Company"), which comprise the balance sheet as of September 30, 2017, and the related statements of operations, member's equity, and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated March 27, 2018.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Company's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the Company's financial statements will not be prevented, or detected and corrected on a timely basis. *A significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the deficiencies described in the accompanying schedule of findings and questioned costs to be material weaknesses (*2017-001*).

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Company's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

BDO

The Company's Response to Findings

The Company's response to the findings identified in our audit are described in the accompanying schedule of findings and questioned costs. The Company's response was not subjected to the auditing procedures applied in the audit of the consolidated financial statements and, accordingly, we express no opinion on it.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Company's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Company's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

BDO USA, LLP

March 27, 2018

Section I - Summary of Auditor's Results

Financial Statements

Type of auditor's report issued:	Unmodified	
Internal control over financial reporting:		
Material weakness(es) identified?	X yes	___ no
Significant deficiency(ies) identified that are not considered to be material weaknesses?	___ yes	X none reported
Noncompliance material to financial statements noted?	___ yes	X no

Section II - Financial Statement Findings

Finding 2017-001

Condition

The Company has a material weakness in internal controls over financial reporting. There were certain, material additional post-closing adjustments identified as a result of our audit procedures, which were not identified by the Company's internal control over the financial statement close process.

Cause

The internal control over financial reporting were not effective in identifying certain required adjustments to the financial statements.

Effect

As a result of this material weakness, the financial reporting process audit adjustments were made to the Company's financial statements in order to be presented in accordance with accounting principles accepted in the United States of America.

Recommendation

The Company should review its policies and procedures over the financial close and reporting process as well as the adequacy of its internal resources.

Views of Responsible Officials

Management agrees with the findings above and has already taken actions to strengthen the internal controls which include the hiring of a Chief Accounting Officer at PMH who will oversee the Company's financial statement close process.

Disposition of Prior Year Findings

Not applicable; there were no findings in the prior year related to the financial statements which are required to be reported in accordance with generally accepted government auditing standards (GAGAS).

Prospect CharterCARE RWMC, LLC

Consolidated Financial Statements

Schedule of Expenditures of Federal Awards and Independent Auditor's Reports as Required by the Uniform Guidance and *Government Auditing Standards*

As of and for the Year Ended
September 30, 2017

(With Independent Auditor's Report Thereon)

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.

BDO

Prospect CharterCARE RWMC, LLC

Consolidated Financial Statements

Schedule of Expenditures of Federal Awards and Independent Auditor's Reports as Required by the Uniform Guidance and *Government Auditing Standards*

As of and for the Year Ended September 30, 2017

Prospect CharterCARE RWMC, LLC

Contents

	Page
Independent Auditor's Report	3 - 4
Consolidated Balance Sheet	5 - 6
Consolidated Statement of Operations	7
Consolidated Statement of Member's Equity	8
Consolidated Statement of Cash Flows	9
Notes to the Consolidated Financial Statements	10 - 25
Schedule of Expenditures of Federal Awards	27
Notes to Schedule of Expenditures of Federal Awards	28
Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*	30 - 31
Independent Auditor's Report on Compliance for Each Major Program; Report on Internal Control over Compliance Required by the Uniform Guidance	32 - 33
Schedule of Findings and Questioned Costs	34 - 35

BDO

Tel: 714-957-3200
Fax: 714-957-1080
www.bdo.com

600 Anton Blvd., Suite 500
Costa Mesa, CA 92626

Independent Auditor's Report

Board of Directors
Prospect CharterCARE RWMC, LLC
Los Angeles, California

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Prospect CharterCARE RWMC, LLC (the "Company"), which comprise the consolidated balance sheet as of September 30, 2017, and the related consolidated statements of operations, member's equity, and cash flows for the year 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 audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit 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 financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company'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 Company'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 CharterCARE RWMC, LLC and its subsidiary as of September 30, 2017, and the results of their operations and their cash flows for the year then ended, in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 1, the Company is financially dependent on its parent companies which have agreed to provide the financial support necessary for the operations of the Company. The accompanying consolidated financial statements do not reflect any adjustments or disclosures that would be required should the parent company discontinue its financial support.

Other Matters

Other Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying schedule of expenditures of federal awards, as required by Title 2 U.S. Code of Federal Regulations (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated April 9, 2018 on our consideration of the Company's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Company's internal control over financial reporting and compliance.

BDO USA, LLP

April 9, 2018

Prospect CharterCARE RWMC, LLC

Consolidated Balance Sheet
(in thousands)

September 30,		2017
Assets		
Current assets		
Cash and cash equivalents	$	299
Restricted cash		2,369
Patient accounts receivable, less allowance for doubtful accounts of $3,974		21,506
Other receivables		9,303
Due from government payers		580
Inventories		3,750
Prepaid expenses and other current assets		1,378
Total current assets		39,185
Property, improvements and equipment, net		30,679
Intangible assets, net		1,561
Equity method investments		4,052
Insurance receivable and other assets		601
Total assets	$	76,078

See accompanying notes to consolidated financial statements.

Prospect CharterCARE RWMC, LLC

Consolidated Balance Sheet
(in thousands)

September 30,		2017
Liabilities and Member's Equity		
Current liabilities		
Accrued medical claims and other healthcare costs payable	$	394
Accounts payable and other accrued liabilities		13,946
Accrued salaries, wages and benefits		6,540
Due to government payers		282
Due to affiliated companies, net		18,357
Current portion of capital leases		596
Current portion of sale-leaseback liability		257
Total current liabilities		40,372
Capital leases, net of current portion		326
Malpractice reserves		3,273
Asset retirement obligations		750
Sale-leaseback liability, net of current portion		3,760
Other long-term liabilities		335
Total liabilities		48,816
Commitments, contingencies and subsequent events		
Member's equity:		
Member contributions		34,241
Accumulated deficit		(6,979)
Total member's equity		27,262
Total liabilities and member's equity	$	76,078

See accompanying notes to consolidated financial statements.

Prospect CharterCARE RWMC, LLC

Consolidated Statement of Operations
(in thousands)

For the year ended September 30,		2017
Revenues:		
Net patient service revenues	$	177,720
Provision for bad debts		(6,190)
Net patient service revenues less provision for bad debts		171,530
Other revenues		3,001
Total net revenues		174,531
Operating Expenses:		
Salaries, wages and benefits		83,968
Supplies		38,638
Purchased services		13,629
Taxes and licenses		11,347
Depreciation and amortization		6,168
Professional fees		6,728
Other		6,219
Management fees		3,665
Utilities		1,792
Research grant expense		120
Insurance		2,799
Lease and rental		1,434
Repairs and maintenance		978
Registry		623
Total operating expenses		178,108
Operating income from unconsolidated equity method investments		507
Operating loss		(3,070)
Other income:		
Interest income, net		(217)
Other income		(89)
Total other income, net		(306)
Net loss	$	(2,764)

See accompanying notes to consolidated financial statements.

Prospect CharterCARE RWMC, LLC

Consolidated Statement of Member's Equity
(in thousands)

	Member Contributions	Retained Earnings (Accumulated Deficit)	Total Member's Equity
Balance at October 1, 2016	$ 34,241	$ 330	$ 34,570
Net loss	-	(2,764)	(2,764)
Noncash distribution	-	(4,545)	(4,545)
Balance at September 30, 2017	$ 34,241	$ (6,979)	$ 27,262

See accompanying notes to consolidated financial statements.

Prospect CharterCARE RWMC, LLC

Consolidated Statement of Cash Flows
(in thousands)

For the year ended September 30,		2017
Operating activities		
Net loss	$	(2,764)
Adjustments to reconcile net loss to net cash used in operating activities:		
Depreciation and amortization		6,168
Provision for bad debts		6,190
Undistributed earnings from equity method investments		(507)
Accretion for asset retirement obligations		(5)
Accretion of sale-leaseback liability		(335)
Gain on sale of property, improvements and equipment		(2,539)
Changes in operating assets and liabilities:		
Change in restricted cash		(633)
Patient accounts receivable and other receivables		(8,527)
Due to/from government payers, net		17
Inventories		467
Prepaid expenses and other current assets		18
Insurance receivable and other assets		(100)
Accrued medical claims and other healthcare		394
Accounts payable and other accrued liabilities		(1,448)
Malpractice reserve		883
Net cash used in operating activities		(182)
Investing activities		
Purchases of property, improvements and equipment		(5,077)
Cash distributions from equity investments		761
Net cash used in investing activities		(4,316)
Financing activities		
Change in due to affiliated companies		5,938
Repayments on financing liability		(193)
Repayments of capital leases		(947)
Net cash provided by financing activities		4,797
Change in cash and cash equivalents		299
Cash and cash equivalents, beginning of year		-
Cash and cash equivalents, end of year	$	299
Supplemental disclosure of cash flow information		
Interest paid	$	1,999
Noncash distribution	$	4,545
Sale-leaseback liability	$	4,545
Capital lease commitments transferred to affiliate	$	1,669

See accompanying notes to consolidated financial statements

1. Organization

Prospect CharterCARE RWMC, LLC ("RWMC") is a wholly-owned subsidiary of Prospect CharterCARE, LLC ("PCC"). PCC is owned 85% by Prospect Medical Holdings, Inc. ("Prospect") and 15% by CharterCARE Community Board. RWMC operates a 220-bed acute care general hospital which provides healthcare services in Providence, Rhode Island and surrounding communities. New University Medical Group, LLC ("New UMG"), a wholly-owned subsidiary of RWMC (together, the "Company"), was formed during the year ended September 30, 2015.

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

The Company is dependent on Prospect to fund ongoing operations. As of September 30, 2017, the Company had a liability of $24,469,000 to Prospect, which is payable on demand, does not bear interest, and is included in due to affiliated companies, net in the accompanying consolidated balance sheets. Prospect does not intend to have the Company repay the liability in a manner which would impair the Company's ability to maintain sufficient liquidity to sustain ongoing operations.

2. Significant Accounting Policies

Principles of Consolidation and 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 RWMC's wholly-owned subsidiary, New UMG, but do not include the accounts of PCC, Prospect or CharterCARE Community Board. All significant intercompany balances and transactions have been eliminated in consolidation.

Revenues

Net Patient Service Revenues

Operating revenue 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, 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 sheet.

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

For the years ended September 30,		2017
Medicare	$	82,046
Medicaid		34,725
Managed Care/Commercial		39,163
Self-Pay/Other		21,786
Total	$	177,720

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 Supplemental Security Income ("SSI") ratios for 2014, which are used in determining disproportionate share payments, were issued on July 19, 2016. To date, the Company has not received any final NPRs since inception on June 20, 2014.

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. Similar to Medicare, cost report settlements are recorded based upon as-filed cost reports and adjusted for tentative and final settlements, if any.

RWMC is a participant in the State of Rhode Island's Disproportionate Share Hospital ("DSH") program, which assists hospitals that provide a disproportionate amount of uncompensated care. Under the program, Rhode Island hospitals, including RWMC, receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low income patients. RWMC recognized revenue related to DSH and Upper Payment Limit ("UPL") reimbursement of $9,458,000 for the year ended September 30, 2017. DSH and UPL payments received were $8,446,000 for the year ended September 30, 2017. The State of Rhode Island also assesses a license fee to all hospitals in Rhode Island based on each hospital's net patient revenue. RWMC recorded license fee expenses of $8,667,000, which is included within taxes and licenses expense within the accompanying statement of operations.

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.

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 indigent and charity care policy.

Charity Care

The Company provides charity care to patients who lack financial resources and are deemed to be medically indigent based on criteria established under the Company's charity care policy. This care is provided without charge or at amounts less than the Company's established rates. Because the Company does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The direct and indirect costs related to this care totaled approximately $547,000 for the year ended September 30, 2017. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. In addition, the Company provides services to other medically indigent patients under various state Medicaid programs. Such programs pay amounts that are less than the cost of the services provided to the recipients. The Company has not changed its charity care or uninsured discount policies during the year ended September 30, 2017.

Provisions for Contractual Allowances and Doubtful Accounts

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 was 16% of gross accounts receivable as of September 30, 2017.

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.

Other Revenues

Other revenues totaled $3,001,000 for the year ended September 30, 2017. Management has evaluated the collectability of other receivables consisting primarily of other revenues and grant revenues and determined no allowance is necessary as of September 30, 2017.

A summary of the principal components of other revenues is as follows:

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. The Company recorded rental revenues of $324,000 for the year ended September 30, 2017.

Research Grant Revenues: The Company receives grant revenue for direct research from the federal government, other institutions and other sources for a range of research areas including oncology, cardiology, HIV and diabetes. The Company recorded research grant revenue of $1,439,000 for the year ended September 30, 2017.

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. Building improvements are generally depreciated over seven years, buildings are depreciated over 10 years, equipment is depreciated over three to seven years and furniture and fixtures are depreciated over five 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.

Long-Lived Assets and Amortizable Intangibles

Intangible assets include trade names. 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 year ended September 30, 2017.

Insurance Reserves

Medical Malpractice Liability Insurance

The Company carries professional and general liability insurance to cover medical malpractice claims. The General Liability coverage is occurrence coverage and the Professional Liability coverage is claims-made coverage. Under the Professional Liability policy, insurance premiums cover only those claims actually reported during the policy term. Should the Professional Liability 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. The Company was included in Prospect's consolidated medical malpractice insurance policy effective June 20, 2014 (inception). Assets and liabilities related to malpractice insurance related to events prior to June 20, 2014 (inception) were not assumed by the Company.

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 recognizes 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. The Company's gross claims liability was $3,273,000 and as of September 30, 2017, and insurance receivables were $478,000 as of September 30, 2017. The gross claims liability and insurance receivables were estimated using a discount factor of 4% and are included within long-term liabilities and long-term assets, respectively, in the accompanying consolidated balance sheet.

Workers' Compensation Insurance

The Company was fully insured for workers' compensation claims with no deductible for the year ended September 30, 2017. Assets and liabilities related to workers' compensation insurance related to events prior to June 20, 2014 (inception) were not assumed by the Company.

Reserve Methodology

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 financial position, results of operations or cash flows.

Employee Health Plans

The Company maintains 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. Commercial insurance policies cover per occurrence losses in excess of $350,000. An actuarially estimated liability of approximately $367,000 for incurred but not reported claims as of September 30, 2017has been included in accrued medical claims and other healthcare costs payable on the accompanying balance sheet.

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 consolidated statement of operations. The Company has accrued $750,000 related to asbestos remediation as of September 30, 2017.

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

The Company held restricted cash of $2,369,000 as of September 30, 2017, which is restricted for research.

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.

Income Taxes

For tax reporting purposes, the Company is treated as a Partnership and is a pass-through entity. Therefore, no provision is made in the accompanying financial statements for liabilities for federal, state or local income taxes since such liabilities are the responsibility of the Company's parent companies. The Company periodically evaluates its tax positions, including its status as a pass-through entity, to evaluate whether it is more likely than not that such positions would be sustained upon examination by a tax authority for all open tax years, as defined by the statute of limitations, based on its technical merits.

As of September 30, 2017, the Company has not established a liability for uncertain tax positions. The Company files income tax returns in the U.S. federal jurisdiction and the state of Rhode Island. Generally, the Company is subject to examination by U.S. federal (or state and local) income tax authorities for three to four years from the filing of a tax return.

Sale-Leaseback Transactions

The Company evaluates sale-leaseback transactions by determining whether the transaction meets the qualifying criteria to be recognized as a sale-leaseback, including the transfer of risk and rewards of ownership as well as the absence of continuing involvement of the Company. When the qualifying criteria for a sale-leaseback transaction are not met, the Company accounts for the transaction as a financing, see Note 5.

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 and Medicaid. The Company received revenues from Medicare and Medicaid as follows (in thousands):

		For the Year Ended September 30, 2017	% of Net Patient Services Revenues
Medicare	$	82,046	46%
Medicaid		34,725	20%
Total	$	116,771	66%

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 amounts due from/to government payers, allowances for contractual discounts and doubtful accounts, professional and general liability claims, impairment of long-lived assets and intangible assets, and asset retirement obligations.

New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued ASU 2014-09, "Revenue from Contracts with Customers (Topic 606)" which defers the effective date of the revenue standard 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. October 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 2014-15, "Presentation of Financial Statements - Going Concern: Disclosures of Uncertainties about an Entity's Ability to Continue as a Going Concern (Subtopic 205-40)" 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 has early adopted this guidance and such adoption did not have a material impact on its consolidated financial statements.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)". The core principle of ASU 2016-02 is that a lessee should recognize the assets and liabilities that arise from leases, including operating leases. Under the new requirements, a lessee will recognize in the statement of financial position a liability to make lease payments (the lease liability) and the right-of-use asset representing the right to the underlying asset for the lease term. For leases with a term of 12 months or less, the lessee is permitted to make an accounting policy election by class of underlying asset not to recognize lease assets and lease liabilities. The recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee have not significantly changed from previous GAAP. The standard is effective for nonpublic entities for fiscal years beginning after December 15, 2019. Early application of the amendment is permitted. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230)". The updated standard addresses eight specific cash flow issues with the objective of reducing diversity in practice. ASU 2016-15 is effective for non-public business entities for annual reporting periods beginning after December 15, 2018, including interim periods within those annual reporting periods. Early adoption is permitted. The Company is assessing the impact of the adoption of ASU 2016-15 on its consolidated financial statements.

On November 17, 2016, the FASB issued Accounting Standards Update (ASU) 2016-18, Statement of Cash Flows (Topic 230): Restricted Cash, providing specific guidance on the cash flow classification and presentation of changes in restricted cash and restricted cash equivalents. The amendments in ASU 2016-18 require that a statement of cash flows explain the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents (collectively "CASH"). Therefore, amounts generally described as restricted cash and restricted cash equivalents should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts shown on the SCF. The amendments in ASU 2016-18 are effective for private business entities for fiscal years beginning after December 15, 2018, and interim periods within those fiscal years. Early adoption is permitted, including adoption in an interim period. The Company is currently evaluating the impact of this accounting standard on its financial statements.

3. Property, Improvements and Equipment

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

September 30,	2017
Property, improvements and equipment:	
Land and land improvements	$ 2,946
Buildings and improvements	23,266
Leasehold improvements	6,164
Equipment	10,362
	42,738
Less: accumulated depreciation	(14,423)
	28,315
Construction in Progress	2,364
Property, improvements and equipment, net	$ 30,679

At September 30, 2017, the Company had assets under capitalized leases of approximately $1,928,000 and related accumulated depreciation of $885,000.

Depreciation expense was $5,260,000 for the years ended September 30, 2017.

CIIH16-000763

4. Intangible Assets

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

	Amortization Period	September 30, 2017
Trade names	5 years	$ 4,540
Total acquisition cost of intangible assets		4,540
Less accumulated amortization		(2,979)
Intangible assets, net		$ 1,561

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives. Amortization expense was $908,000 for the year ended September 30, 2017.

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

Years ended September 30,	
2018	$ 908
2019	653
Total	$ 1,561

The weighted-average remaining useful life for the intangible assets was approximately 2 years as of September 30, 2017.

5. Sale of Real Estate and Sale-Leaseback

PCC previously operated Elmhurst Extended Care ("Elmhurst"), a 206 bed skilled nursing facility, and the Company owned the land and building in which Elmhurst's business was carried out. In December 2016, PCC and the Company entered into a transaction to sell the operations of Elmhurst and the land and building in which Elmhurst operated, to an unrelated third party. PCC's decision to discontinue the operations of this entity was based on the Company's strategy in its market and financial results. The transaction price was approximately $15.2 million, of which approximately $8.3 million was allocated to the land and building. After the land and building were sold, the building was then subdivided into two condominiums, one of which was deeded back to the Company. Additionally, the Company entered into a transaction to lease a portion of the other condominium back for a period of 10 years, with monthly rent of approximately $21,000. This transaction does not qualify for sale leaseback accounting because of the Company's deemed continuing involvement with the buyer-lessor, including the guarantee by PCC, which is considered a form of contingent collateral and results in the transaction being recorded under the financing method. Further, the building cannot be bifurcated, for accounting purposes, between the portion that was leased and the remainder because the transaction does not meet the definition of a minor sale-leaseback, under applicable accounting literature. PCC received and retained the cash received from the seller, and accordingly the transaction has been accounted for as a noncash distribution to PCC. In accordance with applicable accounting literature, as the Company is a wholly owned subsidiary of PCC, the value of the noncash distribution is based on the carrying value of the assets distributed at the time of sale, which was $4,545,000, and accordingly this is the value that the sale-leaseback liability has been set up at that date.

Scheduled payments under the Company's sale-leaseback liability as of September 30, 2017 are as follows (in thousands):

Years ending September 30,		
2018	$	257
2019		257
2020		257
2021		257
2022		257
Thereafter		1,093
		2,380
Plus: reduction in liability to be accreted to interest income		1,637
Total sale-leaseback liability	$	4,017

The total payments to be paid over the remainder of the lease are $2,380,000. The interest rate implicit in the calculation is negative 10.4%. The value of the sale-leaseback liability is based on the building that was sold, not just the part of the building that was leased back, because as noted above the transaction did not meet the definition of a minor sale-leaseback under the literature. Accordingly, the liability is greater than the sum of the future payments to be made under the lease and this gives rise to a negative interest rate.

6. Related Party Transactions

PCC and its Subsidiaries and Prospect East Hospital Advisory Services, LLC ("PEHAS"), a wholly-owned subsidiary of Prospect, entered into a Management Services Agreement ("MSA") as of June 20, 2014, under which PEHAS provides certain administrative and management services to PCC and its Subsidiaries. Management fees due to PEHAS under the MSA consist of 2% of net revenues monthly. The Company recognized management fees of $3,665,000 for the year ended September 30, 2017, which is included within management fee expense in the accompanying statement of operations. As of September 30, 2017, $11,758,000, due pursuant to the MSA, is included in due to affiliates, net, in the accompanying consolidated balance sheet.

The Company recognized $319,000 of rental income from Elmhurst Extended Care for the year ended September 30, 2017, respectively, which is included in other revenues in the accompanying consolidated statement of operations.

7. 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 June 2022. Capital leases bear interest at rates ranging from 3.0% to 4.0% per annum.

The future minimum annual lease payments required under leases in effect at September 30, 2017, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2018	$ 631	$ 398
2019	334	133
2020	-	129
2021	-	74
2022	-	74
Total minimum lease payments	965	$ 808
Less: amounts representing interest	(43)	
	922	
Less: current portion	(596)	
	$ 326	

Lease and rental expense was $1,626,000 for the year ended September 30, 2017.

Contingent Liability for Borrowings by Prospect

The Company is contingently liable as a guarantor among others for amounts borrowed by Prospect on senior secured borrowings and credit facilities at September 30, 2017 and 2016. The obligations and related interest expense related to these credit facilities are not reflected in the Company's financial statements as of September 30, 2017 and 2016, as the borrowings are reflected in the separate consolidated financial statements of Prospect.

Total borrowings outstanding as of September 30, 2017, reflected in the consolidated financial statements of Prospect, but for which the Company is contingently liable as a guarantor, were (in thousands):

September 30,	2017
Senior secured term loan (net of discount of $7,374)	$ 609,813
Less: original issue discount, net	(9,906)
	$ 599,907

On June 30, 2016, Prospect entered into a six-year $625 million senior secured term loan B (the "Term Loan"), the proceeds of which were used to repay $425 million for Holdings' existing 8.375% senior secured notes due during 2019; to repay $60 million for borrowings under Holdings' existing revolving credit facility (the "Replaced Revolver"); to fund acquisitions; and to finance transaction fees and expenses. The Term Loan bears interest at LIBOR (subject to a 1.0% floor) plus 6.0%, and the effective interest rate was 7.00% as of September 30, 2017. The Term Loan was issued with an original discount of 1.5%, or $9,375,000.

Additionally, Prospect refinanced the Replaced Revolver with a new $100 million asset-based revolving credit facility ("ABL Facility" and together with the Term Loan, the "New Senior Secured Credit Facilities"). The ABL facility was amended in August 2016 to $115 million, August 2017 to $155 million and October 2017 to $175 million. The ABL Facility bears interest at a variable base rate plus an applicable spread, contingent on Prospect's ABL Facility availability, as defined in the ABL Facility credit agreement. The ABL Facility effective interest rate was 3.25% as of September 30, 2017. The ABL Facility balance as of September 30, 2017 was $115,300,000. As of September 30, 2017, Prospect had unused letters of credit of $9,800,000, which offset Prospect's ability to borrow additional funds, and the ABL Facility had unused lender commitments of $29,900,000 as of September 30, 2017. The maturity date for the ABL facility is June 30, 2021, and the maturity date for the Term Loan is June 30, 2022. As of September 30, 2017, Prospect was in compliance with the financial covenants of the New Senior Secured Credit Facilities. Subsequent to year end, Prospect refinanced the Term Loan and amended the ABL Facility, see Note 10.

Other Commitments

The Company has additional commitments for reagents that are based on tests performed. They are non-cancelable agreements but the future dollar commitments are not quantifiable as they are volume-driven.

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 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 financial position, results of operations and cash flows for the period in which the effect becomes probable and reasonably estimable.

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. The Company may be subject to significant fines and penalties if found not to be compliant with these federal provisions.

Affordable Care Act

The Patient Protection and Affordable Care Act ("PPACA") has made significant changes to the United States health care system. The legislation impacted multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Under this legislation, 32 states have expanded their Medicaid programs to cover previously uninsured childless adults. In addition, many uninsured individuals have had the opportunity to purchase health insurance via state-based marketplaces, state-based marketplaces using a federal platform, state-partnership marketplaces or the federally-facilitated marketplace. PPACA also implemented a number of health insurance market reforms, such as allowing children to remain an their parents' health insurance until age 26 or prohibiting certain plans from denying coverage based on pre-existing conditions. Nationally, these reforms have reduced number of uninsured.

In light of the transition to a new presidential administration, it is unclear what changes may be made to PPACA. The Tax Cuts and Jobs Act ("TCJA"), passed in December 2017, eliminates the individual mandate under PPACA, effective January 1, 2019. The individual mandate was included in PPACA to address concerns that other market reforms expanding access to coverage might produce adverse selection and higher premiums. The extent to which the repeal of the individual mandate will impact the uninsured rate and 2019 premiums is unclear at this juncture. Future changes to PPACA and in other federal and state legislation could have a material impact on the operations of the Company. The Company is continuing to monitor the legislative environment for risks and uncertainties.

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.

8. Defined Contribution Plan

PCC sponsors a defined contribution plan (the "Plan") covering substantially all employees of the Company who meet certain eligibility requirements. Under the Plan, employees can contribute up to 100% of their compensation up to the IRS deferred annual maximum. The Company may make discretionary matching contributions to the Plan. The Company did not contributions to the Plan for the year ended September 30, 2017.

9. Equity Method Investments

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. 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, 2017, the Company's investments in RWRT, SNERCC, and other minor investments under the equity method were approximately $4,052,000, and are included in equity method investments in the accompanying consolidated balance sheet. For the year ended September 30, 2017, the Company recognized approximately $507,000, as its share of the financial results of RWRT, SNERCC, and other minor investments and received $761,000, in distributions.

Summarized combined unaudited financial information for RWRT and SNERCC as of September 30, 2017 is as follows (in thousands):

September 30,		2017
Cash	$	1,549
Receivables and other current assets		2,121
Total current assets		3,670
Property, improvements and equipment, net		6,104
Goodwill		7,142
Intangible assets		882
Other long-term assets		1,603
Total assets	$	19,401
Accounts payable and accrued liabilities	$	1,201
Other long-term liabilities		400
Equity		17,800
Total liabilities and partner's capital	$	19,401

For the Year Ended September 30,		2017
Revenues	$	16,387
Net income	$	2,841
RWMC's income from equity method investments	$	507

10. Subsequent Events (Unaudited)

The Company has evaluated subsequent events through April 9, 2018, the date the Company's consolidated financial statements were available for issuance.

In December 2017, New UMG entered into a Second Closing to acquire the remaining assets of University Medical Group ("UMG") that were not acquired in the initial acquisition in December 2014. As consideration for the acquisition, New UMG has assumed certain designated liabilities of the practice. As part of the transaction, New UMG has assigned all assets acquired from UMG to New UMG's parent company, Prospect CharterCARE Physicians, LLC, dba CharterCARE Medical Associates ("CCMA"). CCMA entered into a Post Closing Administrative Services Agreement pursuant to which CCMA and its affiliates provide services to the seller of the practice in connection with its termination of all operations and the wind up its affairs and operations.

On February 22, 2018, Prospect entered into an Amended and Restated Term Loan Credit Agreement. Under this agreement, the Term Loan is replaced by a new Term B-1 Loan and Additional Term B-1 Commitment ("Term B-1 Loans"). The total maximum borrowing under the Term B-1 Loans is $1,120 million and such loans bear interest at LIBOR (subject to a 1.0% floor) plus 5.5%, and were issued with an original discount of 2%, and mature on February 24, 2024. Additionally on February 22, 2018, Prospect entered into an Amended and Restated ABL Guarantee And Security Agreement. Under this agreement, the maximum borrowing is $250 million, and the facility bears interest at a variable base rate plus an applicable spread, contingent on the Prospect's ABL Facility availability, as defined in the agreement. The facility matures on February 22, 2023.

Schedule of Expenditures of Federal Awards

Prospect CharterCARE RWMC, LLC

Schedule of Expenditures of Federal Awards
For the Year Ended September 30, 2017

Federal grantor/pass-through grantor	CFDA number	Pass-through number	Expenditures
Department of Health and Human Services:			
Environmental Public Health and Emergency Response	93.074	N/A	26,472
Cancer Research Manpower	93.398	N/A	106,269
Cardiovascular Diseases Research	93.837	N/A	404,498
Allergy and Infectious Diseases Research - Allergy and Infectious Diseases Allergy and Infectious Diseases	93.855	N/A	47,326
Diabetes, Digestive, and Kidney Diseases Extramural Research	93.847	N/A	229,374
Heart Lung and Blood	93.837	N/A	149,098
Total Department of Health and Human Services			963,037
Total direct programs			963,037
Passed through from other organizations:			
Research and development program:			
Department of Defense: Passed through University of Washington	12.420	W81XWH-16-1-0152	18,714
Department of Defense: Passed through The Research Foundation for State University of New York (SUNY)	12.420	W81XWH-17-1-0444	1,793
Department of Health and Human Services:			
Department of Health and Human Services: Passed Through University of Rhode Island	93.969	1UB4HP19208-01-00	944
Total passed-through from other organizations			21,451
Total expenditures of federal awards			$ 984,488

See accompanying notes to schedule of expenditures of federal awards.

Prospect CharterCARE RWMC, LLC

Notes to Schedule of Expenditures of Federal Awards
For the Year Ended September 30, 2015

1. Definition of Reporting Entity

The Schedule of Expenditures of Federal Awards presents the activity of all federal awards of Prospect CharterCARE RWMC, LLC ("RWMC"). All federal awards received directly from federal agencies, as well as federal awards passed through other agencies, are included in this schedule.

2. Basis of Presentation

The information in this Schedule is presented in accordance with the requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Because the Schedule presents only a selected portion of the operations of the Company, it is not intended to and does not present the financial position, changes in net assets or cash flows of the Company.

Independent Auditor's Reports Required by the Uniform Guidance and *Government Auditing Standards*

![BDO]

Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

Board of Directors
Prospect CharterCARE RWMC, LLC
Los Angeles, California

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the consolidated financial statements of Prospect CharterCARE RWMC, LLC (the "Company"), which comprise the consolidated balance sheet as of September 30, 2017 the related consolidated statements of operations, member's equity, and cash flows for the years then ended, and the related notes to the consolidated financial statements, and have issued our report thereon dated April 9, 2018.

Internal Control Over Financial Reporting

In planning and performing our audit of the consolidated financial statements, we considered the Company's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the Company's consolidated financial statements will not be prevented, or detected and corrected on a timely basis. We consider the deficiencies described in the accompanying schedule of findings and questioned costs to be material weaknesses (*2017-001*).

A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

BDO

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Company's consolidated financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of consolidated financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

The Company's Response to Findings

The Company's response to the findings identified in our audit are described in the accompanying schedule of findings and questioned costs. The Company's response was not subjected to the auditing procedures applied in the audit of the consolidated financial statements and, accordingly, we express no opinion on it.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Company's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Company's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

BDO USA, LLP

April 9, 2018

BDO

Tel: 714-957-3200
Fax: 714-957-1080
www.bdo.com

600 Anton Blvd., Suite 500
Costa Mesa, CA 92626

Independent Auditor's Report on Compliance for Each Major Federal Program; Report on Internal Control Over Compliance Required by the Uniform Guidance

Board of Directors
Prospect CharterCARE RWMC, LLC
Los Angeles, California

Report on Compliance for Each Major Federal Program

We have audited Prospect CharterCARE RWMC, LLC's (the "Company") compliance with the types of compliance requirements described in the *OMB Compliance Supplement* that could have a direct and material effect on each of the Company's major federal programs for the year ended September 30, 2017. The Company's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for each of the Company's major federal programs based on our audits of the types of compliance requirements referred to above. We conducted our audits of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the Company's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of the Company's compliance.

Opinion on Each Major Federal Program

In our opinion, the Company complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended September 30, 2017.

Report on Internal Control Over Compliance

Management of the Company is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the Company's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. *A material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. *A significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

BDO USA, LLP

April 9, 2018

Schedule of Findings and Questioned Costs

Prospect CharterCARE RWMC, LLC

Schedule of Findings and Questioned Costs
For the Year Ended September 30, 2017

Section I - Summary of Auditor's Results

Financial Statements

Type of auditor's report issued:	Unmodified			
Internal control over financial reporting:				
Material weakness(es) identified?	X	yes		no
Significant deficiency(ies) identified		yes	X	none reported
Noncompliance material to financial statements noted?		yes	X	no

Federal Awards Section

Internal control over major programs:				
Material weakness(es) identified?		yes	X	no
Significant deficiency(ies) identified		yes	X	none reported
Type of auditor's report issued on compliance for major programs:	Unmodified			
Any audit findings disclosed that are required to be reported in accordance with OMB Circular A-133, section .510(a)?		yes	X	no

Identification of major programs:

CFDA Number/Contract Number	*Name of Federal Program or Cluster*
Various	Research and Development Cluster

Dollar threshold used to distinguish between Type A and Type B programs:	$750,000			
Auditee qualified as low-risk auditee?		yes	X	no

(Continued)

Section II - Financial Statement Findings

Finding 2017-001

Condition

The Company has a material weakness in internal controls over financial reporting. There were certain, material additional post-closing adjustments identified as a result of our audit procedures, which were not identified by the Company's internal control over the financial statement close process.

Cause

The internal control over financial reporting were not effective in identifying certain required adjustments to the financial statements.

Effect

As a result of this material weakness, the financial reporting process audit adjustments were made to the Company's financial statements in order to be presented in accordance with accounting principles accepted in the United States of America.

Recommendation

The Company should review its policies and procedures over the financial close and reporting process as well as the adequacy of its internal resources.

Views of Responsible Officials

Management agrees with the findings above and has already taken actions to strengthen the internal controls which include the hiring of a Chief Accounting Officer at PMH who will oversee the Company's financial statement close process.

Section III - Federal Award Findings and Questioned Costs

There were no findings and questioned costs for federal awards (as defined in 2 CFR 200.516(a)) that were required to be reported.

PROSPECT MEDICAL HOLDINGS, INC.

Consolidated Financial Statements

As of and for the Years Ended September 30, 2018 and 2017

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.

BDO

Prospect Medical Holdings, Inc.

Contents

	Page
Independent Auditor's Report	3
Consolidated Financial Statements:	
Consolidated Balance Sheets	4 - 5
Consolidated Statements of Operations	6
Consolidated Statements of Comprehensive (Loss) Income	7
Consolidated Statements of Stockholder's (Deficit) Equity	8
Consolidated Statements of Cash Flows	9 - 10
Notes to Consolidated Financial Statements	11 - 62

BDO

Tel: 714-957-3200
Fax: 714-957-1080
www.bdo.com

600 Anton Blvd., Suite 500
Costa Mesa, CA 92626

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, 2018 and 2017, and the related consolidated statements of operations, statements of comprehensive (loss) income, statements of stockholder's (deficit) equity, 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, 2018 and 2017, 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

January 25, 2019

Prospect Medical Holdings, Inc.

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

September 30,	2018	2017
Assets		
Current assets		
Cash and cash equivalents	$ 7,694	$ 27,109
Restricted cash	1,742	30,761
Restricted investments	23,779	15,810
Patient accounts receivable, net of allowance for doubtful accounts of $193,439 and $141,775 at September 30, 2018 and 2017, respectively	350,789	358,914
Due from government payers	32,833	51,152
Other receivables, prepaid expenses and other current assets	128,378	191,190
Income tax receivable	2,737	-
Inventories	37,461	36,967
Hospital fee program receivable	211,454	59,209
Total current assets	796,867	771,112
Property, improvements and equipment, net	623,963	576,933
Deferred income taxes, net	1,975	104,323
Goodwill	305,126	310,695
Intangible assets, net	33,619	40,794
Other assets	57,083	58,543
Total assets	$ 1,818,633	$ 1,862,400

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,	2018	2017
Liabilities and Stockholder's (Deficit) Equity		
Current liabilities:		
Accrued medical claims and other healthcare costs payable	$ 62,933	$ 55,485
Accounts payable and other accrued liabilities	328,431	320,246
Accrued salaries, wages and benefits	177,554	144,287
Hospital fee program liability	65,967	1,968
Due to government payers	30,615	23,754
Income taxes payable	-	42,793
Revolving line of credit, net	207,645	113,061
Current portion of capital leases	14,348	11,315
Current portion of long-term debt	18,429	12,509
Other current liabilities	27,831	17,762
Total current liabilities	933,753	743,180
Long-term debt, net of current portion	1,099,441	625,719
Malpractice reserves	77,280	60,722
Capital leases, net of current portion	35,853	37,612
Asset retirement obligations	6,179	6,022
Other long-term liabilities	34,355	21,465
Pension obligations	254,121	300,364
Total liabilities	2,440,982	1,795,084
Commitments and contingencies		
Stockholder's (deficit) equity:		
Common stock, $0.01 par value; 100 shares authorized, issued and outstanding at September 30, 2018 and 2017	1	1
Additional paid-in capital	23,961	22,398
Accumulated other comprehensive income	21,303	8,148
(Accumulated deficit) retained earnings	(676,930)	24,165
Total stockholder's (deficit) equity attributable to Prospect Medical Holdings, Inc.	(631,665)	54,712
Non-controlling interests	9,316	12,604
Total stockholder's (deficit) equity	(622,349)	67,316
Total liabilities and stockholder's (deficit) equity	$ 1,818,633	$ 1,862,400

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Operations
(in thousands)

For the Years Ended September 30,	2018	2017
Revenues:		
Net Hospital Services revenues	$ 2,766,929	$ 2,538,695
Provision for bad debts	(119,414)	(91,203)
Net Hospital Services revenues less provision for bad debts	2,647,515	2,447,492
Medical Group revenues	334,408	391,120
Net Global Risk Management revenues	33,863	20,752
Other revenues	53,848	55,133
Total net revenues	3,069,634	2,914,497
Operating Expenses:		
Hospital operating expenses	2,203,277	2,003,706
Medical Group cost of revenues	267,376	274,639
Global Risk Management cost of revenues	20,430	10,396
General and administrative	529,194	454,576
Depreciation and amortization	97,814	104,348
Total operating expenses	3,118,091	2,847,665
Operating income from unconsolidated joint ventures	2,599	5,388
Operating (loss) income	(45,858)	72,220
Other (income) expense:		
Interest expense and amortization of deferred financing costs, net	101,889	73,190
Loss on early extinguishment of debt	18,422	-
Bargain purchase gain	-	(30,010)
Goodwill impairment	18,800	-
Other expense (income), net	2,148	(1,861)
Total other expense, net	141,259	41,319
(Loss) income before income taxes	(187,117)	30,901
Income tax provision	61,497	554
Net (loss) income from continuing operations	(248,614)	30,347
Income from discontinued operations:		
Income from discontinued operations	-	7,738
Income tax provision	-	2,966
Income on discontinued operations, net of taxes	-	4,772
Net (loss) income before allocation to non-controlling interests	(248,614)	35,119
Net (loss) income attributable to non-controlling interests	(4,449)	867
Net (loss) income attributable to Prospect Medical Holdings, Inc.	$ (244,165)	$ 34,252

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Comprehensive (Loss) Income
(in thousands)

For the Years Ended September 30,	2018	2017
Net (loss) income attributable to Prospect Medical Holdings, Inc.	$ (244,165)	$ 34,252
Other comprehensive income, net of tax:		
Pension obligation and other post-retirement benefits adjustment (net of $6,833 and $(1,794) tax)	12,995	(3,646)
Debt and equity securities, unrealized gain	160	456
Total other comprehensive income (loss), net of tax	13,155	(3,190)
Total comprehensive (loss) income	$ (231,010)	$ 31,062

See accompanying notes to the consolidated financial statements.

CIIH16-000789

Prospect Medical Holdings, Inc.

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

	Number of Common Shares	Common Stock	Additional Paid-in Capital	Accumulated Other Comprehensive Income	Retained Earnings (Accumulated Deficit)	Prospect Medical Holdings, Inc. Stockholder's Equity	Non-controlling Interests	Total Stockholder's (Deficit) Equity
Balance at October 1, 2016	100	$ 1	$ 21,277	$ 11,338	$ (10,087)	$ 22,529	$ 7,227	$ 29,756
Options exercised	-	-	3	-	-	3	-	3
Stock-based compensation	-	-	1,118	-	-	1,118	-	1,118
Non-controlling interest attributed to minority shareholders	-	-	-	-	-	-	4,510	4,510
Net income	-	-	-	-	34,252	34,252	867	35,119
Other comprehensive income, net of tax	-	-	-	(3,190)	-	(3,190)	-	(3,190)
Balance at September 30, 2017	100	1	22,398	8,148	24,165	54,712	12,604	67,316
Options exercised	-	-	853	-	-	853	-	853
Stock-based compensation	-	-	710	-	-	710	-	710
Non-controlling interest attributed to minority shareholders	-	-	-	-	-	-	1,161	1,161
Net income	-	-	-	-	(244,165)	(244,165)	(4,449)	(248,614)
Dividend paid to stockholder	-	-	-	-	(456,930)	(456,930)	-	(456,930)
Other comprehensive income, net of tax	-	-	-	13,155	-	13,155	-	13,155
Balance at September 30, 2018	100	$ 1	$ 23,961	$ 21,303	$ (676,930)	$ (631,665)	$ 9,316	$ (622,349)

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,	2018	2017
Operating activities		
Net (loss) income	$ (248,614)	$ 35,119
Adjustments to reconcile net (loss) income to net cash and cash equivalents provided by operating activities:		
Depreciation and amortization	97,814	104,348
Amortization of deferred financing costs, net	2,702	2,090
Goodwill impairment	18,800	-
Write-off of deferred financing costs	11,709	-
Amortization of original issue discount and premium, net	2,976	1,909
Write-off of asset retirement obligation	-	(272)
Write-off of original issue discount and premium	6,713	-
Provision for bad debts	119,414	91,203
Pension obligation net periodic benefit cost	12,403	13,688
Deferred income taxes, net	97,782	(50,248)
Stock-based compensation	710	1,118
Undistributed earnings from equity method investments	(2,599)	(5,552)
Loss (gain) on sale of equity method investments	280	(2,974)
Loss (gain) on disposal of assets	212	(2,870)
Bargain purchase gain	-	(30,010)
Changes in operating assets and liabilities, net of business combinations:		
Patient accounts receivable	(111,289)	(147,130)
Due to/from government payers, net	25,180	(14,063)
Other receivables, prepaid expenses and other current assets	64,660	(76,754)
Hospital fee program receivable	(152,242)	(16,170)
Inventories	(494)	(2,489)
Hospital fee program liability and deferred revenue	63,999	(16,716)
Income taxes payable/receivable, net	(45,530)	67,523
Deposits and other assets	1,580	19,593
Accrued medical claims and other healthcare costs payable	7,448	2,980
Accounts payable, other accrued liabilities and other long term liabilities	62,091	83,713
Pension obligation	-	(7,174)
Net cash and cash equivalents used in operating activities from discontinued operations	-	(623)
Net cash and cash equivalents provided by operating activities	35,705	50,239
Investing activities		
Purchases of property, improvements and equipment	(98,580)	(56,807)
Purchases of long-term investments	-	(991)
Proceeds from sale of equity method investment	-	2,245
Cash paid for acquisitions, net of cash received and working capital adjustments	(5,780)	(18,373)
Cash in escrow for acquisitions	-	-
Change in restricted cash for acquisitions	-	(21,562)
Proceeds from sale of property and improvements	726	7,840
Distribution received from equity method investments	2,150	2,089
Increase in investments	(7,315)	(10,786)
Net cash and cash equivalents used in investing activities from discontinued operations	-	5,884
Net cash and cash equivalents used in investing activities	(108,799)	(90,461)

Prospect Medical Holdings, Inc.

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

For the Years Ended September 30,	2018	2017
Financing activities		
Borrowings on Senior Secured Notes, net of original issue discount	1,097,600	-
Repayments on Senior Secured Notes	(622,788)	(6,250)
Borrowings on line of credit, net	209,000	59,515
Promissory note	-	3,500
Repayments on retired line of credit, net	(115,300)	-
Proceeds of other long-term debt	-	1,413
Repayments of long-term debt	(1,380)	(1,179)
Proceeds from financing leases, net	-	9,646
Repayment of financing leases	(2,450)	(683)
Repayments of capital leases	(12,419)	(12,313)
Proceeds from exercise of stock options	853	3
Cash paid for deferred financing costs	(19,833)	(2,990)
Change in restricted cash	29,019	(3,082)
Dividend paid to stockholder	(456,930)	-
Excess contribution to pension plan	(41,667)	-
Repayments of insurance premium financing	(10,026)	(9,836)
Net cash and cash equivalents provided by financing activities	53,679	37,744
Decrease in cash and cash equivalents	(19,415)	(2,478)
Cash and cash equivalents, beginning of year	27,109	29,587
Cash and cash equivalents, end of year	$ 7,694	$ 27,109
Supplemental disclosure of cash flow information		
Interest paid (including cash paid on debt extinguishment)	$ 63,650	$ 52,593
Income taxes (received) paid, net	$ (3,485)	$ 13,739
Schedule of non-cash investing and financing activities		
Equipment acquired under capital leases	$ 19,443	$ 12,959
Accrual of property, improvements and equipment	$ 19,995	$ -
Insurance premium financed	$ 9,900	$ 9,836
Partial satisfaction of long-term liability assumed from acquisition of PCC	$ 1,195	$ 1,537
Acquisition of NUMG	$ 7,452	$ -

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.

Liquidity

The Company had a net working capital deficit of $136,886,000 as of September 30, 2018 compared to net working capital surplus of $27,932,000 as of September 30, 2017, respectively. Additionally, the Company had a net loss before income taxes of $187,117,000 for the year ended September 30, 2018 compared to net income before income taxes of $30,901,000 for the year ended September 30, 2017. As of September 30, 2018, the Company has a stockholder's deficit of $622,349,000 compared to stockholder's equity of $67,316,000, as of September 30, 2017. Cash and cash equivalents generated by operations declined to $35,705,000 from $50,239,000 for the years ended September 30, 2018 and 2017, respectively, and total change in cash and cash equivalents decreased year on year from a decline of $2,478,000 for the year ended September 30, 2017 to a decline of $19,415,000 for the year ended September 30, 2018. Total debt, net of discount/ premiums and deferred finance charges increased to $1,117,870,000 at September 30, 2018 compared to $638,228,000 at September 30, 2017. Such increase was primarily due to the Company's entry into New Senior Secured Credit Facilities during the year ended September 30, 2018 (Note 9). As part of the New Senior Secured Credit Facilities, the Company entered into a restated and amended revolving credit facility with a maximum revolving commitment of $250.0 million, which is expandable to $325.0 million. The balance outstanding at September 30, 2018 on the amended revolving credit facility was $207,645,000 comparable to $113,061,000 on the existing revolving credit facility at September 30, 2017. At September 30, 2018, the available balance on the line was approximately $41.0 million. Cash and cash equivalents declined from approximately $27.1 million at September 30, 2017 to approximately $7.7 million at September 30, 2018. The Company has various initiatives in place to generate positive cash flows from operations. From a revenue generating perspective, these include a focus on improving charge capture, improving the success rate on denials, and increasing reimbursements through rate negotiations with managed care payors, as well as improving volumes. From a cost cutting perspective, the initiatives include improvements to labor productivity and the reduction in overtime and use of registry, as well as better controls on supply and pharmacy contracts. Further, there are initiatives to focus on improving both productivity and volumes from the Company's physician groups. The Company is currently investigating new sources of liquidity which may include discussions with both the Company's investors and lenders in relation to additional borrowings. On January 25, 2019, Ivy Holdings made an equity contribution in the amount of $40 million (see Note 15). The Company believes that it will have sufficient cash flows from operations and available revolving facilities to provide sufficient capital resources to sustain operations, investing activities and financing for at least the next twelve months from the date these financial statements were available to be issued.

Hospital Services Segment

As of September 30, 2018, through its subsidiaries the Company owns 20 acute care and behavioral hospitals and multi-level elder care facilities in Southern California, Texas, Rhode Island, New Jersey, Pennsylvania and Connecticut with approximately 3,700 licensed beds, and a network of specialty and primary care clinics. The Hospital Services segment subsidiaries are wholly-owned by Prospect, except for the facilities in Rhode Island, in which Prospect has an 85% interest in the subsidiary that owns such facilities.

Admitting physicians are primarily practitioners in the local area. The hospitals have payment arrangements with Medicare, Medicaid 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 monthly fees ("Capitation"). 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 healthcare services for its affiliated physician organizations in California, Texas, Rhode Island, Connecticut, Pennsylvania and New Jersey. The California network consists of various physician organizations that are generally wholly-owned by Prospect Medical Group, Inc. ("PMG") and managed by the two medical management company subsidiaries that are wholly-owned by Prospect. The Medical Group segment also owns clinic facilities through New Genesis Medical Association ("NGMA") that operates by employing physicians to serve its patients. PMG and NGMA are owned by a nominee physician shareholder pursuant to an assignable option agreement, under which 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.

Most of the physician organizations have entered into Management Service Agreements ("MSA") with Prospect Medical Systems Inc., ("PMS"), and have agreed to pay a management fee to PMS, which is based in part on the costs to the management company and on a percentage of revenues. In return for payment of the management fee, PMS 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, PMS has assumed the obligations for all facilities and employs physician and non-physician personnel for administrative services. The management fee is earned based on a combination of percentage of revenue and share of pre-tax income. The management fees fluctuate based on the revenue and profitability of each physician organization. The Management Agreements are not terminable by the physician organization except in the case of gross negligence, fraud or other illegal acts, or bankruptcy, of PMS.

Prospect consolidates the revenues and expenses of all the physician organizations (except for one entity that is a 50/50 joint venture, which is accounted for under the equity method) from the respective dates of execution of the Management Agreements. All significant inter-entity balances have been eliminated in consolidation. In the case of the joint venture, 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 the joint venture for managing the other owners' share of the joint venture operations.

Prospect has also entered into management services 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. These management services agreements are terminable in accordance with the agreements.

The affiliated physician organizations provided medical services to a combined total of approximately 442,000 and 355,000 enrollees as of September 30, 2018 and 2017, respectively. The enrollees include approximately 255,000 and 159,000 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, 2018 and 2017, respectively. The total paid member months including managed enrollees, for the years ended September 30, 2018 and 2017 was approximately 5,360,000 and 3,991,000, respectively.

Global Risk Management Segment

The Global Risk Management segment has 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 Services and Medical Group segments.

Corporate Segment

The Company established a captive insurance company, Prospect Medical Holding Risk Retention Group, Inc. ("RRG") on June 20, 2016 in the state of Vermont. RRG was formed to provide primary insurance coverage for hospital and physician professional and general liability risks for the Company's subsidiary health care organizations located in Pennsylvania on a claims-made basis. RRG is wholly owned by Prospect Penn, LLC, which is wholly-owned directly by the Company. All intercompany balances and transactions are eliminated upon consolidation.

Additionally, the Company has a captive insurance company based in the Cayman Islands, Connecticut Healthcare Insurance Company ("CHIC"), which provides hospital and physician professional and general liability coverage to all of the Company's hospitals and affiliated subsidiaries except for Crozer and its Pennsylvania subsidiaries (Covered by RRG above). Effective January 1, 2018, ownership of CHIC was transferred from Prospect ECHN, Inc. to make CHIC a direct wholly-owned subsidiary of the Company. CHIC is an exempted Company with limited liability under the Companies Law of the Cayman Islands and it holds a Class "B(i)" Insurer's License under Section 4(3)(b) of the Cayman Islands Insurance Law 2010. CHIC's principal activity is to issue primary policies for hospital liabilities covering Prospect, its subsidiaries and employees, on a claims-made basis. The Company procured excess healthcare professional liability and umbrella liability insurance policy on a claims-made basis covering healthcare professional liability, general liability, automobile liability, employer's liability, helipad liability and non-owned aircraft liability of the Company and its affiliates. This excess coverage is purchased entirely from unrelated commercial insurers. CHIC also provides a deductible reimbursement policy for workers compensation to the Company's California and Connecticut hospital facilities all of which have high deductible program structures or are qualified self-insureds.

On January 1, 2018, CHIC began providing an employee benefit stop-loss policy to all Company subsidiaries. Unlimited excess coverage is purchased from unrelated reinsurance companies.

The Company does not allocate interest expense related to acquisition debt or income taxes to the other reporting segments.

2. Significant Accounting Policies

Principles of Consolidation and 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 Inc. and Ivy Intermediate Holding Inc. The Company has a variable interest in various entities under the Medical Group segment due to the existence of two call options, 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 physician organizations under the Medical Group segment which allows the Company to direct the activities of such physician organizations that most significantly impact their economic performance, retain the right to receive expected residual returns and assume the obligation to absorb losses. Accordingly, the Company is considered to be the primary beneficiary and these entities are consolidated within the accompanying consolidated financial statements.

Operating results for acquisitions are consolidated with the Company's financial statements from their acquisition dates. All significant intercompany balances and transactions have been eliminated in consolidation. Non-controlling interests in less-than-wholly-owned consolidated subsidiaries of the Company are presented as a component of total equity to distinguish between the interests of the Company and the interests of the non-controlling owners.

The consolidation of these entities does not change any legal ownership, and does not change the assets or the liabilities and equity of the Parent Entity as a stand-alone entity. These entities had total revenues of approximately $310,720,000 and $413,866,000 and total net loss of approximately $2,184,000 and net income of approximately $20,298,000 for the years ended September 30, 2018 and 2017, respectively.

The assets and liabilities of the variable interest entities are as follows (in thousands):

September 30,	2018	2017
Assets		
Total current assets	$ 89,882	$ 177,525
Total non-current assets	90,465	18,044
Total assets	$ 180,347	$ 195,569
Liabilities		
Total current liabilities	$ 69,097	$ 82,082
Total long-term liabilities	730	700
Total liabilities	$ 69,827	$ 82,782

Reclassifications

Certain reclassifications were made to the prior year consolidated financial statements in order to conform to the current year presentation.

Revenues

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

For the Years Ended September 30,	2018	2017
Net Hospital Services		
Inpatient	$ 1,625,187	$ 1,423,273
Outpatient	958,715	955,543
Capitation	157,622	110,330
Other	25,405	49,549
Total Hospital Services revenues	2,766,929	2,538,695
Less: Provision for bad debts	(119,414)	(91,203)
Total net Hospital Services revenues less provision for bad debts	2,647,515	2,447,492
Medical Group		
Capitation	307,444	369,185
Management fees	10,501	7,977
Other	16,463	13,958
Total Medical Group revenues	334,408	391,120
Global Risk Management		
Capitation	23,095	13,097
Other	10,768	7,655
Total Global Risk Management revenue	33,863	20,752
Other revenues	53,848	55,133
Total net revenues	$ 3,069,634	$ 2,914,497

The revenues of acquisitions have been included in the accompanying consolidated financial statements for the period from their respective acquisition dates. These revenues also exclude revenues from discontinued operations.

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, managed care and other insurance programs that

CIIH16-000797

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 and exclude revenues from discontinued operations (in thousands):

Years ended September 30,	2018	2017
Medicare	$ 850,197	$ 848,221
Medicaid	905,322	699,340
Managed Care	631,209	607,362
Self-Pay/Other	197,174	223,893
Capitation	157,622	110,330
Other	25,405	49,549
Total patient service revenue	$ 2,766,929	$ 2,538,695

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 persons with end-stage renal disease and certain other beneficiary categories, including eligible disabled persons. Most inpatient hospital services rendered to Medicare program beneficiaries are paid on a fee-for-service basis at prospectively determined rates per discharge, according to a patient classification system based on clinical, diagnostic, and other factors. Most outpatient services also are paid on a fee-for-service basis generally using prospectively determined rates. The Company receives, as appropriate, Medicare disproportionate share hospital ("DSH") and bad debt payments at tentative rates, with final settlement determined after submission of the annual Medicare cost report and audit thereof by the Medicare Administrative Contractor. The Company also receives, as appropriate, Medicare uncompensated care DSH payments, which are generally not subject to cost report audit except to determine eligibility for Medicare DSH. The Company also receives Medicare outlier payments on an ongoing basis during the year for cases that are unusually costly, and under certain circumstances these payments may be reconciled to more closely reflect the costs in excess of outlier thresholds after the submission and audit of the annual Medicare cost report. Normal estimation differences between filed settlements and amounts accrued are reflected in net patient service revenue.

The Company is reimbursed by Medicare for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare Administrative Contractor. The estimated amounts due to or from the program are reviewed and adjusted annually based on the status of such audits and any subsequent appeals. Differences between final settlements and amounts accrued in previous years are reported as adjustments to net patient service revenue in the year that examination is substantially completed.

Although services for most Medicare beneficiaries are paid by the Federal government on a fee-for-service basis, approximately one-third of Medicare beneficiaries are enrolled in a "Medicare Advantage" plan, which is a type of health plan that contracts with the Medicare program to provide hospital and medical benefits to Medicare beneficiaries. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-For-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. For Medicare beneficiaries enrolled in a Medicare Advantage plan, most Medicare services are covered by the plan and are not paid for under fee-for-service Medicare. Certain Medicare Advantage plans make capitation payments to the Company using a "Risk Adjustment model," which compensates providers based on the health status (acuity) of each enrollee. Providers with higher acuity enrollees generally will receive more and those with healthier enrollees will receive less.

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 programs in each state in which it operates at prospectively determined rates for inpatient services and a mixture of fee schedules and cost reimbursement methodologies for outpatient services depending on the specific state regulations. Cost report settlements are recorded based upon as-filed cost reports (if required by the respective facility's state) and adjusted for tentative and final settlements, if any.

The various states in which the Company operates have additional programs in which certain of the Company's facilities participate in, related to medical facilities serving a disproportionate number of low-income patients. The following table shows the revenues generated by these programs during the years ended September 30, 2018 and 2017 (in thousands), which are reflected in Net Hospital Services revenues in the accompanying consolidated statements of operations:

For the years ended September 30,	2018	2017
California Medi-Cal Disproportional Share ("CA DSH") *(a)*	$ 13,761	$ 21,460
Texas Section 1115 Waiver - UCC Pool *(b)*	(7,324)	10,492
Texas Section 1115 Waiver - DSRIP Pool *(b)*	12,712	12,712
Rhode Island DSH and UPL *(c)*	19,035	24,402
New Jersey Health Care Subsidy Funds *(d)*	900	9,040
Pennsylvania State Programs *(e)*	40,344	30,719
Connecticut Medicaid DSH revenue *(f)*	33,152	14,301
	$ 112,580	$ 123,126

(a) Revenues are accrued based on the expected total annual awards. Differences between the estimated and the actual awards are recorded in the period they become known, and are subject to retrospective revision prior to finalization, which could lead to material retractions. The Company records retrospective retractions when they are estimable and probable. Retrospective additional revenues are recorded when the amounts are received.

(b) The program has consisted of three major components: statewide Medicaid managed care, the Uncompensated Care ("UC") pool, and "Delivery System Reform Incentive Payment" (DSRIP). The UC pool contains $3.1 billion in annual funding to cover, among other things, "shortfall" between the cost of providing care to an uninsured patient and the reimbursement amount that Medicaid would pay for that service. DSRIP is an incentive pool with another $3.1 billion in annual funding that allows providers to earn payments for meeting certain CMS and HHSC-approved reporting and

performance metrics for "a wide range of innovative projects. Historically, Nix Health has received payments from both the DSRIP and UC pools. Texas' Medicaid Section 1115 Waiver that CMS approved in December 2017 (the "2017 Waiver") extended the program for an additional five years from October 2017 through September 2022 but made significant changes to the pools. The UC pool will remain at $3.1 billion until September 2019 and will subsequently be adjusted based on aggregate provider data concerning charity care cost in 2017. Widespread failure by providers to report accurate charity care data will result in a "default" pool size of $2.3 billion. The DSRIP program will be phased out during the five-year period as federal matching funds of DSRIP activities will be reduced each year until it ceases entirely in 2021. Some of these funds might be available to support other programs, or if the original DSRIP projects will be continued or incorporated into managed care. Moreover, the impact of UC pool changes, particularly in relation to charity care hospitals, while currently uncertain, will become more evident with each passing deadline over the new Waiver's five-year term.

At September 30, 2017, the Company had recorded a net receivable of approximately $17 million (net of reserves of approximately $5 million) related to State fiscal years 2015 through 2017 in respect of UC monies owed to the Company. As a result of a lawsuit by a hospital in Texas against CMS in relation to the calculation of uncompensated care, the Texas Health and Human Services Commission set aside reserves as a contingency against a reallocation of those funds, pending the outcome of the lawsuit. During the year ended September 30, 2018, the hospital won the lawsuit and it is under appeal. At September 30, 2018, given the additional uncertainty, the Company has recorded a reduction to revenue of approximately $17 million. Accordingly, the net revenues recorded under the UC program for the year ended September 30, 2018 are negative.

(c) Rhode Island hospitals receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low income patients. 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 Company recorded $16,925,000 and $20,137,000 of expense during the years ended September 30, 2018 and 2017, respectively, as a result of the license fee.

(d) The New Jersey Health Care Reform Act of 1992 established Health Care Subsidy Funds to provide certain hospitals in New Jersey with funds necessary to provide charity care and other forms of uncompensated care.

(e) The Company's Pennsylvania hospitals are participants in Pennsylvania statewide hospital assessment, Medicaid Modernization Assessment ("MMA"), which has been extended through June 30, 2023. The assessments have enabled the Commonwealth of Pennsylvania to maintain the updated inpatient payment system, make changes to existing disproportionate share/supplemental payments, and to create new payments where applicable. The Company has also recognized revenues from the Pennsylvania Community Access Fund ("CAF").

(f) The Company's hospitals in Connecticut participate in its Medicaid DSH program and receive additional reimbursement for treating a disproportionate share of low income patients. Connecticut assesses a provider tax based on total net revenue received by a hospital for the provision of inpatient hospital services and outpatient hospital services. The amount of the provider tax is currently the subject of litigation. The state's two-year budget adopted in late 2017 provides for an increase in the provider tax, as well as additional supplemental payments to be paid to hospitals. CMS has approved both parts of the arrangement: the increase in the provider tax, and the additional supplemental payments to be paid to certain hospitals. The state has noted

the potential that further negotiations may be needed between the hospital association and the state given that increases in a portion of the state payments may exceed federal limits.

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.

Laws and regulations governing the third-party payor arrangements are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Normal estimation differences between subsequent cash collections on patient accounts receivable and net patient accounts receivable estimated in the prior year are reported as adjustments to net patient service revenue in the current period.

The following is a summary of due from and due to governmental payers at September 30, 2018 and 2017 (in thousands):

September 30,	2018	2017
Due from government payers:		
Medicaid Disproportionate Share (DSH)	$ 16,673	$ 20,414
Medicare cost report settlements	5,877	7,707
Medicaid Section 1115 receivable	10,283	23,031
	$ 32,833	$ 51,152
Due to government payers:		
Medicare cost report settlements	$ 21,616	$ 17,712
Medicaid cost report settlements	8,999	6,042
	$ 30,615	$ 23,754

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.

California Hospital Fee Program

The Company recognizes revenues related to supplemental Medi-Cal payments under California provider fee programs. These programs are funded by quality assurance fees paid by participating hospitals and matching federal funds.

Based on formulas contained in the legislation as well as modeling done by the California Hospital Association, the Company recognized supplemental payments, included in net patient service revenue, and quality assurance fee expense, included in general and administrative expenses in the accompanying consolidated statements of operations as follows (in thousands):

Years Ended September 30,	2018	2017
Hospital services revenues	$ 284,122	$ 70,620
General and administrative expenses	123,996	46,127
Net pre-tax impact	$ 160,126	$ 24,493

As of September 30, 2018 and 2017, the Company had receivables related to the California Hospital Fee Program of approximately $211,454,000 and $59,209,000, respectively, and had liabilities related to the California Hospital Fee Program of approximately $65,967,000 and $1,968,000, respectively, in the accompanying consolidated balance sheets.

Legislation approved by the State of California in October 2013 created the framework for the hospital fee program to continue in perpetuity without requiring further legislation from the State. In November 2016, California voters approved Proposition 52, which made the hospital fee program permanent and prohibits lawmakers from diverting Medi-Cal funds to pay for anything other than their intended purpose. In December 2017, CMS approved the fee-for-service inpatient and outpatient payments and taxes for the period from January 1, 2017 to June 30, 2019 ("QAF 5"). The increased payments to the Medi-Cal managed plans for the current California Hospital Fee Program period are anticipated to occur the first half of Calendar 2019 when it is anticipated CMS will approve the amended Health Plan contracts. During the year ended September 30, 2018, the Company recorded revenues under the QAF 5 program of $111.9 million related to periods prior to the current fiscal year. Additionally, the Company recorded revenues related to previous hospital fee programs prior to QAF 5 of $14.6 million during the year ended September 30, 2018.

Charity Care

The Company provides charity care to patients who lack financial resources and are deemed to be medically indigent based on criteria established under the Company's charity care policy. This care is provided without charge or at amounts less than the Company's established rates. Because the Company does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The direct and indirect costs related to this care totaled approximately $10,623,000 and $10,653,000 for the years ended September 30, 2018 and 2017, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. In addition, the Company provides services to other medically indigent patients under various state Medicaid programs. Such programs pay amounts that are less than the cost of the services provided to the recipients. The Company has not changed its charity care or uninsured discount policies during the years ended September 30, 2018 and 2017.

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 was 36% and 28% at September 30, 2018 and September 30, 2017, respectively. The allowance for doubtful accounts was $193,439,000 and $141,775,000 as of September 30, 2018 and 2017, respectively.

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.

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 physician organizations 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. During the years ended September 30, 2018 and 2017, the Company returned and recognized as a reduction in revenue, approximately $3,220,000 and $13,105,000, respectively, as a result of the final Hierarchical Condition Category ("HCC") reconciliation.

HMO contracts also include provisions to share in the risk for hospitalization, whereby the physician organization 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, 2018 and 2017, Medical Group revenues included approximately $7,125,000 and $73,454,000, respectively, relating to risk-sharing profit. At September 30, 2018 and 2017, contingent liabilities for carry-forward risk-pool deficits expected to be forgiven, or offset against future surpluses were approximately $92,700,000 and $30,543,000, 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. Performance and incentive revenues recorded during the years ended September 30, 2018 and 2017 were $5,751,000 and $4,469,000, 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 10% of revenues. Management fee revenues recorded during the years ended September 30, 2018 and 2017 were \$5,656,000 and \$6,261,000, respectively. Management fees for revenue for entities that are consolidated are eliminated on consolidation.

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 period. See Note 13 for changes in claims estimates during the years ended September 30, 2018 and 2017.

The Company has contractual reimbursement obligations to providers and discretionary incentive payment obligations to physicians. These payments are in large part predicated on the pay-for-performance, shared risk revenues, and favorable senior capitation risk adjustment payments received by the Company from the health plans. 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. During this period, the Company also finalizes the physician discretionary incentive.

The Company recorded physician incentives expense of approximately \$21,669,000 and \$41,808,000 for the year ended September 30, 2018 and 2017, respectively. As of September 30, 2018 and 2017, physician incentive accruals of approximately \$17,396,000 and \$31,193,000, respectively, were included in accounts payable and other accrued liabilities in the accompanying consolidated financial statements.

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. There were no such premium deficiencies recorded at September 30, 2018 and 2017, respectively.

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 the Hospital Services 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. During the years ended September 30, 2018 and 2017, the Global Risk Management Segment recognized capitation risk adjustments of $5,155,000 and $3,234,000, respectively.

Global Risk Management Cost of Revenues

The cost of health care services consists primarily of the transfer of capitation revenue to the Hospital Services 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. There were no such premium deficiencies recorded at September 30, 2018 or 2017.

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 5 to 40 years, buildings are depreciated over 5 to 40 years, equipment is depreciated over 2 to 15 years and furniture and fixtures are depreciated over 2 to 20 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 12, the Company is required to comply with certain seismic standards as required by the state of California by January 1, 2020 (subject to possible extension of up to 30 months to July 1, 2022, as described in Note 12). 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

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.

Through the year ended September 30, 2017, the Company tested for goodwill impairment as of September 30 each year. During the year ended September 30, 2018, the Company changed the date of the annual goodwill impairment test to July 1. The Company does not believe that the change in assessment date represents a material change in the application of applicable accounting literature. Impairment of goodwill is tested at the reporting unit level, by comparing the reporting unit's carrying amount, including goodwill, to the fair value of the reporting unit. The fair value of the reporting units are estimated. 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 Company has adopted new literature during the year ended September 30, 2018 which changes the goodwill impairment test from a two-step process to a one-step process, which consists of estimating 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. If the estimated fair value of the reporting unit is less than its carrying value, this indicates that goodwill is impaired, and impairment is recorded based on the deficiency of fair value compared to the carrying value. The Company's impairment test related to goodwill during the year ended September 30, 2018 resulted in a full impairment of goodwill related to the Chartercare and East Orange facilities. There were no impairment charges during the year ended September 30, 2017.

Intangible Assets

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, 2018 and 2017.

Insurance Reserves

Medical Malpractice Liability Insurance

The individual physicians who contract with the physician organizations carry their own medical malpractice insurance, some of which may be purchased from RRG or CHIC. 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. The Company's hospitals have a consolidated policy for professional and general liability insurance with separate retentions for each entity. The Pennsylvania MCARE fund provides the $500,000 in excess of $500,000 RRG malpractice coverage for Crozer.

For the current fiscal year, RRG provided primary malpractice insurance ($500,000 per occurrence and $2,500,000 in the aggregate) and general liability ($1,000,000 per occurrence and $2,000,000 in the aggregate). In addition, the RRG provided coverage for losses of $4,000,000 in excess of $1,000,000 for each hospital professional liability claim with no aggregate limit. The RRG also provides additional layers of excess coverage over $5,000,000 up to $20,000,000, which are 100% reinsured by third party insurance carriers through multiple layers. The excess coverage provided for general liability is over $10,000,000 up to $50,000,000, which is also 100% reinsured by third party carriers.

CHIC provided malpractice ($3,000,000 per occurrence and $9,000,000 in the aggregate) and general liability ($1,000,000 per occurrence and $3,000,000 in the aggregate) coverage for ECHN for the year ended September 30, 2017. During the year ended September 30, 2018, CHIC provided malpractice and general liability ($2,000,000 per occurrence) coverage for all facilities except Crozer. CHIC also provided an excess healthcare professional liability and umbrella liability insurance policy on a claims-made basis covering healthcare professional liability, general liability, automobile liability, employers' liability, helipad liability and non-owned aircraft liability. The limit provided was $60,000,000 for each loss event and in the annual aggregate excess of the primary coverage layers described above. This coverage was fully reinsured by third party carriers.

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 its hospitals. At September 30, 2018 and 2017, the total gross claims liability, was $77,280,000 and $60,722,000 and reinsurance recoverable on unpaid losses were $12,834,000 and $9,059,000, respectively, included in other assets on the accompanying consolidated balance sheets, and were estimated using a discount factor ranging from 3.5% to 4%.

Workers' Compensation Insurance

The workers' compensation coverage provides the statutory benefits required by law with a $500,000 deductible reimbursement policy provided by CHIC for the Company's entities located in California and Connecticut. The facilities in Texas have opted out of the Texas Workers' Compensation system as non-subscribers, and provide their employees with benefits for occupational injury or disease through an ERISA plan, and have an Employer's Excess Indemnity policy with a $25,000 deductible with limits of $10,000,000 per occurrence and $25,000,000 aggregate. The facilities in Rhode Island were fully insured for workers' compensation claims with no deductible. East Orange was fully insured for workers' compensation claims with no deductible from March 1, 2017 through September 30, 2018. Crozer has a workers' compensation policy with a $500,000 deductible. At September 30, 2018 and 2017, included in accrued salaries, wages and benefits are accruals for uninsured claims and claims incurred but not reported of approximately $27,776,000 and $28,329,000 and reinsurance recoverable on unpaid losses of $8,557,000 and $7,246,000, respectively, included in other assets on the accompanying consolidated balance sheets. The amounts are estimated based upon an actuarial valuation of claims experience, using a discount factor of 4%.

Reserve Methodology

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 the medical malpractice and workers' compensation 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.

Stock Options

Ivy Holdings has a stock option plan (the "Ivy Plan"), which is administered by the Compensation Committee of the Ivy Holdings Board. The 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 plan. These options granted under the Ivy Plan are exercisable into Ivy Holdings stock and vest based on a number of criteria.

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

Some of the Company's cash is restricted for various purposes including research, regulatory requirements and letters of credit. The Company is also 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. Restricted cash also include certificates of deposit with maturity dates of more than 90 days when purchased.

Restricted Investments

Investments in marketable securities, primarily mutual funds, and are classified as available for sale and are stated at fair value. Adjustments are recorded in the statements of other comprehensive income. Investment securities are exposed to various risk, such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is possible that changes in values of investment securities could occur in the near term and such changes could materially affect investment. These investments are held in the Company's captive insurance companies and are shown as restricted because the state/local regulators require their approval before dividends or return of capital to the Parent Entity.

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 and are classified as a deduction from the carrying amount of the related debt.

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, 2018 and 2017, the Company incurred $2,405,000 and $960,000 of interest and penalties related to income taxes, respectively.

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.

A consolidated federal tax return is filed for Ivy Holdings, with the exception of Nuestra Familia Medical Group Inc., ("Nuestra"), which files its own federal tax returns. The Company files separate state tax returns for California, Texas, Rhode Island, Pennsylvania, Connecticut, New Jersey and Florida. The Company's filed tax returns are generally subject to examination by the IRS and state tax boards for 3 to 4 years.

Sale-Leaseback Transactions

The Company evaluates sale-leaseback transactions by determining whether the transaction meets the qualifying criteria to be recognized as a sale-leaseback, including the transfer of risk and rewards of ownership as well as the absence of continuing involvement of the Company. When the qualifying criteria for a sale-leaseback transaction are not met, the Company accounts for the transaction as a financing (see Note 9).

Comprehensive Income (Loss)

Comprehensive income consists of net income and other gains and losses affecting stockholder's equity that, under generally accepted accounting principles, are excluded from net income (loss) attributable to the Company. For the Company, such items consist primarily of unrealized gains or losses on debt and equity securities as well as changes related to pension and other postretirement liabilities that are not recognized immediately in net periodic benefit costs (see Note 11).

Fair Value of Financial Instruments

Financial instruments consist primarily of cash and cash equivalents, restricted cash, restricted 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, 2018				
Mutual funds	$ 23,779	$ 23,779	$ -	$ -
Total	$ 23,779	$ 23,779	$ -	$ -
As of September 30, 2017				
Certificates of deposit	$ 850	$ 850	$ -	$ -
Mutual funds	14,960	14,960	-	-
Total	$ 15,810	$ 15,810	$ -	$ -

The Company's investments are classified within Level 1 of the fair value hierarchy because they are valued using quoted market prices. The Company's defined benefit pension plan assets are also measured at fair value (see Note 11).

The Company's carrying amount of long-term debt approximated fair value as of September 30, 2018 and 2017, respectively.

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 intangible assets when there are indications of impairment.

During the year ended September 30, 2018, the Company recorded approximately $18.8 million of impairment relating to goodwill, which is reflected in the accompanying consolidated statements of operations.

The Company uses the discounted cash flow approach, the guideline public company approach and the guideline transactions approach to estimate the residual value of the Company's goodwill. The measurement of goodwill is a Level 3 measurement.

The following table provides quantitative information related to the significant unobservable inputs to determine fair value and impairment of goodwill as of September 30, 2018:

Residual Value of Goodwill	Valuation Technique	Unobservable Input	Rates
$ -	Discounted Cash Flow	Weighted average cost of capital	9.3%
		Revenue growth rate	(1.8)% - 11.2%
	Guideline Public Company	LTM revenue multiple	0.5x
		NTM EBITDA multiple	7.0x

There were no nonrecurring measurements as of September 30, 2017.

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, 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 segment and from the Medicare and Medicaid 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.

For the years ended September 30, 2018 and 2017, the Hospital Services segment received a total of 64% and 61% of its net patient revenues from Medicare and Medicaid programs, respectively, and the Medical Group segment received a total of 63% and 64% for the years ended September 30, 2018 and 2017, respectively, of their capitation revenues from its five largest HMOs, as follows (in thousands):

Years Ended September 30,	2018	% of Total Revenue		2017	% of Total Revenue
Hospital Services:					
Government Payers:					
Medicare	$ 850,197	31%		$ 848,221	33%
Medicaid	905,322	33%		699,340	28%
Total	$ 1,755,519	64%		$ 1,547,561	61%
Medical Group:					
HMO A	$ 60,506	20%	HMO A	61,624	21%
HMO B	35,705	12%	HMO F	34,950	12%
HMO F	32,934	11%	HMO B	32,923	11%
HMO D	32,357	11%	HMO D	29,617	10%
HMO C	27,051	9%	HMO C	28,585	10%
Total	$ 188,553	63%		$ 187,699	64%

The Global Risk Management segment received all of their revenues from seven health plans during the years ended September 30, 2018 and 2017.

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 pension obligations and other postretirement benefit reserves, reserves for outcome of legislation and valuation allowances against deferred tax assets.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued ASU 2014-09, "Revenue from Contracts with Customers (Topic 606)" which defers the effective date of the revenue standard 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. October 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. The Company is currently evaluating the effect of this guidance on its consolidated financial statements.

In January 2016, the FASB issued ASU 2016-01, "Financial Instruments (Subtopic 825-10)". ASU 2016-01 requires all equity investments to be measured at fair value with changes in fair value recognized through net income (other than those accounted for under equity method of accounting or those that result in consolidation of the investee). ASU 2016-01 also requires an entity to present separately in other comprehensive income the portion of the total change in the fair value of a liability resulting from a change in the instrument-specific credit risk when the entity has elected to measure the liability at fair value in accordance with the fair value option for financial instruments. In addition, ASU 2016-01 eliminates the requirement to disclose the fair value of financial instruments measured at amortized cost for entities that are not public business entities. ASU 2016-01 is effective for annual and interim periods beginning after December 15, 2017. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)". The core principle of ASU 2016-02 is that a lessee should recognize the assets and liabilities that arise from leases, including operating leases. Under the new requirements, a lessee will recognize in the statement of financial position a liability to make lease payments (the lease liability) and the right-of-use asset representing the right to the underlying asset for the lease term. For leases with a term of 12 months or less, the lessee is permitted to make an accounting policy election by class of underlying asset not to recognize lease assets and lease liabilities. The recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee have not significantly changed from previous GAAP. The standard is effective for nonpublic entities for fiscal years beginning after December 15, 2019. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

In March 2016, the FASB issued ASU 2016-09, "Compensation - Stock Compensation (Topic 718)". The updated standard simplifies several aspects of the accounting for employee share-based payment transactions, including the accounting for income taxes, forfeitures, and statutory tax withholding requirements, as well as classification in the statement of cash flows. ASU 2016-09 is effective for non-public business entities for annual reporting periods beginning after December 15, 2017, including interim periods within those annual reporting periods. The Company is currently evaluating the impact of its pending adoption of the new standard on its consolidated financial statements.

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230)". The updated standard addresses eight specific cash flow issues with the objective of reducing diversity in practice. ASU 2016-15 is effective for non-public business entities for annual reporting periods beginning after December 15, 2018, including interim periods within those annual reporting periods. Early adoption is permitted. The Company is assessing the impact of the adoption of ASU 2016-15 on its consolidated financial statements.

In January 2017, the FASB issued ASU 2017-01, "Business Combinations (Topic 805): Clarifying the Definition of a Business." These amendments clarify the definition of a business. The amendments affect all companies and other reporting organizations that must determine whether they have acquired or sold a business. The definition of a business affects many areas of accounting including acquisitions, disposals, goodwill, and consolidation. The amendments are intended to help companies and other organizations evaluate whether transactions should be accounted for as acquisitions (or disposals) of assets or businesses. This update is effective for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2018. Early adoption is permitted under certain circumstances. The amendments should be applied prospectively as of the beginning of the period of adoption. The Company is evaluating the effect that this update will have on its consolidated financial statements and related disclosures.

In January 2017, the FASB issued ASU 2017-04, "Intangibles-Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment)". The new guidance is effective for fiscal years beginning after December 15, 2019 and interim periods within those fiscal years, and should be applied on a prospective basis. Early adoption is permitted for interim or annual goodwill impairment tests performed on testing dates after January 1, 2017. The new guidance simplifies the current two-step goodwill impairment test by eliminating Step 2 of the test. The new guidance requires a one-step impairment test in which an entity compares the fair value of a reporting unit with its carrying amount and recognizes an impairment charge for the amount by which the carrying amount exceeds the reporting unit's fair value, if any. The Company early adopted this standard in the current fiscal year.

In March 2017, the FASB issued ASU 2017-07, "Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost. The ASU amends ASC Topic 715, Compensation – Retirement Benefits, to require employers that present a measure of operating income in their statements of income to include only the service cost component of net periodic pension costs and net periodic postretirement benefit cost in operating expenses. The ASU also stipulates that only the service cost component of net benefit cost is eligible for capitalization. This guidance is effective for fiscal years beginning after December 15, 2018. Early adoption is permitted as of the beginning of an annual period for which financial statements have not been issued or made available for issuance. Disclosures of the nature of and reason for the change in accounting principle are required in the first interim and annual periods of adoption. The Company is currently evaluating the provisions of ASU 2017-07 and its impact on the Company's consolidated financial position, results of operations and cash flows.

In May 2017, the FASB issued ASU 2017-09, "Modification Accounting for Share-Based Payment Arrangements (Topic 718)", which identifies and provides guidance on the types of changes to share-based payment awards that an entity would be required to apply modification accounting under ASU 2016-09, Stock Compensation (Topic 718). Specifically, an entity would not apply modification accounting if the fair value, vesting conditions and classification of the awards are the same immediately before and after the modification. ASU 2017-09 is effective for annual periods beginning after December 15, 2017 and will be applied prospectively to awards modified on or after the effective date. The Company is currently evaluating the provisions of ASU 2017-09 and its impact on the Company's consolidated financial position, results of operations and cash flows.

In February 2018, the FASB issued ASU 2018-02, "Income Statement - Reporting Comprehensive Income (Topic 220): Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income", which allows a reclassification from accumulated other comprehensive income to retained earnings for the standard tax effects in accumulated other comprehensive income resulting from enactment of the comprehensive tax legislation commonly referred to as the Tax Cuts and Jobs Act (the "Tax Act") and corresponding accounting treatment recorded in the fourth quarter of 2017. The ASU is effective for all entities for fiscal years beginning after December 15, 2018. Early adoption of the amendments in this ASU is permitted. The Company is currently evaluating the provisions of ASU 2018-02 and its impact on the Company's consolidated financial position, results of operations and cash flows.

In August 2018, the FASB issued ASU 2018-14, "Compensation - Retirement Benefits - Defined Benefit plans - General (Topic 715-20): Disclosure Framework - Changes to the Disclosure Requirements for Defined Benefit Plans", which amends ASC 715 to add, remove and clarify disclosure requirements related to defined benefit pension and other postretirement plans. This ASU is effective for fiscal years ending after December 15, 2021. Early adoption is permitted. The Company is currently evaluating the provision of ASU 2018-14 and its impact on its consolidated financial statements and related disclosures.

In August 2018, the FASB issued ASU 2018-15, "Intangibles - Goodwill and Other - Internal - Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract", which provides guidance on implementation costs incurred in a cloud computing arrangement that is a service contract. Specifically, it amends ASC 350 to include in its scope implementation costs of a cloud computing arrangement that is a service contracts and clarifies that a customer should apply ASC 350-40 to determine which implementation costs should be capitalized in such a cloud computing arrangement. The Company has early adopted this literature for the year ended September 30, 2018.

3. Property, Improvements and Equipment

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

September 30,	2018	2017
Land and land improvements	$ 83,446	$ 86,214
Buildings and improvements	386,278	352,194
Leasehold improvements	28,971	26,641
Equipment	331,426	274,577
Furniture and fixtures	5,259	5,184
	835,380	744,810
Less: accumulated depreciation	(304,139)	(219,093)
	531,241	525,717
Construction in Progress	92,722	51,216
Property, improvements and equipment, net	$ 623,963	$ 576,933

At September 30, 2018 and 2017, the Company had assets under capitalized leases of approximately $__________ and $30,986,000, respectively, and related accumulated depreciation of $26,320,000 and $22,960,000, respectively.

Depreciation expense was approximately $91,385,000 and $96,143,000 for the years ended September 30, 2018 and 2017, respectively.

4. Acquisitions

For the years ended September 30, 2018 and 2017, the Company entered into the following material acquisitions. All business combinations were consistent with the Company's strategic growth plan and were accounted for using the acquisition method of accounting. Operating results for each of the acquisitions have been included in the accompanying consolidated financial statements from the date of acquisition. Goodwill arising is primarily attributable to the synergies expected to arise after the acquisitions, and is expected to be deductible for tax purposes for entities that were asset acquisitions.

All assets acquired and liabilities assumed were at fair value with the exception of the defined benefit pension liabilities and other post retirement employee benefits, which allows for an exception to fair value accounting for business combinations in accordance with GAAP. The recognized tax bases (the amount that is attributable for tax purposes) of the assets and liabilities are compared to the financial reporting values of the acquired assets and assumed liabilities (book bases) to determine the appropriate temporary differences. The Company identified temporary differences related to assumed pension liabilities, due primarily to differences in tax law regarding when a liability is or is not assumed in an asset acquisition; this difference in the treatment of the pension liabilities resulted in the recording of deferred tax assets which are reflected in the acquisition accounting and noted in the tables below.

The Company incurred approximately $3.1 million transaction costs during the year end September 30, 2017, which are included in general and administrative expenses in the accompanying consolidated statements of operations. Transaction costs incurred during the year ended September 30, 2018 were immaterial.

2018 acquisitions

In December 2017, New University Medical Group LLC ("New UMG") entered into a Second Closing to acquire the remaining assets of University Medical Group ("UMG") that were not acquired in the initial acquisition in December 2014. As consideration for the acquisition, New UMG has assumed certain designated liabilities of the practice, which consists of various loans payable to subsidiaries of the Company, totaling approximately $7.5 million. Post-acquisition, these liabilities are eliminated on consolidation. There was no cash consideration related to the transaction. The remaining assets and liabilities acquired were immaterial and no value was assigned to them in the purchase price allocation, and accordingly goodwill of $7.5 million arises from the acquisition. New UMG's parent company, Prospect CharterCARE Physicians, LLC, dba CharterCARE Medical Associates ("CCMA"), entered into a Post Closing Administrative Services Agreement pursuant to which CCMA and its affiliates provide services to the seller of the practice in connection with its termination of all operations and the wind up its affairs and operations.

The Company completed the acquisitions of four physician practice acquisitions in Connecticut for an aggregate purchase price of approximately $2.6 million, one physician multi-specialty practice in Pennsylvania for a purchase price of $1.6 million (net of working capital adjustments), three physician medical practices in California for an aggregate purchase price of approximately $800,000, and one physician family practice in Rhode Island for $180,000. All acquisitions were asset acquisitions, except for one stock purchase acquisition in Connecticut for a purchase price of $800,000, and accordingly goodwill arising from that acquisition is not deductible for tax purposes.

2017 acquisitions

On October 1, 2016, the Company acquired substantially all of the assets, and certain liabilities, of Eastern Connecticut Health Network, Inc. and certain of its subsidiaries (collectively, "ECHN") in exchange for cash consideration of $105 million (subject to certain adjustments). The acquired assets include a network of hospitals, outpatient service centers and providers and specialists serving eastern Connecticut. The acquired hospitals are The Manchester Memorial Hospital and The Rockville General Hospital.

On October 1, 2016, the Company acquired substantially all of the assets, and certain liabilities, of Greater Waterbury Health Network, Inc. and certain of its subsidiaries (collectively, "Waterbury") in exchange for cash consideration of $31.8 million (subject to certain adjustments). The acquired assets include Waterbury Hospital, an acute-care hospital with 357 licensed beds, and a network of outpatient centers and affiliated physicians.

The following table summarizes the assets acquired and liabilities assumed in connection with each of the acquisitions in 2017 (in thousands):

	ECHN	Waterbury
Cash and cash equivalents	$ 5,292	$ 3,010
Patient accounts receivable and other receivables	31,238	23,442
Prepaid expenses and other current assets	8,893	4,100
Property, improvements and equipment	100,002	46,298
Intangible assets	3,440	2,870
Other assets	24,071	6,108
Accounts payable and other current liabilities	(39,122)	(24,639)
Capital leases and long term debt	(15,307)	(3,646)
Other long-term liabilities	(15,286)	(7,354)
Deferred tax liabilities ("DTL")	(5,474)	(13,360)
Pension obligations	(66,902)	(11,850)
Noncontrolling interests	(421)	(2,504)
Bargain gains, net of DTL of $5,474 and $13,360, respectively	(8,722)	(21,288)
Consideration	$ 21,702	$ 1,187

In connection with the acquisitions of ECHN and Waterbury, the Company recorded bargain gains (net of deferred tax liabilities) of $30,010,000 which are included in gain on bargain purchase in the accompanying consolidated statements of operations for the year ended September 30, 2017. The bargain gains arose primarily because of the future capital commitment requirements associated with the acquisitions. During the year ended September 30, 2018, the Company identified further adjustments to the purchase price allocations, which resulted in charges to the accompanying consolidated statements of operations of $3,020,000. Such adjustments related primarily to additional liabilities, offset by lower deferred tax liabilities, at Waterbury.

On May 1, 2017, the Company's wholly-owned subsidiary, Prospect Blackstone Valley Surgicare, LLC ("Prospect Blackstone"), completed an asset acquisition of a freestanding ambulatory surgery center located near the facilities in Rhode Island, in exchange for cash consideration of $1.5 million, of which $100,000 is subject to a one-year indemnification escrow hold-back.

5. Discontinued Operations

During the year ended September 30, 2016, the Company determined that it would discontinue the operations of Prospect CharterCARE Elmhurst Extended Care LLC (dba Elmhurst Extended Care), Nix Community General Hospital LLC ("Nix CGH") and Prospect ACO CA, LLC ("CA ACO"). Elmhurst Extended Care and Nix CGH are reported in the Hospital Services segment and the CA ACO is reported in the Global Risk Management segment. During the year ended September 30, 2017, the assets of Elmhurst Extended Care were sold (effective December 22, 2016) and Nix CGH ceased operations (effective October 1, 2016). The Company closed and sold the Elmhurst Extended Care business for proceeds of $13,722,000. Effective April 1, 2017, the Company made a decision to no longer discontinue operations of CA ACO and its onward activities are classified as part of the continuing operations on the consolidated financial statements. The

Company's decision to discontinue the operations of each of the entities was based on the strategy of the Company's management in their respective markets and financial results.

Summarized financial information for discontinued operations is included below (in thousands):

For the Years Ended September 30,	2018	2017
Net Hospital Services revenues	$ -	$ 10,178
Operating expenses	-	(6,941)
Depreciation and amortization	-	(80)
Interest expense	-	(24)
Income on discontinued operations before income taxes	-	3,133
Gain from sale of discontinued operations	-	4,605
Income tax provision	-	2,966
Income on discontinued operations	$ -	$ 4,772

6. Goodwill and Intangible Assets

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

September 30,	2018	2017
Southern California Hospitals	$ 130,912	$ 130,912
Nix Health	3,138	3,138
CharterCARE	-	5,822
California Medical Groups	28,222	27,420
East Orange	-	4,572
Crozer	140,216	138,831
ECHN	483	-
Waterbury	2,155	-
Total	$ 305,126	$ 310,695

The changes in the carrying amount of goodwill for the years ended September 30 are as follows (amounts in thousands):

September 30,	2018	2017
Balance, beginning of year	$ 310,695	$ 341,488
Acquisitions	13,231	2,047
Impairment	(18,800)	-
Adjustments to prior year acquisitions	-	(32,840)
Balance, end of year	$ 305,126	$ 310,695

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

September 30,	Useful lives	2018	2017
HMO membership	14 years	$ 25,200	$ 25,200
Trade names, net of impairment	3 - 20 years	52,583	52,583
Physician guarantees	2 to 3 years	-	723
Customer relationships	7 years	350	350
Other	5 - 6 years	97	117
Gross carrying value		78,230	78,973
Accumulated amortization		(44,611)	(38,179)
Intangible assets, net		$ 33,619	$ 40,794

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, 2018 and 2017 was $6,429,000 and $8,205,000, respectively. There are no expected residual values related to these intangible assets.

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

Years ending September 30,	
2019	$ 6,523
2020	5,350
2021	5,331
2022	3,542
2023	3,022
Thereafter	9,851
	$ 33,619

The weighted-average remaining useful life for the intangible assets was approximately 7 years as of September 30, 2018.

7. 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 Upland Medical Group, a Professional Medical Group and Pomona Valley Medical Group, Inc (collectively "ProMed Entities"), has ownership interests in physician medical groups that provide medical services to ProMed members, including Chaparral Medical Group, Inc., (in which the Company beneficially owns a 13.2% interest). For the years ended September 30, 2018 and 2017, the ProMed Entities paid these groups approximately $19,760,000 and $17,216,000, respectively. As of September 30, 2018 and 2017, the Company had accounts payable and other accrued liabilities due to these related parties of $1,266,000 and $473,000, 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, 2018 or 2017.

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. Under this agreement, the Company received refunds (net of payments) of $5,463,000 and $26,378,000 for the years ended September 30, 2018 and September 30, 2017, respectively.

8. Income Taxes

The components of the income tax (benefit) provision for continuing operations are as follows (in thousands):

For the years ended September 30,	2018	2017
Current:		
Federal	$ (27,738)	$ 42,836
State	(8,547)	8,057
	(36,285)	50,893
Deferred:		
Federal	86,922	(41,809)
State	10,860	(8,529)
	97,782	(50,338)
Total:		
Federal	59,184	1,026
State	2,313	(472)
	$ 61,497	$ 554

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

September 30,	2018	2017
Deferred tax assets:		
Accrued medical claims	$ 4,344	$ 11,317
Malpractice reserves	3,727	9,020
Accounts receivable	24,654	26,693
Accrued salaries & wages	12,562	22,920
Pension obligation	82,697	133,960
Net operating losses	55,231	6,617
Tax Credits	2,870	2,174
Outside basis differences	762	9,706
UTP & other	12,552	5,512
Deferred tax assets	199,399	227,919
Valuation allowance	(119,544)	(10,308)
Net deferred tax assets	79,855	217,611
Deferred tax liabilities:		
Property, plant & equipment	(55,058)	(96,490)
Intangible assets	(8,601)	(7,317)
Prepaid expenses	(2,809)	(3,543)
Other comprehensive income	(11,412)	(5,938)
Deferred tax liabilities	(77,880)	(113,288)
Net deferred tax assets	$ 1,975	$ 104,323

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.

Management assesses the available positive and negative evidence to estimate whether sufficient future pretax income will be generated to permit use of the existing deferred tax assets. A significant piece of objective negative evidence evaluated was the cumulative pretax losses incurred over the three year period ended September 30, 2018. Such objective evidence limits the ability to consider other subjective evidence, such as the Company's projections for future growth. On the basis of this evaluation, at September 30, 2018, a valuation allowance of approximately $119.5 million has been recorded to recognize only the portion of the deferred tax asset that is more likely than not to be realized. The amount of the deferred tax asset considered realizable, however, could be adjusted if estimates of future taxable income during the carryforward period are reduced or increased or if negative objective evidence in the form of cumulative losses is no longer present and additional weight is given to subjective evidence such as the Company's projections for growth.

During fiscal 2018, the Company completed an IRS examination for Prospect Medical Group, Inc. & Subsidiaries' fiscal year 2014 federal income tax return. The Company's IRS examination for Ivy Holdings, Inc. & Subsidiaries fiscal 2014 through 2016 federal income tax returns are also ongoing. No adjustments have been proposed thus far for any of the years under audit. We do not have any ongoing examinations in states. We do not currently anticipate any changes to our unrecognized tax benefits for the next twelve months related to these examinations.

Generally, the Company's tax years 2014 through 2017 are open for federal and state tax examination. As of September 30, 2018, the Company has recorded a liability in the amount of $12.7 million related to uncertain tax positions ("UTP") with respect to impermissible accounting methods for federal income tax purposes, which is recorded in other long-term liabilities in the accompanying consolidated balance sheets. 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.

On December 22, 2017, the Tax Cuts and Jobs Act of 2017 (the "Act") was signed into law making significant changes to the Internal Revenue Code. Changes include, but are not limited to, a corporate tax rate decrease from 35% to 21% effective for tax years beginning after December 31, 2017, limitations on various business deductions such as executive compensation under Internal Revenue Code §162(m), the transition of U.S international taxation from a worldwide tax system to a territorial system, and a one-time transition tax on the mandatory deemed repatriation of cumulative foreign earnings as of December 31, 2017. The United States federal income tax rate reduction was effective as of January 1, 2018. Accordingly, the Company's federal statutory income tax rate for fiscal 2018 reflected a blended rate of approximately 24.5%. The Company has calculated the impact of the Act in its year end income tax provision in accordance with its understanding of the Act and guidance available as of the date of this filing. As a result, the Company has reduced net U.S. deferred tax assets by $25,660,000. As the Company does not have profitable foreign subsidiaries, it does not anticipate any impacts as a result of the mandatory deemed repatriation of cumulative foreign earnings.

On December 22, 2017, Staff Accounting Bulletin No. 118 ("SAB 118") was issued to address the application of US GAAP in situations when an entity does not have the necessary information available, prepared, or analyzed (including computations) in reasonable detail to complete the accounting for certain income tax effects of the Act. Pursuant to SEC Staff Accounting Bulletin ("SAB") 118 (regarding the application of ASC740 associated with the enactment of the Tax Act), the Company believes the accounting under ASC 740 for the provisions of the Tax Act is complete.

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,	2018	2017
Tax provision at statutory rate	25%	35%
State taxes, net of federal benefit	12%	(1)%
Impact of US Tax Reform	(11)%	-
Bargain purchase gain	-	(34)%
Valuation allowance	(55)%	-
UTP	(1)%	-
Other	(2)%	2%
	(32)%	2%

9. Long-Term Debt

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

	2018	2019
Senior secured credit facility (net of discount of $20,085 and $7,374, respectively)	$ 1,094,315	$ 609,813
Other debt *(1)*	39,769	38,321
Less: Deferred financing costs, net ("DFC")	(16,214)	(9,906)
Total Debt, net of discount, premium and DFC	1,117,870	638,228
Less: current maturities	(18,429)	(12,509)
Long-term debt, net of current maturities	$ 1,099,441	$ 625,719

(1) Other debt also includes financing obligations related to sales-leaseback transactions. The financing obligations related to sales-leaseback transactions were $24,614,000 and $26,027,000 for years ended September 30, 2018 and 2017, respectively.

Senior Secured Credit Facilities

On June 30, 2016, the Company entered into a six-year $625 million senior secured term loan B (the "Original Term Loan"), the proceeds of which were used to repay $425 million of PMH's existing 8.375% senior secured notes due during 2019; to repay $60 million of borrowings under the Company's existing revolving credit facility (the "Replaced Revolver"); to fund acquisitions, including the acquisition of Crozer; and to finance transaction fees and expenses. The Original Term Loan bore interest at LIBOR (subject to a 1.0% floor) plus 6.0%. The Original Term Loan was issued with an original discount of 1.5%, or $9,375,000. Additionally, the Company refinanced the Replaced Revolver with a new $100 million asset-based revolving credit facility ("Original ABL Facility" and together with the Original Term Loan, the "New Senior Secured Credit Facilities"). Pursuant to various amendments from August 2016 through October 2017, the aggregate commitment amount under the Original ABL facility was increased in stages to $175 million. The maturity date for the Original ABL Facility was June 30, 2021, and the maturity date for the Term Loan was June 30, 2022.

On February 22, 2018, the Company refinanced and replaced both the Original Term Loan and the Original ABL Facility, and entered into an Amended and Restated Term Loan Credit Agreement (the "Amended TL Agreement"), by and among the Company (as the borrower), the lenders party thereto and JPMorgan Chase Bank, N.A. ("JPMorgan"), as administrative agent and collateral agent. The Amended TL Agreement replaced the Original Term Loan with a new Term B-1 Loan ("Term B-1 Loan"). The principal amount of the Term B-1 Loan is $1,120 million and such loan bears interest at LIBOR (subject to a 1.0% floor) plus 5.5%, which as of September 30, 2018 was 7.625%. The Term B-1 Loan was issued with an original discount of 2% and matures on February 22, 2024.

Additionally, on February 22, 2018, the Company entered into an Amended and Restated ABL Credit Agreement (the "Amended ABL Agreement"), by and among the Company (as the borrower), the lenders party thereto and JPMorgan, as administrative agent and collateral agent. The Amended ABL Agreement replaced the Original ABL Facility. Under the Amended ABL Agreement, the maximum revolving commitment is $250.0 million with ability to expand the facility to $325.0 million, and the new ABL facility (the "New ABL Facility") bears interest at a variable base rate plus an applicable spread that is based on excess availability under the New ABL Facility, as further described in the Amended ABL Agreement, which was 3.875% as of September 30, 2018. The New ABL Facility matures on February 22, 2023. As of September 30, 2018, the available balance on the new ABL facility was $41.0 million.

The proceeds of the Term B-1 Loans and the New ABL Facility (the "New Senior Secured Credit Facilities") were used to refinance the Original Term Loan and the Original ABL Facility, to pay a dividend of $457.0 million to the Company's stockholders, to pay certain expenses associated with the refinancing, to prefund approximately $40 million of pension liabilities of the Company's subsidiaries, to make payments to certain option holders as a result of the Dividend Recapitalization, and to finance certain working capital and other operational needs of the Company and its subsidiaries.

Under applicable accounting literature, deferred financing costs of $11.7 million and outstanding debt discount of $6.7 million as of February 22, 2018 were expensed and presented within loss on debt extinguishment in the accompanying consolidated statements of operations, and new costs of approximately $18.0 million incurred in connection with the refinancing have been capitalized to offset the new long-term debt in the accompanying consolidated balance sheets, and are being amortized over the term of the related debt using the effective interest method.

The New Senior Secured Credit Facilities are guaranteed on a senior secured basis by all assets of the Company and its wholly-owned subsidiaries ("Guarantors") except PHP, CHIC, RRG, Prospect Health Access Network, Inc. and certain immaterial subsidiaries. The New ABL Facility is secured by a first priority security interest on the working capital assets of the Company and the Guarantors and a second priority security interest on their fixed assets. The Term B-1 Loan is secured by a first priority security interest on fixed assets and a second priority security interest on working capital assets. The New Senior Secured Credit Facilities are effectively senior to all of the Company's existing and future indebtedness. The New Term B-1 loan has no financial covenants. However, the consolidated total leverage ratio is required to be calculated and reported on a quarterly basis. If such ratio is above 3.5, then receipts under the QAF 5 program are required to be utilized to pay down principal on the New Term B-1 loan. The Company currently expects to receive QAF 5 payments of approximately $83 million in May 2019, and these are the only expected payments to be received in fiscal 2019 based on current information from the California Hospital Association. The Company has made an accounting election to present all receivables under QAF 5 as current, and to not reflect expected paydowns of debt related to the collection of QAF 5 monies in fiscal 2019 as current debt as the timing is an estimate. The Amended ABL Agreement does not have any financial maintenance covenants. The Amended ABL Agreement has a "springing" fixed charge ratio covenant that applies if excess availability is less than the greater of 10% of the maximum borrowing amount and $22 million. The fixed charge ratio covenant was not required to be tested for the fiscal quarter ended September 30, 2018. The Company was in compliance with all of its debt covenants at September 30, 2018 or obtained a waiver.

Demand Notes

The Company has a commitment from a bank for a $15 million equipment leasing facility to finance various equipment at the Company's hospital facilities. As of September 30, 2018 and 2017, draws under the facility 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. As of September 30, 2018, approximately $15 million had been drawn under the line.

Scheduled payments under the Company's current and long-term debt as of September 30, 2018 are as follows (in thousands):

Years ending September 30,	
2019	$ 18,429
2020	16,869
2021	14,672
2022	13,097
2023	13,228
Thereafter	1,077,874
Total scheduled payments	1,154,169
Less: Senior Secured Notes discount, net	(20,085)
Less: Deferred financing costs, net	(16,214)
Less: Current maturities	(18,429)
Total long-term debt	$ 1,099,441

10. Stockholder's Equity

Equity Based Compensation Plans

Effective December 15, 2010, the Board of Directors of Ivy Holdings adopted the Ivy Plan that initially 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). 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. Under the First Amendment, and subsequent amendments, a further 63,704 shares of common stock of Ivy Holdings ("New Options") can be issued.

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, 2018 and 2017 no compensation cost has been recorded in the Company's consolidated financial statements for the years then ended.

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, 2018 and 2017 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 October 1, 2016	143,201	$ 92.94	$ 445.06	76.2
Granted	29,141	568.55	–	–
Exercised	(100)	30.00	–	–
Canceled/Forfeited	(3,367)	107.81	–	–
Outstanding as of September 30, 2017	168,875	174.91	663.09	73.4
Granted	26,516	418.21	–	–
Exercised	(22,608)	37.74	–	–
Canceled/Forfeited	(9,530)	322.72	–	–
Outstanding as of September 30, 2018 *(1)*	163,253	$ 140.47	$ 156.53	70.5

(1) The number of options outstanding at September 30, 2018 were modified in connection with the Adjusted Exercise Price of the options (see below).

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, 2018, the aggregate intrinsic value of outstanding shares was approximately $25,554,000. As of September 30, 2018, there were 104,496 options that are exercisable at a weighted average exercise price of $47.40.

A summary of Ivy Holdings non-vested options and the changes during the fiscal years ended September 30, 2018 and 2017 is presented as follows for the Initial Options and New Options:

	Shares	Weighted Average Grant Date Fair Value
Ivy Holdings Stock Options:		
Nonvested at October 1, 2016	26,424	$ 97.55
Granted	29,141	299.00
Vested	(17,834)	178.49
Canceled/Forfeited	(3,367)	107.81
Nonvested at September 30, 2017	34,364	225.09
Granted	26,516	188.98
Vested	(17,054)	269.50
Canceled/Forfeited	(9,530)	206.09
Nonvested at September 30, 2018	34,296	$ 181.07

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, 2018 and 2017 was estimated with the following assumptions for Ivy Holdings:

For the years ended September 30,	2018	2017
Weighted average fair value of option grants	$ 188.98	$ 299.00
Estimated fair market value of the Company's common stock on the date of grant	$ 390.14	$ 568.55
Weighted average expected life of the options	5 years	10 years
Risk-free interest rate	0.85%	1.79%
Weighted average expected volatility	60.0%	43.8%
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, 2018 and 2017 was $710,000 and $1,118,000, respectively. At September 30, 2018, there were no unvested options, which could potentially vest over the next nine fiscal years, subject to meeting the vesting requirements noted above. There were no remaining maximum estimated stock compensation expense to be amortized to expense in future periods. 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, 2018 and 2017.

Dividends

The Company distributed approximately $457.0 million in connection with the issuance of "New Senior Secured Credit Facilities" during the year ended September 30, 2018, which was recorded against retained earnings, and was ultimately paid to the common stockholders of Ivy Holdings Inc (see Note 9).

On February 22, 2018, the Board of Directors of Ivy Holdings, Inc. ("the Board") approved special cash in the amount of approximately $33 million in bonus payments were made ("the Bonuses") to Option Holders in connection with the dividend provided that any Bonus with respect to an unvested portion of an option shall be payable upon the date such unvested portion becomes vested and exercisable, subject to the Optionee's continued employment with Prospect through such date. At September 30, 2018 approximately $2.3 million was accrued for bonuses in connection with this. To reflect the Dividend and pursuant to the terms of the Option Plan, the Board further resolved to equitably adjust the Options by reducing the per-share exercise price of the Options to an amount determined with reference to the Bonus amount payable by Prospect Medical with respect to such Option (the "Adjusted Exercise Price").

11. Retirement Benefits

The Company sponsors various employee non-contributory, defined benefit pension plans covering certain full-time employees of Crozer, ECHN and Waterbury.

In connection with the acquisition of Crozer, $100 million of the purchase price was put into an escrow and subsequently used by the Company, as the new sponsor of the Crozer pension plan pursuant to IRS rules and regulations, to fund in part the underfunded plan liability then outstanding. Additionally, within five years after acquisition and subject to applicable filing and authorization by the applicable government agency or entity, the Company will adopt a plan amendment to terminate the plan effective within such five year period and will liquidate, fully fund and satisfy, and pay all benefits owed to participants and beneficiaries of the plan by providing lump sum distributions to participants, purchasing annuities for participants who do not elect a lump sum distribution.

Also in connection with the Crozer acquisition, the plan was frozen with all benefit accruals ceased as of July 1, 2016. With respect to each Represented Employee who is a member of the Laborers' International Union of North America, the Monthly Compensation (as defined), the Credited Service (as defined), the Eligibility Service (as defined) and the accrued benefit was frozen and determined as of July 1, 2016. No benefits accrue since that date. Additionally, the plan was amended to provide that for purposes of determining Vesting Service (as defined) for employees who were employed with the Company before July 1, 2016, years of service shall include all periods of employment completed on and after July 1, 2016, subject to the Break in Service rules (as defined).

On September 3, 2016, the DB Plan was further amended to provide certain Qualifying Participants (as defined) the right to make a Special Benefit Election (as defined) during "2016 Lump Sum Option Window" period from October 15, 2016 through November 30, 2016 to receive or commence receiving his or her vested Accrued Benefit as of December 1, 2016 in accordance with procedures adopted by the Committee.

In conjunction with the acquisition the Company also became the sponsor and assumed CKHS postretirement benefit program (the "OPEB Plan") which is an unfunded medical care and life insurance benefit program, and a supplemental executive retirement plan (the "SERP Plan") which is an unfunded retirement plan that covers a group of current and former executives. These plans were frozen with all benefit accruals ceased as of July 1, 2016. No benefits will accrue since that date. With respect to each Represented Employee who is a member of the Laborers' International Union of North America, benefits will continue to accrue until a settlement of an ongoing union contract negotiation is reached.

ECHN has a defined benefit pension plan that covered substantially all of its employees. The benefits were based upon years of service and compensation for the five highest years during the employee's last 10 years of service. Effective December 31, 2013, ECHN froze the defined-benefit for all remaining participants. During September 2013, the Board passed a resolution to freeze all benefits related to the Defined benefit pension plan. On December 31, 2008, ECHN implemented a soft freeze on the defined benefit pension plan. All qualified employees were eligible to enter into the defined contribution plan, ECHN contributed 3% of eligible employees' salaries. This contribution was non-guaranteed for all employees, except certain union workers covered under a collective bargaining agreement.

ECHN also sponsors a postretirement benefit plan that provides health care benefits to those employees who retired. The criteria to receive this benefit is to be vested in the pension plan, attain age 55 or older and start collecting under the defined benefit plan described above once retired. The retiree must be enrolled into the medical plan on the date of retirement to be eligible for the continuation. Full-time registered nurse retirees from ECHN's Manchester facility (retired prior to October 1, 2005 and were eligible per the collective bargaining agreement) were grandfathered and required to pay at least 50% of the total cost of the medical and dental coverage they elect for themselves under the plan.

Waterbury has a noncontributory defined benefit cash balance plan. It is Waterbury's policy to make contributions to the plan sufficient to meet the minimum funding requirements of applicable laws and regulations. The plan was frozen to non-union participants effective June 30, 2015. Participants who are part of the Connecticut Healthcare Associates Technical Unit remain active in the plan. Non-union employees no longer accrue additional employer contribution credits in the plan. These participants will continue to receive interest credits based on their account balances in accordance with the terms of the plan. They will be entitled to their account balance (the retirement benefit they have earned up to June 30, 2015) plus applicable interest credits after the Plan were frozen.

The activity of the pension plans for the years ended September 30, 2018 and 2017 is as follows (in thousands):

		2018		2017
Changes in benefit obligations				
Projected benefit obligations, beginning of period	$	864,293	$	953,983
Service cost		194		292
Interest cost		27,695		33,193
Plan participant contributions		461		367
Actuarial loss		(48,654)		(31,788)
Benefits paid		(134,185)		(91,045)
Lump sum benefits paid and annuity purchase		(49,628)		-
Plan changes		-		(709)
Projected benefit obligation, end of year	$	660,176	$	864,293
Changes in plan assets				
Fair value of plan assets, beginning of year	$	556,590	$	656,074
Actual return on plan assets		(14,437)		(15,980)
Contributions by plan sponsor		41,667		7,174
Plan participant contributions		461		367
Benefits paid		(134,185)		(91,045)
Lump sum benefits paid and annuity purchase		(49,628)		-
Fair value of plan assets, end of year	$	400,468	$	556,590
Funded status of the plan, end of year	$	(259,708)	$	(307,703)
Accumulated benefit obligation, end of year	$	(259,708)	$	(307,703)

The funded status of the pension plans as of September 30, 2018 and 2017 is as follows (in thousands), split between the pension plans and the post retirement plans:

	2018 Pensions	2018 OPEBs	2017 Pensions	2017 OPEBs
Amounts recognized in the consolidated balance sheets consist of:				
Current liability	$ -	$ 600	$ -	$ 820
Non-current liability	254,121	4,987	300,364	6,519
Amount recognized, end of year	$ 254,121	$ 5,587	$ 300,364	$ 7,339

The components of net periodic benefit cost for the years ended September 30, 2018 and 2017 are as follows (in thousands):

	2018	2017
Components of net periodic benefit cost:		
Service cost	$ 194	$ 292
Interest cost	27,695	33,193
Expected return on plan assets	(16,045)	(19,477)
Effect of settlement	1,457	(2,479)
Amortization of prior service credit	(48)	-
Total net periodic benefit cost	$ 13,253	$ 11,529
Other change in benefit obligations recognized in accumulated other comprehensive income:		
Gain due to assumption change	$ (64,429)	$ (23,922)
Liability (gain) loss due to participant experience	14,118	(7,865)
Asset return loss	30,483	35,456
Prior service cost credit	-	(708)
Amount recognized due to settlement	-	2,479
Total recognized in other comprehensive loss (income) and accumulated other comprehensive loss (income)	$ (19,828)	$ 5,440

The assumptions used in determining the actuarial present value of the projected benefit obligations for pension plans as of September 30, 2018 and 2017 and for the years ended September 30, 2018 and 2017 are as follows:

	2018	2017
Weighted average assumptions used to determine benefit obligations at end of period		
Discount rate	3.23-4.48 %	3.23-3.68 %
Rate of compensation increase	0.00-2.00 %	0.00-2.00 %
Weighted average assumptions used to determine net periodic benefit cost for the period ended		
Discount rate	3.49-4.41 %	3.18-4.01 %
Rate of compensation increase	0.00-2.00 %	0.00-2.00 %
Expected return on the plan assets	0.00-4.50 %	0.00-5.00 %

Assumed health care cost trend rates for the next period used to measure the expected cost of benefits covered by the plan are as follows:

	2018	2017
Health care trend rate assumed for next year	7.0%	7.0%
Rate to which the cost trend is assumed to decline (the ultimate rate)	4.5%	4.5%
Year that the rate reaches the ultimate trend rate	2026	2025

Assumed health care cost trend rates have a significant effect on amounts reported for other postretirement benefit programs. A one-percentage-point change in assumed health care cost trends would have the following effects (in thousands):

	1% Increase	1% Decrease
Effect on other postretirement benefit obligations	$ 5,701	$ 5,486
Effect on total of service and interest cost components	$ 239	$ 228

The asset allocation percentage by major asset class for the plans and the target allocation for 2018 follows:

	Target	2018
Asset class:		
Cash and cash equivalents	0% - 20%	
Fixed income	10% - 100%	94 %
Domestic equity	0% - 100%	
International equity	0% - 40%	
Real estate	0% - 30%	1 %
Alternative investments and hedge funds	0% - 30%	5 %
		100 %

The investment objectives of the plans are to invest consistently with the fiduciary standards of ERISA, to provide for the funding and anticipated withdrawals on an ongoing basis, conserve and enhance the capital value of the plans in real terms while maintaining a moderate risk profile, to minimize principal fluctuations over the investment cycle, and achieve a long-term level of return commensurate with contemporary economic conditions. The expected long-term rate of return with respect to the plans is based on an aggregate of expected capital market returns within each asset category.

The following tables set forth the assets in the plans measured at fair value, by input level (in thousands):

September 30, 2018	Level 1	Level 2	Level 3	Net asset value	Total
Fixed income securities:					
Short-Term Duration	$ -	$ 35,100	$ -	$ -	$ 35,100
Extended Duration	-	125,562	-	-	125,562
Interim Duration	-	41,193	-	-	41,193
Long-Term Duration	-	174,162	-	-	174,162
Real estate	-	-	2,962	-	2,962
Alternative investments	-	-	18,593	-	18,593
Cash and cash equivalents	-	-	-	2,896	2,896
Total	$ -	$ 376,017	$ 21,555	$2,896	$ 400,468

September 30, 2017	Level 1	Level 2	Level 3	Net asset value	Total
Fixed income securities:					
Short-Term Duration	$ -	$ 37,637	$ -	$ -	$ 37,637
Extended Duration	-	163,537	-	-	163,537
Interim Duration	-	53,703	-	-	53,703
Long-Term Duration	-	275,139	-	-	275,139
Real estate	-	-	6,288	-	6,288
Alternative investments	-	-	17,454	-	17,454
Cash and cash equivalents	-	-	-	2,832	2,832
Total	$ -	$ 530,016	$ 23,742	$ 2,832	$ 556,590

Pension plan assets classified as Level 3 in the fair value hierarchy represent investments in which the trustee has used significant unobservable inputs in the valuation model. The hedge funds consist of equity/long/short funds and multi-strategy funds in which fair values have been estimated using the net asset value per share of the investment. The alternative investments primarily consist of investments in limited partnerships that invest in the Public-Private Investment Program which fair values have been estimated using the net asset value per share of the investment.

CIIH16-000835

On an annual basis, the Company assesses the valuation hierarchy for pension assets recorded at fair value. From time to time, assets will be transferred within the fair value hierarchy as a result of changes in, among other things, inputs used, liquidity, or valuation methodologies. During the years ended September 30, 2018 and 2017, there were no transfers in classification within the fair value hierarchy.

The following table is a rollforward of the plans' assets classified within Level 3 of the fair value hierarchy (in thousands):

September 30,	2018	2017
Balance, beginning of year	$ 23,742	$ 62,397
Actual return on plan assets:		
Realized loss	-	(445)
Unrealized (loss) gain	(2,187)	2,283
Purchases	-	5,434
Sales	-	(45,927)
Balance, end of year	$ 21,555	$ 23,742

The expected long-term future benefit payments to retirees with respect to the plans and are as follows (in thousands):

2019	$ 46,620
2020	44,230
2021	43,040
2022	43,270
2023	42,920
2024 - 2028	206,460
	$ 426,540

Waterbury participates in multi-employer pension plans that cover substantially all union employees. Contributions to the plans are based upon a percentage of each participant's total salary. The risks of participating in these multi-employer plans are different from single employer plans in the following aspects:

- Assets contributed to the multi-employer plan by one employer may be used to provide benefits to employees of another participating employer.
- If a participating employer stops contributing to the plan, the unfunded obligation of the plan may be borne by the remaining participating employers.
- If Waterbury chose to stop participating in the multi-employer plans, Waterbury may be required to pay those plans an amount based on the underfunded status of the plans, referred to as a withdrawal liability.

The following table presents Waterbury's participation in these plans as of and for the years ended September 30, 2018 and 2017.

Pension Trust Fund	EIN / Pension Plan	Pension Protection Act ("PPA") Certified Zone Status (1)		FIP / RP Status Pending / Implemented (2)	Contributions		Surcharge Imposed	Exp. Date of CBA (3)
		2018	2017		2018	2017		
Connecticut Health Care Associates Pension Fund	06-1313462	Red	Green	Implemented	$2,140,000	$ 2,018,000	No	9/30/18
New England Health Care Employees Pension Fund	22-3071963	Green	Green	NA	821,000	939,000	No	2/28/17
Total contributions					$2,961,000	$ 2,957,000		

(1) The most recent PPA zone status available in 2018 is for the plan's year-ending during 2017. The zone status is based on information received from the plan and is certified by the plan's actuary. Among other factors, plans in the red zone are generally less than 65 percent funded, plans in the orange zone are less than 80 percent funded and have an accumulated funding deficiency in the current year or projected in the next six years, plans in the yellow zone are less than 80 percent funded, and plans in the green zone are at least 80 percent funded.

(2) The "FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan ("FIP") or a rehabilitation plan ("RP") is either pending or has been implemented. As it relates to the Connecticut Health Care Associates ("CHCA") Pension Plan, the trustees adopted the attached Rehabilitation Plan on May 7, 2018. The Rehabilitation Period, as defined, commences on January 1, 2019 and ends on December 31, 2028.

(3) These agreements are currently under negotiations.

During the years ended September 30, 2018 and 2017, Waterbury's contributions to the CHCA Pension Plan and the New England Health Care Employees Pension Plan represented 98.2% and 2.6% and 98.3% and 2.4% of the total contributions made to the plans by all participating employers, respectively.

Governmental regulations impose certain requirements relative to union-sponsored pension plans. In the event of plan termination or employer withdrawal, an employer may be liable for a portion of the plan's unfunded vested benefits. As of September 30, 2018, Waterbury has not recorded any liabilities for future withdrawal obligations related to the multi-employer plans.

Defined contribution plans

The Company previously sponsored five defined contribution plans covering substantially all employees who meet certain eligibility requirements. Effective May 1, 2018, the plans covering employees at ECHN, Waterbury and Crozer were merged into the plan covering employees at CharterCARE, and the two remaining plans were renamed and segregated between union and non-union employees. 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 certain facilities in Texas, Rhode

Island, Pennsylvania, for which the expense for the employer match was $19,723,000 and $18,088,000 for the years ended September 30, 2018 and 2017, respectively.

12. 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 2030. 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 2.5% to 19.5% per annum.

The future minimum annual lease payments required under leases in effect at September 30, 2018, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2019	$ 16,475	$ 27,031
2020	12,517	24,802
2021	7,384	21,604
2022	3,891	18,515
2023	3,670	16,361
Thereafter	23,733	57,518
Total minimum lease payments	67,670	$ 165,831
Less: amounts representing interest	(17,469)	
	50,201	
Less: current portion	(14,348)	
	$ 35,853	

Rent expense for the years ended September 30, 2018 and 2017 was approximately $47,190,000 and $49,965,000, respectively. Sublease rental income was not material to the consolidated financial statements for the years ended September 30, 2018 and 2017.

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.

Seismic Standards

The Company's California Hospitals (with the exception of Bellflower, which currently only provides psychiatric services) are required to comply with laws that regulate the seismic performance of all aspects of hospital facilities in California and imposes near-term and long-term compliance deadlines for seismic safety assessment, submission of corrective plans, and retrofitting or replacement of medical facilities to comply with current seismic standards. These laws and regulations require hospitals to meet seismic performance standards to ensure that they are capable of providing medical services to the public after an earthquake.

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. Two buildings at Southern California Hospital at Culver City ("SCH Culver City") and one building at Los Angeles Community Hospital ("LACH") do not currently meet the applicable seismic requirements. The three buildings are currently classified at Structural Performance Category 1 ("SPC-1") and, subject to possible deadline extensions discussed below, they must be upgraded to at least SPC-2 by January 1, 2020. That deadline date was set pursuant to an extension granted upon the Company's application submitted in accordance with California Senate Bill 90 (SB 90) and approved by the Office of Statewide Health Planning and Development ("OSHPD").

OSHPD has a voluntary program to re-evaluate the seismic risk of hospital buildings classified as SPC-1. These buildings are considered hazardous and at high 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 the applicable deadline. OSHPD is using Hazards U.S. ("HAZUS"), a state-of-the-art methodology, to reassess the seismic risk of SPC-1 buildings. Once the SPC-1 buildings have been seismically upgraded to SPC-2, they are no longer considered a significant risk to occupants, but they may not be repairable or functional after an earthquake. Participation in the HAZUS program is optional for hospital owners wishing to have their SPC-1 buildings evaluated.

Applications for HAZUS evaluation of seismic risk were submitted for all five of the Company's California acute care facilities: Southern California Hospital at Hollywood ("SCH Hollywood"); SCH Culver City; Los Angeles Community Hospital; Los Angeles Community Hospital at Norwalk ("LACH Norwalk"); and Foothill Regional Medical Center ("Foothill"). All buildings at these five facilities obtained SPC-2 reclassification using HAZUS, except for the aforementioned three buildings at SCH Culver City and LACH which are still classified as SPC-1. Currently, failure to obtain SPC-2 reclassification for the three remaining SPC-1 buildings by January 1, 2020 would mean that the buildings would not be allowed to provide acute care services starting on that date.

Recently enacted Assembly Bill 2190 (AB-2190) could potentially provide an additional extension of up to 30 months (July 1, 2022) to obtain SPC-2 reclassification. Such extension must be requested by April 1, 2019. If granted, any required construction must be begun by April 1, 2020 and final seismic compliance must be achieved by July 1, 2022.

The Company will also be required to make significant capital expenditures in the future to comply with 2030 seismic standards (i.e., upgrade to SPC-4D) for any buildings that will be utilized for hospital facilities beyond January 1, 2030. Such modifications to the hospital facilities could potentially result in environmental remediation liabilities which may be material to the Company.

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, states have also developed their own standards for the privacy and security of health information as well as for reporting certain violations and breaches (for example, California's Confidentiality of Medical Information Act and Lanterman-Petris Short Act) which in some cases are more stringent. Other federal privacy laws may also apply to certain services provided by the Company, including 42 C.F.R. Part 2, which addresses the confidentiality of substance use disorder records. 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") has made significant changes to the United States health care system. The legislation impacted multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Under this legislation, 33 states have expanded their Medicaid programs to cover previously uninsured childless adults, and four additional states voted in 2018 to expand Medicaid or to elect a governor that pledged to expand Medicaid. In addition, many uninsured individuals have had the opportunity to purchase health insurance via state-based marketplaces, state-based marketplaces using a federal platform, state-partnership marketplaces or the federally-facilitated marketplace. PPACA also implemented a number of health insurance market reforms, such as allowing children to remain on their parents' health insurance until age 26 or prohibiting certain plans from denying coverage based on pre-existing conditions. Nationally, these reforms have reduced the number of uninsured individuals.

It is unclear what changes may be made to PPACA with the divided Congress, current presidential administration, and pending litigation over the validity of PPACA. The Administration has promulgated rules to broaden the availability of coverage options that do not comply with the full range of PPACA requirements for individual market coverage, namely Association Health Plans and Short-Term Limited-Duration Insurance. The Administration has also provided additional guidance on state PPACA waivers. These executive actions have been or may be challenged in court. In addition, the Tax Cuts and Jobs Act ("TCJA"), passed in December 2017, eliminates the individual mandate penalty under PPACA, effective January 1, 2019. The individual mandate penalty was included in PPACA to address concerns that other market reforms expanding access to coverage might produce adverse selection and higher premiums. The extent to which the repeal of the individual mandate penalty will impact the uninsured rate and 2019 premiums is unclear at this juncture. On December 14, 2018, the United States District Court for the Northern District of Texas ruled that the individual mandate without the penalty is unconstitutional and that PPACA is therefore invalid in its entirety. Litigation on this issue is ongoing, with the Administration indicating it will continue implementing PPACA pending any appeals, the court ordering expedited briefing on a potential stay and certification of an interlocutory appeal, and pending litigation in the United States District Court for the District of Maryland to ensure continued implementation of PPACA. This litigation along with any future legislative changes to PPACA or other federal and state legislation could have a material impact on the operations of the Company. The Company is continuing to monitor the legislative environment and developments in pending litigation for risks and uncertainties.

Collective Bargaining Agreements

As of September 30, 2018, the Company had approximately 18,300 employees, of whom approximately 5,500 employees or 30% are represented by various labor organizations. Of those, approximately 1,800 employees or 10% of the Company's employees are employed under union contracts that have expired or will expire before September 30, 2019.

Tangible Net Equity ("TNE") Requirement

The Company's affiliated California physician organizations and licensed healthcare service plans may be subject to one or more of the following requirements: minimum working capital, Tangible Net Equity ("TNE"), cash-to-claims ratio and claims payment requirements as prescribed by the California Department of Managed Health Care ("DMHC"). TNE is defined as net assets, less intangibles and amounts due from affiliates, plus subordinated obligations. As of September 30, 2018, the Company's affiliated California physician organizations were in compliance with these regulatory requirements. In January 2019, the Company received inquiries from DMHC related to the calculation of certain receivables for PHP and PMG. The Company is currently responding to the inquiries; however, the conclusion and potential effect on compliance with the requirements are unknown at this time.

Employee Health Plans

The Company offers self-insured EPO/HMO and PPO plans to 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). Prior to January 1, 2018, commercial insurance policies covered per occurrence losses in excess of $750,000 for Crozer, $160,000 for East Orange, $275,000 for CharterCARE, $225,000 for ECHN, $350,000 for Waterbury, $250,000 for all other hospitals and $175,000 for the Medical Group and Corporate segments. Effective January 1, 2018, all locations were covered by insurance policies with CHIC for per occurrence losses in excess of $350,000, except for Crozer for which the limit is $750,000. CHIC maintains reinsurance coverage above $500,000 for all locations except for Crozer, for which the limit is $750,000. An actuarially and internally-estimated liability of approximately $16,566,000 and $10,985,000 for incurred but not reported claims has been included in accrued salaries, wages, and benefits as of September 30, 2018 and 2017, 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.

13. 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, 2018 and 2017 (in thousands):

September 30,	2018	2017
IBNR as of beginning of year	$ 54,283	$ 52,761
Claim expenses incurred during the year:		
Related to current year	301,598	235,207
Related to prior year	7,969	2,841
Total incurred	309,567	238,048
Claims paid during the year:		
Related to current year	(246,369)	(195,678)
Related to prior year	(54,548)	(40,848)
Total paid	(300,917)	(236,526)
IBNR as of end of year	$ 62,933	$ 54,283

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,	2018	2017
Capitation expense	$ 96,027	$ 94,141
Fee-for-service claims expense	171,443	137,860
Other physician compensation	15,097	45,173
Other cost of revenues	5,239	7,861
Total cost of revenues	$ 287,806	$ 285,035

14. Joint Ventures and Unconsolidated Equity Investments

The Company has invested in several joint ventures with unrelated third parties, which are accounted for under the equity method of accounting. As of September 30, 2018 and 2017, CharterCARE owned: 20% of Roger Williams Radiation Therapy and 20% of Southern New England Regional Cancer Center, LLC. ECHN owned: 50% of NRRON, LLC; 50% of Aetna Ambulance Service, Inc.; 50% of Ambulance Service of Manchester, LLC; and 50% of Evergreen Endoscopy Center, LLC. Waterbury owned: 50% of Harold Leever Regional Cancer Center Inc. Crozer owned: 50% of University Technology Park, Inc.; 35% of DCMH MOB Associates; and 21.25% of Delaware Valley Sleep Management Company, LLC. Prospect Medical Group, Inc. owned: 50% of AMVI/Prospect Medical Group. These joint ventures under the equity method are included in the other assets in the accompanying consolidated balance sheets as of September 30, 2018 and 2017 are $24,627,000 and $17,371,000, respectively. For the years ended September 30, 2018 and 2017, the Company received $1,746,000 and $1,636,000, respectively, in distributions for equity method investments, and $404,000 and $453,000, respectively, for cost method investments.

Summarized combined unaudited financial information for the Company's joint ventures as of September 30, 2018 and 2017 for the years then ended is as follows (in thousands):

September 30,	2018	2017
Cash	$ 17,226	$ 16,440
Receivables	8,060	7,590
Other current assets	23,654	23,852
Total current assets	48,940	47,882
Property, improvements and equipment, net	33,757	34,843
Goodwill	7,142	7,142
Intangible assets	852	882
Other long-term assets	3,094	2,921
Total assets	$ 93,785	$ 93,670
Accounts payable and accrued liabilities	5,563	$ 7,180
Other long-term liabilities	5,334	4,275
Equity	82,888	82,215
Total liabilities and partner's capital	$ 93,785	$ 93,670

Years ended September 30,	2018	2017
Revenues	$ 67,554	$ 65,197
Net income	$ 5,039	$ 6,106
PMH's income from equity method investments	$ 1,332	$ 2,015

15. Subsequent Events (Unaudited)

The Company has evaluated subsequent events through January 25, 2019, the date the Company's consolidated financial statements were available for issuance.

On January 25, 2019, Ivy Holdings made an equity contribution in the amount of $40 million to Ivy Intermediate Holding Inc., which was then contributed as equity to the Company.

Prospect CharterCARE, LLC

Consolidated Financial Statements
As of and for the Years Ended
September 30, 2018 and 2017

BDO

Prospect CharterCARE, LLC

Consolidated Financial Statements
As of and for the Years Ended September 30, 2018 and 2017

Prospect CharterCARE, LLC

Contents

	Page
Independent Auditor's Report	3
Consolidated Financial Statements	
Consolidated Balance Sheets	4 - 5
Consolidated Statements of Operations	6
Consolidated Statements of Members' Equity	7
Consolidated Statements of Cash Flows	8
Notes to Consolidated Financial Statements	9 - 30

BDO

Tel: 714-957-3200
Fax: 714-957-1080
www.bdo.com

600 Anton Blvd., Suite 500
Costa Mesa, CA 92626

Independent Auditor's Report

Board of Directors
Prospect CharterCARE, LLC
Los Angeles, California

We have audited the accompanying consolidated financial statements of Prospect CharterCARE, LLC, which comprise the consolidated balance sheets as of September 30, 2018 and 2017, and the related consolidated statements of operations, members' equity, 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 audit 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 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 CharterCARE, LLC and its subsidiaries as of September 30, 2018 and 2017, 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.

Emphasis of Matter

As discussed in Note 1, the Company is financially dependent on its parent company which has agreed to provide the financial support necessary for the operations of the Company. The accompanying financial statements do not reflect any adjustments or disclosures that would be required should the parent company discontinue its financial support.

BDO USA, LLP

July 18, 2019

Prospect CharterCARE, LLC

Consolidated Balance Sheets
(in thousands)

September 30,	2018	2017
Assets		
Current assets		
Cash and cash equivalents	$ -	$ -
Restricted cash	433	3,028
Patient accounts receivable, less allowance for doubtful accounts of $11,141 and $7,245	46,076	42,427
Other receivables	3,306	12,295
Due from government payers	5,533	5,143
Inventories	5,590	5,805
Prepaid expenses and other current assets	2,188	3,286
Total current assets	63,126	71,984
Property, improvements and equipment, net	59,780	53,850
Goodwill	-	5,822
Intangible assets, net	1,211	2,854
Equity method investments	4,088	4,357
Other assets	2,302	1,473
Total assets	$ 130,507	$ 140,340

See accompanying notes to consolidated financial statements.

Prospect CharterCARE, LLC

Consolidated Balance Sheets
(in thousands)

September 30,	2018	2017
Liabilities and Members' Equity		
Current liabilities		
Accounts payable and other accrued liabilities	$ 35,590	$ 26,881
Accrued salaries, wages and benefits	17,696	16,589
Deferred revenue	170	170
Due to government payers	4,796	4,505
Due to affiliated companies, net	26,377	20,056
Current portion of capital leases	798	1,475
Total current liabilities	85,427	69,676
Capital leases, net of current portion	92	895
Asset retirement obligations	2,623	2,438
Deferred revenue, net of current portion	2,270	2,891
Other long-term liabilities	12,674	10,673
Total liabilities	103,086	86,573
Commitments, contingencies, and subsequent events		
Members' equity		
Member contributions	92,108	82,261
Accumulated deficit	(64,687)	(28,494)
Total members' equity	27,421	53,767
Total liabilities and members' equity	$ 130,507	$ 140,340

See accompanying notes to consolidated financial statements.

Prospect CharterCARE, LLC

Consolidated Statements of Operations
(in thousands)

For the Years Ended September 30,	2018	2017
Revenues		
Net patient service revenues	$ 354,578	$ 343,050
Provision for bad debts	(12,598)	(11,936)
Net patient service revenues less provision for bad debts	341,980	331,114
Other revenues	8,102	7,678
Total net revenues	350,082	338,792
Operating Expenses		
Salaries, wages and benefits	196,794	186,382
Supplies	62,507	60,005
Taxes and licenses	22,309	25,581
Purchased services	24,125	21,542
Depreciation and amortization	15,096	13,843
Professional fees	10,988	10,535
Other	11,287	7,277
Insurance	4,620	5,659
Management fees	7,298	7,033
Utilities	4,771	3,993
Lease and rental	5,438	4,792
Research grant expense	2,503	2,231
Repairs and maintenance	2,675	2,315
Registry	887	713
Total operating expenses	371,298	351,901
Operating income from unconsolidated equity method investments	589	605
Operating loss	(20,627)	(12,504)
Other expense (income):		
Interest expense	955	1,131
Goodwill impairment	14,228	-
Other expense (income), net	282	(98)
Net loss from continuing operations	(36,092)	(13,537)
(Loss) Income from discontinued operations	(101)	9,411
Net loss	$ (36,193)	$ (4,126)

See accompanying notes to consolidated financial statements.

Prospect CharterCARE, LLC

Consolidated Statements of Members' Equity
(in thousands)

	Member Contributions	Accumulated Deficit	Total Members' Equity
Balance at October 1, 2016	$ 71,645	$ (24,368)	$ 47,277
Member contributions	10,616	-	10,616
Net loss	-	(4,126)	(4,126)
Balance at September 30, 2017	82,261	(28,494)	53,767
Member contributions	9,847	-	9,847
Net loss	-	(36,193)	(36,193)
Balance at September 30, 2018	$ 92,108	$ (64,687)	$ 27,421

See accompanying notes to consolidated financial statements.

Prospect CharterCARE, LLC

Consolidated Statements of Cash Flows
(in thousands)

For the Years Ended September 30,	2018	2017
Operating activities		
Net loss	$ (36,193)	$ (4,126)
Adjustments to reconcile net loss to net cash provided by (used in) operating activities:		
Depreciation and amortization	15,094	13,843
Provision for bad debts	12,598	11,936
Accretion of interest for asset retirement obligations	185	158
Operating income from equity method investments, net of distributions	(11)	254
Gain on sale of property, improvements and equipment	-	(2,891)
Goodwill impairment	14,228	-
Write-off of investment	280	-
Write-off of asset retirement obligation	-	(272)
Changes in operating assets and liabilities, net of business combinations:		
Change in restricted cash	2,595	(830)
Patient accounts receivable and other receivables	(16,247)	(15,852)
Due to/from government payers, net	(99)	22
Inventories	215	765
Prepaid expenses and other current assets	2,704	(3,324)
Other assets	(829)	(268)
Accounts payable and other accrued liabilities	10,381	8,401
Net cash and cash equivalents used in operating activities from discontinued operations	-	(10,967)
Net cash provided by (used in) operating activities	4,901	(3,151)
Investing activities		
Purchases of property, improvements and equipment	(8,973)	(7,043)
Cash paid for acquisitions	(736)	(2,268)
Proceeds from sale of property, improvements and equipment	-	6,498
Net cash and cash equivalents provided by investing activities from discontinued operations	-	5,882
Net cash (used in) provided by investing activities	(9,709)	3,069
Financing activities		
Member contributions	-	4,153
Increase (decrease) in due to affiliated companies, net	6,288	(7,950)
Repayments of capital leases	(1,480)	(2,036)
Proceeds from financing hospital facility	-	1,824
Net cash provided by (used in) financing activities	4,808	(4,009)
Decrease in cash and cash equivalents	-	(4,091)
Cash and cash equivalents, beginning of year	-	4,091
Cash and cash equivalents, end of year	$ -	$ -
Supplemental disclosure of cash flow information		
Interest paid	$ 955	$ 975
Schedule of non-cash investing and financing activities		
Equipment acquired under capital leases	$ -	$ 366
Non-cash acquisitions	$ 7,692	$ -
Non-cash contributions (Note 7)	$ 9,847	$ 6,463

See accompanying notes to consolidated financial statements.

CIIH16-000853

1. Organization

Prospect CharterCARE, LLC ("PCC" or the "Company") was formed on August 21, 2013 and is owned 85% by Prospect East Holdings, Inc. ("Prospect East"), a wholly-owned subsidiary of Prospect Medical Holdings, Inc. ("Prospect") and 15% by CharterCARE Community Board.

PCC's operating subsidiaries include Prospect CharterCARE RWMC, LLC ("RWMC", dba Roger Williams Medical Center), Prospect CharterCARE SJHSRI, LLC ("SJHSRI", dba St. Joseph Health Center and Our Lady of Fatima Hospital), Prospect CharterCARE Elmhurst, LLC ("Elmhurst Extended Care", sold in fiscal 2017, see Note 5), Prospect CharterCARE Physicians, LLC ("CharterCARE Physicians"), Prospect CharterCARE Ancillary Services, Inc., and New University Medical Group, LLC ("New UMG"), which collectively consist of hospitals, medical centers. The Company provides a comprehensive range of services at Roger Williams Medical Center, St. Joseph's Health Center, and Our Lady of Fatima Hospital. During the year ended September 30, 2018, two new entities were created, Prospect RI Home Health and Hospice, LLC ("PRIHHH"), which is owned by RWMC, and Prospect CharterCARE Home Health and Hospice, LLC ("PCCHHH"), which is owned by PRIHHH and, effective May 1, 2018, the operations of the home health business were transferred from RWMC to PCCHHH.

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

At September 30, 2018, the Company had negative working capital in the amount $22,301,000. The Company is dependent on Prospect to fund ongoing operations. As of September 30, 2018, the Company had a liability of $26,377,000 due to Prospect and its subsidiaries, which is payable on demand, does not bear interest, and is included in due to affiliated companies, net in the accompanying consolidated balance sheets. Prospect does not intend to have the Company repay the liability in a manner which would impair the Company's ability to maintain sufficient liquidity to sustain ongoing operations. Subsequent to year end, Prospect converted approximately $24,700,000 of liabilities into a capital contribution (see Note 12).

2. Significant Accounting Policies

Principles of Consolidation and 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 wholly-owned subsidiaries, but do not include the accounts of the parent companies, Prospect or CharterCARE Community Board.

Operating results for the Company's subsidiaries are consolidated with the Company's financial statements from their acquisition dates. All significant intercompany balances and transactions have been eliminated in consolidation.

Revenues

Net Patient Service Revenues

Operating revenue consists primarily of net patient service revenues. The Company reports net patient service revenues 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, 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 doubtful accounts and exclude revenues for discontinued operations (in thousands):

For the Years Ended September 30,	2018	2017
Medicare	$ 165,882	$ 152,240
Medicaid	74,710	72,948
Managed Care	80,605	74,920
Self-Pay/Other	33,381	42,942
Total	$ 354,578	$ 343,050

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 persons with end-stage renal disease and certain other beneficiary categories, including eligible disabled persons. Most inpatient hospital services rendered to Medicare program beneficiaries are paid on a fee-for-service basis at prospectively determined rates per discharge, according to a patient classification system based on clinical, diagnostic, and other factors. Most outpatient services also are paid on a fee-for-service basis generally using prospectively determined rates. The Company receives, as appropriate, Medicare disproportionate share hospital ("DSH") and bad debt payments at tentative rates, with final settlement determined after submission of the annual Medicare cost report and audit thereof by the Medicare Administrative Contractor. The Company also receives, as appropriate, Medicare uncompensated care DSH payments, which are generally not subject to cost report audit except to determine eligibility for Medicare DSH. The Company also receives Medicare outlier payments on an ongoing basis during the year for cases that are unusually costly, and under certain circumstances these payments may be reconciled to more closely reflect the costs in excess of outlier thresholds after the submission and audit of the annual Medicare cost report. Normal estimation differences between filed settlements and amounts accrued are reflected in net patient service revenue.

The Company is reimbursed by Medicare for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare Administrative Contractor. The estimated amounts due to or from the program are reviewed and adjusted annually based on the status of such audits and any subsequent appeals. Differences between final settlements and amounts accrued in previous years are reported as adjustments to net patient service revenue in the year that examination is substantially completed.

Although services for most Medicare beneficiaries are paid by the Federal government on a fee-for-service basis, approximately one-third of Medicare beneficiaries are enrolled in a "Medicare Advantage" plan, which is a type of health plan that contracts with the Medicare program to provide hospital and medical benefits to Medicare beneficiaries. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-For-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. For Medicare beneficiaries enrolled in a Medicare Advantage plan, most Medicare services are covered by the plan and are not paid for under fee-for-service Medicare. Certain Medicare Advantage plans make capitation payments to the Company using a "Risk Adjustment model," which compensates providers based on the health status (acuity) of each enrollee. Providers with higher acuity enrollees generally will receive more and those with healthier enrollees will receive less.

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. Similar to Medicare, cost report settlements are recorded based upon as-filed cost reports and adjusted for tentative and final settlements, if any.

RWMC and SJHSRI are participants in the State of Rhode Island's Disproportionate Share Hospital ("DSH") program, which assists hospitals that provide a disproportionate amount of uncompensated care. Under the program, Rhode Island hospitals, including RWMC and SJHSRI, receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low-income patients. RWMC and SJHSRI recognized revenue related to DSH and Upper Payment Limit ("UPL") reimbursement of $19,035,000 and $24,402,000 for the years ended September 30, 2018 and 2017, respectively. DSH and UPL payments received were $17,704,000 and $20,249,000 for the years ended September 30, 2018 and 2017, respectively. RWMC and SJHSRI recorded license fee expenses of $16,815,000 and $20,137,000 for the years ended September 30, 2018 and 2017, respectively, which is included within taxes and licenses expense within the accompanying consolidated statements of operations.

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.

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.

Laws and regulations governing the third-party payor arrangements are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Normal estimation differences between subsequent cash collections on patient accounts receivable and net patient accounts receivable estimated in the prior year are reported as adjustments to net patient service revenue in the current period.

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 who lack financial resources and are deemed to be medically indigent based on criteria established under the Company's charity care policy. This care is provided without charge or at amounts less than the Company's established rates. Because the Company does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The direct and indirect costs related to this care totaled approximately $772,000 and $833,000 for the years ended September 30, 2018 and 2017, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. In addition, the Company provides services to other medically indigent patients under various state Medicaid programs. Such programs pay amounts that are less than the cost of the services provided to the recipients. The Company has not changed its charity care or uninsured discount policies during the years ended September 30, 2018 or 2017.

Provisions for Contractual Allowances and Doubtful Accounts

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.

The remainder of this page intentionally left blank.

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 was 20% and 15% of gross accounts receivable as of September 30, 2018 and 2017, respectively.

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.

Other Revenues

Other revenues totaled $8,102,000 and $7,678,000 for the years ended September 30, 2018 and 2017, respectively. A summary of the principal components of other revenues is as follows:

Tuition Revenue: Tuition revenues include student fees and outside course reimbursement and are recognized ratably during the approximately seven months of instruction provided per year. The Company recorded tuition revenues of $2,155,000 and $2,002,000 for the years ended September 30, 2018 and 2017, respectively.

Grant Revenue: The Company receives grant revenue for direct research from the federal government, other institutions and other sources for a range of research areas including oncology, cardiology, HIV and diabetes. The Company recorded grant revenue of $1,925,000 and $1,841,000 for the years ended September 30, 2018 and 2017, respectively.

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. The Company recorded rental revenues of $494,000 and $704,000 for the years ended September 30, 2018 and 2017, respectively.

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. Building improvements are generally depreciated over seven years, buildings are depreciated over 10 years, equipment is depreciated over three to seven years and furniture and fixtures are depreciated over five 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.

Goodwill

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.

Through the year ended September 30, 2017, the Company tested for goodwill impairment as of September 30 each year. During the year ended September 30, 2018, the Company changed the date of the annual goodwill impairment test to July 1. The Company does not believe that the change in assessment date represents a material change in the application of applicable accounting literature. Impairment of goodwill is tested at the reporting unit level, by comparing the reporting unit's carrying amount, including goodwill, to the fair value of the reporting unit. The fair value of the reporting units are estimated. 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 Company has adopted new literature during the year ended September 30, 2018 which changes the goodwill impairment test from a two-step process to a one-step process, which consists of estimating 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. If the estimated fair value of the reporting unit is less than its carrying value, this indicates that goodwill is impaired, and impairment is recorded based on the deficiency of fair value compared to the carrying value. The Company's impairment test related to goodwill during the year ended September 30, 2018 resulted in a full impairment of goodwill. There were no impairment charges during the year ended September 30, 2017.

Intangible Assets

Intangible assets include trade names. 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, 2018 and 2017.

Insurance Reserves

Medical Malpractice Liability Insurance

The Company carries 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. The Company was included in Prospect's consolidated medical malpractice insurance policy effective June 20, 2014 (inception). Assets and liabilities related to malpractice insurance related to events prior to June 20, 2014 (inception) were not assumed by the Company.

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 recognizes 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. The Company's gross claims liability was $9,943,000 and $7,591,000 as of September 30, 2018 and 2017, respectively, and insurance receivables were $2,220,000 and $1,316,000 as of September 30, 2018 and 2017, respectively. The gross claims liability and insurance receivables were estimated using a discount factor of 4% and are included within long-term assets and long-term liabilities, respectively, in the accompanying consolidated balance sheets.

Workers' Compensation Insurance

The Company was fully insured for workers' compensation claims with no deductible during the years ended September 30, 2018 and 2017.

Reserve Methodology

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.

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 statements of operations. The Company has accrued $2,623,000 and $2,438,000 related to asbestos remediation as of September 30, 2018 and 2017, respectively. The liability was estimated using a discount factor which ranged from 7% - 9%.

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

The Company held restricted cash of $433,000 and $3,028,000 as of September 30, 2018 and 2017, respectively, which was restricted for research at the Company's hospitals as well as for School of Nursing grants.

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.

Income Taxes

For tax reporting purposes, the Company is treated as a Partnership. PCC and its wholly-owned subsidiaries are pass-through entities. Therefore, no provision is made in the accompanying consolidated financial statements for liabilities for federal, state or local income taxes since such liabilities are the responsibility of the Company's parent companies. The Company periodically evaluates its tax positions, including its status as a pass-through entity, to evaluate whether it is more likely than not that such positions would be sustained upon examination by a tax authority for all open tax years, as defined by the statute of limitations, based on its technical merits.

As of September 30, 2018 and 2017, the Company has not established a liability for uncertain tax positions. The Company files income tax returns in the U.S. federal jurisdiction and the state of Rhode Island. Generally, the Company is subject to examination by U.S. federal (or state and local) income tax authorities for three to four years from the filing of a tax return.

Fair Value of Financial Instruments

Financial instruments consist primarily of cash and cash equivalents, restricted cash, patient and other accounts receivables, accounts payable and accrued expenses, accrued salaries and benefits, amounts due from/to government payers, capital lease obligations, 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.

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 intangible assets when there are indications of impairment.

During the year ended September 30, 2018, the Company recorded approximately $14.2 million of impairment relating to goodwill, which is reflected in the accompanying consolidated statements of operations.

The Company uses the discounted cash flow approach, the guideline public company approach and the guideline transactions approach to estimate the residual value of the Company's goodwill. The measurement of goodwill is a Level 3 measurement. The following table provides quantitative information related to the significant unobservable inputs to determine fair value and impairment of goodwill as of September 30, 2018:

Residual Value of Goodwill	Valuation Technique	Unobservable Input	Rates
$ -	Discounted Cash Flow	Weighted average cost of capital	9.3%
		Revenue growth rate	2.1% - 2.5%
	Guideline Public Company	LTM EBITDA multiple	7.0x

There were no nonrecurring measurements as of September 30, 2018 and 2017.

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 and Medicaid. The Company received revenues from Medicare and Medicaid as follows (excluding revenues for discontinued operations, in thousands):

Years Ended September 30,	2018	% of Total Revenues	2017	% of Total Revenues
Medicare	$ 165,882	47 %	$ 152,240	44 %
Medicaid	74,710	21 %	72,948	21 %
Total	$ 240,592	68 %	$ 225,188	65 %

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 amounts due from/to government payers, allowances for contractual discounts and doubtful accounts, professional and general liability claims, long-lived assets, intangible assets and asset retirement obligations.

Subsequent Events

The Company has evaluated subsequent events through July 18, 2019, the date the Company's consolidated financial statements were available for issuance.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued ASU 2014-09, "Revenue from Contracts with Customers (Topic 606)," which defers the effective date of the revenue standard 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. October 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. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)." The core principle of ASU 2016-02 is that a lessee should recognize the assets and liabilities that arise from leases, including operating leases. Under the new requirements, a lessee will recognize in the statement of financial position a liability to make lease payments (the lease liability) and the right-of-use asset representing the right to the underlying asset for the lease term. For leases with a term of 12 months or less, the lessee is permitted to make an accounting policy election by class of underlying asset not to recognize lease assets and lease liabilities. The recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee have not significantly changed from previous GAAP. The standard is effective for nonpublic entities for fiscal years beginning after December 15, 2019. Early application of the amendment is permitted. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230)." The updated standard addresses eight specific cash flow issues with the objective of reducing diversity in practice. ASU 2016-15 is effective for non-public business entities for annual reporting periods beginning after December 15, 2018, including interim periods within those annual reporting periods. Early adoption is permitted. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

In January 2017, the FASB issued ASU 2017-01, "Business Combinations (Topic 805): Clarifying the Definition of a Business." These amendments clarify the definition of a business. The amendments affect all companies and other reporting organizations that must determine whether they have acquired or sold a business. The definition of a business affects many areas of accounting including acquisitions, disposals, goodwill, and consolidation. The amendments are intended to help companies and other organizations evaluate whether transactions should be accounted for as acquisitions (or disposals) of assets or businesses. This update is effective for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2018. Early adoption is permitted under certain circumstances. The amendments should be applied prospectively as of the beginning of the period of adoption. The Company is evaluating the effect that this update will have on its consolidated financial statements and related disclosures.

In January 2017, the FASB issued ASU 2017-04, "Intangibles-Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment)." The new guidance is effective for fiscal years beginning after December 15, 2019 and interim periods within those fiscal years, and should be applied on a prospective basis. Early adoption is permitted for interim or annual goodwill impairment tests performed on testing dates after January 1, 2017, and the Company will adopt this standard effective for the year ending September 30, 2018. The new guidance simplifies the current two-step goodwill impairment test by eliminating Step 2 of the test. The new guidance requires a one-step impairment test in which an entity compares the fair value of a reporting unit with its carrying amount and recognizes an impairment charge for the amount by which the carrying amount exceeds the reporting unit's fair value, if any. The Company early adopted this standard in the current fiscal year.

The remainder of this page intentionally left blank.

3. Property, Improvements and Equipment

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

September 30,	2018	2017
Property, improvements and equipment:		
Land and land improvements	$ 7,471	$ 7,468
Buildings and improvements	39,359	35,598
Leasehold improvements	4,334	3,394
Equipment	39,400	35,541
	90,564	82,001
Less: accumulated depreciation	(44,869)	(32,035)
	45,695	49,966
Construction in progress	14,085	3,884
Property, improvements and equipment, net	$ 59,780	$ 53,850

At September 30, 2018 and 2017, the Company had assets under capitalized leases of approximately $4,292,000 and $4,697,000, respectively, and related accumulated depreciation of $1,917,000 and $1,792,000, respectively.

Depreciation expense, excluding discontinued operations, was $13,222,000 and $12,200,000 for the years ended September 30, 2018 and 2017, respectively.

4. Acquisitions

In December 2017, New UMG entered into a Second Closing to acquire the remaining assets of University Medical Group ("UMG") that were not acquired in the initial acquisition in December 2014. As consideration for the acquisition, New UMG has assumed certain designated liabilities of the practice, which consists of various loans payable to subsidiaries of the Company, totaling approximately $7.5 million. Post-acquisition, these liabilities are eliminated on consolidation. There was no cash consideration related to the transaction. The remaining assets and liabilities acquired were immaterial and no value was assigned to them in the purchase price allocation, and accordingly goodwill of $7.5 million arises from the acquisition. The goodwill is deductible for tax purposes at Prospect, with PCC acting as a flow through entity. New UMG's parent company, Prospect CharterCARE Physicians, LLC, dba CharterCARE Medical Associates ("CCMA"), entered into a Post Closing Administrative Services Agreement pursuant to which CCMA and its affiliates provide services to the seller of the practice in connection with its termination of all operations and the wind up its affairs and operations.

Additionally during the year ended September 30, 2018, CharterCARE Physicians entered into asset purchase agreements to acquire three medical practices with primary care physicians. Total cash consideration for the medical practices was $976,000, of which $240,000 was included in accounts payable in the accompanying consolidated balance sheets and paid in October 2018.

During the year ended September 30, 2017, CharterCARE Physicians entered into asset purchase agreements to acquire two medical practices with primary care physicians. Total cash consideration for the medical practices was $1.1 million.

On May 1, 2017, the Company's wholly-owned subsidiary, Prospect Blackstone Valley Surgicare, LLC ("Prospect Blackstone"), completed an asset acquisition of a freestanding ambulatory surgery center located near the CharterCARE facilities in Rhode Island, in exchange for cash consideration of $1.6 million.

The acquisitions were accounted for as business combinations using purchase accounting. Under the purchase accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values. As asset purchases, goodwill acquired is expected to be deductible for tax purposes.

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

For the Years Ended September 30,	2018	2017
Inventories	$ -	$ 374
Improvements and equipment	22	813
Goodwill	8,406	2,048
Capital leases	-	(588)
Accrued purchase consideration due to seller	(240)	(379)
Liabilities assumed	(7,452)	-
Net cash consideration	$ 736	$ 2,268

As mentioned at Note 2, on July 1, 2018, the Company tested for goodwill impairment which resulted in a full impairment of goodwill. This includes the goodwill presented in the table above (see Note 6).

5. Discontinued Operations

During the year ended September 30, 2016, the Company determined that it would discontinue the operations of Prospect CharterCARE Elmhurst Extended Care, LLC (dba Elmhurst Extended Care). The Company's decision to discontinue the operations of each of the entities was based on the Company's management's strategy in their respective markets and financial results. The results of Elmhurst Extended Care's operations are included within loss from discontinued operations in the accompanying consolidated statements of operations.

The remainder of this page intentionally left blank.

Summarized financial information for discontinued operations is included below (in thousands):

For the Years Ended September 30,	2018	2017
Major line items constituting pretax loss of discontinued operations:		
Net revenues	$ (10)	$ 4,324
Operating expenses	91	5,403
Loss on discontinued operation	(101)	(1,079)
Gain from sale of discontinued operations	-	10,490
(Loss) income on discontinued operations	$ (101)	$ 9,411

6. Goodwill and Intangible Assets

Goodwill and intangible assets relate to the Prospect CharterCARE and CharterCARE Physicians medical practices acquisitions. The following is a roll-forward of goodwill for the years ended September 30, 2018 and 2017, respectively (in thousands):

September 30,	2018	2017
Balance, beginning of year	$ 5,822	$ 3,774
Acquisitions	8,406	2,048
Impairment	(14,228)	-
Balance, end of year	$ -	$ 5,822

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

	Amortization Period	September 30, 2018	September 30, 2017
Trade names	5 years	$ 8,130	$ 8,130
Other	5 years	97	97
Total acquisition cost of intangible assets		8,227	8,227
Less accumulated amortization		(7,016)	(5,373)
Intangible assets, net		$ 1,211	$ 2,854

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives. Amortization expense was $1,643,000 and $1,643,000 for the years ended September 30, 2018 and 2017, respectively.

CIIH16-000867

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

Years ended September 30,	
2019	$ 1,190
2020	19
Total	$ 1,209

The weighted-average remaining useful life for the intangible assets was approximately one year as of September 30, 2018.

7. Members' Equity

In accordance with the Amended & Restated Limited Liability Company Agreement of PCC ("LLC Agreement"), the profit or loss of PCC is to be allocated to the members based on their Adjusted Capital Contribution, as defined in the LLC Agreement. Total member contributions were $9,847,000 and $10,616,000 for the years ended September 30, 2018 and 2017, respectively. All of these contributions were made by Prospect and are accounted for as additional member contributions, however, in accordance with the LLC Agreement, the contributions were allocated 85% to Prospect and 15% to CharterCARE Community Board, consistent with their ownership percentages.

The following table breaks out total member non-cash and cash contribution:

September 30,	2018	2017
Cash contributions	$ -	$ 4,153
Non-cash contributions	9,847	6,463
Total	$ 9,847	$ 10,616

The following is a summary of the members' capital accounts (in thousands):

	Prospect	CharterCARE Community Board	Total
Balance at October 1, 2016	$ 40,185	$ 7,092	$ 47,277
Allocated contributions	9,024	1,592	10,616
Net loss	(3,507)	(619)	(4,126)
Balance at September 30, 2017	45,702	8,065	53,767
Allocated contributions	8,370	1,477	9,847
Net loss	(30,764)	(5,429)	(36,193)
Balance at September 30, 2018	$ 23,308	$ 4,113	$ 27,421

8. Related Party Transactions

The Company and Prospect East Hospital Advisory Services, LLC ("PEHAS"), a wholly-owned subsidiary of Prospect, entered into a Management Services Agreement ("MSA") as of June 20, 2014, under which PEHAS provides certain administrative and management services to PCC and its Subsidiaries. Management fees due to PEHAS under the MSA consist of 2% of net revenues monthly. The Company recognized management fees of $7,298,000 and $7,033,000 for the years ended September 30, 2018 and 2017, respectively, which is included within management fees expense in the accompanying consolidated statements of operations. As of September 30, 2018 and 2017, the Company had liabilities related to the MSA due PEHAS of $30,568,000 and $23,270,000, respectively. Subsequent to year-end, Prospect converted the unpaid management fees and certain unpaid payables to Members' Equity (see Note 12).

9. 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 2023. Capital leases bear interest at rates ranging from 4.0% to 6.0% per annum.

The future minimum annual lease payments (net of anticipated sublease income) required under leases in effect at September 30, 2018, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2019	$ 829	$ 452
2020	51	350
2021	44	288
2022	-	283
2023	-	283
Total minimum lease payments	924	$ 1,656
Less: amounts representing interest	(34)	
	890	
Less: current portion	(798)	
	$ 92	

Lease and rental expense was $5,438,000 and $4,792,000 for the years ended September 30, 2018 and 2017, respectively.

CIIH16-000869

Contingent Liability for Borrowings by Prospect

The Company and its Subsidiaries are contingently liable as a guarantor among others for amounts borrowed by Prospect on senior secured borrowings and credit facilities as of September 30, 2018 and 2017. The obligations and related interest expense related to these credit facilities are not reflected in the Company's consolidated financial statements as of September 30, 2018 and 2017, as the borrowings are reflected in the separate consolidated financial statements of Prospect.

Total borrowings outstanding as of September 30, 2018 and 2017, reflected in the consolidated financial statements of Prospect, but for which the Company is contingently liable as a guarantor, were (in thousands):

September 30,	2018	2017
Senior secured term notes (net of discount of $20,085 and $7,374)	$ 1,094,315	$ 609,813
Less: deferred financing costs	(16,214)	(9,906)
	$ 1,078,101	$ 599,907

On June 30, 2016, Prospect entered into a six-year $625 million senior secured term loan B (the "Original Term Loan"), the proceeds of which were used to repay $425 million of PMH's existing 8.375% senior secured notes due during 2019; to repay $60 million of borrowings under the Prospect's existing revolving credit facility (the "Replaced Revolver"); to fund acquisitions, including the acquisition of a fellow subsidiary; and to finance transaction fees and expenses. The Original Term Loan bore interest at LIBOR (subject to a 1.0% floor) plus 6.0%. The Original Term Loan was issued with an original discount of 1.5%, or $9,375,000. Additionally, the Company refinanced the Replaced Revolver with a new $100 million asset-based revolving credit facility ("Original ABL Facility" and together with the Original Term Loan, the "New Senior Secured Credit Facilities"). Pursuant to various amendments from August 2016 through October 2017, the aggregate commitment amount under the Original ABL facility was increased in stages to $175 million. The maturity date for the Original ABL Facility was June 30, 2021, and the maturity date for the Term Loan was June 30, 2022.

On February 22, 2018, the Company refinanced and replaced both the Original Term Loan and the Original ABL Facility, and entered into an Amended and Restated Term Loan Credit Agreement (the "Amended TL Agreement"), by and among the Company (as the borrower), the lenders party thereto and JPMorgan Chase Bank, N.A. ("JPMorgan"), as administrative agent and collateral agent. The Amended TL Agreement replaced the Original Term Loan with a new Term B-1 Loan ("Term B-1 Loan"). The principal amount of the Term B-1 Loan is $1,120 million and such loan bears interest at LIBOR (subject to a 1.0% floor) plus 5.5%, which as of September 30, 2018 was 7.625%. The Term B-1 Loan was issued with an original discount of 2% and matures on February 22, 2024.

Additionally, on February 22, 2018, Prospect entered into an Amended and Restated ABL Credit Agreement (the "Amended ABL Agreement"), by and among the Company (as the borrower), the lenders party thereto and JPMorgan, as administrative agent and collateral agent. The Amended ABL Agreement replaced the Original ABL Facility. Under the Amended ABL Agreement, the maximum revolving commitment is $250.0 million with ability to expand the facility to $325.0 million, and the new ABL facility (the "New ABL Facility") bears interest at a variable base rate plus an applicable spread that is based on excess availability under the New ABL Facility, as further described in the Amended ABL Agreement, which was 3.875% as of September 30, 2018. The New ABL Facility matures on February 22, 2023. As of September 30, 2018, the available balance on the new ABL facility was $41.0 million.

Letter of Credit

As of September 30, 2018, Prospect secured an irrevocable letter of credit for $733,000 on behalf of the Company for its School of Nursing ("School") as required by the U.S. Department of Education. The purpose of the letter of credit is to (i) pay refunds of charges owed on behalf of current or former students, whether or not the School remains open; (ii) to provide for the "teach-out" of currently enrolled students if the School closes; and (iii) to pay any liabilities owed to the U.S. Department of Education.

Other Commitments

The Company has additional commitments for reagents that are based on tests performed. They are non-cancelable agreements but the future dollar commitments are not quantifiable as they are volume-driven.

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.

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, states have also developed their own standards for the privacy and security of health information as well as for reporting certain violations and breaches which in some cases are more stringent. Other federal privacy laws may also apply to certain services provided by the Company, including 42 C.F.R. Part 2, which addresses the confidentiality of substance use disorder records. 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") has made significant changes to the United States health care system. The legislation impacted multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Under this legislation, 33 states have expanded their Medicaid programs to cover previously uninsured childless adults, and four additional states voted in 2018 to expand Medicaid or to elect a governor that pledged to expand Medicaid. In addition, many uninsured individuals have had the opportunity to purchase health insurance via state-based marketplaces, state-based marketplaces using a federal platform, state-partnership marketplaces or the federally-facilitated marketplace. PPACA also implemented a number of health insurance market reforms, such as allowing children to remain on their parents' health insurance until age 26 or prohibiting certain plans from denying coverage based on pre-existing conditions. Nationally, these reforms have reduced the number of uninsured individuals.

It is unclear what changes may be made to PPACA with the divided Congress, current presidential administration, and pending litigation over the validity of PPACA. The Administration has promulgated rules to broaden the availability of coverage options that do not comply with the full range of PPACA requirements for individual market coverage, namely Association Health Plans and Short-Term Limited-Duration Insurance. The Administration has also provided additional guidance on state PPACA waivers. These executive actions have been or may be challenged in court. In addition, the Tax Cuts and Jobs Act ("TCJA"), passed in December 2017, eliminates the individual mandate penalty under PPACA, effective January 1, 2019. The individual mandate penalty was included in PPACA to address concerns that other market reforms expanding access to coverage might produce adverse selection and higher premiums. The extent to which the repeal of the individual mandate penalty will impact the uninsured rate and 2019 premiums is unclear at this juncture. On December 14, 2018, the United States District Court for the Northern District of Texas ruled that the individual mandate without the penalty is unconstitutional and that PPACA is therefore invalid in its entirety. Litigation on this issue is ongoing, with the Administration indicating it will continue implementing PPACA pending any appeals, the court ordering expedited briefing on a potential stay and certification of an interlocutory appeal, and pending litigation in the United States District Court for the District of Maryland to ensure continued implementation of PPACA. This litigation along with any future legislative changes to

PPACA or other federal and state legislation could have a material impact on the operations of the Company. The Company is continuing to monitor the legislative environment and developments in pending litigation for risks and uncertainties.

Collective Bargaining Agreements

Approximately 316 employees at SJHSRI are subject to a collective bargaining agreement with United Nurses and Allied Professionals ("UNAP"), which was effective beginning September 2016 and expires July 2019. During April 2015, a hospital unit consisting of approximately 400 service employees of SJHSRI elected to be represented by UNAP. The parties entered into a collective bargaining agreement which expired in October 2018 and is currently in the process of renegotiations. A small number of employees are subject to a collective bargaining agreement with the Federation of Nurses and Health Professionals ("FNHP"), which expires on July 30, 2021.

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.

10. Defined Contribution Plan

The Company sponsors a defined contribution plan (the "Plan") covering substantially all employees who meet certain eligibility requirements. Under the Plan, employees can contribute up to 100% of their compensation up to the IRS deferred annual maximum. Effective May 1, 2018, the plans covering employees at ECHN, Waterbury and Crozer were merged into the plan covering employees at CharterCARE, and the two remaining plans were renamed and segregated between union and non-union employees. The Company may make discretionary matching contributions to the Plan. Employer contributions to the Plan were $1,925,000 and $839,000 for the years ended September 30, 2018 and 2017, respectively.

11. Equity Method Investments

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. 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, 2018 and 2017, the Company's investments in RWRT, SNERCC, and other minor investments under the equity method were approximately $4,088,000 and $4,357,000, respectively, and are included in equity method investments in the accompanying consolidated balance sheets. For the years ended September 30, 2018 and 2017, the Company recognized approximately $589,000 and $605,000, respectively, as its share of the financial results of RWRT, SNERCC, and other minor investments and received $614,000 and $836,000, respectively, in distributions.

Summarized combined unaudited financial information for RWRT and SNERCC as of and for the years ended September 30, 2018 and 2017 is as follows (in thousands):

September 30,	2018	2017
Cash	$ 2,515	$ 1,549
Receivables and other current assets	3,756	2,121
Total current assets	6,271	3,670
Property, improvements and equipment, net	3,502	6,104
Goodwill	7,142	7,142
Intangible assets	851	882
Other long-term assets	1,569	1,603
Total assets	$ 19,335	$ 19,401
Accounts payable and accrued liabilities	$ 1,052	$ 1,201
Other long-term liabilities	420	400
Equity	17,863	17,800
Total liabilities and partner's capital	$ 19,335	$ 19,401

For the Years Ended September 30,	2018	2017
Revenues	$ 17,278	$ 16,387
Net income	$ 2,953	$ 2,941
Income from equity method investments	$ 589	$ 507

12. Subsequent Events (Unaudited)

On March 1, 2019, Prospect entered into Amendment No. 2 to the Amended and Restated ABL Credit Agreement, by and among Prospect (as the borrower), the lenders party thereto and JPMorgan, as administrative agent and collateral agent. Under this amendment, the maximum revolving commitment is increased from $250.0 million to $280.0 million, and the maximum expansion of the facility has been reduced from $325.0 million to $285.0 million. Additionally, the amendment provides for $40.0 million of a "first in first out" revolving facility, which bears interest at either 2.5% or 3.5% per annum depending on whether they are Eurodollar loans or ABR loans.

Further, on March 25, 2019, Prospect entered into Amendment No. 3 to the Amended and Restated ABL Credit Agreement, by and among Prospect (as the borrower), the lenders party thereto and JPMorgan, as administrative agent and collateral agent. Under this amendment, the maximum revolving commitment is increased from $280.0 million to $285.0 million.

In May 2019, Prospect East, which owns 85% of the Company, made a non-cash capital contribution in the amount of approximately $24.7 million, which consisted of converting unpaid management fees due to PEHAS of approximately $20.0 million and approximately $4.7 million of unpaid invoices that Prospect paid on behalf of the Company at April 30, 2019, into equity.

Prospect CharterCARE SJHSRI, LLC

Financial Statements
As of and for the Years Ended
September 30, 2018 and 2017

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.

BDO

CIIH16-000877

Prospect CharterCARE SJHSRI, LLC

Financial Statements

As of and for the Years Ended September 30, 2018 and 2017

Prospect CharterCARE SJHSRI, LLC

Contents

	Page
Independent Auditor's Report	4 - 5
Balance Sheets	6 - 7
Statements of Operations	8
Statements of Member's Equity	8
Statements of Cash Flows	10
Notes to the Financial Statements	11 - 28
Supplemental Report and Schedule	
Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*	30 - 31
Schedule of Findings and Disposition of Prior Year Findings	32 - 33

CIIH16-000879

BDO

Tel: 714-957-3200
Fax: 714-957-1080
www.bdo.com

600 Anton Blvd., Suite 500
Costa Mesa, CA 92626

Independent Auditor's Report

Board of Directors
Prospect CharterCARE SJHSRI, LLC
Los Angeles, California

Report on the Financial Statements

We have audited the accompanying financial statements of Prospect CharterCARE SJHSRI, LLC (the "Company"), which comprise the balance sheets as of September 30, 2018 and 2017, and the related statements of operations, member's equity, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these 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 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 financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the 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 Company'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 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 financial statements referred to above present fairly, in all material respects, the financial position of the Company as of September 30, 2018 and 2017, and the results of its operations and its cash flows for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 1, the Company is financially dependent on its parent companies which have agreed to provide the financial support necessary for the operations of the Company. The accompanying financial statements do not reflect any adjustments or disclosures that would be required should the parent companies discontinue their financial support.

Other Matters

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying Note 9 of the Company's calculation of its Title IV 90/10 revenue test ("Note 9 - Title IV 90/10") and Note 6 on related party transactions are required by the U.S. Department of Education and is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the Note 9 - Title IV 90/10 information and Note 6 on related party transactions are fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated March 29, 2019 on our consideration of the Company's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Company's internal control over financial reporting and compliance.

BDO USA, LLP

March 29, 2019

Prospect CharterCARE SJHSRI, LLC

Balance Sheets
(in thousands)

September 30,	2018	2017
Assets		
Current assets		
Cash and cash equivalents	$ -	$ -
Restricted cash	166	659
Patient accounts receivable, less allowance for doubtful accounts of $5,491 and $3,633	20,224	17,399
Other receivables	554	969
Due from government payers	894	439
Inventories	1,889	1,751
Prepaid expenses and other current assets	496	922
Total current assets	24,223	22,139
Property, improvements and equipment, net	24,064	23,152
Intangible assets, net	517	1,235
Other assets	881	576
Total assets	$ 49,685	$ 47,102

See accompanying notes to financial statements.

Prospect CharterCARE SJHSRI, LLC

Balance Sheets
(in thousands)

September 30,	2018	2017
Liabilities and Member's Equity		
Current liabilities		
Accrued medical claims and other healthcare costs payable	$ 488	$ 673
Accounts payable and other accrued liabilities	11,438	9,299
Accrued salaries, wages and benefits	4,852	4,483
Deferred revenue	681	971
Due to government payers	424	36
Due to affiliated companies, net	5,657	744
Current portion of capital leases	369	750
Total current liabilities	23,909	16,956
Capital leases, net of current portion	38	408
Deferred revenue, net of current portion	1,514	1,701
Asset retirement obligations	2,092	1,945
Other long-term liabilities	5,771	4,983
Total liabilities	33,324	25,993
Commitments, contingencies, and subsequent events		
Member's equity:		
Member's contributions	28,535	28,535
Accumulated deficit	(12,174)	(7,426)
Total member's equity	16,361	21,109
Total liabilities and member's equity	$ 49,685	$ 47,102

See accompanying notes to financial statements.

Prospect CharterCARE SJHSRI, LLC

Statements of Operations
(in thousands)

For the Years Ended September 30,	2018	2017
Revenues:		
Net patient service revenues	$ 147,129	$ 144,498
Provision for bad debts	(6,096)	(5,819)
Net patient service revenues less provision for bad debts	141,033	138,679
Other revenues	1,715	2,159
Tuition revenues	2,155	2,002
Total net revenues	144,903	142,840
Operating Expenses:		
Salaries, wages and benefits	81,487	80,979
Supplies	19,662	19,948
Taxes and licenses	9,840	9,355
Purchased services	9,980	7,476
Depreciation and amortization	7,846	7,248
Professional fees	5,124	4,075
Other	5,374	3,957
Management fees	2,994	2,981
Utilities	1,957	1,862
Lease and rental	1,536	1,577
Insurance	1,668	2,142
Repairs and maintenance	1,261	1,247
Registry	46	89
Total operating expenses	148,775	142,936
Operating income from unconsolidated equity method investments	-	61
Operating loss	(3,872)	(35)
Other (income) expense:		
Interest expense	876	995
Other income	-	(98)
Total other expense	876	897
Net loss	$ (4,748)	$: (932)

See accompanying notes to financial statements.

Prospect CharterCARE SJHSRI, LLC

Statements of Member's Equity
(in thousands)

	Member's Contributions	Accumulated Deficit	Total Member's Equity
Balance at October 1, 2016	$ 28,535	$ (6,494)	$ 22,041
Net loss	-	(932)	(932)
Balance at September 30, 2017	28,535	(7,426)	21,109
Net loss	-	(4,748)	(4,748)
Balance at September 30, 2018	$ 28,535	$ (12,174)	$ 16,361

See accompanying notes to financial statements.

Prospect CharterCARE SJHSRI, LLC

Statements of Cash Flows
(in thousands)

For the Years Ended September 30,		2018		2017
Operating activities				
Net loss	$	(4,748)	$	(932)
Adjustments to reconcile net loss to net cash and cash equivalents provided by operating activities:				
Depreciation and amortization		7,846		7,248
Provision for bad debts		6,096		5,819
Accretion of interest for asset retirement obligations		156		149
Gain on sale of property, improvements and equipment		-		(167)
Changes in operating assets and liabilities				
Change in restricted cash		493		(197)
Patient accounts receivable and other receivables		(8,506)		(7,045)
Due to/from government payers, net		(67)		(58)
Inventories		(138)		220
Prepaid expenses and other current assets		426		151
Other assets		(305)		7
Accrued medical claims and other healthcare costs		(185)		20
Accounts payable and other accrued liabilities		2,772		1,169
Deferred revenue		(477)		2,672
Net cash and cash equivalents provided by operating activities		3,363		9,056
Investing activities				
Purchases of property, improvements and equipment		(7,525)		(4,862)
Proceeds from sale of property, improvements and equipment		-		483
Net cash and cash equivalents used in investing activities		(7,525)		(4,379)
Financing activities				
Change in due to affiliated companies, net		4,913		(3,740)
Repayments of capital leases		(751)		(937)
Net cash and cash equivalents provided by (used in) financing activities		4,162		(4,677)
Change in cash and cash equivalents		-		-
Cash and cash equivalents, beginning of year		-		-
Cash and cash equivalents, end of year	$	-	$	-
Supplemental disclosure of cash flow information				
Interest paid	$	876	$	756
Schedule of non-cash investing activities				
Transfer of ARO to long-term liabilities	$	-	$	2,391
Equipment acquired under capital lease	$	-	$	408

See accompanying notes to financial statements.

1. Organization

Prospect CharterCARE SJHSRI, LLC ("SJHSRI" or the "Company" dba St. Joseph Health Center and our Lady of Fatima Hospital) is a wholly-owned subsidiary of Prospect CharterCARE, LLC ("PCC"). PCC is owned 85% by Prospect Medical Holdings, Inc. ("Prospect") and 15% by CharterCARE Community Board. SJHSRI operates a 359-bed acute care general hospital which provides healthcare services in North Providence, Rhode Island and surrounding communities. Additionally, SJHSRI operates the St. Joseph School of Nursing and an integrated network of primary care and specialty clinics serving an economically challenged and ethnically diverse population in Providence, Rhode Island.

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

The Company is dependent on its parent companies to fund ongoing operations. As of September 30, 2018, the Company had a net liability of $5,657,000 due to Prospect and to PCC and its subsidiaries, which is payable on demand, does not bear interest, and is included in due to affiliated companies, net in the accompanying balance sheets. Prospect and PCC do not intend to have the Company repay the liability in a manner which would impair the Company's ability to maintain sufficient liquidity to sustain ongoing operations.

2. Significant Accounting Policies

Basis of Presentation

The financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP").

Revenues

Net Patient Service Revenues

Operating revenue consists primarily of net patient service revenues. The Company reports net patient service revenues 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, 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 balance sheets.

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

For the Years Ended September 30,	2018	2017
Medicare	$ 68,242	$ 63,629
Medicaid	33,216	31,842
Managed Care	31,417	30,132
Self-Pay/Other	14,254	18,895
Total	$ 147,129	$ 144,498

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. Most 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 generally paid based on 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. The Company also receives Medicare outlier payments on an ongoing basis during the year for cases that are unusually costly, and under certain circumstances these payments may be reconciled to more closely reflect the costs in excess of outlier thresholds after the submission and audit of the annual Medicare cost report. 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.

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. Similar to Medicare, cost report settlements are recorded based upon as-filed cost reports and adjusted for tentative and final settlements, if any.

SJHSRI is a participant in the State of Rhode Island's Disproportionate Share Hospital ("DSH") program, which assists hospitals that provide a disproportionate amount of uncompensated care. Under the program, Rhode Island hospitals, including SJHSRI, receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low income patients. SJHSRI recognized revenue related to DSH and Upper Payment Limit ("UPL") reimbursement of $9,856,000 and $10,819,000 for the years ended September 30, 2018 and 2017, respectively. DSH and UPL payments received were $9,837,000 and $9,935,000 for the years ended September 30, 2018 and 2017, 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. SJHSRI recorded license fee expenses of $7,616,000 and $7,284,000, respectively, which is included within taxes and licenses expense within the accompanying statements of operations.

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.

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 indigent and charity care policy.

Laws and regulations governing the third-party payor arrangements are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Normal estimation differences between subsequent cash collections on patient accounts receivable and net patient accounts receivable estimated in the prior year are reported as adjustments to net patient service revenue in the current period.

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 financial statements.

Charity Care

The Company provides charity care to patients who lack financial resources and are deemed to be medically indigent based on criteria established under the Company's charity care policy. This care is provided without charge or at amounts less than the Company's established rates. Because the Company does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The direct and indirect costs related to this care totaled approximately $315,000 and $286,000 for the years ended September 30, 2018 and 2017, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. In addition, the Company provides services to other medically indigent patients under various state Medicaid programs. Such programs pay amounts that are less than the cost of the services provided to the recipients. The Company has not changed its charity care or uninsured discount policies during the years ended September 30, 2018 or 2017.

Provisions for Contractual Allowances and Doubtful Accounts

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 was 21% and 17% of gross accounts receivable as of September 30, 2018 and 2017, respectively. The decrease was due to a self-pay discount which took effect during the year ended September 30, 2018, resulting in a decrease in the bad debt allowance required as of September 30, 2018.

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 financial statements.

Other Revenues

Other revenues totaled $1,715,000 and $2,159,000 for the years ended September 30, 2018 and 2017, respectively. A summary of the primary components of other revenues is as follows:

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 rent is recorded on the straight-line method over the terms of the related lease agreements. The Company recorded rental revenues of $208,000 and $380,000 for the years ended September 30, 2018 and 2017, respectively.

Tuition Revenues

Tuition revenues include student fees and outside course reimbursement and are recognized ratably during the approximately 7 months of instruction provided per year. The Company recorded tuition revenues of $2,155,000 and $2,002,000 for the years ended September 30, 2018 and 2017, respectively. Amounts receivable related to tuition revenues were $67,000 and $268,000 as of September 30, 2018 and 2017, respectively, which is included within other receivables in the accompanying balance sheets. The tuition receivable is net of an allowance for uncollectible tuition of $202,000 and $226,000 as of September 30, 2018 and 2017, respectively. The receivable for tuition is included in other receivables in the accompanying balance sheets.

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. Building improvements are generally depreciated over seven years, buildings are depreciated over 10 years, equipment is depreciated over three to seven years and furniture and fixtures are depreciated over five 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.

Long-Lived Assets and Amortizable Intangibles

Intangible assets include trade names. 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, 2018 and 2017.

Insurance Reserves

Medical Malpractice Liability Insurance

The Company carries professional and general liability insurance to cover medical malpractice claims. The General Liability coverage is occurrence coverage and the Professional Liability coverage is claims-made coverage. Under the Professional Liability policy, insurance premiums cover only those claims actually reported during the policy term. Should the Professional Liability 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. The Company was included in Prospect's consolidated medical malpractice insurance policy effective June 20, 2014 (inception). Assets and liabilities related to malpractice insurance related to events prior to June 20, 2014 (inception) were not assumed by the Company.

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 recognizes 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. The Company's gross claims liability was $3,470,000 and $2,535,000 as of September 30, 2018 and 2017, respectively, and insurance receivables were $827,000 and $522,000 as of September 30, 2018, and 2017, respectively. The gross claims liability and insurance receivables were estimated using a discount factor of 4% and are included within long-term assets and long-term liabilities, respectively, in the accompanying balance sheets.

Workers' Compensation Insurance

The Company was fully insured for workers' compensation claims with no deductible for the years ended September 30, 2018 and 2017.

Reserve Methodology

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 financial position, results of operations or cash flows.

Employee Health Plans

The Company maintains 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. Commercial insurance policies cover per occurrence losses in excess of $350,000. An actuarially estimated liability of approximately $488,000 and $673,000 for incurred but not reported claims as of September 30, 2018 and 2017, respectively.

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 statements of operations. The Company has accrued $2,092,000 and $1,945,000 related to asbestos remediation as of September 30, 2018 and 2017, respectively. The Company recorded $156,000 and $149,000 of accretion of the asset retirement obligation during the year ended September 30, 2018 and 2017, respectively.

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

The Company held restricted cash of $166,000 and $659,000 as of September 30, 2018 and 2017, respectively, which is restricted for grants for the Company's School of Nursing.

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.

Sale-Leaseback Transactions

The Company evaluates sale-leaseback transactions by determining whether the transaction meets the qualifying criteria to be recognized as a sale-leaseback, including the transfer of risk and rewards of ownership as well as the absence of continuing involvement of the Company. When the qualifying criteria for a sale-leaseback transaction are not met, the Company accounts for the transaction as a financing.

Income Taxes

For tax reporting purposes, the Company is treated as a Partnership and is a pass-through entity. Therefore, no provision is made in the accompanying financial statements for liabilities for federal, state or local income taxes since such liabilities are the responsibility of the Company's parent companies. The Company periodically evaluates its tax positions, including its status as a pass-through entity, to evaluate whether it is more likely than not that such positions would be sustained upon examination by a tax authority for all open tax years, as defined by the statute of limitations, based on its technical merits.

As of September 30, 2018 and 2017, the Company has not established a liability for uncertain tax positions. The Company files income tax returns in the U.S. federal jurisdiction and the state of Rhode Island. Generally, the Company is subject to examination by U.S. federal (or state and local) income tax authorities for three to four years from the filing of a tax return.

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 and Medicaid. The Company received revenues from Medicare and Medicaid as follows (in thousands):

		For the Year Ended September 30, 2018	% of Net Patient Services Revenues		For the Year Ended September 30, 2017	% of Net Patient Services Revenues
Medicare	$	68,242	46%	$	63,629	44%
Medicaid		33,216	22%		31,842	22%
Total	$	101,458	69%	$	95,471	66%

Use of Estimates

The preparation of 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 financial statements are prepared. Actual results could materially differ from those estimates. Principal areas requiring the use of estimates include amounts due from/to government payers, allowances for contractual discounts and doubtful accounts, professional and general liability claims, employee health benefit claims, long-lived assets, intangible assets and asset retirement obligations.

New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued ASU 2014-09, "Revenue from Contracts with Customers (Topic 606)" which defers the effective date of the revenue standard 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. October 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. The Company is currently evaluating the effect of this guidance on its financial statements.

In January 2016, the FASB issued ASU 2016-01, "Financial Instruments (Subtopic 825-10)". ASU 2016-01 requires all equity investments to be measured at fair value with changes in fair value recognized through net income (other than those accounted for under equity method of accounting or those that result in consolidation of the investee). ASU 2016-01 also requires an entity to present separately in other comprehensive income the portion of the total change in the fair value of a liability resulting from a change in the instrument-specific credit risk when the entity has elected to measure the liability at fair value in accordance with the fair value option for financial instruments. In addition, ASU 2016-01 eliminates the requirement to disclose the fair value of financial instruments measured at amortized cost for entities that are not public business entities. ASU 2016-01 is effective for annual and interim periods beginning after December 15, 2017. The Company is currently evaluating the standard and the impact on its financial statements and footnote disclosures.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)". The core principle of ASU 2016-02 is that a lessee should recognize the assets and liabilities that arise from leases, including operating leases. Under the new requirements, a lessee will recognize in the statement of financial position a liability to make lease payments (the lease liability) and the right-of-use asset representing the right to the underlying asset for the lease term. For leases with a term of 12 months or less, the lessee is permitted to make an accounting policy election by class of underlying asset not to recognize lease assets and lease liabilities. The recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee have not significantly changed from previous GAAP. The standard is effective for nonpublic entities for fiscal years beginning after December 15, 2019. The Company is currently evaluating the standard and the impact on its financial statements and footnote disclosures.

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230)". The updated standard addresses eight specific cash flow issues with the objective of reducing diversity in practice. ASU 2016-15 is effective for non-public business entities for annual reporting periods beginning after December 15, 2018, including interim periods within those annual reporting periods. Early adoption is permitted. The Company is assessing the impact of the adoption of ASU 2016-15 on its financial statements.

In January 2017, the FASB issued ASU 2017-01, "Business Combinations (Topic 805): Clarifying the Definition of a Business." These amendments clarify the definition of a business. The amendments affect all companies and other reporting organizations that must determine whether they have acquired or sold a business. The definition of a business affects many areas of accounting including acquisitions, disposals, goodwill, and consolidation. The amendments are intended to help companies and other organizations evaluate whether transactions should be accounted for as acquisitions (or disposals) of assets or businesses. This update is effective for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2018. Early adoption is permitted under certain circumstances. The amendments should be applied prospectively as of the beginning of the period of adoption. The Company is evaluating the effect that this update will have on its financial statements and related disclosures.

In January 2017, the FASB issued ASU 2017-04, "Intangibles-Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment)". The new guidance is effective for fiscal years beginning after December 15, 2019 and interim periods within those fiscal years, and should be applied on a prospective basis. Early adoption is permitted for interim or annual goodwill impairment tests performed on testing dates after January 1, 2017. The new guidance simplifies the current two-step goodwill impairment test by eliminating Step 2 of the test. The new guidance requires a one-step impairment test in which an entity compares the fair value of a reporting unit with its carrying amount and recognizes an impairment charge for the amount by which the carrying amount exceeds the reporting unit's fair value, if any. The Company early adopted this standard in the current fiscal year.

In August 2018, the FASB issued ASU 2018-15, "Intangibles - Goodwill and Other - Internal - Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract", which provides guidance on implementation costs incurred in a cloud computing arrangement that is a service contract. Specifically, it amends ASC 350 to include in its scope implementation costs of a cloud computing arrangement that is a service contracts and clarifies that a customer should apply ASC 350-40 to determine which implementation costs should be capitalized in such a cloud computing arrangement. The Company has early adopted this literature for the year ended September 30, 2018. The adoption did not have material impact to the financial statements of the Company.

Reclassifications

Certain reclassifications were made to the prior year financial statements in order to conform to the current year presentation.

Subsequent Events

The Company has evaluated subsequent events through March 29, 2019, the date the Company's financial statements were available for issuance.

3. Property, Improvements and Equipment

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

September 30,	2018	2017
Property, improvements and equipment:		
Land and land improvements	$ 4,802	$ 4,692
Buildings and improvements	18,180	16,956
Leasehold improvements	4,048	3,292
Equipment	16,456	14,817
	43,486	39,757
Less: accumulated depreciation	(24,510)	(17,709)
	18,976	22,048
Construction in Progress	5,088	1,104
Property, improvements and equipment, net	$ 24,064	$ 23,152

As of September 30, 2018 and 2017, the Company had assets under capitalized leases of $2,005,000 and $2,410,000, respectively, and related accumulated depreciation of $818,000 and $884,000, respectively.

Depreciation expense was $7,128,000 and $6,530,000 for the years ended September 30, 2018 and 2017, respectively.

4. Intangible Assets

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

	Amortization Period	September 30, 2018	September 30, 2017
Trade names	5 years	$ 3,590	$ 3,590
Total acquisition cost of intangible assets		3,590	3,590
Less accumulated amortization		(3,073)	(2,355)
Intangible assets, net		$ 517	$ 1,235

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives. Amortization expense was $718,000 and $718,000 for the years ended September 30, 2018 and 2017, respectively.

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

The weighted-average remaining useful life for the intangible assets was approximately 1 year as of September 30, 2018.

5. Sale-Leaseback Liability and Deferred Revenue

In October 2016, the Company entered into an agreement under which it granted and conveyed an exclusive easement to a water tower utilized for telecommunications purposes for a 99 year term to an unrelated third party. The agreement also assigned certain of the Company's telecommunications leases. The purchase price was approximately $2,057,000. The income derived from this transaction has been deferred and is being recognized on a straight line basis over the remaining term of the leases, through 2028.

In December 2016, the Company entered into a transaction to sell the former St. Joseph Hospital Campus for $100,000 to an unrelated third party. The purchaser has agreed to make certain required capital improvements as part of this transaction. In connection with this transaction, the Company also entered into a separate agreement to lease back a portion of the facility for 7 years, with options to renew for three 7 year periods, for an initial base rent of $80,000 per month. The lease also provides for the payment of a portion of the property taxes for the facility, consisting of $120,000 per year through 2020 and a pro rata portion of property taxes based on the Company's leased space after 2020. This transaction does not qualify for sale leaseback accounting because of the Company's deemed continuing involvement with the buyer-lessor, including the guarantee by PCC and because the term of the lease agreement is longer than the economic age of the facility. These are considered a form of contingent collateral and results in the transaction being recorded under the financing method. The sale-leaseback liability was $2,289,000 and $2,419,000 at September 30, 2018 and 2017, respectively, which consists of the purchase consideration and the transfer of the ARO balance, and is presented within other long-term liabilities in the accompanying balance sheets.

6. Related Party Transactions

PCC and its Subsidiaries and Prospect East Hospital Advisory Services, LLC ("PEHAS"), a wholly-owned subsidiary of Prospect, entered into a Management Services Agreement ("MSA") as of June 20, 2014, under which PEHAS provides certain administrative and management services to PCC and its Subsidiaries. Management fees due to PEHAS under the MSA consist of 2% of net revenues monthly. The Company recognized management fees of $2,994,000 and $2,981,000 for the years ended September 30, 2018 and 2017, respectively, which is included within management fee expense in the accompanying statements of operations. As of September 30, 2018 and 2017, $12,592,000 and $9,599,000, respectively, due pursuant to the MSA, is included in due to affiliated companies, net, in the accompanying balance sheets.

7. 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 2022. Capital leases bear interest at rates ranging from 4% to 8% per annum.

The future minimum annual lease payments (net of anticipated sublease income) required under leases in effect at September 30, 2018, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2019	$ 384	$ 338
2020	40	255
2021	-	192
2022	-	187
2023	-	187
Total minimum lease payments	424	$ 1,159
Less: amounts representing interest	(17)	
	407	
Less: current portion	(369)	
	$ 38	

Lease and rental expense was $1,536,000 and $1,577,000 for the years ended September 30, 2018 and 2017, respectively.

Contingent Liability for Borrowings by Prospect

The Company is contingently liable as a guarantor among others for amounts borrowed by Prospect on senior secured borrowings and credit facilities at September 30, 2018 and 2017. The obligations and related interest expense related to these credit facilities are not reflected in the Company's

CIIH16-000898

financial statements as of September 30, 2018 and 2017, as the borrowings are reflected in the separate consolidated financial statements of Prospect.

Total borrowings outstanding as of September 30, 2018 and 2017, reflected in the consolidated financial statements of Prospect, but for which the Company is contingently liable as a guarantor, were (in thousands):

September 30,	2018	2017
Senior secured term loan (net of discount of $20,085 and $7,374)	$ 1,094,315	$ 609,813
Less: original issue discount, net	(16,214)	(9,906)
	$ 1,078,101	$ 599,907

On June 30, 2016, Prospect entered into a six-year $625 million senior secured term loan B (the "Original Term Loan"), the proceeds of which were used to repay $425 million of PMH's existing 8.375% senior secured notes due during 2019; to repay $60 million of borrowings under the Prospect's existing revolving credit facility (the "Replaced Revolver"); to fund acquisitions, including the acquisition of Crozer; and to finance transaction fees and expenses. The Original Term Loan bore interest at LIBOR (subject to a 1.0% floor) plus 6.0%. The Original Term Loan was issued with an original discount of 1.5%, or $9,375,000. Additionally, the Company refinanced the Replaced Revolver with a new $100 million asset-based revolving credit facility ("Original ABL Facility" and together with the Original Term Loan, the "New Senior Secured Credit Facilities"). Pursuant to various amendments from August 2016 through October 2017, the aggregate commitment amount under the Original ABL facility was increased in stages to $175 million. The maturity date for the Original ABL Facility was June 30, 2021, and the maturity date for the Term Loan was June 30, 2022.

On February 22, 2018, Prospect refinanced and replaced both the Original Term Loan and the Original ABL Facility, and entered into an Amended and Restated Term Loan Credit Agreement (the "Amended TL Agreement"), by and among the Company (as the borrower), the lenders party thereto and JPMorgan Chase Bank, N.A. ("JPMorgan"), as administrative agent and collateral agent. The Amended TL Agreement replaced the Original Term Loan with a new Term B-1 Loan ("Term B-1 Loan"). The principal amount of the Term B-1 Loan is $1,120.0 million and such loan bears interest at LIBOR (subject to a 1.0% floor) plus 5.5%, which as of September 30, 2018 was 7.625%. The Term B-1 Loan was issued with an original discount of 2% and matures on February 22, 2024.

Additionally, on February 22, 2018, Prospect entered into an Amended and Restated ABL Credit Agreement (the "Amended ABL Agreement"), by and among the Company (as the borrower), the lenders party thereto and JPMorgan, as administrative agent and collateral agent. The Amended ABL Agreement replaced the Original ABL Facility. Under the Amended ABL Agreement, the maximum revolving commitment is $250.0 million with ability to expand the facility to $325.0 million, and the new ABL facility (the "New ABL Facility") bears interest at a variable base rate plus an applicable spread that is based on excess availability under the New ABL Facility, as further described in the Amended ABL Agreement, which was 3.875% as of September 30, 2018. The New ABL Facility matures on February 22, 2023. As of September 30, 2018, the available balance on the new ABL facility was $41.0 million. The Company was in compliance with all of its debt covenants at September 30, 2018 or obtained a waiver. The next assessment for financial statement compliance is March 31, 2019.

Letter of Credit

As of September 30, 2018, Prospect secured an irrevocable letter of credit for $733,000 on behalf of the Company for its School of Nursing ("School") as required by the U.S. Department of Education. The purpose of the letter of credit is to (i) pay refunds of charges owed on behalf of current or former students, whether or not the School remains open; (ii) to provide for the "teach-out" of currently enrolled students if the School closes; and (iii) to pay any liabilities owed to the U.S. Department of Education.

Other Commitments

The Company has additional commitments for reagents that are based on tests performed. They are non-cancelable agreements but the future dollar commitments are not quantifiable as they are volume-driven.

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, states have also developed their own standards for the privacy and security of health information as well as for reporting certain violations and breaches (for example, California's Confidentiality of Medical Information Act and Lanterman-Petris Short Act) which in some cases are more stringent. Other federal privacy laws may also apply to certain services provided by the Company, including 42 C.F.R. Part 2, which addresses the confidentiality of substance use disorder records. 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") has made significant changes to the United States health care system. The legislation impacted multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Under this legislation, 33 states have expanded their Medicaid programs to cover previously uninsured childless adults, and four additional states voted in 2018 to expand Medicaid or to elect a governor that pledged to expand Medicaid. In addition, many uninsured individuals have had the opportunity to purchase health insurance via state-based marketplaces, state-based marketplaces using a federal platform, state-partnership marketplaces or the federally-facilitated marketplace. PPACA also implemented a number of health insurance market reforms, such as allowing children to remain on their parents' health insurance until age 26 or prohibiting certain plans from denying coverage based on pre-existing conditions. Nationally, these reforms have reduced the number of uninsured individuals.

It is unclear what changes may be made to PPACA with the divided Congress, current presidential administration, and pending litigation over the validity of PPACA. The Administration has promulgated rules to broaden the availability of coverage options that do not comply with the full range of PPACA requirements for individual market coverage, namely Association Health Plans and Short-Term Limited-Duration Insurance. The Administration has also provided additional guidance on state PPACA waivers. These executive actions have been or may be challenged in court. In addition, the Tax Cuts and Jobs Act ("TCJA"), passed in December 2017, eliminates the individual mandate penalty under PPACA, effective January 1, 2019. The individual mandate penalty was included in PPACA to address concerns that other market reforms expanding access to coverage might produce adverse selection and higher premiums. The extent to which the repeal of the individual mandate penalty will impact the uninsured rate and 2019 premiums is unclear at this juncture. On December 14, 2018, the United States District Court for the Northern District of Texas ruled that the individual mandate without the penalty is unconstitutional and that PPACA is therefore invalid in its entirety. Litigation on this issue is ongoing, with the Administration indicating it will continue implementing PPACA pending any appeals, the court ordering expedited briefing on a potential stay and certification of an interlocutory appeal, and pending litigation in the United States District Court for the District of Maryland to ensure continued implementation of PPACA. This litigation along with any future legislative changes to PPACA or other federal and state legislation could have a material impact on the operations of the Company. The Company is continuing to monitor the legislative environment and developments in pending litigation for risks and uncertainties.

Collective Bargaining Agreements

The Company has 316 employees that are subject to a collective bargaining agreement with United Nurses and Allied Professionals ("UNAP"), which was effective beginning September 2016 and expires July 2019. During April 2015, a hospital unit consisting of approximately 400 service employees of Fatima elected to be represented by UNAP. The parties entered into a new collective bargaining agreement which expired in October 2018 and is currently in the process of renegotiations. A small number of employees are subject to a collective bargaining agreement with the Federation of Nurses and Health Professionals ("FNHP"), which expires on July 30, 2021.

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.

8. Defined Contribution Plan

Prospect previously sponsored five defined contribution plans covering substantially all employees who meet certain eligibility requirements, of which one plan was sponsored by PCC. Effective May 1, 2018, the plans covering employees at Prospect's facilities in Connecticut and Pennsylvania were merged into the plan covering employees at CharterCARE, and Prospect's two remaining plans were renamed and segregated between union and non-union employees. Under these plans, employees can contribute up to 50% of their compensation up to the IRS deferred annual maximum. The Company may make discretionary matching contributions to the Plan. The Company's contributions to the Plan were $1,096,000 and $1,101,000 for the years ended September 30, 2018 and 2017, respectively, and are included in Employee Benefits in the accompanying statements of operations.

9. Regulatory

General

The Company participates in Student Financial Aid ("SFA") under the Federal Title IV programs administered by the Department of Education ("ED") pursuant to the Higher Education Act of 1965, as amended ("HEA"). The Company must comply with the regulations promulgated under HEA.

Financial Responsibility

All institutions participating in the Title IV Programs must satisfy specific standards of financial responsibility as promulgated by the ED. The ED evaluates institutions for compliance with these standards each year, based on the institution's annual audited financial statements. Compliance with the financial responsibility standards are determined through the calculation of a composite score based upon certain financial ratios as defined in the regulations. Institutions receiving a composite score of 1.5 or greater are considered fully financially responsible. Institutions receiving a composite score between 1.0 and 1.4 are subject to additional monitoring and institutions receiving a composite score below 1.0 are required to submit financial guarantees in order to continue participation in the Title IV programs. As of September 30, 2018, and for the year then ended, the Company's composite score was .9.

Compliance with 90/10 Cash Basis Revenue Regulations

The Company derives a portion of its tuition revenues from SFA received by its students under the Title IV programs administered by the ED pursuant to the HEA. To continue to participate in the SFA programs the Company must comply with the regulations promulgated under HEA. The regulations restrict the proportion of cash receipts for tuition and fees from eligible programs to not more than 90 percent from the Title IV programs. In July 2008, modifications to the regulations were made with respect to amounts to be included in the 90 percent calculations including temporary provisions related to certain Title IV funds received and institutional loans made to students. The modifications also allow for the inclusion of funds received for certain qualifying non-Title IV programs. In addition, the modifications included provisions for institutions that do not comply with the 90 percent rule for a single fiscal year, whereby such institutions would be placed on provisional certification status for a period of two years. Institutions that do not comply with the 90 percent rule for two consecutive fiscal years are subject to the loss of their ability to participate in the SFA programs.

In October 2009, HEA amended the regulations with respect to the disclosure requirements to the 90 percent calculations and allowed institutions to implement the new and amended provisions. The amended provisions require an institution to disclose the dollar amount of the numerator and denominator of its 90 percent calculation as well as the individual revenue amounts by fund source received by the institution.

For the years ended September 30, 2018 and 2017, the Company's 90/10 cash basis revenue test percentages were computed as follows:

(in thousands)	2018	2017
Revenue by Source		
Student Title IV cash basis revenue		
Subsidized loan	$ 344	$ 474
Unsubsidized loan	579	696
Plus loan	55	50
Federal Pell grant	207	245
	$ 1,185	$ 1,465
Student Non-Title IV revenue		
Funds provided from private loans	$ 147	$ 182
State loans	148	193
Scholarships	23	47
Student payments	454	400
	$ 772	$ 822
Student Title IV cash basis revenue	$ 1,185	$ 1,465
Student title IV cash basis revenue + Student Non-Title IV cash basis revenue	$ 1,957	$ 2,287
	61%	64%

Student Default Rate

For each fiscal year, the ED calculates a rate of student defaults for each educational institution which is known as a "cohort default rate." An institution may lose its eligibility to participate in some or all Title IV programs if, for each of the three most recent federal fiscal years for which information is available, 30% or more of its students who became subject to a repayment obligation in that federal fiscal year defaulted on such obligation by the end of the following federal fiscal year. In addition, an institution may lose its eligibility to participate in some or all Title IV programs if its cohort default rate exceeds 40% in the most recent federal fiscal year for which default rates have been calculated by the ED. The Company's 3-Year cohort default rate for the 2018 federal fiscal year was 0.0%. Federal fiscal year 2018 is the most recent year for which this information is available.

10. Subsequent Event (unaudited)

On March 1, 2019, Prospect entered into Amendment No. 2 to the Amended and Restated ABL Credit Agreement, by and among Prospect (as the borrower), the lenders party thereto and JPMorgan, as administrative agent and collateral agent. Under this amendment, the maximum revolving commitment is increased from $250.0 million to $280.0 million, and the maximum expansion of the facility has been reduced from $325.0 million to $285.0 million. Additionally, the amendment provides for $40.0 million of a "first in first out" revolving facility, which bears interest at either 2.5% or 3.5% per annum depending on whether they are Eurodollar loans or ABR loans.

Further, on March 25, 2019, Prospect entered into Amendment No. 3 to the Amended and Restated ABL Credit Agreement, by and among Prospect (as the borrower), the lenders party thereto and JPMorgan, as administrative agent and collateral agent. Under this amendment, the maximum revolving commitment is increased from $280.0 million to $285.0 million.

Supplemental Report and Schedule

BDO

Tel: 714-957-3200
Fax: 714-957-1080
www.bdo.com

600 Anton Blvd., Suite 500
Costa Mesa, CA 92626

Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

Board of Directors
Prospect CharterCARE SJHSRI, LLC
Los Angeles, California

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Prospect CharterCARE SJHSRI, LLC (the "Company"), which comprise the balance sheet as of September 30, 2018, and the related statements of operations, member's equity, and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated March 29, 2019.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Company's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the Company's financial statements will not be prevented, or detected and corrected on a timely basis. *A significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the deficiencies described in the accompanying schedule of findings and questioned costs to be material weaknesses (*2018-001, 2018-002, and 2018-003*).

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Company's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

BDO

The Company's Response to Findings

The Company's response to the findings identified in our audit are described in the accompanying schedule of findings and questioned costs. The Company's response was not subjected to the auditing procedures applied in the audit of the consolidated financial statements and, accordingly, we express no opinion on it.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Company's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Company's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

BDO USA, LLP

March 29, 2019

Prospect CharterCARE SJHSRI, LLC

Schedule of Findings and Disposition of Prior Year Findings

Section I - Summary of Auditor's Results

Financial Statements

Type of auditor's report issued:	Unmodified	
Internal control over financial reporting:		
Material weaknesses identified?	X yes	____ no
Significant deficiencies identified that are not considered to be material weaknesses?	____ yes	X none reported
Noncompliance material to financial statements noted?	____ yes	X no

Section II - Financial Statement Findings

Finding 2018-001

<u>*Condition*</u>

The Company has a material weakness in internal controls over financial reporting. The Company's control environment has not been maintained in a way to appropriately and positively influence the effectiveness of the organization's internal control. Accordingly, this material weakness is a causal factor that allowed for greater opportunity for management to override existing internal controls.

<u>*Cause*</u>

The Company did not maintain an executive and managerial tone that supported an effective internal control environment. This impacted the operating effectiveness of the Company's independent reviews, approval and authorizations, and other internal controls designed to prevent or detect material misstatements over financial reporting.

<u>*Effect*</u>

As a result of this material weakness, transfers from restricted accounts were made without sufficient reconciliation and were not subject to an appropriate level of independent review, approval, and authorization prior to being executed.

<u>*Recommendation*</u>

The Company should review its policies and procedures over cash management and treasury as well as the adequacy of its internal resources.

<u>*Views of Responsible Officials*</u>

Management acknowledges the comment and has taken the following steps to resolve: (a) implementation of the appropriate reconciliation process; and (b) the Company has separated the Treasury function from the Chief Financial Officer's role and that function now reports directly to the CEO. Additionally those that have access to the bank accounts are aware that transfers cannot be made from restricted accounts and the Treasurer is responsible for monitoring this.

Disposition of Prior Year Findings

Finding 2017-001

Condition

The Company has a material weakness in internal controls over financial reporting. There were certain, material additional post-closing adjustments identified as a result of our audit procedures, which were not identified by the Company's internal control over the financial statement close process.

Status

Management believes that this finding has been resolved.

Prospect CharterCARE RWMC, LLC

Consolidated Financial Statements

As of and for the Years Ended
September 30, 2018 and 2017

BDO

Prospect CharterCARE RWMC, LLC

Consolidated Financial Statements

As of and for the Years Ended September 30, 2018 and 2017

Prospect CharterCARE RWMC, LLC

Contents

	Page
Independent Auditor's Report	3-4
Consolidated Balance Sheets	6-7
Consolidated Statements of Operations	8
Consolidated Statements of Member's Equity	9
Consolidated Statements of Cash Flows	10
Notes to the Consolidated Financial Statements	11 - 30

BDO

Tel: 714-957-3200
Fax: 714-957-1080
www.bdo.com

600 Anton Blvd., Suite 500
Costa Mesa, CA 92626

Independent Auditor's Report

Board of Directors
Prospect CharterCARE RWMC, LLC
Los Angeles, California

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Prospect CharterCARE RWMC, LLC (the "Company"), which comprise the consolidated balance sheets as of September 30, 2018 and 2017, and the related consolidated statements of operations, member's equity, 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 audit 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 financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company'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 Company'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 CharterCARE RWMC, LLC and its subsidiary as of September 30, 2018 and 2017, 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.

Emphasis of Matter

As discussed in Note 1, the Company is financially dependent on its parent companies which have agreed to provide the financial support necessary for the operations of the Company. The accompanying consolidated financial statements do not reflect any adjustments or disclosures that would be required should the parent company discontinue its financial support.

BDO USA, LLP

July 18, 2019

Consolidated Financial Statements

Prospect CharterCARE RWMC, LLC

Consolidated Balance Sheets
(in thousands)

September 30,		2018		2017
Assets				
Current assets				
Cash and cash equivalents	$	-	$	299
Restricted cash		267		2,369
Patient accounts receivable, less allowance for doubtful accounts of $5,284 and $3,974, respectively		22,400		21,506
Other receivables		2,171		9,303
Due from government payers		402		580
Inventories		3,332		3,750
Prepaid expenses and other current assets		768		1,378
Total current assets		29,340		39,185
Property, improvements and equipment, net		35,044		30,679
Intangible assets, net		653		1,561
Equity method investments		4,063		4,052
Insurance receivable and other assets		872		601
Total assets	$	69,972	$	76,078

See accompanying notes to consolidated financial statements.

Prospect CharterCARE RWMC, LLC

Consolidated Balance Sheets
(in thousands)

September 30,		2018		2017
Liabilities and Member's Equity				
Current liabilities				
Accrued medical claims and other healthcare costs payable	$	491	$	394
Accounts payable and other accrued liabilities		17,154		13,946
Accrued salaries, wages and benefits		7,152		6,540
Due to government payers		74		282
Due to affiliated companies, net		20,750		18,357
Current portion of capital leases		326		596
Current portion of sale-leaseback liability		257		257
Total current liabilities		46,204		40,372
Capital leases, net of current portion		-		326
Malpractice reserves		4,243		3,273
Asset retirement obligations		839		750
Sale-leaseback liability, net of current portion		3,117		3,760
Other long-term liabilities		315		335
Total liabilities		54,718		48,816
Commitments, contingencies and subsequent events				
Member's equity				
Member contributions		34,241		34,241
Accumulated deficit		(18,987)		(6,979)
Total member's equity		15,254		27,262
Total liabilities and member's equity	$	69,972	$	76,078

See accompanying notes to consolidated financial statements.

Prospect CharterCARE RWMC, LLC

Consolidated Statements of Operations
(in thousands)

For the years ended September 30,	2018	2017
Revenues		
Net patient service revenues	$ 181,353	$ 177,720
Provision for bad debts	(5,996)	(6,190)
Net patient service revenues less provision for bad debts	175,357	171,530
Other revenues	2,819	3,001
Total net revenues	178,176	174,531
Operating Expenses		
Salaries, wages and benefits	86,715	83,968
Supplies	39,889	38,638
Purchased services	12,714	13,629
Taxes and licenses	12,151	11,347
Depreciation and amortization	7,124	6,168
Professional fees	5,422	6,728
Other	5,969	6,219
Management fees	3,721	3,665
Utilities	2,400	1,792
Research grant expense	2,503	120
Insurance	1,869	2,799
Lease and rental	1,210	1,434
Repairs and maintenance	1,254	978
Registry	720	623
Total operating expenses	183,661	178,108
Operating income from unconsolidated equity method investments	589	507
Operating loss	(4,896)	(3,070)
Other (income) expense:		
Interest income, net	(340)	(217)
Goodwill impairment	7,452	-
Other income	-	(89)
Total other expense (income), net	7,112	(306)
Net loss	$ (12,008)	$ (2,764)

See accompanying notes to consolidated financial statements.

Prospect CharterCARE RWMC, LLC

Consolidated Statements of Member's Equity
(in thousands)

	Member Contributions	Retained Earnings (Accumulated Deficit)	Total Member's Equity
Balance at October 1, 2016	$ 34,241	$ 330	$ 34,571
Net loss	-	(2,764)	(2,764)
Noncash distribution	-	(4,545)	(4,545)
Balance at September 30, 2017	34,241	(6,979)	27,262
Net loss	-	(12,008)	(12,008)
Balance at September 30, 2018	$ 34,241	$ (18,987)	$ 15,254

See accompanying notes to consolidated financial statements.

Prospect CharterCARE RWMC, LLC

Consolidated Statements of Cash Flows
(in thousands)

For the years ended September 30,		2018		2017
Operating activities				
Net loss	$	(12,008)	$	(2,764)
Adjustments to reconcile net loss to net cash provided by (used in) operating activities:				
Depreciation and amortization		7,124		6,168
Provision for bad debts		5,996		6,190
Undistributed earnings from equity method investments		(589)		(507)
Asset retirement obligations amortization (accretion), net		89		(5)
Accretion of sale-leaseback liability		(386)		(335)
Goodwill impairment		7,452		-
Changes in operating assets and liabilities:				
Change in restricted cash		2,102		(633)
Patient accounts receivable and other receivables		(7,141)		(8,527)
Due to/from government payers, net		(30)		17
Inventories		418		467
Prepaid expenses and other current assets		610		18
Insurance receivable and other assets		(271)		(100)
Accrued medical claims and other healthcare costs payable		97		394
Accounts payable and other accrued liabilities		3,412		(1,448)
Malpractice reserve		970		883
Net cash provided by (used in) operating activities		7,845		(182)
Investing activities				
Purchases of property, improvements and equipment		(2,548)		(1,872)
Cash distributions from equity investments		578		761
Net cash used in investing activities		(1,970)		(1,111)
Financing activities				
Change in due to affiliated companies		(5,321)		2,732
Repayments on financing liability		(257)		(193)
Repayments of capital leases		(596)		(947)
Net cash (used in) provided by financing activities		(6,174)		1,592
Change in cash and cash equivalents		(299)		299
Cash and cash equivalents, beginning of year		299		-
Cash and cash equivalents, end of year	$	-	$	299
Supplemental disclosure of cash flow information				
Interest paid	$	45	$	1,999
Noncash distribution	$	-	$	4,545
Sale-leaseback liability	$	-	$	4,545
Noncash acquisition	$	7,452	$	-
Noncash capital additions	$	7,714	$	3,206
Capital lease commitments transferred to affiliate	$	-	$	1,669

See accompanying notes to consolidated financial statements

1. Organization

Prospect CharterCARE RWMC, LLC ("RWMC") is a wholly-owned subsidiary of Prospect CharterCARE, LLC ("PCC"). PCC is owned 85% by Prospect Medical Holdings, Inc. ("Prospect") and 15% by CharterCARE Community Board. RWMC operates a 220-bed acute care general hospital which provides healthcare services in Providence, Rhode Island and surrounding communities. New University Medical Group, LLC ("New UMG"), a wholly-owned subsidiary of RWMC (together, the "Company"), was formed during the year ended September 30, 2015. During the year ended September 30, 2018, two new entities were created, Prospect RI Home Health and Hospice, LLC ("PRIHHH"), which is owned by RWMC, and Prospect CharterCARE Home Health and Hospice, LLC ("PCCHHH"), which is owned by PRIHHH and, effective May 1, 2018, the operations of the home health business were transferred from RWMC to PCCHHH.

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

The Company is dependent on Prospect to fund ongoing operations. As of September 30, 2018, the Company had a liability of $20,750,000 due to Prospect and its subsidiaries, which is payable on demand, does not bear interest, and is included in due to affiliated companies, net in the accompanying consolidated balance sheets. Prospect does not intend to have the Company repay the liability in a manner which would impair the Company's ability to maintain sufficient liquidity to sustain ongoing operations.

2. Significant Accounting Policies

Principles of Consolidation and 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 RWMC's wholly-owned subsidiaries but do not include the accounts of PCC, Prospect or CharterCARE Community Board. All significant intercompany balances and transactions have been eliminated in consolidation.

Revenues

Net Patient Service Revenues

Operating revenue 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, 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 net patient service revenues (net of contractual allowances and discounts) before provision for bad debts (in thousands):

For the years ended September 30,	2018	2017
Medicare	$ 87,715	$ 82,046
Medicaid	37,616	34,725
Managed Care/Commercial	39,313	39,163
Self-Pay/Other	16,709	21,786
Total	$ 181,353	$ 177,720

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 persons with end-stage renal disease and certain other beneficiary categories, including eligible disabled persons. Most inpatient hospital services rendered to Medicare program beneficiaries are paid on a fee-for-service basis at prospectively determined rates per discharge, according to a patient classification system based on clinical, diagnostic, and other factors. Most outpatient services also are paid on a fee-for-service basis generally using prospectively determined rates. The Company receives, as appropriate, Medicare disproportionate share hospital ("DSH") and bad debt payments at tentative rates, with final settlement determined after submission of the annual Medicare cost report and audit thereof by the Medicare Administrative Contractor. The Company also receives, as appropriate, Medicare uncompensated care DSH payments, which are generally not subject to cost report audit except to determine eligibility for Medicare DSH. The Company also receives Medicare outlier payments on an ongoing basis during the year for cases that are unusually costly, and under certain circumstances these payments may be reconciled to more closely reflect the costs in excess of outlier thresholds after the submission and audit of the annual Medicare cost report. Normal estimation differences between filed settlements and amounts accrued are reflected in net patient service revenue.

The Company is reimbursed by Medicare for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare Administrative Contractor. The estimated amounts due to or from the program are reviewed and adjusted annually based on the status of such audits and any subsequent appeals. Differences between final settlements and amounts accrued in previous years are reported as adjustments to net patient service revenue in the year that examination is substantially completed.

Although services for most Medicare beneficiaries are paid by the Federal government on a fee-for-service basis, approximately one-third of Medicare beneficiaries are enrolled in a "Medicare Advantage" plan, which is a type of health plan that contracts with the Medicare program to provide hospital and medical benefits to Medicare beneficiaries. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-For-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. For Medicare beneficiaries enrolled in a Medicare Advantage plan, most Medicare services are covered by the plan and are not paid for under fee-for-service Medicare. Certain Medicare Advantage plans make capitation payments to the Company using a "Risk Adjustment model," which compensates providers based on the health status (acuity) of each enrollee. Providers with higher acuity enrollees generally will receive more and those with healthier enrollees will receive less.

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. *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. Similar to Medicare, cost report settlements are recorded based upon as-filed cost reports and adjusted for tentative and final settlements, if any.

RWMC is a participant in the State of Rhode Island's Dipropionate Share Hospital ("DSH") program, which assists hospitals that provide a disproportionate amount of uncompensated care. Under the program, the Company's hospitals receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low-income patients. RWMC recognized revenue related to DSH and Upper Payment Limit ("UPL") reimbursement of 9,179,000 and $9,458,000 for the years ended September 30, 2018 and 2017, respectively. DSH and UPL payments received were $8,787,000 and $8,446,000 for the years ended September 30, 2018 and 2017, 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 Company recorded $9,199,000 and $8,667,000 of expense during the years ended September 30, 2018 and 2017, respectively, 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.

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 indigent and charity care policy.

Charity Care

The Company provides charity care to patients who lack financial resources and are deemed to be medically indigent based on criteria established under the Company's charity care policy. This care is provided without charge or at amounts less than the Company's established rates. Because the Company does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The direct and indirect costs related to this care totaled approximately $457,000 and $547,000 for the years ended September 30, 2018 and 2017, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. In addition, the Company provides services to other medically indigent patients under various state Medicaid programs. Such programs pay amounts that are less than the cost of the services provided to the recipients. The Company has not changed its charity care or uninsured discount policies during the years ended September 30, 2018 or 2017.

Provisions for Contractual Allowances and Doubtful Accounts

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 was 19% and 16% of gross accounts receivable as of September 30, 2018 and 2017, respectively.

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.

Other Revenues

Other revenues totaled $2,819,000 and $3,001,000 for the years ended September 30, 2018 and 2017, respectively. Management has evaluated the collectability of other receivables consisting primarily of other revenues and grant revenues and determined no allowance is necessary as of September 30, 2018 or 2017.

A summary of the principal components of other revenues is as follows:

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. The Company recorded rental revenues of $264,000 and $547,000 for the years ended September 30, 2018 and 2017, respectively.

Research Grant Revenues: The Company receives grant revenue for direct research from the federal government, other institutions and other sources for a range of research areas including oncology, cardiology, HIV and diabetes. The Company recorded research grant revenue of $1,597,000 and $1,439,000 for the years ended September 30, 2018 and 2017, respectively.

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. Building improvements are generally depreciated over seven years, buildings are depreciated over 10 years, equipment is depreciated over three to seven years and furniture and fixtures are depreciated over five 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.

Goodwill

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.

The Company's annual impairment testing date is July 1. Impairment of goodwill is tested at the reporting unit level, by comparing the reporting unit's carrying amount, including goodwill, to the fair value of the reporting unit. The fair value of the reporting units are estimated. 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 Company has adopted new literature during the year ended September 30, 2018 which changes the goodwill impairment test from a two-step process to a one-step process, which consists of estimating 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. If the estimated fair value of the reporting unit is less than its carrying value, this indicates that goodwill is impaired, and impairment is recorded based on the deficiency of fair value compared to the carrying value. The Company's impairment test related to goodwill during the year ended September 30, 2018 resulted in a full impairment of goodwill. There were no impairment charges during the year ended September 30, 2017 because there was no goodwill on the consolidated balance sheet at September 30, 2017.

Intangible Assets

Intangible assets include trade names. 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, 2018 or 2017.

The remainder of this page intentionally left blank.

Insurance Reserves

Medical Malpractice Liability Insurance

The Company carries professional and general liability insurance to cover medical malpractice claims. The General Liability coverage is occurrence coverage and the Professional Liability coverage is claims-made coverage. Under the Professional Liability policy, insurance premiums cover only those claims actually reported during the policy term. Should the Professional Liability 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. The Company was included in Prospect's consolidated medical malpractice insurance policy effective June 20, 2014 (inception). Assets and liabilities related to malpractice insurance related to events prior to June 20, 2014 (inception) were not assumed by the Company.

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 recognizes 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. The Company's gross claims liability was $4,243,000 and $3,273,000 as of September 30, 2018 and 2017, respectively, and insurance receivables were $872,000 and $478,000 as of September 30, 2018 and 2017, respectively. The gross claims liability and insurance receivables were estimated using a discount factor of 4% and are included within long-term assets and long-term liabilities, respectively, in the accompanying consolidated balance sheets.

Workers' Compensation Insurance

The Company was fully insured for workers' compensation claims with no deductible during the years ended September 30, 2018 and 2017.

Reserve Methodology

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 financial position, results of operations or cash flows.

Employee Health Plans

The Company maintains 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. Commercial insurance policies cover per occurrence losses in excess of $350,000. An actuarially estimated liability of approximately $491,000 and $367,000 for incurred but not reported claims as of September 30, 2018 and 2017, respectively.

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 consolidated statement of operations. The Company has accrued $839,000 and $750,000 related to asbestos remediation as of September 30, 2018 and 2017, respectively.

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

The Company held restricted cash of $267,000 and $2,369,000 as of September 30, 2018 and 2017, respectively, which is restricted for research.

Inventories

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

Income Taxes

For tax reporting purposes, the Company is treated as a Partnership and is a pass-through entity. Therefore, no provision is made in the accompanying financial statements for liabilities for federal, state or local income taxes since such liabilities are the responsibility of the Company's parent companies. The Company periodically evaluates its tax positions, including its status as a pass-through entity, to evaluate whether it is more likely than not that such positions would be sustained upon examination by a tax authority for all open tax years, as defined by the statute of limitations, based on its technical merits.

As of September 30, 2018 and 2017, the Company has not established a liability for uncertain tax positions. The Company files income tax returns in the U.S. federal jurisdiction and the state of Rhode Island. Generally, the Company is subject to examination by U.S. federal (or state and local) income tax authorities for three to four years from the filing of a tax return.

Fair Value of Financial Instruments

Financial instruments consist primarily of cash and cash equivalents, restricted cash, patient and other accounts receivables, accounts payable and accrued expenses, accrued salaries and benefits, amounts due from/to government payers, capital lease obligations, 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.

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 intangible assets when there are indications of impairment.

During the year ended September 30, 2018, the Company recorded approximately $7.5 million of impairment relating to goodwill, which is reflected in the accompanying consolidated statements of operations.

The Company uses the discounted cash flow approach, the guideline public company approach and the guideline transactions approach to estimate the residual value of the Company's goodwill. The measurement of goodwill is a Level 3 measurement. The following table provides quantitative information related to the significant unobservable inputs to determine fair value and impairment of goodwill as of September 30, 2018:

Residual Value of Goodwill	Valuation Technique	Unobservable Input	Rates
$ -	Discounted Cash Flow	Weighted average cost of capital	9.3%
		Revenue growth rate	2.1% - 2.5%
	Guideline Public Company	LTM EBITDA multiple	7.0x

There were no nonrecurring measurements as of September 30, 2017.

Sale-Leaseback Transactions

The Company evaluates sale-leaseback transactions by determining whether the transaction meets the qualifying criteria to be recognized as a sale-leaseback, including the transfer of risk and rewards of ownership as well as the absence of continuing involvement of the Company. When the qualifying criteria for a sale-leaseback transaction are not met, the Company accounts for the transaction as a financing, see Note 6.

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.

The remainder of this page intentionally left blank.

Financial instruments that potentially subject the Company to concentrations of credit risk consist of receivables due from Medicare and Medicaid. The Company received revenues from Medicare and Medicaid as follows (in thousands):

	For the Year Ended September 30, 2018	% of Net Patient Services Revenues	For the Year Ended September 30, 2017	% of Net Patient Services Revenues
Medicare	$ 87,715	48%	$ 82,046	46%
Medicaid	37,616	21%	34,725	20%
Total	$ 125,331	69%	$ 116,771	66%

Use of Estimates

The preparation of consolidated financial statements in conformity with GAAP 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 amounts due from/to government payers, allowances for contractual discounts and doubtful accounts, professional and general liability claims, impairment of long-lived assets and intangible assets, and asset retirement obligations.

New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued ASU 2014-09, "Revenue from Contracts with Customers (Topic 606)" which defers the effective date of the revenue standard 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. October 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. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)." The core principle of ASU 2016-02 is that a lessee should recognize the assets and liabilities that arise from leases, including operating leases. Under the new requirements, a lessee will recognize in the statement of financial position a liability to make lease payments (the lease liability) and the right-of-use asset representing the right to the underlying asset for the lease term. For leases with a term of 12 months or less, the lessee is permitted to make an accounting policy election by class of underlying asset not to recognize lease assets and lease liabilities. The recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee have not significantly changed from previous GAAP. The standard is effective for nonpublic entities for fiscal years beginning after December 15, 2019. Early application of the amendment is permitted. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230)." The updated standard addresses eight specific cash flow issues with the objective of reducing diversity in practice. ASU 2016-15 is effective for non-public business entities for annual reporting periods beginning after December 15, 2018, including interim periods within those annual reporting periods. Early adoption is permitted. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

In January 2017, the FASB issued ASU 2017-04, "Intangibles-Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment)." The new guidance is effective for fiscal years beginning after December 15, 2019 and interim periods within those fiscal years, and should be applied on a prospective basis. Early adoption is permitted for interim or annual goodwill impairment tests performed on testing dates after January 1, 2017, and the Company will adopt this standard effective for the year ending September 30, 2018. The new guidance simplifies the current two-step goodwill impairment test by eliminating Step 2 of the test. The new guidance requires a one-step impairment test in which an entity compares the fair value of a reporting unit with its carrying amount and recognizes an impairment charge for the amount by which the carrying amount exceeds the reporting unit's fair value, if any. The Company early adopted this standard in the current fiscal year.

Subsequent Events

The Company has evaluated subsequent events through July 18, 2019, the date the Company's consolidated financial statements were available for issuance.

The remainder of this page intentionally left blank.

3. Property, Improvements and Equipment

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

September 30,		2018		2017
Property, improvements and equipment:				
Land and land improvements	$	2,946	$	2,946
Buildings and improvements		25,801		23,266
Leasehold improvements		6,253		6,164
Equipment		11,948		10,362
		46,948		42,738
Less: accumulated depreciation		(20,517)		(14,423)
		26,431		28,315
Construction in Progress		8,613		2,364
Property, improvements and equipment, net	$	35,044	$	30,679

At September 30, 2018 and 2017, the Company had assets under capitalized leases of approximately $1,928,000 and $1,928,000, respectively and related accumulated depreciation of $967,000 and $885,000, respectively.

Depreciation expense was $6,216,000 and $5,260,000 for the years ended September 30, 2018 and 2017, respectively.

4. Acquisition

In December 2017, New UMG entered into a Second Closing to acquire the remaining assets of University Medical Group ("UMG") that were not acquired in the initial acquisition in December 2014. As consideration for the acquisition, New UMG has assumed certain designated liabilities of the practice, which consists of various loans payable to subsidiaries of the Company, totaling approximately $7.5 million. Post-acquisition, these liabilities are eliminated on consolidation. There was no cash consideration related to the transaction. The remaining assets and liabilities acquired were immaterial and no value was assigned to them in the purchase price allocation, and accordingly goodwill of $7.5 million arises from the acquisition. New UMG's parent company, Prospect CharterCARE Physicians, LLC, dba CharterCARE Medical Associates ("CCMA"), entered into a Post Closing Administrative Services Agreement pursuant to which CCMA and its affiliates provide services to the seller of the practice in connection with its termination of all operations and the wind up its affairs and operations.

This acquisition was 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. As asset purchases, goodwill acquired is expected to be deductible for tax purposes.

5. Goodwill and Intangible Assets

Goodwill relates to the acquisition of UMG. The following is a roll-forward of goodwill for the years ended September 30, 2018 and 2017, respectively (in thousands):

September 30,	2018	2017
Balance, beginning of year	$ -	$ -
Acquisition	7,452	-
Impairment	(7,452)	-
Balance, end of year	$ -	$ -

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

	Amortization Period	September 30, 2018	September 30, 2017
Trade names	5 years	$ 4,540	$ 4,540
Total acquisition cost of intangible assets		4,540	4,540
Less accumulated amortization		(3,887)	(2,979)
Intangible assets, net		$ 653	$ 1,561

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives. Amortization expense was $908,000 and $908,000 for the years ended September 30, 2018 and 2017, respectively.

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

Years ended September 30,	
2019	$ 653
	$ 653

The weighted-average remaining useful life for the intangible assets was approximately 1 year as of September 30, 2018.

6. Sale of Real Estate and Sale-Leaseback

PCC previously operated Elmhurst Extended Care ("Elmhurst"), a 206 bed skilled nursing facility, and the Company owned the land and building in which Elmhurst's business was carried out. In December 2016, PCC and the Company entered into a transaction to sell the operations of Elmhurst and the land and building in which Elmhurst operated, to an unrelated third party. PCC's decision to discontinue the operations of this entity was based on the Company's strategy in its market and financial results. The transaction price was approximately $15.2 million, of which approximately $8.3 million was allocated to the land and building. After the land and building were sold, the building was then subdivided into two condominiums, one of which was deeded back to the Company. Additionally, the Company entered into a transaction to lease a portion of the other condominium back for a period of 10 years, with monthly rent of approximately $21,000. This transaction does not qualify for sale leaseback accounting because of the Company's deemed continuing involvement with the buyer-lessor, including the guarantee by PCC, which is considered a form of contingent collateral and results in the transaction being recorded under the financing method. Further, the building cannot be bifurcated, for accounting purposes, between the portion that was leased and the remainder because the transaction does not meet the definition of a minor sale-leaseback, under applicable accounting literature. PCC received and retained the cash received from the seller, and accordingly the transaction has been accounted for as a noncash distribution to PCC. In accordance with applicable accounting literature, as the Company is a wholly owned subsidiary of PCC, the value of the noncash distribution is based on the carrying value of the assets distributed at the time of sale, which was $4,545,000, and accordingly this is the value that the sale-leaseback liability has been set up at that date.

Scheduled payments under the Company's sale-leaseback liability as of September 30, 2018 are as follows (in thousands):

Years ending September 30,		
2019	$	257
2020		257
2021		257
2022		257
2023		257
Thereafter		836
		2,121
Plus: reduction in liability to be accreted to interest income		1,253
Total sale-leaseback liability	$	3,374

The total payments to be paid over the remainder of the lease are $2,121,000. The interest rate implicit in the calculation is negative 10.4%. The value of the sale-leaseback liability is based on the building that was sold, not just the part of the building that was leased back, because as noted above the transaction did not meet the definition of a minor sale-leaseback under the literature. Accordingly, the liability is greater than the sum of the future payments to be made under the lease and this gives rise to a negative interest rate.

7. Related Party Transactions

PCC and its Subsidiaries and Prospect East Hospital Advisory Services, LLC ("PEHAS"), a wholly-owned subsidiary of Prospect, entered into a Management Services Agreement ("MSA") as of June 20, 2014, under which PEHAS provides certain administrative and management services to PCC and its Subsidiaries. Management fees due to PEHAS under the MSA consist of 2% of net revenues monthly. The Company recognized management fees of $3,721,000 and $3,665,000 for the years ended September 30, 2018 and 2017, respectively, which is included within management fee expense in the accompanying statement of operations. As of September 30, 2018 and 2017, $15,478,000 and $11,758,000, respectively, due pursuant to the MSA, is included in due to affiliates, net, in the accompanying consolidated balance sheets.

The Company recognized $0 and $227,000 of rental income from Elmhurst Extended Care for the years ended September 30, 2018 and September 30, 2017 respectively, which is included in other revenues in the accompanying consolidated statements of operations.

8. 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 2023. Capital leases bear interest at rates ranging from 5.25% to 6.0% per annum.

The future minimum annual lease payments required under leases in effect at September 30, 2018, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2019	$ 334	$ 114
2020	-	96
2021	-	96
2022	-	96
2023	-	96
Total minimum lease payments	334	$ 498
Less: amounts representing interest	(8)	
	326	
Less: current portion	(326)	
	$ -	

Lease and rental expense was $1,210,000 and $1,434,000 for the years ended September 30, 2018 and 2017, respectively.

Contingent Liability for Borrowings by Prospect

The Company and its Subsidiaries are contingently liable as a guarantor among others for amounts borrowed by Prospect on senior secured borrowings and credit facilities as of September 30, 2018. The obligations and related interest expense related to these credit facilities are not reflected in the Company's consolidated financial statements as of September 30, 2018, as the borrowings are reflected in the separate consolidated financial statements of Prospect.

Total borrowings outstanding as of September 30, 2018 and 2017, reflected in the consolidated financial statements of Prospect, but for which the Company is contingently liable as a guarantor, were (in thousands):

September 30,	2018	2017
Senior secured term notes (net of discount of $20,085 and $7,374)	$ 1,094,315	$ 609,813
Less: deferred financing costs	(16,214)	(9,906)
	$ 1,078,101	$ 599,907

On June 30, 2016, Prospect entered into a six-year $625 million senior secured term loan B (the "Original Term Loan"), the proceeds of which were used to repay $425 million of PMH's existing 8.375% senior secured notes due during 2019; to repay $60 million of borrowings under the Prospect's existing revolving credit facility (the "Replaced Revolver"); to fund acquisitions, including the acquisition of Crozer; and to finance transaction fees and expenses. The Original Term Loan bore interest at LIBOR (subject to a 1.0% floor) plus 6.0%. The Original Term Loan was issued with an original discount of 1.5%, or $9,375,000. Additionally, the Company refinanced the Replaced Revolver with a new $100 million asset-based revolving credit facility ("Original ABL Facility" and together with the Original Term Loan, the "New Senior Secured Credit Facilities"). Pursuant to various amendments from August 2016 through October 2017, the aggregate commitment amount under the Original ABL facility was increased in stages to $175 million. The maturity date for the Original ABL Facility was June 30, 2021, and the maturity date for the Term Loan was June 30, 2022.

On February 22, 2018, the Company refinanced and replaced both the Original Term Loan and the Original ABL Facility, and entered into an Amended and Restated Term Loan Credit Agreement (the "Amended TL Agreement"), by and among the Company (as the borrower), the lenders party thereto and JPMorgan Chase Bank, N.A. ("JPMorgan"), as administrative agent and collateral agent. The Amended TL Agreement replaced the Original Term Loan with a new Term B-1 Loan ("Term B-1 Loan"). The principal amount of the Term B-1 Loan is $1,120 million and such loan bears interest at LIBOR (subject to a 1.0% floor) plus 5.5%, which as of September 30, 2018 was 7.625%. The Term B-1 Loan was issued with an original discount of 2% and matures on February 22, 2024.

Additionally, on February 22, 2018, Prospect entered into an Amended and Restated ABL Credit Agreement (the "Amended ABL Agreement"), by and among the Company (as the borrower), the lenders party thereto and JPMorgan, as administrative agent and collateral agent. The Amended ABL Agreement replaced the Original ABL Facility. Under the Amended ABL Agreement, the maximum revolving commitment is $250.0 million with ability to expand the facility to $325.0 million, and the new ABL facility (the "New ABL Facility") bears interest at a variable base rate plus an applicable spread that is based on excess availability under the New ABL Facility, as further described in the Amended ABL Agreement, which was 3.875% as of September 30, 2018. The New ABL Facility matures on February 22, 2023. As of September 30, 2018, the available balance on the new ABL facility was $41.0 million.

Other Commitments

The Company has additional commitments for reagents that are based on tests performed. They are non-cancelable agreements but the future dollar commitments are not quantifiable as they are volume-driven.

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.

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, states have also developed their own standards for the privacy and security of health information as well as for reporting certain violations and breaches which in some cases are more stringent. Other federal privacy laws may also apply to certain services provided by the Company, including 42 C.F.R. Part 2, which addresses the confidentiality of substance use disorder records. 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") has made significant changes to the United States health care system. The legislation impacted multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Under this legislation, 33 states have expanded their Medicaid programs to cover previously uninsured childless adults, and four additional states voted in 2018 to expand Medicaid or to elect a governor that pledged to expand Medicaid. In addition, many uninsured individuals have had the opportunity to purchase health insurance via state-based marketplaces, state-based marketplaces using a federal platform, state-partnership marketplaces or the federally-facilitated marketplace. PPACA also implemented a number of health insurance market reforms, such as allowing children to remain on their parents' health insurance until age 26 or prohibiting certain plans from denying coverage based on pre-existing conditions. Nationally, these reforms have reduced the number of uninsured individuals.

It is unclear what changes may be made to PPACA with the divided Congress, current presidential administration, and pending litigation over the validity of PPACA. The Administration has promulgated rules to broaden the availability of coverage options that do not comply with the full range of PPACA requirements for individual market coverage, namely Association Health Plans and Short-Term Limited-Duration Insurance. The Administration has also provided additional guidance on state PPACA waivers. These executive actions have been or may be challenged in court. In addition, the Tax Cuts and Jobs Act ("TCJA"), passed in December 2017, eliminates the individual mandate penalty under PPACA, effective January 1, 2019. The individual mandate penalty was included in PPACA to address concerns that other market reforms expanding access to coverage might produce adverse selection and higher premiums. The extent to which the repeal of the individual mandate penalty will impact the uninsured rate and 2019 premiums is unclear at this juncture. On December 14, 2018, the United States District Court for the Northern District of Texas ruled that the individual mandate without the penalty is unconstitutional and that PPACA is therefore invalid in its entirety. Litigation on this issue is ongoing, with the Administration indicating it will continue implementing PPACA pending any appeals, the court ordering expedited briefing on a potential stay and certification of an interlocutory appeal, and pending litigation in the United States District Court for the District of Maryland to ensure continued implementation of PPACA. This litigation along with any future legislative changes to PPACA or other federal and state legislation could have a material impact on the operations of the Company. The Company is continuing to monitor the legislative environment and developments in pending litigation for risks and uncertainties.

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.

9. Defined Contribution Plan

Prospect previously sponsored five defined contribution plans covering substantially all employees who meet certain eligibility requirements, of which one plan was sponsored by PCC. Effective May 1, 2018, the plans covering employees at Prospect's facilities in Connecticut and Pennsylvania were merged into the plan covering employees at CharterCARE, and Prospect's two remaining plans were renamed and segregated between union and non-union employees. Under these plans, employees can contribute up to 50% of their compensation up to the IRS deferred annual maximum. The Company may make discretionary matching contributions to the Plan. The Company's contributions to the Plan were $586,000 and $0 for the years ended September 30, 2018 and 2017, respectively, and are included in Employee Benefits in the accompanying statements of operations.

10. Equity Method Investments

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. 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, 2018 and 2017, the Company's investments in RWRT, SNERCC, and other minor investments under the equity method were approximately $4,063,000 and $4,052,000, respectively, and are included in equity method investments in the accompanying consolidated balance sheet. For the year ended September 30, 2018 and 2017, the Company recognized approximately $589,000 and $507,000, respectively, as its share of the financial results of RWRT, SNERCC, and other minor investments and received $578,000 and $761,000, respectively, in distributions.

The remainder of this page intentionally left blank.

Summarized combined unaudited financial information for RWRT and SNERCC as of September 30, 2018 and September 30, 2017 is as follows (in thousands):

September 30,	2018	2017
Cash	$ 2,515	$ 1,549
Receivables and other current assets	3,756	2,121
Total current assets	6,271	3,670
Property, improvements and equipment, net	3,502	6,104
Goodwill	7,142	7,142
Intangible assets	851	882
Other long-term assets	1,569	1,603
Total assets	$ 19,335	$ 19,401
Accounts payable and accrued liabilities	$ 1,052	$ 1,201
Other long-term liabilities	420	400
Equity	17,863	17,800
Total liabilities and partner's capital	$ 19,335	$ 19,401

For the Year Ended September 30,	2018	2017
Revenues	$ 17,278	$ 16,387
Net income	$ 2,953	$ 2,941
RWMC's income from equity method investments	$ 589	$ 507

11. Subsequent Events (Unaudited)

On March 1, 2019, Prospect entered into Amendment No. 2 to the Amended and Restated ABL Credit Agreement, by and among Prospect (as the borrower), the lenders party thereto and JPMorgan, as administrative agent and collateral agent. Under this amendment, the maximum revolving commitment is increased from $250.0 million to $280.0 million, and the maximum expansion of the facility has been reduced from $325.0 million to $285.0 million. Additionally, the amendment provides for $40.0 million of a "first in first out" revolving facility, which bears interest at either 2.5% or 3.5% per annum depending on whether they are Eurodollar loans or ABR loans.

Further, on March 25, 2019, Prospect entered into Amendment No. 3 to the Amended and Restated ABL Credit Agreement, by and among Prospect (as the borrower), the lenders party thereto and JPMorgan, as administrative agent and collateral agent. Under this amendment, the maximum revolving commitment is increased from $280.0 million to $285.0 million.

PROSPECT MEDICAL HOLDINGS, INC.

Consolidated Financial Statements

As of and for the Years Ended
September 30, 2019 and 2018

BDO

Prospect Medical Holdings, Inc.

Contents

	Page
Independent Auditor's Report	3
Consolidated Financial Statements:	
Consolidated Balance Sheets	4 - 5
Consolidated Statements of Operations	6
Consolidated Statements of Comprehensive Loss	7
Consolidated Statements of Stockholder's Deficit	8
Consolidated Statements of Cash Flows	9 - 10
Notes to Consolidated Financial Statements	11 - 62

BDO

Tel: 714-957-3200
Fax: 714-957-1080
www.bdo.com

600 Anton Blvd., Suite 500
Costa Mesa, CA 92626

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, 2019 and 2018, and the related consolidated statements of operations, statements of comprehensive loss, statements of stockholder's deficit, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated 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, 2019 and 2018, 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 20, 2019

Prospect Medical Holdings, Inc.

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

September 30,	2019	2018
Assets		
Current assets		
Cash and cash equivalents	$ 52,091	$ 7,694
Cash held in escrow	70,000	-
Restricted cash	1,485	1,742
Restricted investments	29,540	23,779
Patient accounts receivable, net of allowance for doubtful accounts of $165,719 and $151,279 at September 30, 2019 and 2018, respectively	306,587	317,412
Due from government payers	20,270	21,409
Other receivables, prepaid expenses and other current assets	118,000	117,026
Income tax receivable	-	2,737
Inventories	34,229	32,624
Hospital fee program receivable	167,530	211,454
Current assets held for sale	37,277	60,990
Total current assets	837,009	796,867
Property, improvements and equipment, net	538,471	513,690
Deferred income taxes, net	823	1,975
Goodwill	302,377	301,988
Intangible assets, net	25,545	31,822
Other assets	118,022	56,922
Long term assets held for sale	44,120	115,369
Total assets	$ 1,866,367	$ 1,818,633

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,	2019	2018
Liabilities and Stockholder's Deficit		
Current liabilities:		
Accrued medical claims and other healthcare costs payable	$ 72,508	$ 62,887
Accounts payable and other accrued liabilities	264,252	298,996
Accrued salaries, wages and benefits	179,997	167,705
Hospital fee program liability	24,362	65,966
Due to government payers	28,606	29,137
Income taxes payable	7,395	-
Revolving line of credit, net	70,000	207,645
Current portion of capital leases	10,238	12,933
Current portion of long-term debt	18,983	18,429
Current portion of MPT liabilities	43,145	-
Other current liabilities	25,249	27,831
Current liabilities held for sale	33,939	42,224
Total current liabilities	778,674	933,753
Long-term debt, net of current portion	187,367	1,098,441
Malpractice reserves	133,300	73,532
Capital leases, net of current portion	30,372	29,230
Asset retirement obligations	5,602	6,179
Other long-term liabilities	48,706	32,949
Pension obligations	302,372	254,121
MPT liabilities, net of current portion	1,338,040	-
Long term liabilities held for sale	11,994	12,777
Total liabilities	2,836,427	2,440,982
Commitments and contingencies		
Stockholder's deficit:		
Common stock, $0.01 par value; 100 shares authorized, issued and outstanding at September 30, 2019 and 2018	1	1
Additional paid-in capital	64,961	23,961
Accumulated other comprehensive (loss) income	(23,236)	21,303
Accumulated deficit	(1,019,073)	(676,930)
Total stockholder's deficit attributable to Prospect Medical Holdings, Inc.	(977,347)	(631,665)
Non-controlling interests	7,287	9,316
Total stockholder's deficit	(970,060)	(622,349)
Total liabilities and stockholder's deficit	$ 1,866,367	$ 1,818,633

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Operations
(in thousands)

For the Years Ended September 30,	2019	2018
Revenues:		
Net Hospital Segment patient services revenues	$ 2,487,156	$ 2,576,844
Provision for bad debts	(98,306)	(100,026)
Net Hospital segment patient services revenues less provision for bad debts	2,388,850	2,476,818
Other non-patient Hospital revenues	49,377	45,828
Net Hospital Segment revenues	2,438,227	2,522,646
Medical Group revenues	353,954	334,408
Global Risk Management revenues	49,696	33,863
Corporate revenues	7,321	2,971
Total net revenues	2,849,198	2,893,888
Operating Expenses:		
Hospital operating expenses	1,966,380	2,029,219
Medical Group cost of revenues	259,631	267,376
Global Risk Management cost of revenues	33,444	20,430
General and administrative	501,586	486,543
Depreciation and amortization	92,011	85,051
Total operating expenses	2,853,052	2,888,619
Operating income from unconsolidated joint ventures	5,889	2,599
Operating income	2,035	7,868
Other expense:		
Interest expense and amortization of deferred financing costs, net	127,835	100,190
Loss on early extinguishment of debt	30,052	18,422
Goodwill impairment	-	14,228
Other expense, net	2,858	2,231
Total other expense, net	160,745	135,071
Loss before income taxes	(158,710)	(127,203)
Income tax provision	16,455	62,786
Net loss from continuing operations	(175,165)	(189,989)
Loss from discontinued operations:		
Loss from discontinued operations	(141,539)	(59,914)
Income tax benefit	18,234	1,289
Loss on discontinued operations, net of taxes	(123,305)	(58,625)
Loss before allocation to non-controlling interests	(298,470)	(248,614)
Net loss attributable to non-controlling interests	(734)	(4,449)
Net loss attributable to Prospect Medical Holdings, Inc.	$ (297,736)	$ (244,165)

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Comprehensive Loss
(in thousands)

For the Years Ended September 30,	**2019**	2018
Net loss attributable to Prospect Medical Holdings, Inc.	**$ (297,736)**	$ (244,165)
Other comprehensive (expense) income, net of tax:		
Pension obligation and other post-retirement benefits adjustment (net of $251 and $6,833 tax)	**(45,796)**	12,995
Debt and equity securities, unrealized gain	**1,257**	160
Total other comprehensive (loss) income, net of tax	**(44,539)**	13,155
Total comprehensive loss	**$ (342,275)**	$ (231,010)

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

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

	Number of Common Shares	Common Stock	Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings (Accumulated Deficit)	Prospect Medical Holdings, Inc. Stockholder's (Deficit) Equity	Non-controlling Interests	Total Stockholder's (Deficit) Equity
Balance at October 1, 2017	100	$ 1	$ 22,398	$ 8,148	$ 24,165	$ 54,712	$ 12,604	$ 67,316
Options exercised	-	-	853	-	-	853	-	853
Stock-based compensation	-	-	710	-	-	710	-	710
Non-controlling interest attributed to minority shareholders	-	-	-	-	-	-	1,161	1,161
Net loss	-	-	-	-	(244,165)	(244,165)	(4,449)	(248,614)
Dividend paid to stockholder	-	-	-	-	(456,930)	(456,930)	-	(456,930)
Other comprehensive income, net of tax	-	-	-	13,155	-	13,155	-	13,155
Balance at September 30, 2018	100	1	23,961	21,303	(676,930)	(631,665)	9,316	(622,349)
Non-controlling interest attributed to minority shareholders	-	-	-	-	-	-	(1,295)	(1,295)
Net loss	-	-	-	-	(297,736)	(297,736)	(734)	(298,470)
Capital contribution from stockholder	-	-	41,000	-	-	41,000	-	41,000
Dividend paid to stockholder	-	-	-	-	(44,407)	(44,407)	-	(44,407)
Other comprehensive loss, net of tax	-	-	-	(44,539)	-	(44,539)	-	(44,539)
Balance at September 30, 2019	100	$ 1	$ 64,961	$ (23,236)	$ (1,019,073)	$ (977,347)	$ 7,287	$ (970,060)

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,	2019	2018
Operating activities		
Net loss	$ (298,470)	$ (248,614)
Adjustments to reconcile net loss to net cash and cash equivalents used in operating activities:		
Depreciation and amortization	92,011	85,051
Amortization of deferred financing costs, net	4,484	2,702
Goodwill impairment	-	14,228
Write-off of deferred financing costs	13,444	11,411
Amortization of original issue discount and premium, net	3,478	2,976
Write-off of original issue discount and premium	16,608	6,713
Provision for bad debts	98,306	100,026
Pension obligation net periodic benefit cost	17,411	12,403
Excess contribution to pension plan	(15,939)	(41,667)
Deferred income taxes, net	1,152	97,782
Stock-based compensation	-	710
Undistributed earnings from unconsolidated joint ventures	(5,889)	(2,599)
Gain on sale of equity method investments	-	280
Loss (gain) on disposal of assets	3,398	(976)
Changes in operating assets and liabilities, net of business combinations:		
Patient accounts receivable	(87,481)	(93,310)
Due to/from government payers, net	608	11,668
Other receivables, prepaid expenses and other current assets	(974)	57,185
Hospital fee program receivable	43,924	(152,242)
Hospital fee program liability	(41,604)	63,999
Inventories	(1,605)	(93)
Income taxes payable/receivable, net	10,132	(45,530)
Other assets	(36,325)	1,580
Accrued medical claims and other healthcare costs payable	9,621	8,175
Accounts payable, other accrued liabilities and other long term liabilities	2,399	51,482
Net cash and cash equivalents used in operating activities from discontinued operations	99,863	50,698
Net cash and cash equivalents used in operating activities	(71,448)	(5,962)
Investing activities		
Purchases of property, improvements and equipment	(52,075)	(70,543)
Cash paid for acquisitions, net of cash received and working capital adjustments	(390)	(5,780)
Proceeds from sale of property and improvements	-	726
Distribution received from equity and cost method investments	2,355	2,150
Increase in investments	(4,253)	(7,315)
Net cash and cash equivalents used in investing activities from discontinued operations	(11,224)	(28,037)
Net cash and cash equivalents used in investing activities	(65,587)	(108,799)

Prospect Medical Holdings, Inc.

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

For the Years Ended September 30,	2019	2018
Financing activities		
Borrowings on Senior Secured Notes, net of original issue discount	-	1,097,600
Repayments on Senior Secured Notes	(1,114,400)	(622,788)
Borrowings on line of credit	290,000	385,000
Repayments on line of credit	(429,000)	(176,000)
Repayments on retired line of credit, net	-	(115,300)
Proceeds of other long-term debt	175,538	-
Repayments of long-term debt	(7,346)	(1,380)
Repayment of financing leases	(2,082)	(2,450)
Repayments of capital leases	(14,509)	(11,318)
Proceeds from exercise of stock options	-	853
Cash paid for deferred financing costs	(526)	(19,536)
Change in restricted cash	257	29,019
Change in cash held in escrow	(70,000)	-
Capital contribution from stockholder	41,000	-
Dividend paid to stockholder	(44,407)	(456,930)
Repayments of insurance premium financing	(37)	(10,026)
Cash paid for deferred financing costs related to MPT liability transaction	(21,781)	-
Proceeds from MPT liability transactions	1,385,796	-
Repayment of MPT liability transactions	(5,447)	-
Net cash and cash equivalents used in financing activities from discontinued operations	(1,624)	(1,398)
Net cash and cash equivalents provided by financing activities	181,432	95,346
Increase (decrease) in cash and cash equivalents	44,397	(19,415)
Cash and cash equivalents, beginning of year	7,694	27,109
Cash and cash equivalents, end of year	$ 52,091	$ 7,694
Supplemental disclosure of cash flow information		
Interest paid (including cash paid on debt extinguishment)	$ 101,251	$ 53,070
Income taxes received	$ 343	$ 3,485
Schedule of non-cash investing and financing activities		
Equipment acquired under capital leases	$ 15,213	$ 16,849
Accrual of property, improvements and equipment	$ 47,113	$ 19,249
Insurance premium financed	$ -	$ 9,900
Partial satisfaction of long-term liability assumed from acquisition of PCC	$ -	$ 1,195
Acquisition of NUMG	$ -	$ 7,452

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.

Hospital Services Segment

As of September 30, 2019, through its subsidiaries, the Company owns 16 acute care and behavioral hospitals and multi-level elder care facilities in Southern California, Rhode Island, Pennsylvania and Connecticut with approximately 3,100 licensed beds, and a network of specialty and primary care clinics. The Hospital Services segment subsidiaries are wholly-owned by Prospect, except for the facilities in Rhode Island, in which Prospect has an 85% interest in the subsidiary that owns such facilities.

Additionally, at September 30, 2019, through its subsidiaries the Company owns 4 acute care and behavioral health hospitals in Texas and New Jersey, which are in the process of being closed or sold. According, and as further discussed in Note 5, for all periods presented the assets and liabilities of these businesses have been classified as "held for sale," and the operations (as it relates to revenues and expenses that will no longer continue post sale) have been shown within discontinued operations. All of the footnotes in these financial statements refer to continuing operations unless otherwise stated.

Admitting physicians are primarily practitioners in the local area. The hospitals have payment arrangements with Medicare, Medicaid 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 monthly fees ("Capitation"). 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 healthcare services for its affiliated physician organizations in California, Texas, Rhode Island, Connecticut, Pennsylvania and New Jersey. The California network consists of various IPAs that are generally wholly-owned by Prospect Medical Group, Inc. ("PMG") and managed by the two medical management company subsidiaries that are wholly-owned by Prospect. The Company's networks in its other states consist of IPA subsidiaries of Prospect Provider Groups, Inc. The Medical Group segment also owns clinic facilities in California, Rhode Island, Pennsylvania and Connecticut that operate by employing physicians to serve their patients. In California, the clinic facilities are owned through New Genesis Medical Association ("NGMA"). PMG and NGMA are owned by a nominee physician shareholder pursuant to an assignable option agreement, under which 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.

Most of the physician organizations in California and Texas have entered into Management Service Agreements ("MSA") with Prospect Medical Systems Inc., ("PMS"), and have agreed to pay a management fee to PMS, which is based in part on the costs to the management company and on a percentage of revenues. In Rhode Island, Pennsylvania, Connecticut and New Jersey, the physician organizations have entered into Administrative Services Agreements ("ASA") with PMS pursuant to which they have agreed to reimburse PMS for the costs of certain administrative services provided by PMS on their behalf. In return for payment of the management fee, PMS 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, PMS has assumed the obligations for all facilities and employs physician and non-physician personnel for administrative services. The management fee is earned based on a combination of percentage of revenue and share of pre-tax income. The management fees fluctuate based on the revenue and profitability of each physician organization. The MSAs are not terminable by the physician organization except in the case of gross negligence, fraud or other illegal acts, or bankruptcy, of PMS. The services provided under an ASA are more limited than those provided under an MSA and each ASA is terminable by either party upon the delivery of 90 days prior written notice thereof.

Prospect consolidates the revenues and expenses of all the physician organizations (except for one entity that is a 50/50 joint venture, which is accounted for under the equity method) from the respective dates of execution of the Management Agreements. All significant inter-entity balances have been eliminated in consolidation. In the case of the joint venture, 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 the joint venture for managing the other owners' share of the joint venture operations.

Prospect has also entered into management services 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. These management services agreements are terminable in accordance with the agreements.

The affiliated physician organizations provided medical services to a combined total of approximately 445,000 and 442,000 enrollees as of September 30, 2019 and 2018, respectively. The enrollees include approximately 237,000 and 255,000 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, 2019 and 2018, respectively. The total paid member months including managed enrollees, for the years ended September 30, 2019 and 2018 was approximately 5,435,000 and 5,360,000, respectively.

Global Risk Management Segment

The Global Risk Management segment exists in pursuit of the Company coordinated regional care ("CRC") operating model and risk management platform. CRC has subsidiaries in California, Texas, Rhode Island, Pennsylvania, Connecticut and New Jersey, and has accountable care organizations operating in Rhode Island, Pennsylvania and New Jersey. These entities contract with third-party health plans and the Centers for Medicare and Medicaid Services ("CMS") on progressive risk reimbursement models leading to global risk contracts for physicians, other medical services and institutional services including hospital inpatient and outpatient services, home health, skilled nursing facility and other institutional services. In turn, the global risk management entities contract with owned and third-party independent physician associations, owned and third-party hospitals and other health care providers to assume and manage this global risk. Through these contracts, the Company manages health plan member populations with a focus on delivering coordinated care to members across our network of physicians and providers under risk and value-based contracts. This segment also includes Coordinated Regional Care Group, Inc. ("CRCG"). CRCG incurs development and operating costs related to the Global Risk Management segment for new markets and strategic initiatives.

Corporate Segment

The Company has two captive insurance companies, Prospect Medical Holding Risk Retention Group, Inc. ("RRG"), based in Vermont, and Connecticut Healthcare Insurance Company ("CHIC"), based in the Cayman Islands. RRG was formed to provide primary insurance coverage for hospital and physician professional and general liability risks for the Company's subsidiary health care organizations located in Pennsylvania on a claims-made basis. CHIC provides hospital and physician professional and general liability coverage to all of the Company's hospitals and affiliated subsidiaries except for Prospect Crozer, LLC ("Crozer") and its Pennsylvania subsidiaries. CHIC is an exempted Company with limited liability under the Companies Law of the Cayman Islands and it holds a Class "B(i)" Insurer's License under Section 4(3)(b) of the Cayman Islands Insurance Law 2010. CHIC's principal activity is to issue primary policies for hospital liabilities covering Prospect, its subsidiaries and employees, on a claims-made basis. The Company procured excess healthcare professional liability and umbrella liability insurance policy on a claims-made basis covering healthcare professional liability, general liability, automobile liability, employer's liability, helipad liability and non-owned aircraft liability of the Company and its affiliates. This excess coverage is purchased entirely from unrelated commercial insurers. CHIC also provides a deductible reimbursement policy for workers compensation to the Company's facilities all of which have high deductible program structures or are qualified self-insureds.

On January 1, 2018, CHIC began providing an employee benefit stop-loss policy to all Company subsidiaries. Unlimited excess coverage is purchased from unrelated reinsurance companies.

The Company does not allocate interest expense related to acquisition debt or income taxes to the other reporting segments.

2. Significant Accounting Policies

Principles of Consolidation and 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 Inc. and Ivy Intermediate Holding Inc. The Company has a variable interest in various entities under the Medical Group segment due to the existence of two call options, 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 physician organizations under the Medical Group segment which allows the Company to direct the activities of such physician organizations that most significantly impact their economic performance, retain the right to receive expected residual returns and assume the obligation to absorb losses. Accordingly, the Company is considered to be the primary beneficiary and these entities are consolidated within the accompanying consolidated financial statements.

Operating results for acquisitions are consolidated with the Company's financial statements from their acquisition dates. All significant intercompany balances and transactions have been eliminated in consolidation. Non-controlling interests in less-than-wholly-owned consolidated subsidiaries of the Company are presented as a component of total equity to distinguish between the interests of the Company and the interests of the non-controlling owners.

The consolidation of these entities does not change any legal ownership, and does not change the assets or the liabilities and equity of the Parent Entity as a stand-alone entity. These entities had total revenues of approximately $330,930,000 and $310,720,000 and total net income of approximately $14,245,000 and net loss of approximately $2,184,000 for the years ended September 30, 2019 and 2018, respectively. The assets and liabilities of the variable interest entities are as follows (in thousands):

September 30,	2019	2018
Assets		
Total current assets	$ 86,966	$ 89,882
Total non-current assets	89,049	90,465
Total assets	$ 176,015	$ 180,347
Liabilities		
Total current liabilities	$ 52,120	$ 69,097
Total long-term liabilities	730	730
Total liabilities	$ 52,850	$ 69,827

The remainder of this page intentionally left blank.

Revenues

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

For the Years Ended September 30,	2019	2018
Net Hospital Services		
Inpatient	$ 1,392,340	$ 1,497,923
Outpatient	926,645	902,122
Capitation	148,800	157,968
Other	19,371	18,831
Total Hospital Segment patient service revenues	2,487,156	2,576,844
Less: Provision for bad debts	(98,306)	(100,026)
Total Net Hospital Segment patient service revenues less provision for bad debts	2,388,850	2,476,818
Other non-patient revenues	49,377	45,828
Total Hospital Segment revenues	2,438,227	2,522,646
Medical Group		
Capitation	302,734	297,965
Management fees	15,044	10,501
Other	36,176	25,942
Total Medical Group revenues	353,954	334,408
Global Risk Management		
Capitation	37,018	23,095
Other	12,678	10,768
Total Global Risk Management revenue	49,696	33,863
Corporate Segment revenues	7,321	2,971
Total net revenues	$ 2,849,198	$ 2,893,888

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, 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 and exclude revenues from discontinued operations (in thousands):

Years ended September 30,	2019	2018
Medicare	$ 822,407	$ 801,222
Medicaid	750,909	874,865
Managed Care	579,141	559,463
Self-Pay/Other	166,528	164,495
Capitation	148,800	157,968
Other	19,371	18,831
Total patient service revenue	$ 2,487,156	$ 2,576,844

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 persons with end-stage renal disease and certain other beneficiary categories, including eligible disabled persons. Most inpatient hospital services rendered to Medicare program beneficiaries are paid on a fee-for-service basis at prospectively determined rates per discharge, according to a patient classification system based on clinical, diagnostic, and other factors. Most outpatient services also are paid on a fee-for-service basis generally using prospectively determined rates. The Company receives, as appropriate, Medicare disproportionate share hospital ("DSH") and bad debt payments at tentative rates, with final settlement determined after submission of the annual Medicare cost report and audit thereof by the Medicare Administrative Contractor. The Company also receives, as appropriate, Medicare uncompensated care DSH payments, which are generally not subject to cost report audit except to determine eligibility for Medicare DSH. The Company also receives Medicare outlier payments on an ongoing basis during the year for cases that are unusually costly, and under certain circumstances these payments may be reconciled to more closely reflect the costs in excess of outlier thresholds after the submission and audit of the annual Medicare cost report. Normal estimation differences between filed settlements and amounts accrued are reflected in net patient service revenue.

The Company is reimbursed by Medicare for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare Administrative Contractor. The estimated amounts due to or from the program are reviewed and adjusted annually based on the status of such audits and any subsequent appeals. Differences between final settlements and amounts accrued in previous years are reported as adjustments to net patient service revenue in the year that examination is substantially completed.

Although services for most Medicare beneficiaries are paid by the Federal government on a fee-for-service basis, approximately one-third of Medicare beneficiaries are enrolled in a "Medicare Advantage" plan, which is a type of health plan that contracts with the Medicare program to provide hospital and medical benefits to Medicare beneficiaries. Medicare Advantage Plans include Health

Maintenance Organizations, Preferred Provider Organizations, Private Fee-For-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. For Medicare beneficiaries enrolled in a Medicare Advantage plan, most Medicare services are covered by the plan and are not paid for under fee-for-service Medicare. Certain Medicare Advantage plans make capitation payments to the Company using a "Risk Adjustment model," which compensates providers based on the health status (acuity) of each enrollee. Providers with higher acuity enrollees generally will receive more and those with healthier enrollees will receive less.

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 fee-for-service component of Medicaid programs in each state in which it operates at prospectively determined rates for inpatient services and a mixture of fee schedules and cost reimbursement methodologies for outpatient services depending on the specific state regulations. Cost report settlements are recorded based upon as-filed cost reports (if required by the respective facility's state) and adjusted for tentative and final settlements, if any. In addition, in California, Rhode Island, and Pennsylvania, a substantial portion of Medicaid beneficiaries are enrolled in Medicaid managed care organizations. The Company received payments for services furnished to these beneficiaries based on negotiated contract rates or non-contract payment methodologies where the Company does not have a contract with the managed care organization.

The various states in which the Company operates have additional programs in which certain of the Company's facilities participate in, related to medical facilities serving a disproportionate number of low-income patients. The following table shows the revenues generated by these programs during the years ended September 30, 2019 and 2018 (in thousands), which are reflected in Net Hospital Services revenues in the accompanying consolidated statements of operations:

For the years ended September 30,	**2019**	2018
California Medi-Cal Disproportional Share ("CA DSH") *(a)*	$ **28,967**	$ 13,761
Rhode Island DSH and Upper Payment Limit ("UPL") *(b)*	**20,456**	19,035
Pennsylvania State Programs *(c)*	**68,831**	40,344
Connecticut Medicaid DSH revenue *(d)*	**26,338**	33,152
	$ **144,592**	$ 106,292

(a) Revenues are accrued based on the expected total annual awards. Differences between the estimated and the actual awards are recorded in the period they become known, and are subject to retrospective revision prior to finalization, which could lead to material retractions. The Company records retrospective retractions when they are estimable and probable. Retrospective additional revenues are recorded when the amounts are received.

(b) Rhode Island hospitals receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low-income patients. 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 Company recorded $17,565,000 and $16,925,000 of expense during the years ended September 30, 2019 and 2018, respectively, as a result of the license fee.

(c) The Company's Pennsylvania hospitals are participants in Pennsylvania statewide hospital assessment, Medicaid Modernization Assessment ("MMA"), which has been extended through June 30, 2023. The assessments have enabled the Commonwealth of Pennsylvania to maintain

the updated inpatient payment system, make changes to existing disproportionate share/supplemental payments, and to create new payments where applicable. The Company has also recognized revenues from the Pennsylvania Community Access Fund ("CAF").

(d) The Company's hospitals in Connecticut participate in its Medicaid DSH program and receive additional reimbursement for treating a disproportionate share of low-income patients. Connecticut assesses a provider tax based on total net revenue received by a hospital for the provision of inpatient hospital services and outpatient hospital services. The state's 2020/2021 budget eliminated a scheduled reduction in the hospital's tax rates on inpatient and outpatient services by maintaining the rates at fiscal year 2019 levels but requiring the base year for calculating the tax to be adjusted each biennium. The State has made a Medicaid supplemental payment to hospitals for the first quarter of the State's 2020-21 fiscal year prior to obtaining federal approval, and has announced that this payment would be recovered if federal approval was not obtained. The amount of the provider tax has also been the subject of litigation, which was recently settled. However, the final settlement is contingent on federal approval of the state's tax waiver and proposed Medicaid State Plan Amendments, as well as on the state's General Assembly approval and adoption of implementing legislation. The proposed settlement agreement is estimated to have a financial impact on hospitals of approximately $1.8 billion in state and federal funds between now and 2026. The agreement includes a one-time payment or refund of approximately $79 million to hospitals, along with declining taxes on hospitals and corresponding increasing state payments to facilities during the applicable time period. The state can ask the court to modify the agreement if the state's overall costs are between $50 and $100 million, and the state can terminate the agreement if the state's overall costs rise by $100 million.

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.

Laws and regulations governing the third-party payor arrangements are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Normal estimation differences between subsequent cash collections on patient accounts receivable and net patient accounts receivable estimated in the prior year are reported as adjustments to net patient service revenue in the current period.

The following is a summary of due from and due to governmental payers at September 30, 2019 and 2018 (in thousands):

September 30,	2019	2018
Due from government payers:		
Medicaid Disproportionate Share	$ 19,301	$ 16,545
Medicare cost report settlements	969	4,691
Medicaid Section 1115 receivable	-	173
	$ 20,270	$ 21,409
Due to government payers:		
Medicare cost report settlements	$ 19,464	$ 20,323
Medicaid cost report settlements	9,142	8,814
	$ 28,606	$ 29,137

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.

California Hospital Fee Program

The Company recognizes revenues related to supplemental Medi-Cal payments under California provider fee programs. These programs are funded by quality assurance fees paid by participating hospitals and matching federal funds.

Based on formulas contained in the legislation as well as modeling done by the California Hospital Association, the Company recognized supplemental payments, included in net patient service revenue, and quality assurance fee expense, included in general and administrative expenses in the accompanying consolidated statements of operations as follows (in thousands):

Years Ended September 30,	2019	2018
Hospital services revenues	$ 122,976	$ 284,122
General and administrative expenses	53,775	123,996
Net pre-tax impact	$ 69,201	$ 160,126

As of September 30, 2019 and 2018, the Company had receivables related to the California Hospital Fee Program of approximately $167,530,000 and $211,454,000, respectively, and had liabilities related to the California Hospital Fee Program of approximately $24,362,000 and $65,996,000, respectively, in the accompanying consolidated balance sheets.

Legislation approved by the State of California in October 2013 created the framework for the hospital fee program to continue in perpetuity without requiring further legislation from California. In November 2016, California voters approved Proposition 52, which made the hospital fee program permanent and prohibits lawmakers from diverting Medi-Cal funds to pay for anything other than their intended purpose.

In December 2017, CMS approved the fee-for-service inpatient and outpatient payments and taxes for the period from January 1, 2017 to June 30, 2019 ("QAF 5"). CMS has not yet approved the amended Health Plan contracts. During the year ended September 30, 2018, the Company recorded revenues under the QAF 5 program of $111.9 million related to periods prior to the current fiscal year. Additionally, the Company recorded revenues related to previous hospital fee programs prior to QAF 5 of $14.6 million during the year ended September 30, 2018. The current cycle of the California Hospital Fee Program relates to the period from July 1, 2019 through December 31, 2021 ("QAF 6"). This cycle has not yet been approved by CMS and accordingly the Company has not recorded any revenues or expenses related to QAF 6 (or any prior program) during the fourth quarter of the year ended September 30, 2019.

Charity Care

The Company provides charity care to patients who lack financial resources and are deemed to be medically indigent based on criteria established under the Company's charity care policy. This care is provided without charge or at amounts less than the Company's established rates. Because the Company does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The direct and indirect costs related to this care totaled approximately $7,559,000 and $8,787,000 for the years ended September 30, 2019 and 2018, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. In addition, the Company provides services to other medically indigent patients under various state Medicaid programs. Such programs pay amounts that are less than the cost of the services provided to the recipients. The Company has not changed its charity care or uninsured discount policies during the years ended September 30, 2019 and 2018.

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 was 35% and 32% at September 30, 2019 and September 30, 2018, respectively. The allowance for doubtful accounts was approximately $165,719,000 and $151,279,000 as of September 30, 2019 and 2018, respectively, and the increase results from a determination at September 30, 2019 to fully reserve for all patient accounts receivable over 365 days old.

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.

Medical Group Segment

Medical Group Revenues

Operating revenue of the Medical Group segment consists primarily of payments for medical services procured by certain entities included within the Medical Group segment ("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 physician organizations 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. During the years ended September 30, 2019 and 2018, the Company returned and recognized as a reduction in revenue, approximately $1,749,000 and $3,220,000, respectively, as a result of the final Hierarchical Condition Category ("HCC") reconciliation.

HMO contracts also include provisions to share in the risk for hospitalization, whereby the physician organization 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, 2019 and 2018, Medical Group revenues included approximately $10,482,000 and $7,125,000, respectively, relating to risk-sharing profit. At September 30, 2019 and 2018, contingent liabilities for carry-forward risk-pool deficits expected to be forgiven, or offset against future surpluses were approximately $88,991,000 and $92,700,000, 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. Performance and incentive revenues recorded during the years ended September 30, 2019 and 2018 were $11,221,000 and $5,751,000, 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 10% of revenues. Management fee revenues recorded during the years ended September 30, 2019 and 2018 were $10,248,000 and $5,656,000, respectively. Management fees for revenue for entities that are consolidated are eliminated on consolidation.

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 period. See Note 14 for changes in claims estimates during the years ended September 30, 2019 and 2018.

The Company has contractual reimbursement obligations to providers and discretionary incentive payment obligations to physicians. These payments are in large part predicated on the pay-for-performance, shared risk revenues, and favorable senior capitation risk adjustment payments received by the Company from the health plans. 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. During this period, the Company also finalizes the physician discretionary incentive.

The Company recorded physician incentives expense of approximately $17,643,000 and $21,669,000 for the years ended September 30, 2019 and 2018, respectively. As of September 30, 2019 and 2018, physician incentive accruals of approximately $14,351,000 and $17,396,000, respectively, were included in accounts payable and other accrued liabilities in the accompanying consolidated financial statements.

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. There were no such premium deficiencies recorded at September 30, 2019 and 2018, respectively.

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 the Hospital Services and Medical Group segments, under which up to 98% of capitation revenue received is transferred to these segments. During the years ended September 30, 2019 and 2018, capitation revenue received from health plans was $267,300,000 and $254,795,000, respectively, of which $105,755,000 and $101,563,000, and $120,119,000 and $116,957,000 was transferred to our Hospital Services segment and Medical Group segment, respectively.

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. During the years ended September 30, 2019 and 2018, the Global Risk Management Segment recognized capitation risk adjustments of $4,552,000 and $5,155,000, respectively.

Global Risk Management Cost of Revenues

The cost of health care services consists primarily of the transfer of capitation revenue to the Hospital Services 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, record a premium deficiency reserve. There were no such premium deficiencies recorded at September 30, 2019 or 2018.

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 5 to 40 years, buildings are depreciated over 5 to 40 years, equipment is depreciated over 2 to 15 years and furniture and fixtures are depreciated over 2 to 20 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 13, the Company is required to comply with certain seismic standards as required by the state of California by dates ranging from February 2021 through June 2022. 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

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. The Company's annual goodwill impairment test is conducted on July 1. Impairment of goodwill is tested at the reporting unit level, by comparing the reporting unit's carrying amount, including goodwill, to the fair value of the reporting unit. The fair value of the reporting units are estimated. 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 one-step process which consists of estimating 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. If the estimated fair value of the reporting unit is less than its carrying value, this indicates that goodwill is impaired, and impairment is recorded based on the deficiency of fair value compared to the carrying value. The

Company's impairment test related to goodwill during the year ended September 30, 2018 resulted in a full impairment of goodwill related to the Rhode Island facilities. There were no impairment charges during the year ended September 30, 2019.

Intangible Assets

Intangible assets include customer relationships, trade names, and favorable leaseholds. 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, 2019 and 2018.

Insurance Reserves

Medical Malpractice Liability Insurance

The individual physicians who contract with the physician organizations carry their own medical malpractice insurance, some of which may be purchased from RRG or CHIC. 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. The Company's hospitals have a consolidated policy for professional and general liability insurance with separate retentions for each entity. The Pennsylvania MCARE fund provides the $500,000 in excess of $500,000 RRG malpractice coverage for Crozer.

For the current fiscal year, RRG provided primary malpractice insurance ($500,000 per occurrence and $2,500,000 in the aggregate) and general liability ($1,000,000 per occurrence and $2,000,000 in the aggregate). In addition, the RRG provided coverage for losses of $4,000,000 in excess of $1,000,000 for each hospital professional liability claim with no aggregate limit. RRG also provides additional layers of excess coverage over $5,000,000 up to $20,000,000, which are 100% reinsured by third party insurance carriers through multiple layers. The excess coverage provided for general liability is over $10,000,000 up to $50,000,000, which is also 100% reinsured by third party carriers. Additionally, there is $1,000,000 per occurrence and $3,000,000 in the aggregate) coverage for non-healthcare provider professional liability.

During the year ended September 30, 2018, CHIC provided malpractice and general liability ($2,000,000 per occurrence) coverage for all facilities except Crozer and Prospect ECHN, Inc. ("ECHN"). During the year ended September 30, 2019, CHIC provided malpractice and general liability ($5,000,000 per occurrence and $37 million in the aggregate) coverage for all facilities, except Crozer. CHIC also provided an excess healthcare professional liability and umbrella liability insurance policy on a claims-made basis covering healthcare professional liability, general liability, automobile liability, employers' liability, helipad liability and non-owned aircraft liability. The limit provided was $80,000,000 and $60,000,000 (during the years ended September 30, 2019 and 2018, respectively) for each loss event and in the annual aggregate excess of the primary coverage layers described above. This coverage was fully reinsured by third party carriers.

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 its hospitals. At September 30, 2019 and 2018, the total gross claims liability, was $133,300,000 and $73,532,000 and reinsurance recoverable on unpaid losses were $49,552,000 and $12,834,000, respectively, included in other assets on the accompanying consolidated balance sheets, and were estimated using a discount factor ranging from 3.50% to 4.00%.

Workers' Compensation Insurance

The workers' compensation coverage provides the statutory benefits required by law with a $500,000 deductible reimbursement policy provided by CHIC for the Company's entities located in California and Connecticut, and for the year ended September 30, 2019, Pennsylvania (covered in fiscal 2018 for the first $500,000 with a third party carrier). The facilities in Rhode Island were fully insured for workers' compensation claims with no deductible. At September 30, 2019 and 2018, included in accrued salaries, wages and benefits are accruals for uninsured claims and claims incurred but not reported of approximately $29,182,000 and $27,776,000 and reinsurance recoverable on unpaid losses of $3,134,000 and $8,557,000, respectively, included in other assets on the accompanying consolidated balance sheets. The amounts are estimated based upon an actuarial valuation of claims experience, using a discount factor of 4%.

Reserve Methodology

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 the medical malpractice and workers' compensation 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.

Stock Options

Ivy Holdings has a stock option plan (the "Ivy Plan"), which is administered by the Compensation Committee of the Ivy Holdings Board. The 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 plan. These options granted under the Ivy Plan are exercisable into Ivy Holdings stock and vest based on a number of criteria.

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

Some of the Company's cash is restricted for various purposes including research, regulatory requirements and letters of credit. The Company is also 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. Restricted cash also include certificates of deposit with maturity dates of more than 90 days when purchased.

Cash Held in Escrow

The Company holds $70 million of the cash at September 30, 2019 which is held in in escrow and is expected to be contributed to the Company's pension plans during the year ending September 30, 2020.

Restricted Investments

Investments in marketable securities, primarily mutual funds, and are classified as available for sale and are stated at fair value. Unrealized gains and losses are recorded in the statements of other comprehensive income. Investment securities are exposed to various risk, such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is possible that changes in values of investment securities could occur in the near term and such changes could materially affect investment. These investments are held in the Company's captive insurance companies and are shown as restricted because the state/local regulators require their approval before dividends or return of capital to the Parent Entity.

Inventories

Inventories of supplies are valued at the lower of amounts that approximate the weighted average cost or net realizable value, which approximates market value, and are expensed as incurred. Inventories consist primarily of medical and surgical supplies and pharmaceuticals.

Internal Use Software

Included within other receivables, prepaid expenses and other current assets are hosting arrangements related to the Oracle suite of products, which are accounted for as service contracts. The gross carrying amount of capitalized service costs was approximately $12,100,000 and $149,000 at September 30, 2019 and 2018, respectively. There is no expected residual value for capitalized costs. At September 30, 2019 and 2018, there was approximately $12,100,000 and $149,000, respectively, of capitalized costs for hosting arrangements accounted for as service contracts that is was in the development stage and amortization is scheduled to commence once the project is complete and ready for its intended use. The estimated amortization period is 5 years. There was no amortization expense for the years ended September 30, 2019 and 2018, respectively.

Deferred Financing Costs

Deferred financing costs are amortized over the period in which the related debt is outstanding using the effective interest method and are classified as a deduction from the carrying amount of the related debt. As it relates to MPT liabilities, deferred financing costs are classified in other assets in the accompanying consolidated balance sheets.

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 year ended September 30, 2018, the Company incurred $2,405,000 of interest and penalties related to income taxes, which were reversed during the year ended September 30, 2019.

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.

A consolidated federal tax return is filed for Ivy Holdings, with the exception of Nuestra Familia Medical Group Inc., ("Nuestra"), which files its own federal tax returns. The Company files separate state tax returns for California, Texas, Rhode Island, Pennsylvania, Connecticut, New Jersey and Florida. The Company's filed tax returns are generally subject to examination by the IRS and state tax boards for 3 to 4 years.

Sale-Leaseback Transactions

The Company evaluates sale-leaseback transactions by determining whether the transaction meets the qualifying criteria to be recognized as a sale-leaseback, including the transfer of risk and rewards of ownership as well as the absence of continuing involvement of the Company. When the qualifying criteria for a sale-leaseback transaction are not met, the Company accounts for the transaction as a financing (see Notes 9 and 10).

Comprehensive Income

Comprehensive income consists of net income and other gains and losses affecting stockholder's equity that, under generally accepted accounting principles, are excluded from net income (loss) attributable to the Company. For the Company, such items consist primarily of unrealized gains or losses on debt and equity securities as well as changes related to pension and other postretirement liabilities that are not recognized immediately in net periodic benefit costs (see Note 12).

Fair Value of Financial Instruments

Financial instruments consist primarily of cash and cash equivalents, restricted cash, restricted 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, MPT liability 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):

September 30, 2019	Total	Level 1	Level 2	Level 3
Mutual funds	$ 29,540	$ 29,540	$ -	$ -
September 30, 2018				
Mutual funds	$ 23,779	$ 23,779	$ -	$ -

The Company's investments are classified within Level 1 of the fair value hierarchy because they are valued using quoted market prices. The Company's defined benefit pension plan assets are also measured at fair value (see Note 12).

The Company's carrying amount of long-term debt approximated fair value as of September 30, 2019 and 2018, respectively.

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 intangible assets when there are indications of impairment.

During the year ended September 30, 2018, the Company recorded approximately $14,228,000 of impairment relating to goodwill, which is reflected in the accompanying consolidated statements of operations.

The Company uses the discounted cash flow approach and the guideline public company approach to estimate the residual value of the Company's goodwill. The measurement of goodwill is a Level 3 measurement.

The following table provides quantitative information related to the significant unobservable inputs to determine fair value of goodwill as of September 30, 2018:

Residual Value of Goodwill	Valuation Technique	Unobservable Input	Rates
$ -	Discounted Cash Flow	Weighted average cost of capital	9.3%
		Revenue growth rate	2.1% - 2.5%
	Guideline Public Company	LTM revenue multiple	0.5x
		NTM EBITDA multiple	7.0x

There were no nonrecurring measurements as of September 30, 2019.

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, 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 segment and from the Medicare and Medicaid 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.

For the years ended September 30, 2019 and 2018, the Hospital Services segment received a total of 63% and 65% of its net patient revenues from Medicare and Medicaid programs, respectively, and the Medical Group segment received a total of 65% and 62% for the years ended September 30, 2019 and 2018, respectively, of their capitation revenues from its five largest HMOs, as follows (in thousands):

Years Ended September 30,	**2019**	**% of Total Revenue**		2018	% of Total Revenue
Hospital Services:					
Government Payers:					
Medicare	**$ 822,407**	**33%**		$ 801,222	31%
Medicaid	**750,909**	**30%**		874,865	34%
Total	**$ 1,573,316**	**63%**		$ 1,676,087	65%
Medical Group:					
HMO A	**$ 61,087**	**20%**	HMO A	60,506	20%
HMO B	**35,674**	**12%**	HMO B	35,705	11%
HMO E	**34,684**	**11%**	HMO F	32,934	11%
HMO F	**34,207**	**11%**	HMO D	32,357	11%
HMO D	**32,617**	**11%**	HMO C	27,051	9%
Total	**$ 198,269**	**65%**		$ 188,553	62%

The Global Risk Management segment received all of their revenues from seven health plans during the years ended September 30, 2019 and 2018.

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 pension obligations and other postretirement benefit reserves, reserves for outcome of legislation and valuation allowances against deferred tax assets.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, "Revenue from Contracts with Customers (Topic 606)" with an effective date deferred 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, and interim periods within fiscal years beginning after December 15, 2019. 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 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. The Company is currently evaluating the effect of this guidance on its consolidated financial statements.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)". The core principle of ASU 2016-02 is that a lessee should recognize the assets and liabilities that arise from leases, including operating leases. Under the new requirements, a lessee will recognize in the statement of financial position a liability to make lease payments (the lease liability) and the right-of-use asset representing the right to the underlying asset for the lease term. For leases with a term of 12 months or less, the lessee is permitted to make an accounting policy election by class of underlying asset not to recognize lease assets and lease liabilities. The recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee have not significantly changed from previous GAAP. The standard was originally scheduled to effective for nonpublic entities for fiscal years beginning after December 15, 2019. In November 2019 the FASB issued ASU 2019-10, "Financial Instruments—Credit Losses (Topic 326), Derivatives and Hedging (Topic 815), and Leases (Topic 842)" which delay the effective date by one year to December 2020. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230)". The updated standard addresses eight specific cash flow issues with the objective of reducing diversity in practice. ASU 2016-15 is effective for non-public business entities for annual reporting periods beginning after December 15, 2018, including interim periods within those annual reporting periods. Early adoption is permitted. The Company is assessing the impact of the adoption of ASU 2016-15 on its consolidated financial statements.

In March 2017, the FASB issued ASU 2017-07, "Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost. The ASU amends ASC Topic 715, Compensation – Retirement Benefits, to require employers that present a measure of operating income in their statements of income to include only the service cost component of net periodic pension costs and net periodic postretirement benefit cost in operating expenses. The ASU also stipulates that only the service cost component of net benefit cost is eligible for capitalization. This guidance is effective for fiscal years beginning after December 15, 2018. Early adoption is permitted as of the beginning of an annual period for which financial statements have not been issued or made available for issuance. Disclosures of the nature of and reason for the change in accounting principle are required in the first interim and annual periods of adoption. The Company is currently evaluating the provisions of ASU 2017-07 and its impact on the Company's consolidated financial position, results of operations and cash flows.

In August 2018, the FASB issued ASU 2018-14, "Compensation - Retirement Benefits - Defined Benefit plans - General (Topic 715-20): Disclosure Framework - Changes to the Disclosure Requirements for Defined Benefit Plans", which amends ASC 715 to add, remove and clarify disclosure requirements related to defined benefit pension and other postretirement plans. This ASU is effective for fiscal years ending after December 15, 2021. Early adoption is permitted. The Company is currently evaluating the provision of ASU 2018-14 and its impact on its consolidated financial statements and related disclosures.

Reclassifications

Certain reclassifications were made to the prior year consolidated financial statements in order to conform to the current year presentation, and primarily relate to presentation of discontinued operations (see Note 5).

3. Property, Improvements and Equipment

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

September 30,	2019	2018
Land and land improvements	$ 68,403	$ 75,801
Buildings and improvements	359,570	316,217
Leasehold improvements	12,097	8,758
Equipment	373,153	283,008
Furniture and fixtures	5,288	4,705
	818,511	688,489
Less: accumulated depreciation	(342,106)	(248,162)
	476,405	440,327
Construction in Progress	62,066	73,363
Property, improvements and equipment, net	$ 538,471	$ 513,690

At September 30, 2019 and 2018, the Company had assets under capitalized leases of approximately $53,861,000 and $31,784,000, respectively, and related accumulated depreciation of $10,771,000 and $12,433,000, respectively.

Depreciation expense was approximately $83,683,000 and $78,153,000 for the years ended September 30, 2019 and 2018, respectively.

Included within equipment is capitalized software costs, which relate to significant system conversions. The estimated amortization period is 5 years. The gross carrying amount of capitalized software for internal use (related to the Cerner suite of products) was approximately $39,538,000 and $14,557,000 at September 30, 2019 and 2018, respectively, and the net carrying amount considering accumulated amortization was approximately $37,449,000 and $14,557,000 at September 30, 2019 and 2018, respectively. There is no expected residual value for capitalized internal-use software. At September 30, 2019 and 2018, there was approximately $28,355,000 and $7,914,000, respectively, of capitalized costs for internal-use software that is in the development stage and amortization is scheduled to commence once the software project is complete and ready for its intended use. Amortization expense was $2,050,000 and $0 for the years ended September 30, 2019 and 2018, respectively.

4. Acquisitions

For the years ended September 30, 2019 and 2018, the Company entered into the following material acquisitions. All business combinations were consistent with the Company's strategic growth plan and were accounted for using the acquisition method of accounting. Operating results for each of the acquisitions have been included in the accompanying consolidated financial statements from the date of acquisition. Goodwill arising is primarily attributable to the synergies expected to arise after the acquisitions, and is expected to be deductible for tax purposes for entities that were asset acquisitions, but is not is expected to be deductible for tax purposes for entities that were stock acquisitions.

All assets acquired and liabilities assumed were at fair value with the exception of the defined benefit pension liabilities and other post retirement employee benefits, which allows for an exception to fair value accounting for business combinations in accordance with GAAP. The recognized tax bases (the amount that is attributable for tax purposes) of the assets and liabilities are compared to the financial reporting values of the acquired assets and assumed liabilities (book bases) to determine the appropriate temporary differences. The Company identified temporary differences related to assumed pension liabilities, due primarily to differences in tax law regarding when a liability is or is not assumed in an asset acquisition; this difference in the treatment of the pension liabilities resulted in the recording of deferred tax assets which are reflected in the acquisition accounting and noted in the tables below.

Transaction costs incurred during the years ended September 30, 2019 and 2018 were immaterial.

2019 acquisitions

The Company completed the acquisitions of 10 physician practices in Connecticut and Pennsylvania for an aggregate purchase price of approximately $400,000. All acquisitions were asset acquisitions.

2018 acquisitions

In December 2017, New University Medical Group LLC ("New UMG") entered into a Second Closing to acquire the remaining assets of University Medical Group ("UMG") that were not acquired in the initial acquisition in December 2014. As consideration for the acquisition, New UMG has assumed certain designated liabilities of the practice, which consists of various loans payable to subsidiaries of the Company, totaling approximately $7.5 million. Post-acquisition, these liabilities are eliminated on consolidation. There was no cash consideration related to the transaction. The remaining assets and liabilities acquired were immaterial and no value was assigned to them in the purchase price allocation, and accordingly goodwill of $7.5 million arises from the acquisition. New UMG's parent company, Prospect CharterCARE Physicians, LLC, dba CharterCARE Medical Associates ("CCMA"), entered into a Post Closing Administrative Services Agreement pursuant to which CCMA and its affiliates provide services to the seller of the practice in connection with its termination of all operations and the wind up its affairs and operations.

The Company completed the acquisitions of four physician practice acquisitions in Connecticut for an aggregate purchase price of approximately $2.6 million, one physician multi-specialty practice in Pennsylvania for a purchase price of $1.6 million (net of working capital adjustments), three physician medical practices in California for an aggregate purchase price of approximately $800,000, and one physician family practice in Rhode Island for $180,000. All acquisitions were asset acquisitions, except for one stock purchase acquisition in Connecticut for a purchase price of $800,000.

5. Discontinued Operations

During the year ended September 30, 2019, the Company made the determination to sell the operations of Nix Hospital System ("Nix Health") in Texas and East Orange General Hospital ("EOGH") in New Jersey. The initial plan as approved by the Company's Board of Directors in March 2019 was to sell both Nix Health and EOGH as "going concern" businesses. Subsequent to the initial plan, the plans for Nix Health changed as a result of interest in the market place. The decision to sell the acute hospital building as a real estate transaction was made in August 2019. The hospital closed to patient admissions in September 2019 and as of September 30, 2019 had no patients "in-house". The building is under contract for sale for $28.5 million and the sale is expected to close in the second quarter of fiscal 2020. The decision was made in October 2019 to initially consolidate, and then close, the behavioral business. The two behavioral health businesses were closed in November 2019. Efforts are underway to sell the building that is owned and sublease the building that is leased. Negotiations continue with a number of potential buys with respect to the sale of EOGH. The Company's decision to discontinue the operations of each of these entities was based on the strategy of the Company's management in their respective markets and financial results.

Accordingly, as of September 30, 2019 and 2018, the assets and liabilities of these businesses have been classified as "held for sale," and the operations (as it relates to revenues and expenses that will no longer continue post sale) have been shown within discontinued operations.

In connection with the presentation of discontinued operations, the Company was required to test the long lived assets for impairment as of September 30, 2019. As part of that impairment test: (i) goodwill at Nix Health was fully impaired; (ii) property, plant and equipment at EOGH was impaired by approximately $55.9 million and at Nix Health was impaired by $17.8 million, respectively.

Summarized financial information for discontinued operations is included below (in thousands):

September 30,	2019	2018
Patient accounts receivable, net of allowance for doubtful accounts and other receivables	$ 26,037	$ 33,377
Due from government payors	2,022	11,424
Other receivables, prepaid expenses and other current assets	7,732	11,352
Inventories	1,486	4,837
Total current assets	37,277	60,990
Property, improvements and equipment, net	42,401	110,273
Goodwill	-	3,138
Intangible assets, net	1,555	1,797
Other assets	164	161
Total assets of the disposal groups classified as held for sale in the consolidated balance sheets	$ 81,397	$ 176,359

September 30,	2019	2018
Accrued medical claims and other healthcare costs payable	$ 53	$ 46
Accounts payable and other accrued liabilities	23,325	29,436
Accrued salaries, wages and benefits	7,929	9,849
Due to government payers	855	1,478
Current portion of capital leases	1,777	1,415
Total current liabilities	33,939	42,224
Long-term debt, net of current portion	946	1,000
Malpractice reserves	2,677	3,748
Capital leases, net of current portion	7,310	6,623
Other long-term liabilities	1,061	1,406
Total liabilities of the disposal groups classified as held for sale in the consolidated balance sheets	$ 45,933	$ 55,001

For the Years Ended September 30,	2019	2018
Net patient service revenues	$ 189,063	$ 190,085
Provision for bad debts	(19,953)	(19,388)
Net patient service revenues	169,110	170,697
Other non-patient revenues	4,762	5,049
Total revenues	173,872	175,746
Hospital operating expenses	181,145	174,058
General and administrative	47,829	42,651
Depreciation and amortization	7,224	12,763
Total operating expenses	236,198	229,472
Net operating loss	(62,326)	(53,726)
Interest expense, net	1,708	1,699
Goodwill impairment	3,138	4,572
Property, improvement and equipment impairment	73,682	-
Other expense (income), net	685	(83)
Total other expense, net	79,213	6,188
Loss on discontinued operations before income taxes	(141,539)	(59,914)
Income tax benefit	18,234	1,289
Loss on discontinued operations, net of taxes	$ (123,305)	$ (58,625)

6. Goodwill and Intangible Assets

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

September 30,	2019	2018
Southern California Hospitals	$ 130,912	$ 130,912
California Medical Groups	28,222	28,222
Crozer	140,216	140,216
ECHN	535	483
Waterbury	2,492	2,155
Total	$ 302,377	$ 301,988

The changes in the carrying amount of goodwill for the years ended September 30 are as follows (amounts in thousands):

September 30,	2019	2018
Balance, beginning of year	$ 301,988	$ 302,985
Acquisitions	389	13,231
Impairment	-	(14,228)
Balance, end of year	$ 302,377	$ 301,988

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

September 30,	Useful lives	2019	2018
HMO membership	14 years	$ 25,200	$ 25,200
Trade names, net of impairment	3 - 20 years	42,030	50,160
Customer relationships	7 years	-	350
Other	5 - 6 years	97	97
Gross carrying value		67,327	75,807
Accumulated amortization		(41,782)	(43,985)
Intangible assets, net		$ 25,545	$ 31,822

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, 2019 and 2018 was $6,278,000 and $6,898,000, respectively. There are no expected residual values related to these intangible assets.

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

Years ending September 30,	
2020	$ 5,108
2021	5,088
2022	3,299
2023	2,780
2024	2,780
Thereafter	6,490
	$ 25,545

The weighted-average remaining useful life for the intangible assets was approximately 7 years as of September 30, 2019.

7. 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 Upland Medical Group, a Professional Medical Group and Pomona Valley Medical Group, Inc (collectively "ProMed Entities"), has ownership interests in physician medical groups that provide medical services to ProMed members, including Chaparral Medical Group, Inc., (in which the Company beneficially owns a 13.2% interest). For the years ended September 30, 2019 and 2018, the ProMed Entities paid these groups approximately $21,922,000 and $19,760,000, respectively. As of September 30, 2019 and 2018, the Company had accounts payable and other accrued liabilities due to these related parties of $806,000 and $1,266,000, 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. As of September 30, 2019 and 2018, there was approximately $500,000 and $0 payable, respectively, included in accounts payable and other accrued liabilities on the accompanying consolidated balance sheets.

During the year ended September 30, 2019, the Company received a capital contribution from Ivy Intermediate of $41.0 million and paid a dividend of approximately $44.4 million (see Note 11).

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. Under this agreement, the Company received refunds (net of payments) of $(343,000) and $5,463,000 for the years ended September 30, 2019 and September 30, 2018, respectively.

8. Income Taxes

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

For the years ended September 30,	2019	2018
Current:		
Federal	$ 11,940	$ (41,703)
State	3,353	(8,549)
	15,293	(50,252)
Deferred:		
Federal	1,162	100,529
State	-	12,509
	1,162	113,038
Total:		
Federal	13,102	58,826
State	3,353	3,960
	$ 16,455	$ 62,786

The remainder of this page intentionally left blank.

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

September 30,	2019	2018
Deferred tax assets:		
Accrued medical claims	$ 3,443	$ 4,265
Malpractice reserves	3,254	3,202
Accounts receivable	26,596	22,136
Accrued salaries & wages	13,478	10,530
Pension obligation	65,919	81,847
Net operating losses	44,026	51,567
Tax Credits	1,719	2,870
Outside basis differences	7,244	755
Lease liability	132,400	-
UTP & other	-	7,730
Deferred tax assets	298,079	184,902
Valuation allowance	(203,335)	(105,909)
Net deferred tax assets	94,744	78,993
Deferred tax liabilities:		
Property, plant & equipment	(72,053)	(54,863)
Intangible assets	(6,642)	(8,626)
Prepaid expenses	(2,969)	(2,222)
Other comprehensive income	(11,585)	(11,307)
UTP & other	(672)	-
Deferred tax liabilities	(93,921)	(77,018)
Net deferred tax assets	$ 823	$ 1,975

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.

Management assesses the available positive and negative evidence to estimate whether sufficient future pretax income will be generated to permit use of the existing deferred tax assets. A significant piece of objective negative evidence evaluated was the cumulative pretax losses incurred over the three year period ended September 30, 2019. Such objective evidence limits the ability to consider other subjective evidence, such as the Company's projections for future growth. On the basis of this evaluation, at September 30, 2019 and 2018, a valuation allowance of approximately $203.3 million and $105.9 million, respectively, was recorded to recognize only the portion of the deferred tax asset that is more likely than not to be realized. The amount of the deferred tax asset considered realizable, however, could be adjusted if estimates of future taxable income during the carryforward period are reduced or increased or if negative objective evidence in the form of cumulative losses is no longer present and additional weight is given to subjective evidence such as the Company's projections for growth.

During fiscal 2019, the Company completed an IRS examination for Ivy Holdings, Inc. & Subsidiaries fiscal 2014 through 2016 federal income tax returns without any adjustment to reported taxable income The Company is under examinations by the California Franchise Tax Board for tax years ended September 30, 2014 through 2016. The Company does not currently anticipate any changes to our unrecognized tax benefits for the next twelve months related to these examinations.

The Company's tax years 2016 and 2017 are open for federal tax examination, and generally the states are open for tax years 2015 through 2017. During the year ended September 30, 2018, the Company recorded a liability in the amount of $12.7 million related to uncertain tax positions ("UTP") with respect to impermissible accounting methods for federal income tax purposes, which was recorded in other long-term liabilities in the accompanying consolidated balance sheets. During the year ended September 30, 2019, The Company has removed the UTP liability due to filing with IRS for a change from an improper to a proper accounting method change.

On December 22, 2017, the Tax Cuts and Jobs Act of 2017 (the "Act") was signed into law making significant changes to the Internal Revenue Code. Changes include, but are not limited to, a corporate tax rate decrease from 35% to 21% effective for tax years beginning after December 31, 2017, limitations on various business deductions such as executive compensation under Internal Revenue Code §162(m), the transition of U.S international taxation from a worldwide tax system to a territorial system, and a one-time transition tax on the mandatory deemed repatriation of cumulative foreign earnings as of December 31, 2017. The United States federal income tax rate reduction was effective as of January 1, 2018. As a result, the Company reduced net U.S. deferred tax assets by $25,660,000 during the year ended September 30, 2018. As the Company does not have profitable foreign subsidiaries, it does not anticipate any impacts as a result of the mandatory deemed repatriation of cumulative foreign earnings.

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,	**2019**	2018
Tax provision at statutory rate	**21%**	25%
State taxes, net of federal benefit	**16%**	15%
Impact of US Tax Reform	**0%**	(16)%
Valuation allowance	**(56)%**	(77)%
UTP	**8%**	(2)%
Other	**1%**	4%
	(10)%	(51)%

9. Long-Term Debt

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

September 30,	2019	2018
Senior secured credit facility (net of discount of $0 and $20,085, respectively)	$ -	$ 1,094,315
Other debt *(1)*	206,350	38,769
Less: Deferred financing costs, net ("DFC")	-	(16,214)
Total Debt, net of discount and DFC	206,350	1,116,870
Less: current maturities	(18,983)	(18,429)
Long-term debt, net of current maturities	$ 187,367	$ 1,098,441

(1) Other debt includes (i) financing obligations related to sales-leaseback transactions. The financing obligations related to sales-leaseback transactions were $23,152,000 and $24,614,000 for years ended September 30, 2019 and 2018, respectively, excluding the sale leaseback transaction in entered into in fiscal 2019 with MPT (see Note 10) and (ii) debt related to the Foothill ($51,267,000) and TRS Notes ($112,937,000) entered into in fiscal 2019 with MPT (see Note 10).

Senior Secured Credit Facilities

On June 30, 2016, the Company entered into a six-year $625,000,000 senior secured term loan B (the "Original Term Loan"). The Original Term Loan was issued with an original discount of 1.50%, or $9,375,000. Additionally, the Company refinanced the previous revolver with a new $100,000,000 asset-based revolving credit facility ("Original ABL Facility" and together with the Original Term Loan, the "New Senior Secured Credit Facilities"). Pursuant to various amendments from August 2016 through October 2017, the aggregate commitment amount under the Original ABL facility was increased in stages to $175,000,000. The original maturity date for the Original ABL Facility was June 30, 2021, and the original maturity date for the Term Loan was June 30, 2022.

On February 22, 2018, the Company refinanced and replaced both the Original Term Loan and the Original ABL Facility, and entered into an Amended and Restated Term Loan Credit Agreement (the "Amended TL Agreement"), by and among the Company (as the borrower), the lenders party thereto and JPMorgan Chase Bank, N.A. ("JPMorgan"), as administrative agent and collateral agent. The Amended TL Agreement replaced the Original Term Loan with a new Term B-1 Loan ("Term B-1 Loan"). The principal amount of the Term B-1 Loan was $1,120,000,000 and such loan incurred interest at LIBOR (subject to a 1.00% floor) plus 5.50%. The Term B-1 Loan was issued with an original discount of 2.00% and was originally scheduled to mature on February 22, 2024. The Term B-1 Loan was repaid on August 23, 2019 (see Note 10).

Additionally, on February 22, 2018, the Company entered into an Amended and Restated ABL Credit Agreement (the "Amended ABL Agreement"), by and among the Company (as the borrower), the lenders party thereto and JPMorgan, as administrative agent and collateral agent. The Amended ABL Agreement replaced the Original ABL Facility. Under the Amended ABL Agreement, the maximum revolving commitment was $250,000,000 with ability to expand the facility to $325,000,000, and the new ABL facility (the "New ABL Facility") bears interest at a variable base rate plus an applicable spread that is based on excess availability under the New ABL Facility, as further described in the Amended ABL Agreement, which was 6.0% as of September 30, 2019. From January 2019 through July 2019 the Company entered into various amendments to the Amended ABL Agreement. Such amendments (i) waived certain events of default at September 30, 2018; (ii) increased the maximum revolving commitment from $250.0 million to $280.0 million, and further to $285.0 million, while simultaneously reducing and removing future expansion of the facility; (iii) introduced $40.0 million of a first in last out ("FILO") revolving facility, which incurred interest at either 2.5% or 3.5% per annum depending on whether they are Eurodollar loans or ABR loans (which were repaid on August 23, 2019); (iv) provides for a reduction in the maximum revolving commitment by $20.0 million and $10.0 million upon the future planned closure or disposition of Nix Health and EOGH, respectively. The New ABL Facility matures on February 22, 2023. As of September 30, 2019, the outstanding balance and the available balance on the New ABL facility was approximately $70.0 million and $175.6 million, respectively.

The proceeds of the Term B-1 Loans and the New ABL Facility (the "New Senior Secured Credit Facilities") were used to refinance the Original Term Loan and the Original ABL Facility, to pay a dividend of $457,000,000 to the Company's stockholders, to pay certain expenses associated with the refinancing, to prefund approximately $40,000,000 of pension liabilities of the Company's subsidiaries, to make payments to certain option holders as a result of the referenced dividend, and to finance certain working capital and other operational needs of the Company and its subsidiaries.

Under applicable accounting literature, during the year ended September 30, 2018, deferred financing costs of $11,700,000 and outstanding debt discount of $6,700,000 as of February 22, 2018 were expensed and presented within loss on debt extinguishment in the accompanying consolidated statements of operations, and new costs of approximately $18,000,000 incurred in connection with the refinancing were capitalized to offset the new long-term debt in the accompanying consolidated balance sheets, and are being amortized over the term of the related debt using the effective interest method. In connection with the repayment of the Term B-1 Loan (see Note 10), and under applicable accounting literature, during the year ended September 30, 2019, deferred financing costs of $13,444,000 and outstanding debt discount of $16,608,000 were expensed and are presented within loss on debt extinguishment in the accompanying consolidated statements of operations.

The New ABL Facility is secured by a first priority security interest on the working capital assets of the Company and its wholly-owned subsidiaries except Prospect Health Plan, Inc., CHIC, RRG, Prospect Health Access Network, Inc. and certain immaterial subsidiaries and a second priority security interest on their fixed assets. The Amended ABL Agreement does not have any financial maintenance covenants. The Amended ABL Agreement has a "springing" fixed charge ratio covenant that applies if excess availability is less than the greater of 10% of the maximum borrowing amount and $22,000,000. The fixed charge ratio covenant was not required to be tested for the fiscal quarter ended September 30, 2019.

Demand Notes

The Company has a commitment from a bank for a $15,000,000 equipment leasing facility to finance various equipment at the Company's hospital facilities. As of September 30, 2019 and 2018, draws under the facility 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 1.50% with a floor of 4.50% and payable monthly. As of September 30, 2019, approximately $15,000,000 had been drawn under the line.

Scheduled payments under the Company's current and long-term debt as of September 30, 2019 are as follows (in thousands):

Years ending September 30,	
2020	$ 18,983
2021	15,289
2022	13,140
2023	13,106
2024	13,412
Thereafter	132,420
Total scheduled payments	206,350
Less: Current maturities	(18,983)
Total long-term debt	$ 187,367

10. Transactions with MPT

On August 23, 2019, the Company closed a series of transactions with affiliates of Medical Properties Trust, Inc. ("MPT"), a publicly traded Real Estate Investment Trust ("REIT"). Under these transactions, the Company sold to MPT the Company's hospital buildings in California (excluding Foothill Regional Medical Center ("Foothill"), Connecticut and Pennsylvania for an aggregate purchase price of $1,386,000,000. Concurrent with the sale transactions, the Company entered into two master lease agreements whereby the hospital properties and related medical office buildings were leased back for an initial 15 year term, with options to extend twice for an additional 5 years each and for a further 4.75 year extension. Monthly rent is defined as 7.5% of the lease base, subject to annual escalation of consumer price index, limited to a minimum of 2% and a maximum of 4%. For the first master lease, the Company has the option to buy the properties at their fair value at the end of the lease term. For the second master lease, the Company has the option to purchase at a price that is fixed at the time of entering into the lease (the "Option Price"). If the Company chooses not to exercise this option, and the fair value at the end of the lease is below the Option Price, then the Company must pay MPT a sum equal to the difference between the fair value and the Option Price. These transactions do not qualify for sale leaseback accounting because of the Company's deemed continuing involvement with the buyer-lessor, including the requirements to pay reserves for major repairs, and the option to purchase included in the lease, which are considered a form of contingent collateral and results in the transaction being recorded under the financing method. All of the legal entities that are parties to the master lease agreement (which are the hospital entities themselves) provide cross guarantees on all of the obligations to MPT, which guarantees include both lease payments under the master lease as well as indebtedness due to MPT. The balance due under the leases is reflected in MPT liabilities in the accompanying consolidated financial statements.

Further, the Company obtained a mortgage on the Foothill property. This mortgage is secured by the buildings at Foothill. The interest on this mortgage is 7.5% per annum and is subject to annual escalation of consumer price index, limited to a minimum of 2% and a maximum of 4%. The maturity date of this loan is in August 2034. MPT can purchase the property on event of default or at end of term, or if Company does not exercise purchase rights for the aforementioned leased properties. Additionally, if the Foothill property is no longer used as collateral for a promissory note payable to Prospect Medical Group, Inc. ("PMG"), one of the Company's California Medical Groups, then MPT shall have the right to purchase the Foothill property and lease it back to the Company under the second master lease agreement, for an amount equal to the outstanding principal balance. The referenced promissory note payable to PMG has been included in the calculation of PMG's Tangible Net Equity in connection with requirements of the California Department of Managed Health Care. The balance due under the promissory note payable to MPT is reflected in long term debt in the accompanying consolidated financial statements (see Note 9).

Additionally, the Company entered into a promissory note (the "TRS Note"), under which MPT has advanced to the Company $112,937,000 related to and secured by the value of the properties in Rhode Island. The interest on this note is 7.5% per annum and is subject to annual escalation of consumer price index, limited to a minimum of 2% and a maximum of 4%. The maturity date of this note is the earlier of August 2022 or the conversion to and sale-leaseback of the properties in Rhode Island. The balance due under this note is reflected in long term debt in the accompanying consolidated financial statements (see Note 9).

All of the agreements referenced in this footnote are cross-collateralized and cross defaulted. Based on annualized Adjusted EBITDAR (as defined) achieved over the three years from the transaction date, additional amounts between $50 million to $250 million will be payable to the Company. As of September 30, 2019, there has been no accounting for these amounts in the consolidated financial statements. The proceeds from these transactions were used to pay off in full the Term B-1 Loan and to pay down the amounts outstanding under the Amended ABL Agreements (see Note 9) and the FILO facility, as well as fund a restricted cash account for the future paydown of the Company's pension liabilities and to provide working capital.

The MPT transaction documents contain certain customary covenants and restrictions and a financial covenant based on EBITDAR performance.

Interest expense under these agreements was $6,649,000 for the year ended September 30, 2019.

See Note 13 for future minimum lease payments related to sale leaseback commitments as of September 30, 2019.

11. Stockholder's Equity

Equity Based Compensation Plans

Effective December 15, 2010, the Board of Directors of Ivy Holdings adopted the Ivy Plan that initially 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). 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. Under the First Amendment, and subsequent amendments, a further 63,704 shares of common stock of Ivy Holdings ("New Options") can be issued.

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, 2019 and 2018, no compensation cost has been recorded in the Company's consolidated financial statements for the years then ended. See Note 16 for Merger Agreement that was entered into subsequent to year-end.

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, 2019 and 2018 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 October 1, 2017	168,875	$ 174.91	$ 663.09	73.4
Granted	26,516	418.21	–	–
Exercised	(22,608)	37.74	–	–
Canceled/Forfeited	(9,530)	322.72	–	–
Outstanding as of September 30, 2018 (1)	163,253	140.47	156.53	70.5
Granted	–	–	–	–
Exercised	–	–	–	–
Canceled/Forfeited	(14,233)	231.42	–	–
Outstanding as of September 30, 2019	149,020	$ 131.79	$ –	56.2

(1) The number of options outstanding at September 30, 2018 were modified in connection with the Adjusted Exercise Price of the options (see below).

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, 2019, the outstanding shares had no aggregate intrinsic value. As of September 30, 2019, there were 101,448 options that are exercisable at a weighted average exercise price of $47.23.

A summary of Ivy Holdings non-vested options and the changes during the fiscal years ended September 30, 2019 and 2018 is presented as follows for the Initial Options and New Options:

	Shares	Weighted Average Grant Date Fair Value
Ivy Holdings Stock Options:		
Nonvested at October 1, 2017	34,364	$ 225.09
Granted	26,516	188.98
Vested	(17,054)	269.50
Canceled/Forfeited	(9,530)	206.09
Nonvested at September 30, 2018	34,296	181.07
Granted	—	—
Vested	—	—
Canceled/Forfeited	(1,876)	200.11
Nonvested at September 30, 2019	32,420	$ 179.97

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.

There were no options granted during the year ended September 30, 2019. Fair value for options granted during the year ended September 30, 2018 was estimated with the following assumptions for Ivy Holdings:

September 30,	2018
Weighted average fair value of option grants	$ 188.98
Estimated fair market value of the Company's common stock on the date of grant	$ 390.14
Weighted average expected life of the options	5 years
Risk-free interest rate	0.85%
Weighted average expected volatility	60.0%
Dividend yield	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, 2019 and 2018 was $0 and $710,000, respectively. At September 30, 2019, there were no unvested options, which could potentially vest over the next nine fiscal years, subject to meeting the vesting requirements noted above. There were no remaining maximum estimated stock compensation expense to be amortized to expense in future periods. 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, 2019 and 2018.

Contributions

On January 25, 2019 and on February 6, 2019, Ivy Holdings made equity contributions in the amount of $40,000,000 and $1,000,000, respectively, to Ivy Intermediate Holding Inc., which was then contributed as equity to the Company.

Dividends

On February 22, 2018, the Board of Directors of Ivy Holdings, Inc. (the "Board") approved special cash in the amount of approximately $33,000,000 in bonus payments were made ("the Bonuses") to Option Holders in connection with the dividend provided that any Bonus with respect to an unvested portion of an option shall be payable upon the date such unvested portion becomes vested and exercisable, subject to the Optionee's continued employment with Prospect through such date. At September 30, 2019 and 2018, approximately $2,300,000 was accrued for bonuses in connection with this. To reflect the Dividend and pursuant to the terms of the Option Plan, the Board further resolved to equitably adjust the Options by reducing the per-share exercise price of the Options to an amount determined with reference to the Bonus amount payable by Prospect Medical with respect to such Option (the "Adjusted Exercise Price").

The Company distributed approximately $456,930,000 in connection with the issuance of "New Senior Secured Credit Facilities" during the year ended September 30, 2018, which was recorded against retained earnings, and was ultimately paid to the common stockholders of Ivy Holdings, Inc. (see Note 9).

The Company distributed approximately $44,407,000 during the year ended September 30, 2019, which was recorded against accumulated deficit.

12. Retirement Benefits

The Company sponsors various employee non-contributory, defined benefit pension plans covering certain full-time employees of Crozer, ECHN and Prospect Waterbury, Inc. ("Waterbury").

In connection with the acquisition of Crozer, $100 million of the purchase price was put into an escrow and subsequently used by the Company, as the new sponsor of the Crozer pension plan ("DB Plan") pursuant to IRS rules and regulations, to fund in part the underfunded plan liability then outstanding. Additionally, within five years after acquisition and subject to applicable filing and authorization by the applicable government agency or entity, the Company will adopt a plan amendment to terminate the plan effective within such five year period and will liquidate, fully fund and satisfy, and pay all benefits owed to participants and beneficiaries of the plan by providing lump sum distributions to participants, purchasing annuities for participants who do not elect a lump sum distribution.

Also, in connection with the Crozer acquisition, the plan was frozen with all benefit accruals ceased as of July 1, 2016. With respect to each Represented Employee who is a member of the Laborers' International Union of North America, the Monthly Compensation (as defined), the Credited Service (as defined), the Eligibility Service (as defined) and the accrued benefit was frozen and determined as of July 1, 2016. No benefits accrue since that date. Additionally, the plan was amended to provide that for purposes of determining Vesting Service (as defined) for employees who were employed with the Company before July 1, 2016, years of service shall include all periods of employment completed on and after July 1, 2016, subject to the Break in Service rules (as defined).

On September 3, 2016, the DB Plan was further amended to provide certain Qualifying Participants (as defined) the right to make a Special Benefit Election (as defined) during "2016 Lump Sum Option Window" period from October 15, 2016 through November 30, 2016 to receive or commence receiving his or her vested Accrued Benefit as of December 1, 2016 in accordance with procedures adopted by the Committee.

In conjunction with the acquisition the Company also became the sponsor and assumed CKHS postretirement benefit program (the "OPEB Plan") which is an unfunded medical care and life insurance benefit program, and a supplemental executive retirement plan (the "SERP Plan") which is an unfunded retirement plan that covers a group of current and former executives. These plans were frozen with all benefit accruals ceased as of July 1, 2016. No benefits will accrue since that date. With respect to each Represented Employee who is a member of the Laborers' International Union of North America, benefits will continue to accrue until a settlement of an ongoing union contract negotiation is reached.

ECHN has a defined benefit pension plan that covered substantially all of its employees. The benefits were based upon years of service and compensation for the five highest years during the employee's last 10 years of service. Effective December 31, 2013, ECHN froze the defined-benefit for all remaining participants. During September 2013, the Board passed a resolution to freeze all benefits related to the

Defined benefit pension plan. On December 31, 2008, ECHN implemented a soft freeze on the defined benefit pension plan. All qualified employees were eligible to enter into the defined contribution plan, ECHN contributed 3% of eligible employees' salaries. This contribution was non-guaranteed for all employees, except certain union workers covered under a collective bargaining agreement.

ECHN also sponsors a postretirement benefit plan that provides health care benefits to those employees who retired. The criteria to receive this benefit is to be vested in the pension plan, attain age 55 or older and start collecting under the defined benefit plan described above once retired. The retiree must be enrolled into the medical plan on the date of retirement to be eligible for the continuation. Full-time registered nurse retirees from ECHN's Manchester facility (retired prior to October 1, 2005 and were eligible per the collective bargaining agreement) were grandfathered and required to pay at least 50% of the total cost of the medical and dental coverage they elect for themselves under the plan.

Waterbury has a noncontributory defined benefit cash balance plan. It is Waterbury's policy to make contributions to the plan sufficient to meet the minimum funding requirements of applicable laws and regulations. The plan was frozen to non-union participants effective June 30, 2015. Participants who are part of the Connecticut Healthcare Associates Technical Unit remain active in the plan. Non-union employees no longer accrue additional employer contribution credits in the plan. These participants will continue to receive interest credits based on their account balances in accordance with the terms of the plan. They will be entitled to their account balance (the retirement benefit they have earned up to June 30, 2015) plus applicable interest credits after the Plan were frozen.

The activity of the pension plans for the years ended September 30, 2019 and 2018 is as follows (in thousands):

September 30,	*2019*	*2018*
Changes in benefit obligations		
Projected benefit obligations, beginning of period	$ 660,176	$ 864,293
Service cost	181	194
Interest cost	28,432	27,695
Plan participant contributions	918	461
Actuarial loss	115,016	(48,654)
Benefits paid	(20,482)	(134,185)
Lump sum benefits paid and annuity purchase	(15,606)	(49,628)
Plan changes	(21)	-
Projected benefit obligation, end of year	$ 768,614	$ 660,176
Changes in plan assets		
Fair value of plan assets, beginning of year	$ 400,468	$ 556,590
Actual return on plan assets	80,668	(14,437)
Contributions by plan sponsor	15,939	41,667
Plan participant contributions	327	461
Benefits paid	(21,108)	(134,185)
Lump sum benefits paid and annuity purchase	(15,606)	(49,628)
Fair value of plan assets, end of year	$ 460,688	$ 400,468
Funded status of the plan, end of year	$ (307,926)	$ (259,708)
Accumulated benefit obligation, end of year	$ (307,926)	$ (259,708)

The funded status of the pension plans as of September 30, 2019 and 2018 is as follows (in thousands), split between the pension plans and the post retirement plans:

	2019 Pensions	2019 OPEBs	2019 Total	2018 Pensions	2018 OPEBs	2018 Total
Current liability	$ -	$ 500	$ 500	$ -	$ 600	$ 600
Non-current liability	302,372	5,054	307,426	254,121	4,987	259,108
	$ 302,372	$ 5,554	$ 307,926	$ 254,121	$ 5,587	$ 259,708

The components of net periodic benefit cost for the years ended September 30, 2019 and 2018 are as follows (in thousands):

September 30,	2019	2018
Components of net periodic benefit cost:		
Service cost	$ 181	$ 194
Interest cost	28,432	27,695
Expected return on plan assets	(11,154)	(16,045)
Effect of settlement	-	1,457
Amortization of prior service credit	(48)	(48)
Total net periodic benefit cost	$ 17,411	$ 13,253
Other change in benefit obligations recognized in accumulated other comprehensive income:		
(Gain) Loss due to assumption change	$ 111,382	$ (64,429)
Loss due to participant experience	4,849	14,118
Amortization of net loss	63	-
Asset return (gain) loss	(70,275)	30,483
Prior service cost	28	-
Total recognized in other comprehensive loss (income) and accumulated other comprehensive loss (income)	$ 46,047	$ (19,828)

The remainder of this page intentionally left blank.

The assumptions used in determining the actuarial present value of the projected benefit obligations for pension plans as of September 30, 2019 and 2018 and for the years ended September 30, 2019 and 2018 are as follows:

	2019	2018
Weighted average assumptions used to determine benefit obligations at end of period		
Discount rate	**2.92-3.31%**	3.23-4.48 %
Rate of compensation increase	**0.00-2.00%**	0.00-2.00 %
Weighted average assumptions used to determine net periodic benefit cost for the period ended		
Discount rate	**4.24-4.48%**	3.49-4.41 %
Rate of compensation increase	**0.00-2.00%**	0.00-2.00 %
Expected return on the plan assets	**0.00-4.50%**	0.00-4.50 %

Assumed health care cost trend rates for the next period used to measure the expected cost of benefits covered by the plan are as follows:

	2019	2018
Health care trend rate assumed for next year	**6.75%**	7.00%
Rate to which the cost trend is assumed to decline (the ultimate rate)	**4.50%**	4.50%
Year that the rate reaches the ultimate trend rate	**2027**	2026

Assumed health care cost trend rates have a significant effect on amounts reported for other postretirement benefit programs. A one-percentage-point change in assumed health care cost trends would have the following effects (in thousands):

	1% Increase	1% Decrease
Effect on other postretirement benefit obligations	$95	$87
Effect on total of service and interest cost components	$3	$3

The asset allocation percentage by major asset class for the plans and the target allocation for 2019 follows:

	Target	2019
Asset class:		
Cash and cash equivalents	0% - 20%	1 %
Fixed income	10% - 100%	95 %
Domestic equity	0% - 100%	
International equity	0% - 40%	
Real estate	0% - 30%	
Alternative investments and hedge funds	0% - 30%	4 %
		100 %

The investment objectives of the plans are to invest consistently with the fiduciary standards of ERISA, to provide for the funding and anticipated withdrawals on an ongoing basis, conserve and enhance the capital value of the plans in real terms while maintaining a moderate risk profile, to minimize principal fluctuations over the investment cycle, and achieve a long-term level of return commensurate with contemporary economic conditions. The expected long-term rate of return with respect to the plans is based on an aggregate of expected capital market returns within each asset category.

The following tables set forth the assets in the plans measured at fair value, by input level (in thousands):

September 30, 2019	**Level 1**	**Level 2**	**Level 3**	**Net asset value**	**Total**
Fixed income securities:					
Short-Term Duration	$ -	$ 36,534	$ -	$ -	$ 36,534
Extended Duration	-	172,610	-	-	172,610
Interim Duration	-	48,328	-	-	48,328
Long-Term Duration	-	181,570	-	-	181,570
Real estate	-	-	1,056	-	1,056
Alternative investments	-	-	17,809	-	17,809
Cash and cash equivalents	-	-	-	2,781	2,781
Total	$ -	$ 439,042	$ 18,865	$ 2,781	$ 460,688

September 30, 2018	Level 1	Level 2	Level 3	Net asset value	Total
Fixed income securities:					
Short-Term Duration	$ -	$ 35,100	$ -	$ -	$ 35,100
Extended Duration	-	125,562	-	-	125,562
Interim Duration	-	41,193	-	-	41,193
Long-Term Duration	-	174,162	-	-	174,162
Real estate	-	-	2,962	-	2,962
Alternative investments	-	-	18,593	-	18,593
Cash and cash equivalents	-	-	-	2,896	2,896
Total	$ -	$ 376,017	$ 21,555	$ 2,896	$ 400,468

Pension plan assets classified as Level 3 in the fair value hierarchy represent investments in which the trustee has used significant unobservable inputs in the valuation model. The hedge funds consist of equity/long/short funds and multi-strategy funds in which fair values have been estimated using the net asset value per share of the investment. The alternative investments primarily consist of investments in limited partnerships that invest in the Public-Private Investment Program which fair values have been estimated using the net asset value per share of the investment.

On an annual basis, the Company assesses the valuation hierarchy for pension assets recorded at fair value. From time to time, assets will be transferred within the fair value hierarchy as a result of changes in, among other things, inputs used, liquidity, or valuation methodologies. During the years ended September 30, 2019 and 2018, there were no transfers in classification within the fair value hierarchy.

The following table is a rollforward of the plans' assets classified within Level 3 of the fair value hierarchy (in thousands):

September 30,	2019	2018
Balance, beginning of year	$ 21,555	$ 23,742
Actual return on plan assets:		
Realized loss	-	-
Unrealized (loss) gain	(2,690)	(2,187)
Purchases	-	-
Sales	-	-
Balance, end of year	$ 18,865	$ 21,555

The expected long-term future benefit payments to retirees with respect to the plans and are as follows (in thousands):

2020	$ 44,970
2021	40,450
2022	41,940
2023	42,760
2024	43,750
2025 - 2029	216,990
	$ 430,860

Waterbury participates in multi-employer pension plans that cover substantially all union employees. Contributions to the plans are based upon a percentage of each participant's total salary. The risks of participating in these multi-employer plans are different from single employer plans in the following aspects:

- Assets contributed to the multi-employer plan by one employer may be used to provide benefits to employees of another participating employer.
- If a participating employer stops contributing to the plan, the unfunded obligation of the plan may be borne by the remaining participating employers.
- If Waterbury chose to stop participating in the multi-employer plans, Waterbury may be required to pay those plans an amount based on the underfunded status of the plans, referred to as a withdrawal liability.

The following table presents Waterbury's participation in these plans as of and for the years ended September 30, 2019 and 2018.

Pension Trust Fund	EIN / Pension Plan	Pension Protection Act ("PPA") Certified Zone Status *(1)* 2019	Pension Protection Act ("PPA") Certified Zone Status *(1)* 2018	FIP / RP Status Pending / Implemented *(2)*	Contributions 2019	Contributions 2018	Surcharge Imposed	Exp. Date of CBA
Connecticut Health Care Associates Pension Fund	06-1313462	Red	Red	Implemented	$2,122,000	$2,140,000	No	7/1/22
New England Health Care Employees Pension Fund	22-3071963	Green	Green	NA	754,000	821,000	No	3/15/21
Total contributions					$2,876,000	$2,961,000		

(1) The most recent PPA zone status available in 2019 is for the plan's year-ending during 2018. The zone status is based on information received from the plan and is certified by the plan's actuary. Among other factors, plans in the red zone are generally less than 65 percent funded, plans in the orange zone are less than 80 percent funded and have an accumulated funding deficiency in the current year or projected in the next six years, plans in the yellow zone are less than 80 percent funded, and plans in the green zone are at least 80 percent funded.

(2) The "FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan ("FIP") or a rehabilitation plan ("RP") is either pending or has been implemented. As it relates to the Connecticut Health Care Associates ("CHCA") Pension Plan, the trustees adopted a Rehabilitation Plan on May 7, 2018. The Rehabilitation Period, as defined, commenced on January 1, 2019 and ends on December 31, 2028. The trustees updated the Rehabilitation Plan on December 12, 2019 which reflects various reductions to plan benefits effective January 1, 2020.

During the years ended September 30, 2019 and 2018, Waterbury's contributions to the CHCA Pension Plan and the New England Health Care Employees Pension Plan represented 98.1% and 2.4% and 98.2% and 2.6% of the total contributions made to the plans by all participating employers, respectively.

Governmental regulations impose certain requirements relative to union-sponsored pension plans. In the event of plan termination or employer withdrawal, an employer may be liable for a portion of the plan's unfunded vested benefits. As of September 30, 2019, Waterbury has not recorded any liabilities for future withdrawal obligations related to the multi-employer plans.

Defined contribution plans

The Company previously sponsored five defined contribution plans covering substantially all employees who meet certain eligibility requirements. Effective May 1, 2018, the plans covering employees at ECHN, Waterbury and Crozer were merged into the plan covering employees at CharterCARE, and the two remaining plans were renamed and segregated between union and non-union employees. 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 certain facilities in Rhode Island and Pennsylvania, for which the expense for the employer match was $18,863,000 and $19,723,000 for the years ended September 30, 2019 and 2018, respectively.

13. 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 2034. 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 2.5% to 41.0% per annum.

The future minimum annual lease payments required under leases in effect at September 30, 2019, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases	MPT Liability*
2020	$ 12,661	$ 22,455	$ 103,935
2021	9,157	18,685	106,273
2022	4,903	16,987	109,461
2023	4,018	14,195	112,745
2024	2,889	12,887	116,128
Thereafter	19,855	56,273	1,358,111
Total minimum lease payments	53,483	$ 141,482	1,906,653
Less: amounts representing interest	(12,873)		(572,644)
Add: amounts representing land	-		47,176
	40,610		1,381,185
Less: current portion	(10,238)		(43,145)
	$ 30,372		$ 1,338,040

* *Excludes debt related to the Foothill and TRS Notes entered into in fiscal 2019 with MPT (see Note 10).*

Rent expense related to operating leases for the years ended September 30, 2019 and 2018 was approximately $44,959,000 and $46,124,000, respectively. Sublease rental income was not material to the consolidated financial statements for the years ended September 30, 2019 and 2018.

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.

Seismic Standards

The Company's California Hospitals (with the exception of Bellflower, which currently only provides psychiatric services) are required to comply with laws that regulate the seismic performance of all aspects of hospital facilities in California and imposes near-term and long-term compliance deadlines for seismic safety assessment, submission of corrective plans, and retrofitting or replacement of medical facilities to comply with current seismic standards. These laws and regulations require hospitals to meet seismic performance standards to ensure that they are capable of providing medical services to the public after an earthquake.

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. Two buildings at Southern California Hospital at Culver City ("SCH Culver City") and one building at Los Angeles Community Hospital ("LACH") do not currently meet the applicable seismic requirements. The three buildings are currently classified at Structural Performance Category 1 ("SPC-1") and, subject to possible deadline extensions discussed below, they must be upgraded to at least SPC-2 by January 1, 2020. That deadline date was set pursuant to an extension granted upon the Company's application submitted in accordance with California Senate Bill 90 (SB 90) and approved by the Office of Statewide Health Planning and Development ("OSHPD").

OSHPD has a voluntary program to re-evaluate the seismic risk of hospital buildings classified as SPC-1. These buildings are considered hazardous and at high 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 the applicable deadline. OSHPD is using Hazards U.S. ("HAZUS"), a state-of-the-art methodology, to reassess the seismic risk of SPC-1 buildings. Once the SPC-1 buildings have been seismically upgraded to SPC-2, they are no longer considered a significant risk to occupants, but they may not be repairable or functional after an earthquake. Participation in the HAZUS program is optional for hospital owners wishing to have their SPC-1 buildings evaluated.

Applications for HAZUS evaluation of seismic risk were submitted for all five of the Company's California acute care facilities: Southern California Hospital at Hollywood ("SCH Hollywood"); SCH Culver City; Los Angeles Community Hospital; Los Angeles Community Hospital at Norwalk ("LACH Norwalk"); and Foothill. All buildings at these five facilities obtained SPC-2 reclassification using HAZUS, except for the aforementioned three buildings at SCH Culver City and LACH which are still classified as SPC-1. Currently, failure to obtain SPC-2 reclassification for the three remaining SPC-1 buildings by January 1, 2020 would mean that the buildings would not be allowed to provide acute care services starting on that date.

Recently enacted Assembly Bill 2190 (AB-2190) was utilized to request additional extension. OSHPD granted extensions to 06/01/2022, 10/01/2021, and 02/01/2021 for Tower Building (at SCH Culver City), Pavilion Building (at SCH Culver City), and LACH respectively. For all three buildings, the construction must start by April 1, 2020 for AB-2190 extensions to be valid. SCH-Culver City is evaluating pursuing an alternate "replacement" scheme that would relocate the Emergency department into the adjoining One-Story Building which currently classified as an SPC-2 structure. The Tower Building would be retained as a 'non-hospital' OSHPD building useable for lower acuity services such as behavioral health and subacute/skilled nursing services.

The Company will also be required to make significant capital expenditures in the future to comply with 2030 seismic standards (i.e., upgrade to SPC-4D and NPC-4D/5) for any buildings that will be utilized for hospital facilities beyond January 1, 2030. Such modifications to the hospital facilities could potentially result in environmental remediation liabilities which may be material to the Company.

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, states have also developed their own standards for the privacy and security of health information as well as for reporting certain violations and breaches (for example, California's Confidentiality of Medical Information Act and Lanterman-Petris Short Act) which in some cases are more stringent. Other federal privacy laws may also apply to certain services provided by the Company, including 42 C.F.R. Part 2, which addresses the confidentiality of substance use disorder records. 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") has made significant changes to the United States health care system. The legislation impacted multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Under this legislation, 33 states have expanded their Medicaid programs to cover previously uninsured childless adults, and four additional states voted in 2018 to expand Medicaid or to elect a governor that pledged to expand Medicaid. In addition, many uninsured individuals have had the opportunity to purchase health insurance via state-based marketplaces, state-based marketplaces using a federal platform, state-partnership marketplaces or the federally-facilitated marketplace. PPACA also implemented a number of health insurance market reforms, such as allowing children to remain on their parents' health insurance until age 26 or prohibiting certain plans from denying coverage based on pre-existing conditions. Nationally, these reforms have reduced the number of uninsured individuals.

It is unclear what changes may be made to PPACA with the divided Congress, current presidential administration, and pending litigation over the validity of PPACA. The Administration has promulgated rules to broaden the availability of coverage options that do not comply with the full range of PPACA requirements for individual market coverage, namely Association Health Plans and Short-Term Limited-Duration Insurance. The Administration has also provided additional guidance on state PPACA waivers. These executive actions have been or may be challenged in court. In addition, the Tax Cuts and Jobs Act ("TCJA"), passed in December 2017, eliminates the individual mandate penalty under PPACA, effective January 1, 2019. The individual mandate penalty was included in PPACA to address concerns that other market reforms expanding access to coverage might produce adverse selection and higher premiums. The extent to which the repeal of the individual mandate penalty will impact the uninsured rate and future premiums are unclear at this juncture. On December 14, 2018, the United States District Court for the Northern District of Texas ruled that the individual mandate without the penalty is unconstitutional and that PPACA is therefore invalid in its entirety. Litigation on this issue is ongoing, with a decision pending from a panel of the United States Court of Appeals for the Fifth Circuit following oral arguments in July 2019. This litigation along with any future legislative changes to PPACA or other federal and state legislation could have a material impact on the operations of the Company. The Company is continuing to monitor the legislative environment and developments in pending litigation for risks and uncertainties.

Collective Bargaining Agreements

As of September 30, 2019, the Company had approximately 17,800 employees, of whom approximately 5,500 employees or 31% are represented by various labor organizations. Of those, approximately 1,300 employees or 7% of the Company's employees are employed under union contracts that have expired or will expire before September 30, 2020.

Tangible Net Equity ("TNE") Requirement

The Company's affiliated California physician organizations and licensed healthcare service plans may be subject to one or more of the following requirements: minimum working capital, Tangible Net Equity, cash-to-claims ratio and claims payment requirements as prescribed by the California Department of Managed Health Care ("DMHC"). TNE is defined as net assets, less intangibles and amounts due from affiliates, plus subordinated obligations. As of September 30, 2019, the Company's affiliated California physician organizations were in compliance with these regulatory requirements.

Employee Health Plans

The Company offers self-insured EPO/HMO and PPO plans to 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). Prior to January 1, 2018, commercial insurance policies covered per occurrence losses. Effective January 1, 2018, all locations were covered by insurance policies with CHIC for per occurrence losses in excess of $350,000, except for Crozer for which the limit is $750,000. CHIC maintains reinsurance coverage above $500,000 for all locations except for Crozer, for which the limit is $750,000. An actuarially and internally-estimated liability of approximately $12,808,000 and $16,566,000 for incurred but not reported claims has been included in accrued salaries, wages, and benefits as of September 30, 2019 and 2018, 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.

14. 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 years ended September 30, 2019 and 2018 (in thousands):

September 30,	2019	2018
IBNR as of beginning of year	$ 62,887	$ 53,510
Claim expenses incurred during the year:		
Related to current year	296,817	301,598
Related to prior year	4,523	8,667
Total incurred	301,340	310,265
Claims paid during the year:		
Related to current year	(229,417)	(246,369)
Related to prior year	(62,302)	(54,519)
Total paid	(291,719)	(300,888)
IBNR as of end of year	$ 72,508	$ 62,887

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,	2019	2018
Capitation expense	$ 98,254	$ 96,027
Fee-for-service claims expense	167,702	171,443
Other physician compensation	24,561	15,097
Other cost of revenues	2,558	5,239
Total cost of revenues	$ 293,075	$ 287,806

15. Joint Ventures and Unconsolidated Equity Investments

The Company has invested in several joint ventures with unrelated third parties, which are accounted for under the equity method of accounting. As of September 30, 2019 and 2018, CharterCARE owned: 20% of Roger Williams Radiation Therapy and 20% of Southern New England Regional Cancer Center, LLC. ECHN owned: 50% of NRRON, LLC; 50% of Aetna Ambulance Service, Inc.; 50% of Ambulance Service of Manchester, LLC; and 50% of Evergreen Endoscopy Center, LLC. Waterbury owned: 50% of Harold Leever Regional Cancer Center Inc. Crozer owned: 50% of University Technology Park, Inc. and 21.25% of Delaware Valley Sleep Management Company, LLC. Prospect Medical Group, Inc. owned: 50% of AMVI/Prospect Medical Group. These joint ventures under the equity method are included in the other assets in the accompanying consolidated balance sheets as of September 30, 2019 and 2018 are $28,119,000 and $24,627,000, respectively. For the years ended September 30, 2019 and 2018, the Company received $1,828,000 and $1,746,000, respectively, in distributions for equity method investments, and $527,000 and $404,000, respectively, for cost method investments.

Summarized combined unaudited financial information for the Company's joint ventures as of September 30, 2019 and 2018 and for the years then ended is as follows (in thousands):

September 30,	2019	2018
Cash	$ 18,976	$ 17,226
Receivables	10,096	8,060
Other current assets	21,329	23,654
Total current assets	50,401	48,940
Property, improvements and equipment, net	32,972	33,757
Goodwill	7,142	7,142
Intangible assets	821	852
Other long-term assets	2,904	3,094
Total assets	94,240	93,785
Accounts payable and accrued liabilities	5,827	5,563
Other long-term liabilities	6,116	5,334
Equity	82,297	82,888
Total liabilities and partner's capital	$ 94,240	$ 93,785

Years ended September 30,	2019	2018
Revenues	$ 74,095	$ 67,554
Net income	$ 12,178	$ 5,039
PMH's income from equity method investments	$ 5,358	$ 1,332

16. Subsequent Events

The Company has evaluated subsequent events through December 20, 2019, the date the Company's consolidated financial statements were available for issuance.

Effective October 2, 2019, Ivy Holdings entered into an Agreement and Plan of Merger ("Merger Agreement") with Chamber, Inc. ("Chamber"), Chamber Merger Sub, Inc. and affiliates of LGP. Chamber is owned by two individuals who hold the largest individual shareholdings in Ivy Holdings. The Merger Agreement contemplates, among other things, (i) the purchase of Ivy Holdings by and merger into by Chamber Merger Sub, Inc. (ii) the buyout of all of the other current stockholders of Ivy Holdings, (iii) the termination of all options that have not previously been exercised. The Merger Agreement is subject to regulatory approval by various state agencies and is expected to close during the year ended September 30, 2020.

Prospect CharterCARE, LLC

Consolidated Financial Statements
As of and for the Years Ended
September 30, 2019 and 2018

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 CharterCARE, LLC

Consolidated Financial Statements

As of and for the Years Ended September 30, 2019 and 2018

Contents

	Page
Independent Auditor's Report	3
Consolidated Financial Statements	
Consolidated Balance Sheets	4 - 5
Consolidated Statements of Operations	6
Consolidated Statements of Members' Equity	7
Consolidated Statements of Cash Flows	8
Notes to Consolidated Financial Statements	9 - 27

BDO

Tel: 714-957-3200
Fax: 714-957-1080
www.bdo.com

600 Anton Blvd., Suite 500
Costa Mesa, CA 92626

Independent Auditor's Report

Board of Directors
Prospect CharterCARE, LLC
Los Angeles, California

We have audited the accompanying consolidated financial statements of Prospect CharterCARE, LLC, (the "Company") which comprise the consolidated balance sheets as of September 30, 2019 and 2018, and the related consolidated statements of operations, members' equity, 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 audit 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 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 CharterCARE, LLC and its subsidiaries as of September 30, 2019 and 2018, 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.

Emphasis of Matter

As discussed in Note 1, the Company is financially dependent on its parent company which has agreed to provide the financial support necessary for the operations of the Company. The accompanying financial statements do not reflect any adjustments or disclosures that would be required should the parent company discontinue its financial support.

BDO USA, LLP

February 6, 2020

Prospect CharterCARE, LLC

Consolidated Balance Sheets
(in thousands)

September 30,		2019		2018
Assets				
Current assets				
Cash and cash equivalents	$	-	$	-
Restricted cash		**174**		433
Patient accounts receivable, less allowance for doubtful accounts of $17,871 and $11,141		**49,713**		46,076
Other receivables		**2,895**		3,306
Due from government payers		**5,531**		5,533
Inventories		**5,974**		5,590
Prepaid expenses and other current assets		**3,812**		2,188
Total current assets		**68,099**		63,126
Property, improvements and equipment, net		**60,918**		59,780
Intangible assets, net		**19**		1,211
Equity method investments		**3,675**		4,088
Other assets		**1,970**		2,302
Total assets	$	**134,681**	$	130,507

See accompanying notes to consolidated financial statements.

Prospect CharterCARE, LLC

Consolidated Balance Sheets
(in thousands)

September 30,		2019		2018
Liabilities and Members' Equity				
Current liabilities				
Accounts payable and other accrued liabilities	$	**33,382**	$	35,590
Accrued salaries, wages and benefits		**18,150**		17,696
Deferred revenue		**170**		170
Due to government payers		**4,900**		4,796
Due to affiliated companies, net		**16,694**		26,377
Current portion of capital leases		**49**		798
Total current liabilities		**73,345**		85,427
Capital leases, net of current portion		**43**		92
Asset retirement obligations		**3,123**		2,623
Deferred revenue, net of current portion		**1,484**		2,270
Other long-term liabilities		**10,964**		12,674
Total liabilities		**88,959**		103,086
Commitments and contingencies				
Members' equity				
Member contributions		**120,105**		92,108
Accumulated deficit		**(74,383)**		(64,687)
Total members' equity		**45,722**		27,421
Total liabilities and members' equity	$	**134,681**	$	130,507

See accompanying notes to consolidated financial statements.

Prospect CharterCARE, LLC

Consolidated Statements of Operations
(in thousands)

For the Years Ended September 30,	2019	2018
Revenues		
Net patient service revenues	$ 362,109	$ 354,578
Provision for bad debts	(14,290)	(12,598)
Net patient service revenues less provision for bad debts	347,819	341,980
Other non-patient Hospital revenues	8,879	8,102
Total net revenues	356,698	350,082
Operating Expenses		
Salaries, wages and benefits	189,268	196,794
Supplies	61,933	62,507
Taxes and licenses	22,911	22,309
Purchased services	29,817	24,125
Depreciation and amortization	15,048	15,096
Professional fees	16,545	10,988
Other	3,461	11,287
Insurance	4,091	4,620
Management fees	7,395	7,298
Utilities	5,159	4,771
Lease and rental	5,185	5,438
Research grant expense	2,626	2,503
Repairs and maintenance	1,702	2,675
Registry	699	887
Total operating expenses	365,840	371,298
Operating income from unconsolidated equity method investments	560	589
Operating loss	(8,582)	(20,627)
Other expense (income):		
Interest expense	1,023	955
Goodwill impairment	-	14,228
Other expense (income), net	-	282
Total other (income) expense, net	1,023	15,465
Net loss from continuing operations	(9,605)	(36,092)
Loss from discontinued operations	(91)	(101)
Net loss	$ (9,696)	$ (36,193)

See accompanying notes to consolidated financial statements.

Prospect CharterCARE, LLC

Consolidated Statements of Members' Equity
(in thousands)

	Member Contributions	Accumulated Deficit	Total Members' Equity
Balance at October 1, 2017	$ 82,261	(28,494)	$ 53,767
Member contributions	9,847	-	9,847
Net loss	-	(36,193)	(36,193)
Balance at September 30, 2018	92,108	(64,687)	27,421
Member contributions	27,997	-	27,997
Net loss	-	(9,696)	(9,696)
Balance at September 30, 2019	$ 120,105	$ (74,383)	$ 45,722

See accompanying notes to consolidated financial statements.

Prospect CharterCARE, LLC

Consolidated Statements of Cash Flows
(in thousands)

For the Years Ended September 30,	2019	2018
Operating activities		
Net loss	$ (9,696)	$ (36,193)
Adjustments to reconcile net loss to net cash (used in) provided by operating activities:		
Depreciation and amortization	14,292	15,094
Provision for bad debts	(14,290)	12,598
Accretion of interest for asset retirement obligations	756	185
Undistributed earnings from equity method investments	(560)	(589)
Goodwill impairment	-	14,228
Write-off of investment	-	280
Changes in operating assets and liabilities, net of business combinations:		
Change in restricted cash	259	2,595
Patient accounts receivables	10,653	(16,247)
Due to/from government payers, net	106	(99)
Inventories	(384)	215
Prepaid expenses, other receivables and other current assets	(1,213)	2,704
Other assets	332	(829)
Accounts payable and other accrued liabilities	(5,163)	10,381
Net cash (used in) provided by operating activities	(4,908)	4,323
Investing activities		
Purchases of property, improvements and equipment	(9,926)	(8,973)
Cash distributions from equity investments	973	578
Cash paid for acquisitions, net of cash received	-	(736)
Net cash used in investing activities	(8,953)	(9,131)
Financing activities		
Increase in due to affiliated companies, net	14,659	6,288
Repayments of capital leases	(798)	(1,480)
Net cash provided by financing activities	13,861	4,808
Change in cash and cash equivalents	-	-
Cash and cash equivalents, beginning of year	-	-
Cash and cash equivalents, end of year	$ -	$ -
Supplemental disclosure of cash flow information		
Interest paid	$ 1,019	$ 955
Schedule of non-cash investing and financing activities		
Accrual of property, improvements and equipment	$ 4,322	$ -
Non-cash acquisitions	$ -	$ 7,692
Non-cash contributions (Note 6)	$ 27,997	$ 9,847

See accompanying notes to consolidated financial statements.

1. Organization

Prospect CharterCARE, LLC ("PCC" or the "Company") is owned 85% by Prospect East PMH, Inc. ("Prospect East"), a wholly-owned subsidiary of Prospect Medical PMH, Inc. ("Prospect" or "PMH") and 15% by CharterCARE Community Board.

The Company provides a comprehensive range of services at Roger Williams Medical Center ("RWMC") and Our Lady of Fatima Hospital ("Fatima" or "SJHRI").

Admitting physicians are primarily practitioners in the local area. The hospitals have payment arrangements with Medicare, Medicaid and other third-party payers, including commercial insurance carriers, health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs"). A School of Nursing (the "School") was operated out of the Hospital locations. As of September 30, 2019, the School has been closed.

At September 30, 2019, the Company had negative working capital in the amount $5,077,000. The Company is dependent on Prospect to fund ongoing operations. As of September 30, 2019, the Company had a liability of $16,694,000 due to Prospect and its subsidiaries, which is payable on demand, does not bear interest, and is included in due to affiliated companies, net in the accompanying consolidated balance sheets. Prospect does not intend to have the Company repay the liability in a manner which would impair the Company's ability to maintain sufficient liquidity to sustain ongoing operations. During the year ended September 30, 2019, Prospect converted approximately $24,700,000 of liabilities into a capital contribution.

2. Significant Accounting Policies

Principles of Consolidation and 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 wholly-owned subsidiaries, but do not include the accounts of the parent companies, Prospect or CharterCARE Community Board.

Operating results for the Company's subsidiaries are consolidated with the Company's financial statements from their acquisition dates. All significant intercompany balances and transactions have been eliminated in consolidation.

Revenues

Net Patient Service Revenues

Operating revenue consists primarily of net patient service revenues. The Company reports net patient service revenues 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, 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 doubtful accounts and exclude revenues for discontinued operations (in thousands):

For the Years Ended September 30,	2019	2018
Medicare	$ 151,701	$ 165,882
Medicaid	86,573	74,710
Managed Care	82,955	80,605
Self-Pay/Other	40,880	33,381
Total	$ 362,109	$ 354,578

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 persons with end-stage renal disease and certain other beneficiary categories, including eligible disabled persons. Most inpatient hospital services rendered to Medicare program beneficiaries are paid on a fee-for-service basis at prospectively determined rates per discharge, according to a patient classification system based on clinical, diagnostic, and other factors. Most outpatient services also are paid on a fee-for-service basis generally using prospectively determined rates. The Company receives, as appropriate, Medicare disproportionate share hospital ("DSH") and bad debt payments at tentative rates, with final settlement determined after submission of the annual Medicare cost report and audit thereof by the Medicare Administrative Contractor. The Company also receives, as appropriate, Medicare uncompensated care DSH payments, which are generally not subject to cost report audit except to determine eligibility for Medicare DSH. The Company also receives Medicare outlier payments on an ongoing basis during the year for cases that are unusually costly, and under certain circumstances these payments may be reconciled to more closely reflect the costs in excess of outlier thresholds after the submission and audit of the annual Medicare cost report. Normal estimation differences between filed settlements and amounts accrued are reflected in net patient service revenue.

The Company is reimbursed by Medicare for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare Administrative Contractor. The estimated amounts due to or from the program are reviewed and adjusted annually based on the status of such audits and any subsequent appeals. Differences between final settlements and amounts accrued in previous years are reported as adjustments to net patient service revenue in the year that examination is substantially completed.

Although services for most Medicare beneficiaries are paid by the Federal government on a fee-for-service basis, approximately one-third of Medicare beneficiaries are enrolled in a "Medicare Advantage" plan, which is a type of health plan that contracts with the Medicare program to provide hospital and medical benefits to Medicare beneficiaries. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-For-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. For Medicare beneficiaries enrolled in a Medicare Advantage plan, most Medicare services are covered by the plan and are not paid for under fee-for-service Medicare. Certain Medicare Advantage plans make capitation payments to the Company using a "Risk Adjustment model," which compensates providers based on the health status (acuity) of each enrollee. Providers with higher acuity enrollees generally will receive more and those with healthier enrollees will receive less.

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. Similar to Medicare, cost report settlements are recorded based upon as-filed cost reports and adjusted for tentative and final settlements, if any.

RWMC and SJHSRI are participants in the State of Rhode Island's Disproportionate Share Hospital ("DSH") program, which assists hospitals that provide a disproportionate amount of uncompensated care. Under the program, Rhode Island hospitals, including RWMC and SJHSRI, receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low-income patients. RWMC and SJHSRI recognized revenue related to DSH and Upper Payment Limit ("UPL") reimbursement of $20,456,000 and $19,035,000 for the years ended September 30, 2019 and 2018, respectively. DSH and UPL payments received were $20,074,000 and $17,704,000 for the years ended September 30, 2019 and 2018, respectively. RWMC and SJHSRI recorded license fee expenses of $17,565,000 and $16,815,000 for the years ended September 30, 2019 and 2018, respectively, which is included within taxes and licenses expense within the accompanying consolidated statements of operations.

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.

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.

Laws and regulations governing the third-party payor arrangements are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Normal estimation differences between subsequent cash collections on patient accounts receivable and net patient accounts receivable estimated in the prior year are reported as adjustments to net patient service revenue in the current period.

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 who lack financial resources and are deemed to be medically indigent based on criteria established under the Company's charity care policy. This care is provided without charge or at amounts less than the Company's established rates. Because the Company does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The direct and indirect costs related to this care totaled approximately $501,000 and $772,000 for the years ended September 30, 2019 and 2018, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. In addition, the Company provides services to other medically indigent patients under various state Medicaid programs. Such programs pay amounts that are less than the cost of the services provided to the recipients. The Company has not changed its charity care or uninsured discount policies during the years ended September 30, 2019 or 2018.

Provisions for Contractual Allowances and Doubtful Accounts

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 was 26% and 19% of gross patient accounts receivable as of September 30, 2019 and 2018, respectively, and the increase results from a determination at September 30, 2019 to fully reserve for all patient accounts receivable over 365 days old.

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.

Other Non-Patient Hospital Revenues

Other non-patient Hospital revenues totaled $8,879,000 and $8,102,000 for the years ended September 30, 2019 and 2018, respectively. The principal components of other non-patient Hospital revenues include tuition revenue, grant revenue and rental revenue.

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. Building improvements are generally depreciated over seven years, buildings are depreciated over 10 years, equipment is depreciated over three to seven years and furniture and fixtures are depreciated over five 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.

Goodwill

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. The Company's annual goodwill impairment test is conducted on July 1. Impairment of goodwill is tested at the reporting unit level, by comparing the reporting unit's carrying amount, including goodwill, to the fair value of the reporting unit. The fair value of the reporting units are estimated. 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 one-step process which consists of estimating 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. If the estimated fair value of the reporting unit is less than its carrying value, this indicates that goodwill is impaired, and impairment is recorded based on the deficiency of fair value compared to the carrying value. The Company's impairment test related to goodwill during the year ended

September 30, 2018 resulted in a full impairment of goodwill related to the Rhode Island facilities. There was no goodwill as of and during the year ended September 30, 2019.

Intangible Assets

Intangible assets include trade names. 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, 2019 and 2018.

Insurance Reserves

Medical Malpractice Liability Insurance

The Company carries 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.

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 recognizes 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. The Company's gross claims liability was $8,498,000 and $9,943,000 as of September 30, 2019 and 2018, respectively, and insurance receivables were $1,881,000 and $2,220,000 as of September 30, 2019 and 2018, respectively. The gross claims liability and insurance receivables were estimated using a discount factor of 4% and are included within long-term liabilities and long-term assets, respectively, in the accompanying consolidated balance sheets.

Workers' Compensation Insurance

The Company was fully insured for workers' compensation claims with no deductible during the years ended September 30, 2019 and 2018.

Reserve Methodology

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.

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 statements of operations. The Company has accrued $3,123,000 and $2,623,000 related to asbestos remediation as of September 30, 2019 and 2018, respectively. The liability was estimated using a discount factor which ranged from 1% and 7%.

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

The Company held restricted cash of $174,000 and $433,000 as of September 30, 2019 and 2018, respectively, which was restricted for research at the Company's hospitals as well as for School grants.

Inventories

Inventories of supplies are valued at the lower of amounts that approximate the weighted average cost or net realizable value, which approximates market value, and are expensed as incurred. Inventories consist primarily of medical and surgical supplies and pharmaceuticals.

Income Taxes

For tax reporting purposes, the Company is treated as a Partnership. The Company and its wholly-owned subsidiaries are pass-through entities. Therefore, no provision is made in the accompanying consolidated financial statements for liabilities for federal, state or local income taxes since such liabilities are the responsibility of the Company's parent companies. The Company periodically evaluates its tax positions, including its status as a pass-through entity, to evaluate whether it is more likely than not that such positions would be sustained upon examination by a tax authority for all open tax years, as defined by the statute of limitations, based on its technical merits.

As of September 30, 2019 and 2018, the Company has not established a liability for uncertain tax positions. The Company files income tax returns in the U.S. federal jurisdiction and the state of Rhode Island. Generally, the Company is subject to examination by U.S. federal (or state and local) income tax authorities for three to four years from the filing of a tax return.

Fair Value of Financial Instruments

Financial instruments consist primarily of cash and cash equivalents, restricted cash, patient and other accounts receivables, accounts payable and accrued expenses, accrued salaries and benefits, amounts due from/to government payers, capital lease obligations, 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.

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 intangible assets when there are indications of impairment.

During the year ended September 30, 2018, the Company recorded approximately $14,228,000 of impairment relating to goodwill, which is reflected in the accompanying consolidated statements of operations.

The Company uses the discounted cash flow approach, the guideline public company approach and the guideline transactions approach to estimate the residual value of the Company's goodwill. The measurement of goodwill is a Level 3 measurement.

The following table provides quantitative information related to the significant unobservable inputs to determine fair value and impairment of goodwill as of September 30, 2018:

Residual Value of Goodwill	Valuation Technique	Unobservable Input	Rates
$ -	Discounted Cash Flow	Weighted average cost of capital	9.3%
		Revenue growth rate	2.1% - 2.5%
	Guideline Public Company	LTM EBITDA multiple	7.0x

There were no non-recurring measurements as of September 30, 2019.

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 and Medicaid. The Company received revenues from Medicare and Medicaid as follows (excluding revenues for discontinued operations, in thousands):

Years Ended September 30,	2019	% of Total Revenues	2018	% of Total Revenues
Medicare	$ 151,701	42 %	$ 165,882	47 %
Medicaid	86,573	24 %	74,710	21 %
Total	$ 238,274	66 %	$ 240,592	68 %

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 amounts due from/to government payers, allowances for contractual discounts and doubtful accounts, professional and general liability claims, long-lived assets, intangible assets and asset retirement obligations.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, "Revenue from Contracts with Customers (Topic 606)" with an effective date deferred 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, and interim periods within fiscal years beginning after December 15, 2019. 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 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. The Company is currently evaluating the effect of this guidance on its consolidated financial statements.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)". The core principle of ASU 2016-02 is that a lessee should recognize the assets and liabilities that arise from leases, including operating leases. Under the new requirements, a lessee will recognize in the statement of financial position a liability to make lease payments (the lease liability) and the right-of-use asset representing the right to the underlying asset for the lease term. For leases with a term of 12 months or less, the lessee is permitted to make an accounting policy election by class of underlying asset not to recognize lease assets and lease liabilities. The recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee have not significantly changed from previous GAAP. The standard was originally scheduled to effective for nonpublic entities for fiscal years beginning after December 15, 2019. In November 2019 the FASB issued ASU 2019-10, "Financial Instruments—Credit Losses (Topic 326), Derivatives and Hedging (Topic 815), and Leases (Topic 842)" which delayed the effective date by one year to December 2020. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230)". The updated standard addresses eight specific cash flow issues with the objective of reducing diversity in practice.

ASU 2016-15 is effective for non-public business entities for annual reporting periods beginning after December 15, 2018, including interim periods within those annual reporting periods. Early adoption is permitted. The Company is assessing the impact of the adoption of ASU 2016-15 on its consolidated financial statements.

3. Property, Improvements and Equipment

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

September 30,	2019	2018
Property, improvements and equipment:		
Land and land improvements	$ 7,471	$ 7,471
Buildings and improvements	40,163	39,359
Leasehold improvements	4,410	4,334
Equipment	43,253	39,400
	95,297	90,564
Less: accumulated depreciation	(57,977)	(44,869)
	37,320	45,695
Construction in progress	23,598	14,085
Property, improvements and equipment, net	$ 60,918	$ 59,780

At September 30, 2019 and 2018, the Company had assets under capitalized leases of approximately $4,292,000 and $4,292,000, respectively, and related accumulated depreciation of $2,661,000 and $1,917,000, respectively.

Depreciation expense was $13,100,000 and $13,222,000 for the years ended September 30, 2019 and 2018, respectively.

4. Acquisitions

In December 2017, New University Medical Group ("New UMG") entered into a Second Closing to acquire the remaining assets of University Medical Group ("UMG") that were not acquired in the initial acquisition in December 2014. As consideration for the acquisition, New UMG has assumed certain designated liabilities of the practice, which consists of various loans payable to subsidiaries of the Company, totaling approximately $7.5 million. Post-acquisition, these liabilities are eliminated on consolidation. There was no cash consideration related to the transaction. The remaining assets and liabilities acquired were immaterial and no value was assigned to them in the purchase price allocation, and accordingly goodwill of $7.5 million from the acquisition. The goodwill is deductible for tax purposes at Prospect, with PCC acting as a flow through entity. New UMG's parent company, Prospect CharterCARE Physicians, LLC, dba CharterCARE Medical Associates ("CCMA"), entered into a Post Closing Administrative Services Agreement pursuant to which CCMA and its affiliates provide services to the seller of the practice in connection with its termination of all operations and the wind up its affairs and operations.

Additionally, during the year ended September 30, 2018, CharterCARE Physicians entered into asset purchase agreements to acquire three medical practices with primary care physicians. Total cash consideration for the medical practices was $976,000, of which $240,000 was included in accounts payable in the accompanying consolidated balance sheets and paid in October 2018.

The acquisitions were accounted for as business combinations using the acquisition method of accounting. Under the acquisition accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values. As asset purchases, goodwill acquired is expected to be deductible for tax purposes.

The following table summarizes the assets acquired and liabilities assumed in connection with the acquisitions during fiscal 2018 (in thousands):

For the Year Ended September 30,	2018
Improvements and equipment	$ 22
Goodwill	8,406
Accrued purchase consideration due to seller	(240)
Liabilities assumed	(7,452)
Net cash consideration	$ 736

As mentioned at Note 2, on July 1, 2018, the Company tested for goodwill impairment which resulted in a full impairment of goodwill. This includes the goodwill presented in the table above (see Note 5).

5. Goodwill and Intangible Assets

Goodwill and intangible assets relate to the Prospect CharterCARE and CharterCARE Physicians medical practices acquisitions, as well as the acquisition of New UMG. The following is a roll-forward of goodwill for the years ended September 30, 2019 and 2018, respectively (in thousands):

September 30,	2019	2018
Balance, beginning of year	$ -	$ 5,822
Acquisitions	-	8,406
Impairment	-	(14,228)
Balance, end of year	$ -	-

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

	Amortization Period	September 30, 2019	September 30, 2018
Trade names	5 years	$ 8,130	$ 8,130
Other	5 years	97	97
Total acquisition cost of intangible assets		8,227	8,227
Less accumulated amortization		(8,208)	(7,016)
Intangible assets, net		$ 19	$ 1,211

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives. Amortization expense was $1,192,000 and $1,643,000 for the years ended September 30, 2019 and 2018, respectively.

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

Years ended September 30,	
2020	$ 19

The weighted-average remaining useful life for the intangible assets was approximately one month as of September 30, 2019.

6. Members' Equity

In accordance with the Amended & Restated Limited Liability Company Agreement of PCC ("LLC Agreement"), the profit or loss of PCC is to be allocated to the members based on their Adjusted Capital Contribution, as defined in the LLC Agreement. Total member contributions were $27,997,000 and $9,847,000 for the years ended September 30, 2019 and 2018, respectively. For the year ended September 30, 2019 and 2018, contributions were non-cash transactions. All of these contributions were made by Prospect and are accounted for as additional member contributions, however, in accordance with the LLC Agreement, the contributions were allocated 85% to Prospect and 15% to CharterCARE Community Board, consistent with their ownership percentages.

The following is a summary of the members' capital accounts (in thousands):

	Prospect	CharterCARE Community Board	Total
Balance at October 1, 2017	$ 45,702	$ 8,065	$ 53,767
Allocated contributions	8,370	1,477	9,847
Net loss	(30,764)	(5,429)	(36,193)
Balance at September 30, 2018	23,308	4,113	27,421
Allocated contributions	23,798	4,199	27,997
Net loss	(9,108)	(1,607)	(10,715)
Balance at September 30, 2019	$ 37,998	$ 6,705	$ 44,703

7. Related Party Transactions

The Company and Prospect East Hospital Advisory Services, LLC ("PEHAS"), a wholly-owned subsidiary of Prospect, entered into a Management Services Agreement ("MSA") as of June 20, 2014, under which PEHAS provides certain administrative and management services to PCC and its Subsidiaries. Management fees due to PEHAS under the MSA consist of 2% of net revenues monthly. The Company recognized management fees of $7,395,000 and $7,298,000 for the years ended September 30, 2019 and 2018, respectively, which is included within management fees expense in the accompanying consolidated statements of operations. As of September 30, 2019 and 2018, the Company had liabilities related to the MSA due PEHAS of $37,959,000 and $30,568,000, respectively.

In May 2019, Prospect East, which owns 85% of the Company, made a non-cash capital contribution in the amount of approximately $24.7 million, which consisted of converting unpaid management fees due to PEHAS of approximately $20.0 million and approximately $4.7 million of unpaid invoices that Prospect paid on behalf of the Company at April 30, 2019, into equity.

8. 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 2021. Capital leases bear interest at rates ranging from 1.5% to 4.3% per annum.

The future minimum annual lease payments (net of anticipated sublease income) required under leases in effect at September 30, 2019, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2020	$ 50	$ 400
2021	44	34
2022	-	15
2023	-	-
2024	-	-
Total minimum lease payments	94	$ 449
Less: amounts representing interest	(2)	
	92	
Less: current portion	(49)	
	$ 43	

Lease and rental expense was $5,185,000 and $5,438,000 for the years ended September 30, 2019 and 2018, respectively.

Contingent Liability for Borrowings by Prospect

The Company is contingently liable as a guarantor, among others, for amounts borrowed by PMH on senior secured notes (through August 23, 2019), credit facilities at September 30, 2019 and 2018. Additionally, as of September 30, 2019 the Company is a pledger for all of the transactions that PMH has entered into with affiliates of Medical Properties Trust, Inc. ("MPT"), a publicly traded Real Estate Investment Trust, on August 23, 2019.

The obligations and related interest expense related to these credit facilities are not reflected in the Company's consolidated financial statements as of and for the years ended September 30, 2019 and 2018, as the borrowings are reflected in the separate consolidated financial statements of PMH.

Total borrowings outstanding as of September 30, 2019, reflected in the consolidated financial statements of PMH, but for which the Company is contingently liable as a guarantor, were (in thousands):

September 30,	2019	2018
Senior secured credit facility (net of discount of $0 and $20,085, respectively)	$ -	$ 1,094,315
Less: Deferred financing costs, net ("DFC")	-	(16,214)
Total Debt, net of discount, premium and DFC	$ -	$ 1,078,101

On June 30, 2016, PMH entered into a six-year $625,000,000 senior secured term loan B (the "Original Term Loan"). The Original Term Loan was issued with an original discount of 1.50%, or $9,375,000. Additionally, PMH refinanced the previous revolver with a new $100,000,000 asset-based revolving credit facility ("Original ABL Facility" and together with the Original Term Loan, the "New Senior Secured Credit Facilities"). Pursuant to various amendments from August 2016 through October 2017, the aggregate commitment amount under the Original ABL facility was increased in stages to $175,000,000. The original maturity date for the Original ABL Facility was June 30, 2021, and the original maturity date for the Term Loan was June 30, 2022.

On February 22, 2018, PMH refinanced and replaced both the Original Term Loan and the Original ABL Facility, and entered into an Amended and Restated Term Loan Credit Agreement (the "Amended TL Agreement"), by and among PMH (as the borrower), the lenders party thereto and JPMorgan Chase Bank, N.A. ("JPMorgan"), as administrative agent and collateral agent. The Amended TL Agreement replaced the Original Term Loan with a new Term B-1 Loan ("Term B-1 Loan"). The principal amount of the Term B-1 Loan is $1,120.0 million and such loan incurred interest at LIBOR (subject to a 1.0% floor) plus 5.5%. The Term B-1 Loan was issued with an original discount of 2% and was originally scheduled to mature on February 22, 2024. The Term B-1 Loan was repaid on August 23, 2019 by the proceeds totaling $1.55 billion from a series of transactions that PMH entered into with affiliates of MPT (see further discussion below).

Additionally, on February 22, 2018, PMH entered into an Amended and Restated ABL Credit Agreement (the "Amended ABL Agreement"), by and among PMH (as the borrower), the lenders party thereto and JPMorgan, as administrative agent and collateral agent. The Amended ABL Agreement replaced the Original ABL Facility. Under the Amended ABL Agreement, the maximum revolving commitment was $250,000,000 with ability to expand the facility to $325,000,000, and the new ABL facility (the "New ABL Facility") bears interest at a variable base rate plus an applicable spread that is based on excess availability under the New ABL Facility, as further described in the Amended ABL Agreement, which was 6.0% as of September 30, 2019. From January 2019 through July 2019 PMH entered into various amendments to the Amended ABL Agreement. Such amendments (i) waived certain events of default at September 30, 2018; (ii) increased the maximum revolving commitment from $250.0 million to $280.0 million, and further to $285.0 million, while simultaneously reducing and removing future expansion of the facility; (iii) introduced $40.0 million of a first in last out ("FILO") revolving facility, which incurred interest at either 2.5% or 3.5% per annum depending on whether they are Eurodollar loans or ABR loans (which were repaid on August 23, 2019); (iv) provides for a reduction in the maximum revolving commitment by $20.0 million and $10.0 million upon the future planned closure or disposition of Nix Health and EOGH, respectively. The New ABL Facility matures on February 22, 2023. As of September 30, 2019, the outstanding balance and the available balance on the New ABL facility was approximately $70.0 million and $175.6 million, respectively. On August 23, 2019, PMH closed a series of transactions with affiliates of MPT. Under these transactions, PMH sold to MPT its hospital buildings in California (excluding Foothill Regional Medical Center ("Foothill"), Connecticut and Pennsylvania for an aggregate purchase price of $1,386,000,000. Concurrent with the sale transactions, PMH entered into two master lease agreements whereby the hospital properties and related medical office buildings were leased back for an initial 15 year term, with options to extend twice for an additional 5 years each and for a further 4.75 year extension. Monthly rent is defined as 7.5% of the lease base, subject to annual escalation of consumer price index, limited to a minimum of 2% and a maximum of 4%. For the first master lease, PMH has the option to buy the properties at their fair value at the end of the lease term. For the second master lease, PMH has the option to purchase at a price that is fixed at the time of entering into the lease (the "Option Price"). If PMH chooses not to exercise this option, and the fair value at the end of the lease is below the Option

Price, then PMH must pay MPT a sum equal to the difference between the fair value and the Option Price. All of the legal entities that are parties to the master lease agreement (which are the hospital entities themselves) provide cross guarantees on all of the obligations to MPT, which guarantees include both lease payments under the master lease as well as indebtedness due to MPT. The balance under sale-leaseback liabilities was $1,331,000,000 at September 30, 2019, as reflected in PMH's consolidated financial statements.

Further, PMH obtained a mortgage on the Foothill property. This mortgage is secured by the buildings at Foothill. The interest on this mortgage is 7.5% per annum and is subject to annual escalation of consumer price index, limited to a minimum of 2% and a maximum of 4%. The maturity date of this loan is in August 2034. MPT can purchase the property on event of default or at end of term, or if Company does not exercise purchase rights for the aforementioned leased properties. Additionally, if the Foothill property is no longer used as collateral for a promissory note payable to Prospect Medical Group, Inc. ("PMG"), , then MPT shall have the right to purchase the Foothill property and lease it back to PMH under the second master lease agreement, for an amount equal to the outstanding principal balance. The referenced promissory note payable to PMG has been included in the calculation of PMG's Tangible Net Equity in connection with requirements of the California Department of Managed Health Care. The balance under this mortgage loan was $51,276,000 at September 30, 2019, as reflected in PMH's consolidated financial statements.

Additionally, PMH entered into a promissory note (the "TRS Note"), under which MPT has advanced to PMH $112,937,000 related to the value of the properties in Rhode Island. The interest on this note is 7.5% per annum and is subject to annual escalation of consumer price index, limited to a minimum of 2% and a maximum of 4%. The maturity date of this note is the earlier of July 2022 or the conversion to and sale-leaseback of the properties in Rhode Island. The balance under this mortgage loan was $112,215,000 at September 30, 2019, as reflected in PMH's consolidated financial statements.

All of the agreements with MPT are cross-collateralized and cross defaulted. The MPT transaction documents contain certain customary covenants and restrictions and a financial covenant based on EBITDAR performance, and PMH was in compliance with such covenants at September 30, 2019.

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.

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, states have also developed their own standards for the privacy and security of health information as well as for reporting certain violations and breaches (for example, California's Confidentiality of Medical Information Act and Lanterman-Petris Short Act) which in some cases are more stringent. Other federal privacy laws may also apply to certain services provided by the Company, including 42 C.F.R. Part 2, which addresses the confidentiality of substance use disorder records. 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") has made significant changes to the United States health care system. The legislation impacted multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Under this legislation, 33 states have expanded their Medicaid programs to cover previously uninsured childless adults, and four additional states voted in 2018 to expand Medicaid or to elect a governor that pledged to expand Medicaid. In addition, many uninsured individuals have had the opportunity to purchase health insurance via state-based marketplaces, state-based marketplaces using a federal platform, state-partnership marketplaces or the federally-facilitated marketplace. PPACA also implemented a number of health insurance market reforms, such as allowing children to remain on their parents' health insurance until age 26 or prohibiting certain plans from denying coverage based on pre-existing conditions. Nationally, these reforms have reduced the number of uninsured individuals.

It is unclear what changes may be made to PPACA with the divided Congress, current presidential administration, and pending litigation over the validity of PPACA. The Administration has promulgated rules to broaden the availability of coverage options that do not comply with the full range of PPACA requirements for individual market coverage, namely Association Health Plans and Short-Term Limited-Duration Insurance. The Administration has also provided additional guidance on state PPACA waivers. These executive actions have been or may be challenged in court. In addition, the Tax Cuts and Jobs Act ("TCJA"), passed in December 2017, eliminates the individual mandate penalty under PPACA, effective January 1, 2019. The individual mandate penalty was included in PPACA to address concerns that other market reforms expanding access to coverage might produce adverse selection and higher premiums. The extent to which the repeal of the individual mandate penalty will impact the uninsured rate and future premiums are unclear at this juncture. On December 14, 2018, the

United States District Court for the Northern District of Texas ruled that the individual mandate without the penalty is unconstitutional and that PPACA is therefore invalid in its entirety. Litigation on this issue is ongoing, with a decision pending from a panel of the United States Court of Appeals for the Fifth Circuit following oral arguments in July 2019. This litigation along with any future legislative changes to PPACA or other federal and state legislation could have a material impact on the operations of the Company. The Company is continuing to monitor the legislative environment and developments in pending litigation for risks and uncertainties.

Collective Bargaining Agreements

The Company has 304 employees that are subject to a collective bargaining agreement with United Nurses and Allied Professionals ("UNAP"), which was effective beginning July 15, 2019 and expires July 31, 2019. During April 2015, a hospital unit consisting of approximately 430 service employees of Fatima elected to be represented by UNAP. The parties entered into a new collective bargaining agreement which was effective beginning July 2, 2019 and expires on June 30, 2022. A small number of employees are subject to a collective bargaining agreement with the Federation of Nurses and Health Professionals ("FNHP"), which expires on July 30, 2021.

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.

9. Defined Contribution Plan

Prospect sponsors defined contribution plans (the "Plans") covering substantially all employees who meet certain eligibility requirements. Under the Plans, employees can contribute up to 100% of their compensation up to the IRS deferred annual maximum. Effective May 1, 2018, the plans covering employees at Prospect's facilities in Connecticut and Pennsylvania merged into the plans covering employees at CharterCARE, and the two remaining plans were renamed and segregated between union and non-union employees. The Company may make discretionary matching contributions to the Plans. Employer contributions to the Plan were $1,981,000 and $1,925,000 for the years ended September 30, 2019 and 2018, respectively.

10. Equity Method Investments

RWMC 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. 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, 2019 and 2018, the Company's investments in RWRT, SNERCC, and other minor investments under the equity method were approximately $3,675,000 and $4,088,000, respectively, and are included in equity method investments in the accompanying consolidated balance sheets. For the years ended September 30, 2019 and 2018, the Company recognized approximately $560,000 and $589,000, respectively, as its share of the financial results of RWRT, SNERCC, and other minor investments and received $973,000 and $614,000, respectively, in distributions.

Summarized combined unaudited financial information for RWRT and SNERCC as of and for the years ended September 30, 2019 and 2018 is as follows (in thousands):

September 30,	2019	2018
Cash	$ 1,905	$ 2,515
Receivables and other current assets	1,683	3,756
Total current assets	3,588	6,271
Property, improvements and equipment, net	3,849	3,502
Goodwill	7,142	7,142
Intangible assets	821	851
Other long-term assets	1,532	1,569
Total assets	$ 16,932	$ 19,335
Accounts payable and accrued liabilities	$ 1,304	$ 1,052
Other long-term liabilities	948	420
Equity	14,680	17,863
Total liabilities and partner's capital	$ 16,932	$ 19,335

For the Years Ended September 30,	2019	2018
Revenues	$ 16,678	$ 17,278
Net income	$ 2,461	$ 2,953
Income from equity method investments	$ 560	$ 589

11. Subsequent Events

The Company has evaluated subsequent events through February 6, 2020, the date the Company's consolidated financial statements were available for issuance.

Prospect CharterCARE SJHSRI, LLC

Financial Statements
As of and for the Years Ended
September 30, 2019 and 2018

BDO

Prospect ChartерCARE SJHSRI, LLC

Financial Statements

As of and for the Years Ended September 30, 2019 and 2018

Prospect CharterCARE SJHSRI, LLC

Contents

	Page
Independent Auditor's Report	4 - 5
Balance Sheets	6 - 7
Statements of Operations	8
Statements of Member's Equity	9
Statements of Cash Flows	10
Notes to the Financial Statements	11 - 27
Supplemental Report and Schedule	
Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*	29 - 30
Schedule of Findings and Questioned Costs	31
Summary Schedule of Prior Audit Findings	32 - 33

Tel: 714-957-3200
Fax: 714-957-1080
www.bdo.com

600 Anton Blvd., Suite 500
Costa Mesa, CA 92626

Independent Auditor's Report

Board of Directors
Prospect CharterCARE SJHSRI, LLC
Los Angeles, California

Report on the Financial Statements

We have audited the accompanying financial statements of Prospect CharterCARE SJHSRI, LLC (the "Company"), which comprise the balance sheets as of September 30, 2019 and 2018, and the related statements of operations, member's equity, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these 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 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 financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the 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 Company'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 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 financial statements referred to above present fairly, in all material respects, the financial position of the Company as of September 30, 2019 and 2018, and the results of its operations and its cash flows for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

BDO

Emphasis of Matter

As discussed in Note 1, the Company is financially dependent on its parent companies which have agreed to provide the financial support necessary for the operations of the Company. The accompanying financial statements do not reflect any adjustments or disclosures that would be required should the parent companies discontinue their financial support.

Other Matters

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying Note 9 of the Company's calculation of its Title IV 90/10 revenue test ("Note 9 - Title IV 90/10") and Note 6 on related party transactions are required by the U.S. Department of Education and is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the Note 9 - Title IV 90/10 information and Note 6 on related party transactions are fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated February 6, 2020 on our consideration of the Company's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Company's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Company's internal control over financial reporting and compliance.

BDO USA, LLP

February 6, 2020

Prospect CharterCARE SJHSRI, LLC

Balance Sheets
(in thousands)

September 30,	2019	2018
Assets		
Current assets		
Cash and cash equivalents	$ -	$ -
Restricted cash	13	166
Patient accounts receivable, less allowance for doubtful accounts of $8,458 and $5,491	20,929	20,224
Other receivables	451	554
Due from government payers	499	894
Inventories	1,996	1,889
Prepaid expenses and other current assets	655	496
Total current assets	24,543	24,223
Property, improvements and equipment, net	23,726	24,064
Intangible assets, net	-	517
Other assets	614	881
Total assets	$ 48,883	$ 49,685

See accompanying notes to financial statements.

Prospect CharterCARE SJHSRI, LLC

Balance Sheets
(in thousands)

September 30,		2019		2018
Liabilities and Member's Equity				
Current liabilities				
Accrued medical claims and other healthcare costs payable	$	-	$	488
Accounts payable and other accrued liabilities		12,032		11,438
Accrued salaries, wages and benefits		4,642		4,852
Deferred revenue		170		681
Due to government payers		5		424
Due to affiliated companies, net		5,241		5,657
Current portion of capital leases		38		369
Total current liabilities		22,128		23,909
Capital leases, net of current portion		-		38
Deferred revenue, net of current portion		1,327		1,514
Asset retirement obligations		2,290		2,092
Other long-term liabilities		5,001		5,771
Total liabilities		30,746		33,324
Commitments and contingencies				
Member's equity:				
Member's contributions		28,535		28,535
Accumulated deficit		(10,398)		(12,174)
Total member's equity		18,137		16,361
Total liabilities and member's equity	$	48,883	$	49,685

See accompanying notes to financial statements.

CIIH16-001038

Prospect CharterCARE SJHSRI, LLC

Statements of Operations
(in thousands)

For the Years Ended September 30,	2019	2018
Revenues:		
Net patient service revenues	$ **147,297**	$ 147,129
Provision for bad debts	**(6,813)**	(6,096)
Net patient service revenues less provision for bad debts	**140,484**	141,033
Other non-patient Hospital revenues	**2,781**	3,870
Total net revenues	**143,265**	144,903
Operating Expenses:		
Salaries, wages and benefits	**75,334**	81,487
Supplies	**19,200**	19,662
Taxes and licenses	**10,037**	9,840
Purchased services	**12,015**	9,980
Depreciation and amortization	**7,188**	7,846
Professional fees	**6,512**	5,124
Other	**1,258**	5,374
Management fees	**2,954**	2,994
Utilities	**2,125**	1,957
Lease and rental	**1,544**	1,536
Insurance	**1,508**	1,668
Repairs and maintenance	**671**	1,261
Registry	**293**	46
Total operating expenses	**140,639**	148,775
Operating income from unconsolidated equity method investments	**13**	-
Operating income (loss)	**2,639**	(3,872)
Other expense:		
Interest expense	**863**	876
Total other expense	**863**	876
Net income (loss)	$ **1,776**	$ (4,748)

See accompanying notes to financial statements.

Prospect CharterCARE SJHSRI, LLC

Statements of Member's Equity
(in thousands)

	Member's Contributions	Accumulated Deficit	Total Member's Equity
Balance at October 1, 2017	$ 28,535	$ (7,426)	$ 21,109
Net loss	-	(4,748)	(4,748)
Balance at September 30, 2018	28,535	(12,174)	16,361
Net income	-	1,776	1,776
Balance at September 30, 2019	$ 28,535	$ (10,398)	$ 18,137

See accompanying notes to financial statements.

Prospect CharterCARE SJHSRI, LLC

Statements of Cash Flows
(in thousands)

For the Years Ended September 30,	2019	2018
Operating activities		
Net income (loss)	$ 1,776	$ (4,748)
Adjustments to reconcile net income (loss) to net cash and cash equivalents provided by operating activities:		
Depreciation and amortization	6,810	7,846
Provision for bad debts	6,813	6,096
Accretion of interest for asset retirement obligations	378	156
Changes in operating assets and liabilities		
Change in restricted cash	153	493
Patient accounts receivable and other receivables	(7,415)	(8,506)
Due to/from government payers, net	(23)	(67)
Inventories	(107)	(138)
Prepaid expenses and other current assets	(159)	426
Other assets	267	(305)
Accrued medical claims and other healthcare costs	(488)	(185)
Accounts payable and other accrued liabilities	(833)	2,772
Deferred revenue	(698)	(477)
Net cash and cash equivalents provided by operating activities	6,474	3,363
Investing activities		
Purchases of property, improvements and equipment	(3,624)	(7,525)
Net cash and cash equivalents used in investing activities	(3,624)	(7,525)
Financing activities		
Change in due to affiliated companies, net	(2,481)	4,913
Repayments of capital leases	(369)	(751)
Net cash and cash equivalents (used in) provided by financing activities	(2,850)	4,162
Change in cash and cash equivalents	-	-
Cash and cash equivalents, beginning of year	-	-
Cash and cash equivalents, end of year	$ -	$ -
Supplemental disclosure of cash flow information		
Interest paid	$ 753	$ 876
Schedule of non-cash investing activities		
Accrual of property, improvements and equipment	$ 1,952	$ 188

See accompanying notes to financial statements.

1. Organization

Prospect CharterCARE SJHSRI, LLC ("SJHSRI" or the "Company" dba St. Joseph Health Center and our Lady of Fatima Hospital) is a wholly-owned subsidiary of Prospect CharterCARE, LLC ("PCC"). PCC is owned 85% by Prospect Medical Holdings, Inc. ("Prospect" or "PMH") and 15% by CharterCARE Community Board. SJHSRI operates a 359-bed acute care general hospital which provides healthcare services in North Providence, Rhode Island and surrounding communities. Additionally, SJHSRI operated the St. Joseph School of Nursing (the "School") and an integrated network of primary care and specialty clinics serving an economically challenged and ethnically diverse population in Providence, Rhode Island. As of September 30, 2019, the School has been closed.

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

The Company is dependent on its parent companies to fund ongoing operations. As of September 30, 2019, the Company had a net liability of $5,241,000 due to Prospect and to PCC and its subsidiaries, which is payable on demand, does not bear interest, and is included in due to affiliated companies, net in the accompanying balance sheets. Prospect and PCC do not intend to have the Company repay the liability in a manner which would impair the Company's ability to maintain sufficient liquidity to sustain ongoing operations.

2. Significant Accounting Policies

Basis of Presentation

The financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP").

Revenues

Net Patient Service Revenues

Operating revenue consists primarily of net patient service revenues. The Company reports net patient service revenues 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, 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 balance sheets.

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

For the Years Ended September 30,	2019	2018
Medicare	$ 59,521	$ 68,242
Medicaid	42,055	33,216
Managed Care	29,950	31,417
Self-Pay/Other	15,771	14,254
Total	$ 147,297	$ 147,129

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. Most 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 generally paid based on 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. The Company also receives Medicare outlier payments on an ongoing basis during the year for cases that are unusually costly, and under certain circumstances these payments may be reconciled to more closely reflect the costs in excess of outlier thresholds after the submission and audit of the annual Medicare cost report. 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.

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. Similar to Medicare, cost report settlements are recorded based upon as-filed cost reports and adjusted for tentative and final settlements, if any.

SJHSRI is a participant in the State of Rhode Island's Disproportionate Share Hospital ("DSH") program, which assists hospitals that provide a disproportionate amount of uncompensated care. Under the program, Rhode Island hospitals, including SJHSRI, receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low income patients. SJHSRI recognized revenue related to DSH and Upper Payment Limit ("UPL") reimbursement of $9,868,000 and $9,856,000 for the years ended September 30, 2019 and 2018, respectively. DSH and UPL payments received were $9,734,000 and $9,837,000 for the years ended September 30, 2019 and 2018, 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. SJHSRI recorded license fee expenses of $8,062,000 and $7,616,000, respectively, which is included within taxes and licenses expense within the accompanying statements of operations.

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.

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 indigent and charity care policy.

Laws and regulations governing the third-party payor arrangements are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Normal estimation differences between subsequent cash collections on patient accounts receivable and net patient accounts receivable estimated in the prior year are reported as adjustments to net patient service revenue in the current period.

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 financial statements.

Charity Care

The Company provides charity care to patients who lack financial resources and are deemed to be medically indigent based on criteria established under the Company's charity care policy. This care is provided without charge or at amounts less than the Company's established rates. Because the Company does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The direct and indirect costs related to this care totaled approximately $280,000 and $315,000 for the years ended September 30, 2019 and 2018, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. In addition, the Company provides services to other medically indigent patients under various state Medicaid programs. Such programs pay amounts that are less than the cost of the services provided to the recipients. The Company has not changed its charity care or uninsured discount policies during the years ended September 30, 2019 or 2018.

Provisions for Contractual Allowances and Doubtful Accounts

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 was 29% and 21% of gross patient accounts receivable as of September 30, 2019 and 2018, respectively. The decrease was due to a self-pay discount which took effect during the year ended September 30, 2019, resulting in a decrease in the bad debt allowance required as of September 30, 2019.

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 financial statements.

Other Non-Patient Hospital Revenues

Other non-patient Hospital revenues totaled $2,781,000 and $3,870,000 for the years ended September 30, 2019 and 2018, respectively. The principal components of other non-patient Hospital revenues include tuition revenue and rental revenue. Management has evaluated the collectability of other receivables consisting primarily of other non-patient Hospital revenues and determined no allowance is necessary as of September 30, 2019 or 2018.

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. Building improvements are generally depreciated over seven years, buildings are depreciated over 10 years, equipment is depreciated over three to seven years and furniture and fixtures are depreciated over five 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.

Long-Lived Assets and Amortizable Intangibles

Intangible assets include trade names. 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, 2019 and 2018.

Insurance Reserves

Medical Malpractice Liability Insurance

The Company carries professional and general liability insurance to cover medical malpractice claims. The General Liability coverage is occurrence coverage and the Professional Liability coverage is claims-made coverage. Under the Professional Liability policy, insurance premiums cover only those claims actually reported during the policy term. Should the Professional Liability 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.

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 recognizes 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. The Company's gross claims liability was $2,895,000 and $3,470,000 as of September 30, 2019 and 2018, respectively, and insurance receivables were $565,000 and $827,000 as of September 30, 2019, and 2018, respectively. The gross claims liability and insurance receivables were estimated using a discount factor of 4% and are included within long-term liabilities and long-term assets, respectively, in the accompanying balance sheets.

Workers' Compensation Insurance

The Company was fully insured for workers' compensation claims with no deductible for the years ended September 30, 2019 and 2018.

Reserve Methodology

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 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 financial position, results of operations or cash flows.

Employee Health Plans

The Company maintains 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. Commercial insurance policies cover per occurrence losses in excess of $350,000. An actuarially estimated liability of approximately $0 and $488,000 for incurred but not reported claims as of September 30, 2019 and 2018, respectively. As of September 30, 2019, Prospect has assumed the liability related to employee health plans.

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 statements of operations. The Company has accrued $2,290,000 and $2,092,000 related to asbestos remediation as of September 30, 2019 and 2018, respectively. The Company recorded $378,000 and $156,000 of accretion of the asset retirement obligation during the year ended September 30, 2019 and 2018, respectively.

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

The Company held restricted cash of $13,000 and $166,000 as of September 30, 2019 and 2018, respectively, which is restricted for grants for the Company's School of Nursing.

Inventories

Inventories of supplies are valued at the lower of amounts that approximate the weighted average cost or net realizable value, which approximates market value, and are expensed as incurred. Inventories consist primarily of medical and surgical supplies and pharmaceuticals.

Sale-Leaseback Transactions

The Company evaluates sale-leaseback transactions by determining whether the transaction meets the qualifying criteria to be recognized as a sale-leaseback, including the transfer of risk and rewards of ownership as well as the absence of continuing involvement of the Company. When the qualifying criteria for a sale-leaseback transaction are not met, the Company accounts for the transaction as a financing.

Income Taxes

For tax reporting purposes, the Company is treated as a Partnership and is a pass-through entity. Therefore, no provision is made in the accompanying financial statements for liabilities for federal, state or local income taxes since such liabilities are the responsibility of the Company's parent companies. The Company periodically evaluates its tax positions, including its status as a pass-through entity, to evaluate whether it is more likely than not that such positions would be sustained upon examination by a tax authority for all open tax years, as defined by the statute of limitations, based on its technical merits.

As of September 30, 2019 and 2018, the Company has not established a liability for uncertain tax positions. The Company files income tax returns in the U.S. federal jurisdiction and the state of Rhode Island. Generally, the Company is subject to examination by U.S. federal (or state and local) income tax authorities for three to four years from the filing of a tax return.

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 and Medicaid. The Company received revenues from Medicare and Medicaid as follows (in thousands):

	For the Year Ended September 30, 2019	% of Net Patient Services Revenues	For the Year Ended September 30, 2018	% of Net Patient Services Revenues
Medicare	$ 59,521	40%	$ 68,242	46 %
Medicaid	42,055	29%	33,216	22 %
Total	$ 101,576	69%	$ 101,458	68 %

Use of Estimates

The preparation of 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 financial statements are prepared. Actual results could materially differ from those estimates. Principal areas requiring the use of estimates include amounts due from/to government payers, allowances for contractual discounts and doubtful accounts, professional and general liability claims, employee health benefit claims, long-lived assets, intangible assets and asset retirement obligations.

New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, "Revenue from Contracts with Customers (Topic 606)" with an effective date deferred 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, and interim periods within fiscal years beginning after December 15, 2019. 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 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. The Company is currently evaluating the effect of this guidance on its financial statements.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)". The core principle of ASU 2016-02 is that a lessee should recognize the assets and liabilities that arise from leases, including operating leases. Under the new requirements, a lessee will recognize in the statement of financial position a liability to make lease payments (the lease liability) and the right-of-use asset representing the right to the underlying asset for the lease term. For leases with a term of 12 months or less, the lessee is permitted to make an accounting policy election by class of underlying asset not to recognize lease assets and lease liabilities. The recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee have not significantly changed from previous GAAP. The standard was originally scheduled to effective for nonpublic entities for fiscal years beginning after December 15, 2019. In November 2019 the FASB issued ASU 2019-10, "Financial Instruments—Credit Losses (Topic 326), Derivatives and Hedging (Topic 815), and Leases (Topic 842)" which delayed the effective date by one year to December 2020. The Company is currently evaluating the standard and the impact on its financial statements and footnote disclosures.

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230)". The updated standard addresses eight specific cash flow issues with the objective of reducing diversity in practice. ASU 2016-15 is effective for non-public business entities for annual reporting periods beginning after December 15, 2018, including interim periods within those annual reporting periods. Early adoption is permitted. The Company is assessing the impact of the adoption of ASU 2016-15 on its financial statements.

Reclassifications

Certain reclassifications were made to the prior year financial statements in order to conform to the current year presentation.

3. Property, Improvements and Equipment

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

September 30,	2019	2018
Property, improvements and equipment:		
Land and land improvements	$ 4,802	$ 4,802
Buildings and improvements	18,183	18,180
Leasehold improvements	4,048	4,048
Equipment	17,943	16,456
	44,976	43,486
Less: accumulated depreciation	(30,424)	(24,510)
	14,552	18,976
Construction in Progress	9,174	5,088
Property, improvements and equipment, net	$ 23,726	$ 24,064

As of September 30, 2019 and 2018, the Company had assets under capitalized leases of $2,205,000 and $2,005,000, respectively, and related accumulated depreciation of $1,154,000 and $818,000, respectively.

Depreciation expense was $6,293,000 and $7,128,000 for the years ended September 30, 2019 and 2018, respectively.

4. Intangible Assets

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

	Amortization Period	September 30, 2019	September 30, 2018
Trade names	5 years	$ 3,590	$ 3,590
Total acquisition cost of intangible assets		3,590	3,590
Less accumulated amortization		(3,590)	(3,073)
Intangible assets, net		$ -	$ 517

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives. Amortization expense was $517,000 and $718,000 for the years ended September 30, 2019 and 2018, respectively.

There is no future amortization expense as of September 30, 2019.

5. Sale-Leaseback Liability and Deferred Revenue

In October 2016, the Company entered into an agreement under which it granted and conveyed an exclusive easement to a water tower utilized for telecommunications purposes for a 99 year term to an unrelated third party. The agreement also assigned certain of the Company's telecommunications leases. The purchase price was approximately $2,057,000. The income derived from this transaction has been deferred and is being recognized on a straight line basis over the remaining term of the leases, through 2028.

In December 2016, the Company entered into a transaction to sell the former St. Joseph Hospital Campus for $100,000 to an unrelated third party. The purchaser has agreed to make certain required capital improvements as part of this transaction. In connection with this transaction, the Company also entered into a separate agreement to lease back a portion of the facility for 7 years, with options to renew for three 7 year periods, for an initial base rent of $80,000 per month. The lease also provides for the payment of a portion of the property taxes for the facility, consisting of $120,000 per year through 2020 and a pro rata portion of property taxes based on the Company's leased space after 2020. This transaction does not qualify for sale-leaseback accounting because of the Company's deemed continuing involvement with the buyer-lessor, including the guarantee by PCC and because the term of the lease agreement is longer than the economic age of the facility. These are considered a form of contingent collateral and results in the transaction being recorded under the financing method. The sale-leaseback liability, which consists of the purchase consideration and the transfer of the ARO balance, and is presented within other long-term liabilities in the accompanying balance sheets.

Scheduled payments under the Company's sale-leaseback liability as of September 30, 2019 are as follows (in thousands):

Years ending September 30,		
2020	$	260
2021		367
2022		519
2023		734
2024		226
		2,106
Plus: reduction in liability to be accreted to interest income		1,974
Total sale-leaseback liability	$	4,080

The total payments to be paid over the remainder of the lease are $2,106,000. The interest rate implicit in the calculation is negative 35.1%. The value of the sale-leaseback liability is based on the building that was sold, not just the part of the building that was leased back, because as noted above the transaction did not meet the definition of a minor sale-leaseback under the literature. Accordingly, the liability is greater than the sum of the future payments to be made under the lease and this gives rise to a negative interest rate.

6. Related Party Transactions

PCC and its Subsidiaries and Prospect East Hospital Advisory Services, LLC ("PEHAS"), a wholly-owned subsidiary of Prospect, entered into a Management Services Agreement ("MSA") as of June 20, 2014, under which PEHAS provides certain administrative and management services to PCC and its Subsidiaries. Management fees due to PEHAS under the MSA consist of 2% of net revenues monthly. The Company recognized management fees of $2,954,000 and $2,994,000 for the years ended September 30, 2019 and 2018, respectively, which is included within management fee expense in the accompanying statements of operations. As of September 30, 2019 and 2018, $15,546,000 and $12,592,000, respectively, due pursuant to the MSA, is included in due to affiliated companies, net, in the accompanying balance sheets.

7. 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 2020. Capital leases bear interest at 4.3% per annum.

The future minimum annual lease payments (net of anticipated sublease income) required under leases in effect at September 30, 2019, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2020	$ 40	$ 156
2021	-	11
2022	-	-
2023	-	-
2024	-	-
Total minimum lease payments	40	$ 167
Less: amounts representing interest	(2)	
	38	
Less: current portion	(38)	
	$ -	

Lease and rental expense was $1,544,000 and $1,536,000 for the years ended September 30, 2019 and 2018, respectively.

Contingent Liability for Borrowings by Prospect

The Company is contingently liable as a guarantor, among others, for amounts borrowed by PMH on senior secured notes (through August 23, 2019), credit facilities at September 30, 2019 and 2018. Additionally, as of September 30, 2019 the Company is a pledger for all of the transactions that PMHs has entered into with affiliates of Medical Properties Trust, Inc. ("MPT"), a publicly traded Real Estate Investment Trust, on August 23, 2019.

The obligations and related interest expense related to these credit facilities are not reflected in the Company's financial statements as of and for the years ended September 30, 2019 and 2018, as the borrowings are reflected in the separate consolidated financial statements of PMH.

Total borrowings outstanding as of September 30, 2019, reflected in the consolidated financial statements of PMH, but for which the Company is contingently liable as a guarantor, were (in thousands):

September 30,	2019	2018
Senior secured credit facility (net of discount of $0 and $20,085, respectively)	$ -	$ 1,094,315
Less: Deferred financing costs, net ("DFC")	-	(16,214)
Total Debt, net of discount, premium and DFC	$ -	$ 1,078,101

On June 30, 2016, PMH entered into a six-year $625,000,000 senior secured term loan B (the "Original Term Loan"). The Original Term Loan was issued with an original discount of 1.50%, or $9,375,000. Additionally, the Company refinanced the previous revolver with a new $100,000,000 asset-based revolving credit facility ("Original ABL Facility" and together with the Original Term Loan, the "New Senior Secured Credit Facilities"). Pursuant to various amendments from August 2016 through October 2017, the aggregate commitment amount under the Original ABL facility was increased in stages to $175,000,000. The original maturity date for the Original ABL Facility was June 30, 2021, and the original maturity date for the Term Loan was June 30, 2022.

On February 22, 2018, PMH refinanced and replaced both the Original Term Loan and the Original ABL Facility, and entered into an Amended and Restated Term Loan Credit Agreement (the "Amended TL Agreement"), by and among PMH (as the borrower), the lenders party thereto and JPMorgan Chase Bank, N.A. ("JPMorgan"), as administrative agent and collateral agent. The Amended TL Agreement replaced the Original Term Loan with a new Term B-1 Loan ("Term B-1 Loan"). The principal amount of the Term B-1 Loan is $1,120.0 million and such loan incurred interest at LIBOR (subject to a 1.0% floor) plus 5.5%. The Term B-1 Loan was issued with an original discount of 2% and was originally scheduled to mature on February 22, 2024. The Term B-1 Loan was repaid on August 23, 2019 by the proceeds totaling $1.55 billion from a series of transactions that PMH entered into with affiliates of MPT (see further discussion below).

Additionally, on February 22, 2018, PMH entered into an Amended and Restated ABL Credit Agreement (the "Amended ABL Agreement"), by and among PMHs (as the borrower), the lenders party thereto and JPMorgan, as administrative agent and collateral agent. The Amended ABL Agreement replaced the Original ABL Facility. Under the Amended ABL Agreement, the maximum revolving commitment was $250,000,000 with ability to expand the facility to $325,000,000, and the new ABL facility (the "New ABL Facility") bears interest at a variable base rate plus an applicable spread that is based on excess availability under the New ABL Facility, as further described in the Amended ABL Agreement, which was 6.0% as of September 30, 2019. From January 2019 through July 2019 PMH entered into various amendments to the Amended ABL Agreement. Such amendments (i) waived certain events of default at September 30, 2018; (ii) increased the maximum revolving commitment from $250.0 million to $280.0 million, and further to $285.0 million, while simultaneously reducing and removing future expansion of the facility; (iii) introduced $40.0 million of a first in last out ("FILO") revolving facility, which incurred interest at either 2.5% or 3.5% per

CIIH16-001053

annum depending on whether they are Eurodollar loans or ABR loans (which were repaid on August 23, 2019); (iv) provides for a reduction in the maximum revolving commitment by $20.0 million and $10.0 million upon the future planned closure or disposition of Nix Health and EOGH, respectively. The New ABL Facility matures on February 22, 2023. As of September 30, 2019, the outstanding balance and the available balance on the New ABL facility was approximately $70.0 million and $175.6 million, respectively. On August 23, 2019, PMH closed a series of transactions with affiliates of MPT. Under these transactions, PMH sold to MPT its hospital buildings in California (excluding Foothill Regional Medical Center ("Foothill"), Connecticut and Pennsylvania for an aggregate purchase price of $1,386,000,000. Concurrent with the sale transactions, PMH entered into two master lease agreements whereby the hospital properties and related medical office buildings were leased back for an initial 15 year term, with options to extend twice for an additional 5 years each and for a further 4.75 year extension. Monthly rent is defined as 7.5% of the lease base, subject to annual escalation of consumer price index, limited to a minimum of 2% and a maximum of 4%. For the first master lease, PMH has the option to buy the properties at their fair value at the end of the lease term. For the second master lease, PMH has the option to purchase at a price that is fixed at the time of entering into the lease (the "Option Price"). If PMH chooses not to exercise this option, and the fair value at the end of the lease is below the Option Price, then PMH must pay MPT a sum equal to the difference between the fair value and the Option Price. All of the legal entities that are parties to the master lease agreement (which are the hospital entities themselves) provide cross guarantees on all of the obligations to MPT, which guarantees include both lease payments under the master lease as well as indebtedness due to MPT. The balance under sale-leaseback liabilities was $1,331,000,000 at September 30, 2019, as reflected in PMH's consolidated financial statements.

Further, PMH obtained a mortgage on the Foothill property. This mortgage is secured by the buildings at Foothill. The interest on this mortgage is 7.5% per annum and is subject to annual escalation of consumer price index, limited to a minimum of 2% and a maximum of 4%. The maturity date of this loan is in August 2034. MPT can purchase the property on event of default or at end of term, or if Company does not exercise purchase rights for the aforementioned leased properties. Additionally, if the Foothill property is no longer used as collateral for a promissory note payable to Prospect Medical Group, Inc. ("PMG"), then MPT shall have the right to purchase the Foothill property and lease it back to PMH under the second master lease agreement, for an amount equal to the outstanding principal balance. The referenced promissory note payable to PMG has been included in the calculation of PMG's Tangible Net Equity in connection with requirements of the California Department of Managed Health Care. The balance under this mortgage loan was $51,276,000 at September 30, 2019, as reflected in PMH's consolidated financial statements.

Additionally, PMH entered into a promissory note (the "TRS Note"), under which MPT has advanced to PMH $112,937,000 related to the value of the properties in Rhode Island. The interest on this note is 7.5% per annum and is subject to annual escalation of consumer price index, limited to a minimum of 2% and a maximum of 4%. The maturity date of this note is the earlier of July 2022 or the conversion to and sale-leaseback of the properties in Rhode Island. The balance under this mortgage loan was $112,937,000 at September 30, 2019, as reflected in PMH's consolidated financial statements.

All of the agreements with MPT are cross-collateralized and cross defaulted. The MPT transaction documents contain certain customary covenants and restrictions and a financial covenant based on EBITDAR performance, and PMH was in compliance with such covenants at September 30, 2019.

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 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 financial position, results of operations and cash flows for the period in which the effect becomes probable and reasonably estimable.

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, states have also developed their own standards for the privacy and security of health information as well as for reporting certain violations and breaches (for example, California's Confidentiality of Medical Information Act and Lanterman-Petris Short Act) which in some cases are more stringent. Other federal privacy laws may also apply to certain services provided by the Company, including 42 C.F.R. Part 2, which addresses the confidentiality of substance use disorder records. 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") has made significant changes to the United States health care system. The legislation impacted multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Under this legislation, 33 states have expanded their Medicaid programs to cover previously uninsured childless adults, and four additional states voted in 2018 to expand Medicaid or to elect a governor that pledged to expand Medicaid. In addition, many uninsured individuals have had the opportunity to purchase health insurance via state-based marketplaces, state-based marketplaces using a federal platform, state-partnership marketplaces or the federally-facilitated marketplace. PPACA also implemented a number of health insurance market reforms, such as allowing children to remain on their parents' health insurance until age 26 or prohibiting certain plans from denying coverage based on pre-existing conditions. Nationally, these reforms have reduced the number of uninsured individuals.

It is unclear what changes may be made to PPACA with the divided Congress, current presidential administration, and pending litigation over the validity of PPACA. The Administration has promulgated rules to broaden the availability of coverage options that do not comply with the full range of PPACA requirements for individual market coverage, namely Association Health Plans and Short-Term Limited-Duration Insurance. The Administration has also provided additional guidance on state PPACA waivers. These executive actions have been or may be challenged in court. In addition, the Tax Cuts and Jobs Act ("TCJA"), passed in December 2017, eliminates the individual mandate penalty under PPACA, effective January 1, 2019. The individual mandate penalty was included in PPACA to address concerns that other market reforms expanding access to coverage might produce adverse selection and higher premiums. The extent to which the repeal of the individual mandate penalty will impact the uninsured rate and future premiums are unclear at this juncture. On December 14, 2018, the United States District Court for the Northern District of Texas ruled that the individual mandate without the penalty is unconstitutional and that PPACA is therefore invalid in its entirety. Litigation on this issue is ongoing, with a decision pending from a panel of the United States Court of Appeals for the Fifth Circuit following oral arguments in July 2019. This litigation along with any future legislative changes to PPACA or other federal and state legislation could have a material impact on the operations of the Company. The Company is continuing to monitor the legislative environment and developments in pending litigation for risks and uncertainties.

Collective Bargaining Agreements

The Company has 304 employees that are subject to a collective bargaining agreement with United Nurses and Allied Professionals ("UNAP"), which was effective beginning July 15, 2019 and expires July 31, 2019. During April 2015, a hospital unit consisting of approximately 430 service employees of Fatima elected to be represented by UNAP. The parties entered into a new collective bargaining agreement which was effective beginning July 2, 2019 and expires on June 30, 2022. A small number of employees are subject to a collective bargaining agreement with the Federation of Nurses and Health Professionals ("FNHP"), which expires on July 30, 2021.

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.

8. Defined Contribution Plan

Prospect sponsors defined contribution plans (the "Plans") covering substantially all employees who meet certain eligibility requirements. Under the Plans, employees can contribute up to 100% of their compensation up to the IRS deferred annual maximum. Effective May 1, 2018, the plans covering employees at Prospect's facilities in Connecticut and Pennsylvania merged into the plans covering employees at CharterCARE, and the two remaining plans were renamed and segregated between union and non-union employees. The Company may make discretionary matching contributions to the Plans. Employer contributions to the Plan were $1,118,000 and $1,096,000 for the years ended September 30, 2019 and 2018, respectively.

9. Regulatory

General

The Company participates in Student Financial Aid ("SFA") under the Federal Title IV programs administered by the Department of Education ("ED") pursuant to the Higher Education Act of 1965, as amended ("HEA"). The Company must comply with the regulations promulgated under HEA.

Financial Responsibility

All institutions participating in the Title IV Programs must satisfy specific standards of financial responsibility as promulgated by the ED. The ED evaluates institutions for compliance with these standards each year, based on the institution's annual audited financial statements. Compliance with the financial responsibility standards are determined through the calculation of a composite score based upon certain financial ratios as defined in the regulations. Institutions receiving a composite score of 1.5 or greater are considered fully financially responsible. Institutions receiving a composite score between 1.0 and 1.4 are subject to additional monitoring and institutions receiving a composite score below 1.0 are required to submit financial guarantees in order to continue participation in the Title IV programs. As of September 30, 2019, and for the year then ended, the Company's composite score was 1.5.

Compliance with 90/10 Cash Basis Revenue Regulations

The Company derives a portion of its tuition revenues from SFA received by its students under the Title IV programs administered by the ED pursuant to the HEA. To continue to participate in the SFA programs the Company must comply with the regulations promulgated under HEA. The regulations restrict the proportion of cash receipts for tuition and fees from eligible programs to not more than 90 percent from the Title IV programs. In July 2008, modifications to the regulations were made with respect to amounts to be included in the 90 percent calculations including temporary provisions related to certain Title IV funds received and institutional loans made to students. The modifications also allow for the inclusion of funds received for certain qualifying non-Title IV programs. In addition, the modifications included provisions for institutions that do not comply with the 90 percent rule for a single fiscal year, whereby such institutions would be placed on provisional certification status for a period of two years. Institutions that do not comply with the 90 percent rule for two consecutive fiscal years are subject to the loss of their ability to participate in the SFA programs.

In October 2009, HEA amended the regulations with respect to the disclosure requirements to the 90 percent calculations and allowed institutions to implement the new and amended provisions. The amended provisions require an institution to disclose the dollar amount of the numerator and denominator of its 90 percent calculation as well as the individual revenue amounts by fund source received by the institution.

For the years ended September 30, 2019 and 2018, the Company's 90/10 cash basis revenue test percentages were computed as follows:

(in thousands)	2019	2018
Revenue by Source		
Student Title IV cash basis revenue		
Subsidized loan	$ 113	$ 344
Unsubsidized loan	216	579
Plus loan	15	55
Federal Pell grant	73	207
	$ 417	$ 1,185
Student Non-Title IV revenue		
Funds provided from private loans	$ 59	$ 147
State loans	40	148
Scholarships	6	23
Student payments	200	454
	$ 305	$ 772
Student Title IV cash basis revenue	$ 417	$ 1,185
Student title IV cash basis revenue + Student Non-Title IV cash basis revenue	$ 722	$ 1,957
	58%	61%

10. Subsequent Event

The Company has evaluated subsequent events through February 6, 2020, the date the Company's financial statements were available for issuance.

Supplemental Report and Schedule

BDO

Tel: 714-957-3200
Fax: 714-957-1080
www.bdo.com

600 Anton Blvd., Suite 500
Costa Mesa, CA 92626

Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

Board of Directors
Prospect CharterCARE SJHSRI, LLC
Los Angeles, California

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Prospect CharterCARE SJHSRI, LLC (the "Company"), which comprise the balance sheet as of September 30, 2019, and the related statements of operations, member's equity, and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated February 6, 2020.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Company's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the Company's financial statements will not be prevented, or detected and corrected on a timely basis. *A significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Company's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

BDO

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Company's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Company's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

BDO USA, LLP

February 6, 2020

Section I - Summary of Auditor's Results

Financial Statements

Type of auditor's report issued:	Unmodified	
Internal control over financial reporting:		
Material weaknesses identified?	______ yes	__X__ no
Significant deficiencies identified?	______ yes	__X__ none reported
Noncompliance material to financial statements noted?	______ yes	__X__ no

Section II - Financial Statement Findings

There were no findings as of September 30, 2019 and for the year ended.

Status of Prior Audit Findings

2018 Findings Status

Condition

The Company had a material weakness in internal controls over financial reporting. The Company's control environment had not been maintained in a way to appropriately and positively influence the effectiveness of the organization's internal control. Accordingly, this material weakness is a causal factor that allowed for greater opportunity for management to override existing internal controls.

Status

Management believes this finding has been resolved.

CharterCARE
HEALTH PARTNERS

Status of Prior Audit Findings

2018 Findings Status

Condition

The Company had a material weakness in internal controls over financial reporting. The Company's control environment had not been maintained in a way to appropriately and positively influence the effectiveness of the organization's internal control. Accordingly, this material weakness is a causal factor that allowed for greater opportunity for management to override existing internal controls.

Status

Management believes this finding has been resolved.

Prospect CharterCARE RWMC, LLC

Consolidated Financial Statements

As of and for the Years Ended
September 30, 2019 and 2018

CIIH16-001066

Prospect CharterCARE RWMC, LLC

Consolidated Financial Statements

As of and for the Years Ended September 30, 2019 and 2018

Prospect CharterCARE RWMC, LLC

Contents

	Page
Independent Auditor's Report	3 - 4
Consolidated Balance Sheets	6 - 7
Consolidated Statements of Operations	8
Consolidated Statements of Member's Equity	9
Consolidated Statements of Cash Flows	10
Notes to the Consolidated Financial Statements	11 - 29

BDO

Tel: 714-957-3200
Fax: 714-957-1080
www.bdo.com

600 Anton Blvd., Suite 500
Costa Mesa, CA 92626

Independent Auditor's Report

Board of Directors
Prospect CharterCARE RWMC, LLC
Los Angeles, California

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Prospect CharterCARE RWMC, LLC (the "Company"), which comprise the consolidated balance sheets as of September 30, 2019 and 2018, and the related consolidated statements of operations, member's equity, 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 audit 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 financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company'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 Company'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 CharterCARE RWMC, LLC and its subsidiary as of September 30, 2019 and 2018, 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.

Emphasis of Matter

As discussed in Note 1, the Company is financially dependent on its parent companies which have agreed to provide the financial support necessary for the operations of the Company. The accompanying consolidated financial statements do not reflect any adjustments or disclosures that would be required should the parent company discontinue its financial support.

BDO USA, LLP

February 6, 2020

Consolidated Financial Statements

Prospect CharterCARE RWMC, LLC

Consolidated Balance Sheets
(in thousands)

September 30,	2019	2018
Assets		
Current assets		
Cash and cash equivalents	$ -	$ -
Restricted cash	158	267
Patient accounts receivable, less allowance for doubtful accounts of $9,166 and $5,284, respectively	25,276	22,400
Other receivables	1,121	2,171
Due from government payers	792	402
Inventories	3,657	3,332
Prepaid expenses and other current assets	749	768
Total current assets	31,753	29,340
Property, improvements and equipment, net	37,076	35,044
Intangible assets, net	-	653
Equity method investments	3,650	4,063
Insurance receivable and other assets	584	872
Total assets	$ 73,063	$ 69,972

See accompanying notes to consolidated financial statements.

Prospect CharterCARE RWMC, LLC

Consolidated Balance Sheets
(in thousands)

September 30,		2019		2018
Liabilities and Member's Equity				
Current liabilities				
Accrued medical claims and other healthcare costs payable	$	-	$	491
Accounts payable and other accrued liabilities		14,122		17,154
Accrued salaries, wages and benefits		7,597		7,152
Due to government payers		214		74
Due to affiliated companies, net		25,834		20,750
Current portion of capital leases		-		326
Current portion of sale-leaseback liability		257		257
Total current liabilities		48,024		46,204
Malpractice reserves		3,211		4,243
Asset retirement obligations		1,333		839
Sale-leaseback liability, net of current portion		2,539		3,117
Other long-term liabilities		297		315
Total liabilities		55,404		54,718
Commitments and contingencies				
Member's equity				
Member contributions		34,241		34,241
Accumulated deficit		(16,582)		(18,987)
Total member's equity		17,659		15,254
Total liabilities and member's equity	$	73,063	$	69,972

See accompanying notes to consolidated financial statements.

CIIH16-001073

Prospect CharterCARE RWMC, LLC

Consolidated Statements of Operations
(in thousands)

For the years ended September 30,		2019		2018
Revenues				
Net patient service revenues	$	187,275	$	181,353
Provision for bad debts		(6,986)		(5,996)
Net patient service revenues less provision for bad debts		180,289		175,357
Other non-patient Hospital revenues		3,012		2,819
Total net revenues		183,301		178,176
Operating Expenses				
Salaries, wages and benefits		84,126		86,715
Supplies		39,285		39,889
Purchased services		14,726		12,714
Taxes and licenses		12,636		12,151
Depreciation and amortization		7,867		7,124
Professional fees		8,040		5,422
Other		1,745		5,969
Management fees		3,791		3,721
Utilities		2,586		2,400
Research grant expense		2,626		2,503
Insurance		1,821		1,869
Lease and rental		1,126		1,210
Repairs and maintenance		858		1,254
Registry		406		720
Total operating expenses		181,639		183,661
Operating income from unconsolidated equity method investments		560		589
Operating income (loss)		2,222		(4,896)
Other (income) expense:				
Interest income, net		(183)		(340)
Goodwill impairment		-		7,452
Total other (income) expense, net		(183)		7,112
Net income (loss)	$	2,405	$	(12,008)

See accompanying notes to consolidated financial statements.

Prospect CharterCARE RWMC, LLC

Consolidated Statements of Member's Equity
(in thousands)

	Member Contributions	Accumulated Deficit	Total Member's Equity
Balance at October 1, 2017	$ 34,241	$ (6,979)	$ 27,262
Net loss	-	(12,008)	(12,008)
Balance at September 30, 2018	34,241	(18,987)	15,254
Net income	-	2,405	2,405
Balance at September 30, 2019	$ 34,241	$ (16,582)	$ 17,659

See accompanying notes to consolidated financial statements.

Prospect CharterCARE RWMC, LLC

Consolidated Statements of Cash Flows
(in thousands)

For the years ended September 30,	2019	2018
Operating activities		
Net income (loss)	$ 2,405	$ (12,008)
Adjustments to reconcile net income (loss) to net cash provided by operating activities:		
Depreciation and amortization	7,297	7,124
Provision for bad debts	6,986	5,996
Undistributed earnings from equity method investments	(560)	(589)
Asset retirement obligations amortization, net	570	89
Accretion of sale-leaseback liability	(322)	(386)
Goodwill impairment	-	7,452
Changes in operating assets and liabilities:		
Change in restricted cash	109	(2,102)
Patient accounts receivable and other receivables	(8,812)	(7,141)
Due to/from government payers, net	(250)	(30)
Inventories	(325)	418
Prepaid expenses and other current assets	19	610
Insurance receivable and other assets	288	(271)
Accrued medical claims and other healthcare costs payable	(491)	97
Accounts payable and other accrued liabilities	(3,059)	3,412
Malpractice reserve	(1,032)	970
Net cash provided by operating activities	2,823	7,845
Investing activities		
Purchases of property, improvements and equipment	(6,060)	(2,548)
Cash distributions from equity investments	973	578
Net cash used in investing activities	(5,087)	(1,970)
Financing activities		
Change in due to affiliated companies	2,846	(5,321)
Repayments on sale-leaseback liability	(256)	(257)
Repayments of capital leases	(326)	(596)
Net cash provided by (used in) financing activities	2,264	(6,174)
Change in cash and cash equivalents	-	(299)
Cash and cash equivalents, beginning of year	-	299
Cash and cash equivalents, end of year	$ -	$ -
Supplemental disclosure of cash flow information		
Interest paid	$ 13	$ 45
Schedule of non-cash investing and financing activities		
Noncash acquisition	$ -	$ 7,452
Accrual of property, improvements and equipment	$ 2,211	$ 7,714

See accompanying notes to consolidated financial statements.

1. Organization

Prospect CharterCARE RWMC, LLC ("RWMC" or the "Company") is a wholly-owned subsidiary of Prospect CharterCARE, LLC ("PCC"). PCC is owned 85% by Prospect Medical Holdings, Inc. ("Prospect" or "PMH") and 15% by CharterCARE Community Board. RWMC operates a 220-bed acute care general hospital which provides healthcare services in Providence, Rhode Island and surrounding communities.

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

The Company is dependent on Prospect to fund ongoing operations. As of September 30, 2019, the Company had a liability of $25,834,000 due to Prospect and its subsidiaries, which is payable on demand, does not bear interest, and is included in due to affiliated companies, net in the accompanying consolidated balance sheets. Prospect does not intend to have the Company repay the liability in a manner which would impair the Company's ability to maintain sufficient liquidity to sustain ongoing operations.

2. Significant Accounting Policies

Principles of Consolidation and 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 RWMC's wholly-owned subsidiaries but do not include the accounts of PCC, Prospect or CharterCARE Community Board. All significant intercompany balances and transactions have been eliminated in consolidation.

Revenues

Net Patient Service Revenues

Operating revenue 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, 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 net patient service revenues (net of contractual allowances and discounts) before provision for bad debts (in thousands):

For the years ended September 30,		2019		2018
Medicare	$	84,913	$	87,715
Medicaid		40,525		37,616
Managed Care/Commercial		41,527		39,313
Self-Pay/Other		20,310		16,709
Total	$	187,275	$	181,353

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 persons with end-stage renal disease and certain other beneficiary categories, including eligible disabled persons. Most inpatient hospital services rendered to Medicare program beneficiaries are paid on a fee-for-service basis at prospectively determined rates per discharge, according to a patient classification system based on clinical, diagnostic, and other factors. Most outpatient services also are paid on a fee-for-service basis generally using prospectively determined rates. The Company receives, as appropriate, Medicare disproportionate share hospital ("DSH") and bad debt payments at tentative rates, with final settlement determined after submission of the annual Medicare cost report and audit thereof by the Medicare Administrative Contractor. The Company also receives, as appropriate, Medicare uncompensated care DSH payments, which are generally not subject to cost report audit except to determine eligibility for Medicare DSH. The Company also receives Medicare outlier payments on an ongoing basis during the year for cases that are unusually costly, and under certain circumstances these payments may be reconciled to more closely reflect the costs in excess of outlier thresholds after the submission and audit of the annual Medicare cost report. Normal estimation differences between filed settlements and amounts accrued are reflected in net patient service revenue.

The Company is reimbursed by Medicare for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports and audits thereof by the Medicare Administrative Contractor. The estimated amounts due to or from the program are reviewed and adjusted annually based on the status of such audits and any subsequent appeals. Differences between final settlements and amounts accrued in previous years are reported as adjustments to net patient service revenue in the year that examination is substantially completed.

Although services for most Medicare beneficiaries are paid by the Federal government on a fee-for-service basis, approximately one-third of Medicare beneficiaries are enrolled in a "Medicare Advantage" plan, which is a type of health plan that contracts with the Medicare program to provide hospital and medical benefits to Medicare beneficiaries. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-For-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. For Medicare beneficiaries enrolled in a Medicare Advantage plan, most Medicare services are covered by the plan and are not paid for under fee-for-service Medicare. Certain Medicare Advantage plans make capitation payments to the Company using a "Risk Adjustment model," which compensates providers based on the health status (acuity) of each enrollee. Providers with higher acuity enrollees generally will receive more and those with healthier enrollees will receive less.

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. *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. Similar to Medicare, cost report settlements are recorded based upon as-filed cost reports and adjusted for tentative and final settlements, if any.

RWMC is a participant in the State of Rhode Island's DSH program, which assists hospitals that provide a disproportionate amount of uncompensated care. Under the program, the Company's hospitals receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low-income patients. RWMC recognized revenue related to DSH and Upper Payment Limit ("UPL") reimbursement of $10,587,000 and $9,179,000 for the years ended September 30, 2019 and 2018, respectively. DSH and UPL payments received were $10,340,000 and $8,787,000 for the years ended September 30, 2019 and 2018, 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 Company recorded $9,495,000 and $9,199,000 of expense during the years ended September 30, 2019 and 2018, respectively, 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.

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 indigent and charity care policy.

Charity Care

The Company provides charity care to patients who lack financial resources and are deemed to be medically indigent based on criteria established under the Company's charity care policy. This care is provided without charge or at amounts less than the Company's established rates. Because the Company does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The direct and indirect costs related to this care totaled approximately $183,000 and $457,000 for the years ended September 30, 2019 and 2018, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. In addition, the Company provides services to other medically indigent patients under various state Medicaid programs. Such programs pay amounts that are less than the cost of the services provided to the recipients. The Company has not changed its charity care or uninsured discount policies during the years ended September 30, 2019 or 2018.

Provisions for Contractual Allowances and Doubtful Accounts

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 was 27% and 19% of gross patient accounts receivable as of September 30, 2019 and 2018, respectively, and the increase results from a determination at September 30, 2019 to fully reserve for all patient accounts receivable over 365 days old.

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.

Other Non-Patient Hospital Revenues

Other non-patient Hospital revenues totaled $3,012,000 and $2,819,000 for the years ended September 30, 2019 and 2018, respectively. The principal components of other non-patient Hospital revenues include grant revenue and rental revenue. Management has evaluated the collectability of other receivables consisting primarily of other non-patient Hospital revenues and determined no allowance is necessary as of September 30, 2019 or 2018.

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. Building improvements are generally depreciated over seven years, buildings are depreciated over 10 years, equipment is depreciated over three to seven years and furniture and fixtures are depreciated over five 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.

Goodwill

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. The Company's annual goodwill impairment test is conducted on July 1. Impairment of goodwill is tested at the reporting unit level, by comparing the reporting unit's carrying amount, including goodwill, to the fair value of the reporting unit. The fair value of the reporting units are estimated. 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 one-step process which consists of estimating 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. If the estimated fair value of the reporting unit is less than its carrying value, this indicates that goodwill is impaired, and impairment is recorded based on the deficiency of fair value compared to the carrying value. The Company's impairment test related to goodwill during the year ended September 30, 2018 resulted in a full impairment of goodwill related to the Rhode Island facilities. There were no impairment charges during the year ended September 30, 2019.

Intangible Assets

Intangible assets include trade names. 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, 2019 or 2018.

Insurance Reserves

Medical Malpractice Liability Insurance

The Company carries professional and general liability insurance to cover medical malpractice claims. The General Liability coverage is occurrence coverage and the Professional Liability coverage is claims-made coverage. Under the Professional Liability policy, insurance premiums cover only those claims actually reported during the policy term. Should the Professional Liability 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.

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 recognizes 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. The Company's gross claims liability was $3,211,000 and $4,243,000 as of September 30, 2019 and 2018, respectively, and insurance receivables were $584,000 and $872,000 as of September 30, 2019 and 2018, respectively. The gross claims liability and insurance receivables were estimated using a discount factor of 4% and are included within long-term assets and long-term liabilities, respectively, in the accompanying consolidated balance sheets.

Workers' Compensation Insurance

The Company was fully insured for workers' compensation claims with no deductible during the years ended September 30, 2019 and 2018.

Reserve Methodology

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 financial position, results of operations or cash flows.

Employee Health Plans

The Company maintains 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. Commercial insurance policies cover per occurrence losses in excess of $350,000. An actuarially estimated liability of approximately $0 and $491,000 for incurred but not reported claims as of September 30, 2019 and 2018, respectively. As of September 30, 2019, Prospect has assumed the liability related to employee health plans.

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 consolidated statement of operations. The Company has accrued $832,000 and $839,000 related to asbestos remediation as of September 30, 2019 and 2018, respectively. The Company recorded $570,000 and $46,000 of accretion of the asset retirement obligation during the year ended September 30, 2019 and 2018, respectively.

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

The Company held restricted cash of $158,000 and $267,000 as of September 30, 2019 and 2018, respectively, which is restricted for research.

Inventories

Inventories of supplies are valued at the lower of amounts that approximate the weighted average cost or net realizable value, which approximates market value, and are expensed as incurred. Inventories consist primarily of medical and surgical supplies and pharmaceuticals.

Income Taxes

For tax reporting purposes, the Company is treated as a Partnership and is a pass-through entity. Therefore, no provision is made in the accompanying financial statements for liabilities for federal, state or local income taxes since such liabilities are the responsibility of the Company's parent companies. The Company periodically evaluates its tax positions, including its status as a pass-through entity, to evaluate whether it is more likely than not that such positions would be sustained upon examination by a tax authority for all open tax years, as defined by the statute of limitations, based on its technical merits.

As of September 30, 2019 and 2018, the Company has not established a liability for uncertain tax positions. The Company files income tax returns in the U.S. federal jurisdiction and the state of Rhode Island. Generally, the Company is subject to examination by U.S. federal (or state and local) income tax authorities for three to four years from the filing of a tax return.

Fair Value of Financial Instruments

Financial instruments consist primarily of cash and cash equivalents, restricted cash, patient and other accounts receivables, accounts payable and accrued expenses, accrued salaries and benefits, amounts due from/to government payers, capital lease obligations, 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.

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 intangible assets when there are indications of impairment.

During the year ended September 30, 2018, the Company recorded approximately $7,452,000 of impairment relating to goodwill, which is reflected in the accompanying consolidated statements of operations.

The Company uses the discounted cash flow approach, the guideline public company approach and the guideline transactions approach to estimate the residual value of the Company's goodwill. The measurement of goodwill is a Level 3 measurement.

The following table provides quantitative information related to the significant unobservable inputs to determine fair value and impairment of goodwill as of September 30, 2018:

Residual Value of Goodwill	Valuation Technique	Unobservable Input	Rates
$ -	Discounted Cash Flow	Weighted average cost of capital	9.3%
		Revenue growth rate	2.1% - 2.5%
	Guideline Public Company	LTM EBITDA multiple	7.0x

There were no nonrecurring measurements as of September 30, 2019.

Sale-Leaseback Transactions

The Company evaluates sale-leaseback transactions by determining whether the transaction meets the qualifying criteria to be recognized as a sale-leaseback, including the transfer of risk and rewards of ownership as well as the absence of continuing involvement of the Company. When the qualifying criteria for a sale-leaseback transaction are not met, the Company accounts for the transaction as a financing, see Note 6.

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 and Medicaid. The Company received revenues from Medicare and Medicaid as follows (in thousands):

	For the Year Ended September 30, 2019	% of Net Patient Services Revenues	For the Year Ended September 30, 2018	% of Net Patient Services Revenues
Medicare	$ 84,913	45%	$ 87,715	48%
Medicaid	40,525	22%	37,616	21%
Total	$ 125,438	67%	$ 125,331	69%

Use of Estimates

The preparation of consolidated financial statements in conformity with GAAP 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 amounts due from/to government payers, allowances for contractual discounts and doubtful accounts, professional and general liability claims, impairment of long-lived assets, and asset retirement obligations.

New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, "Revenue from Contracts with Customers (Topic 606)" with an effective date deferred 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, and interim periods within fiscal years beginning after December 15, 2019. 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 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. The Company is currently evaluating the effect of this guidance on its consolidated financial statements.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)". The core principle of ASU 2016-02 is that a lessee should recognize the assets and liabilities that arise from leases, including operating leases. Under the new requirements, a lessee will recognize in the statement of financial position a liability to make lease payments (the lease liability) and the right-of-use asset representing the right to the underlying asset for the lease term. For leases with a term of 12 months or less, the lessee is permitted to make an accounting policy election by class of underlying asset not to recognize lease assets and lease liabilities. The recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee have not significantly changed from previous GAAP. The standard was originally scheduled to effective for nonpublic entities for fiscal years beginning after December 15, 2019. In November 2019 the FASB issued ASU 2019-10, "Financial Instruments—Credit Losses (Topic 326), Derivatives and Hedging (Topic 815), and Leases (Topic 842)" which delay the effective date by one year to December 2020. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230)". The updated standard addresses eight specific cash flow issues with the objective of reducing diversity in practice. ASU 2016-15 is effective for non-public business entities for annual reporting periods beginning after December 15, 2018, including interim periods within those annual reporting periods. Early adoption is permitted. The Company is assessing the impact of the adoption of ASU 2016-15 on its consolidated financial statements.

3. Property, Improvements and Equipment

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

September 30,	2019	2018
Property, improvements and equipment:		
Land and land improvements	$ 2,946	$ 2,946
Buildings and improvements	26,602	25,801
Leasehold improvements	334	6,253
Equipment	19,668	11,948
	49,550	46,948
Less: accumulated depreciation	(26,756)	(20,517)
	22,794	26,431
Construction in Progress	14,282	8,613
Property, improvements and equipment, net	$ 37,076	$ 35,044

At September 30, 2019 and 2018, the Company had assets under capitalized leases of approximately $1,928,000 and $1,928,000, respectively and related accumulated depreciation of $1,302,000 and $967,000, respectively.

Depreciation expense was $6,644,000 and $6,216,000 for the years ended September 30, 2019 and 2018, respectively.

4. Acquisition

In December 2017, New University Medical Group ("New UMG") entered into a Second Closing to acquire the remaining assets of University Medical Group ("UMG") that were not acquired in the initial acquisition in December 2014. As consideration for the acquisition, New UMG has assumed certain designated liabilities of the practice, which consists of various loans payable to subsidiaries of the Company, totaling approximately $7.5 million. Post-acquisition, these liabilities are eliminated on consolidation. There was no cash consideration related to the transaction. The remaining assets and liabilities acquired were immaterial and no value was assigned to them in the purchase price allocation, and accordingly goodwill of $7.5 million from the acquisition. The goodwill is deductible for tax purposes at Prospect, with PCC acting as a flow through entity. New UMG's parent company, Prospect CharterCARE Physicians, LLC, dba CharterCARE Medical Associates ("CCMA"), entered into a Post Closing Administrative Services Agreement pursuant to which CCMA and its affiliates provide services to the seller of the practice in connection with its termination of all operations and the wind up its affairs and operations.

The acquisitions were accounted for as business combinations using the acquisition method of accounting. Under the acquisition accounting method, assets acquired and liabilities assumed are recorded based on their estimated fair values. As asset purchases, goodwill acquired is expected to be deductible for tax purposes.

As mentioned at Note 2, on July 1, 2018, the Company tested for goodwill impairment which resulted in a full impairment of goodwill. This includes the goodwill presented in the table above (see Note 5).

5. Goodwill and Intangible Assets

Goodwill relates to the acquisition of New UMG. The following is a roll-forward of goodwill for the years ended September 30, 2019 and 2018, respectively (in thousands):

September 30,	2019	2018
Balance, beginning of year	$ -	$ -
Acquisition	-	7,452
Impairment	-	(7,452)
Balance, end of year	$ -	$ -

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

	Amortization Period	September 30, 2019	September 30, 2018
Trade names	5 years	$ 4,540	$ 4,540
Total acquisition cost of intangible assets		4,540	4,540
Less accumulated amortization		(4,540)	(3,887)
Intangible assets, net		$ -	$ 653

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives. Amortization expense was $653,000 and $908,000 for the years ended September 30, 2019 and 2018, respectively.
There is no future amortization expense as of September 30, 2019.

6. Sale of Real Estate and Sale-Leaseback

PCC previously operated Elmhurst Extended Care ("Elmhurst"), a 206 bed skilled nursing facility, and the Company owned the land and building in which Elmhurst's business was carried out. In December 2016, PCC and the Company entered into a transaction to sell the operations of Elmhurst and the land and building in which Elmhurst operated, to an unrelated third party. PCC's decision to discontinue the operations of this entity was based on the Company's strategy in its market and financial results. The transaction price was approximately $15.2 million, of which approximately $8.3 million was allocated to the land and building. After the land and building were sold, the building was then subdivided into two condominiums, one of which was deeded back to the Company. Additionally, the Company entered into a transaction to lease a portion of the other condominium back for a period of 10 years, with monthly rent of approximately $21,000. This transaction does not qualify for sale-leaseback accounting because of the Company's deemed continuing involvement with the buyer-lessor, including the guarantee by PCC, which is considered a form of contingent collateral and results in the transaction being recorded under the financing method. Further, the building cannot be bifurcated, for accounting purposes, between the portion that was leased and the remainder because the transaction does not meet the definition of a minor sale-leaseback, under applicable accounting literature. PCC received and retained the cash received from the seller, and accordingly the transaction has been accounted for as a noncash distribution to PCC. In accordance with applicable accounting literature, as the Company is a wholly owned subsidiary of PCC, the value of the noncash distribution is based on the carrying value of the assets distributed at the time of sale, which was $4,545,000, and accordingly this is the value that the sale-leaseback liability has been set up at that date.

Scheduled payments under the Company's sale-leaseback liability as of September 30, 2019 are as follows (in thousands):

Years ending September 30,		
2020	$	257
2021		257
2022		257
2023		257
2024		257
Thereafter		580
		1,865
Plus: reduction in liability to be accreted to interest income		931
Total sale-leaseback liability	$	2,796

The total payments to be paid over the remainder of the lease are $1,865,000. The interest rate implicit in the calculation is negative 10.4%. The value of the sale-leaseback liability is based on the building that was sold, not just the part of the building that was leased back, because as noted above the transaction did not meet the definition of a minor sale-leaseback under the literature. Accordingly, the liability is greater than the sum of the future payments to be made under the lease and this gives rise to a negative interest rate.

7. Related Party Transactions

PCC and its Subsidiaries and Prospect East Hospital Advisory Services, LLC ("PEHAS"), a wholly-owned subsidiary of Prospect, entered into a Management Services Agreement ("MSA") as of June 20, 2014, under which PEHAS provides certain administrative and management services to PCC and its Subsidiaries. Management fees due to PEHAS under the MSA consist of 2% of net revenues monthly. The Company recognized management fees of $3,791,000 and $3,721,000 for the years ended September 30, 2019 and 2018, respectively, which is included within management fee expense in the accompanying statement of operations. As of September 30, 2019 and 2018, $19,269,000 and $15,478,000, respectively, due pursuant to the MSA, is included in due to affiliates, net, in the accompanying consolidated balance sheets.

8. Commitments and Contingencies

Leases

The future minimum annual lease payments required under leases in effect at September 30, 2019, are as follows (in thousands):

For the Years ending September 30,		Operating Leases
2020	$	244
2021		23
2022		15
Total minimum lease payments	$	282

Lease and rental expense was $1,126,000 and $1,210,000 for the years ended September 30, 2019 and 2018, respectively.

Contingent Liability for Borrowings by Prospect

The Company is contingently liable as a guarantor, among others, for amounts borrowed by PMH on senior secured notes (through August 23, 2019), credit facilities at September 30, 2019 and 2018. Additionally, as of September 30, 2019 the Company is a pledger for all of the transactions that PMH has entered into with affiliates of Medical Properties Trust, Inc. ("MPT"), a publicly traded Real Estate Investment Trust, on August 23, 2019.

The obligations and related interest expense related to these credit facilities are not reflected in the Company's consolidated financial statements as of and for the years ended September 30, 2019 and 2018, as the borrowings are reflected in the separate consolidated financial statements of PMH.

Total borrowings outstanding as of September 30, 2019, reflected in the consolidated financial statements of PMH, but for which the Company is contingently liable as a guarantor, were (in thousands):

September 30,	2019	2018
Senior secured credit facility (net of discount of $0 and $20,085, respectively)	$ -	$ 1,094,315
Less: Deferred financing costs, net ("DFC")	-	(16,214)
Total Debt, net of discount, premium and DFC	$ -	$ 1,078,101

On June 30, 2016, PMH entered into a six-year $625,000,000 senior secured term loan B (the "Original Term Loan"). The Original Term Loan was issued with an original discount of 1.50%, or $9,375,000. Additionally, PMH refinanced the previous revolver with a new $100,000,000 asset-based revolving credit facility ("Original ABL Facility" and together with the Original Term Loan, the "New Senior Secured Credit Facilities"). Pursuant to various amendments from August 2016 through October 2017, the aggregate commitment amount under the Original ABL facility was increased in stages to $175,000,000. The original maturity date for the Original ABL Facility was June 30, 2021, and the original maturity date for the Term Loan was June 30, 2022.

On February 22, 2018, PMH refinanced and replaced both the Original Term Loan and the Original ABL Facility, and entered into an Amended and Restated Term Loan Credit Agreement (the "Amended TL Agreement"), by and among PMH (as the borrower), the lenders party thereto and JPMorgan Chase Bank, N.A. ("JPMorgan"), as administrative agent and collateral agent. The Amended TL Agreement replaced the Original Term Loan with a new Term B-1 Loan ("Term B-1 Loan"). The principal amount of the Term B-1 Loan is $1,120.0 million and such loan incurred interest at LIBOR (subject to a 1.0% floor) plus 5.5%. The Term B-1 Loan was issued with an original discount of 2% and was originally scheduled to mature on February 22, 2024. The Term B-1 Loan was repaid on August 23, 2019 by the proceeds totaling $1.55 billion from a series of transactions that PMH entered into with affiliates of MPT (see further discussion below).

Additionally, on February 22, 2018, PMH entered into an Amended and Restated ABL Credit Agreement (the "Amended ABL Agreement"), by and among PMH (as the borrower), the lenders party thereto and JPMorgan, as administrative agent and collateral agent. The Amended ABL Agreement replaced the Original ABL Facility. Under the Amended ABL Agreement, the maximum revolving commitment was $250,000,000 with ability to expand the facility to $325,000,000, and the new ABL facility (the "New ABL Facility") bears interest at a variable base rate plus an applicable spread that is based on excess availability under the New ABL Facility, as further described in the Amended ABL Agreement, which was 6.0% as of September 30, 2019. From January 2019 through July 2019 PMH entered into various amendments to the Amended ABL Agreement. Such amendments (i) waived certain events of default at September 30, 2018; (ii) increased the maximum revolving commitment from $250.0 million to $280.0 million, and further to $285.0 million, while simultaneously reducing and removing future expansion of the facility; (iii) introduced $40.0 million of a first in last out ("FILO") revolving facility, which incurred interest at either 2.5% or 3.5% per annum depending on whether they are Eurodollar loans or ABR loans (which were repaid on August 23, 2019); (iv) provides for a reduction in the maximum revolving commitment by $20.0 million and $10.0 million upon the future planned closure or disposition of Nix Health and EOGH, respectively. The New ABL Facility matures on February 22, 2023. As of September 30, 2019, the outstanding balance and the available balance on the New ABL facility was approximately $70.0 million and $175.6 million, respectively. On August 23, 2019, PMH closed a series of transactions with affiliates of MPT. Under these transactions, PMH sold to MPT its hospital buildings in California (excluding Foothill Regional Medical Center ("Foothill"), Connecticut and Pennsylvania for an aggregate purchase price of $1,386,000,000. Concurrent with the sale transactions, PMH entered into two master lease agreements whereby the hospital properties and related medical office buildings were leased back for an initial 15 year term, with options to extend twice for an additional 5 years each and for a further 4.75 year extension. Monthly rent is defined as 7.5% of the lease base, subject to annual escalation of consumer price index, limited to a minimum of 2% and a maximum of 4%. For the first master lease, PMH has the option to buy the properties at their fair value at the end of the lease term. For the second master lease, PMH has the option to purchase at a price that is fixed at the time of entering into the lease (the "Option Price"). If PMH chooses not to exercise this option, and the fair value at the end of the lease is below the Option Price, then PMH must pay MPT a sum equal to the difference between the fair value and the Option Price. All of the legal entities that are parties to the master lease agreement (which are the hospital entities themselves) provide cross guarantees on all of the obligations to MPT, which guarantees include both lease payments under the master lease as well as indebtedness due to MPT. The balance under sale-leaseback liabilities was $1,331,000,000 at September 30, 2019, as reflected in PMH's consolidated financial statements.

Further, PMH obtained a mortgage on the Foothill property. This mortgage is secured by the buildings at Foothill. The interest on this mortgage is 7.5% per annum and is subject to annual escalation of consumer price index, limited to a minimum of 2% and a maximum of 4%. The maturity date of this loan is in August 2034. MPT can purchase the property on event of default or at end of term, or if Company does not exercise purchase rights for the aforementioned leased properties. Additionally, if the Foothill property is no longer used as collateral for a promissory note payable to Prospect Medical Group, Inc. ("PMG"), then MPT shall have the right to purchase the Foothill property and lease it back to PMH under the second master lease agreement, for an amount equal to the outstanding principal balance. The referenced promissory note payable to PMG has been included in the calculation of PMG's Tangible Net Equity in connection with requirements of the California Department of Managed Health Care. The balance under this mortgage loan was $51,276,000 at September 30, 2019, as reflected in PMH's consolidated financial statements.

Additionally, PMH entered into a promissory note (the "TRS Note"), under which MPT has advanced to PMH $112,937,000 related to the value of the properties in Rhode Island. The interest on this note is 7.5% per annum and is subject to annual escalation of consumer price index, limited to a minimum of 2% and a maximum of 4%. The maturity date of this note is the earlier of July 2022 or the conversion to and sale-leaseback of the properties in Rhode Island. The balance under this mortgage loan was $112,215,000 at September 30, 2019, as reflected in PMH's consolidated financial statements.

All of the agreements with MPT are cross-collateralized and cross defaulted. The MPT transaction documents contain certain customary covenants and restrictions and a financial covenant based on EBITDAR performance, and PMH was in compliance with such covenants at September 30, 2019.

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.

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, states have also developed their own standards for the privacy and security of health information as well as for reporting certain violations and breaches (for example, California's Confidentiality of Medical Information Act and Lanterman-Petris Short Act) which in some cases are more stringent. Other federal privacy laws may also apply to certain services provided by the Company, including 42 C.F.R. Part 2, which addresses the confidentiality of substance use disorder records. 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") has made significant changes to the United States health care system. The legislation impacted multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Under this legislation, 33 states have expanded their Medicaid programs to cover previously uninsured childless adults, and four additional states voted in 2018 to expand Medicaid or to elect a governor that pledged to expand Medicaid. In addition, many uninsured individuals have had the opportunity to purchase health insurance via state-based marketplaces, state-based marketplaces using a federal platform, state-partnership marketplaces or the federally-facilitated marketplace. PPACA also implemented a number of health insurance market reforms, such as allowing children to remain on their parents' health insurance until age 26 or prohibiting certain plans from denying coverage based on pre-existing conditions. Nationally, these reforms have reduced the number of uninsured individuals.

It is unclear what changes may be made to PPACA with the divided Congress, current presidential administration, and pending litigation over the validity of PPACA. The Administration has promulgated rules to broaden the availability of coverage options that do not comply with the full range of PPACA requirements for individual market coverage, namely Association Health Plans and Short-Term Limited-Duration Insurance. The Administration has also provided additional guidance on state PPACA waivers. These executive actions have been or may be challenged in court. In addition, the Tax Cuts and Jobs Act ("TCJA"), passed in December 2017, eliminates the individual mandate penalty under PPACA, effective January 1, 2019. The individual mandate penalty was included in PPACA to address concerns that other market reforms expanding access to coverage might produce adverse selection and higher premiums. The extent to which the repeal of the individual mandate penalty will impact the uninsured rate and future premiums are unclear at this juncture. On December 14, 2018, the United States District Court for the Northern District of Texas ruled that the individual mandate without the penalty is unconstitutional and that PPACA is therefore invalid in its entirety. Litigation on this issue is ongoing, with a decision pending from a panel of the United States Court of Appeals for the Fifth Circuit following oral arguments in July 2019. This litigation along with any future legislative changes to PPACA or other federal and state legislation could have a material impact on the operations of the Company. The Company is continuing to monitor the legislative environment and developments in pending litigation for risks and uncertainties.

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.

9. Defined Contribution Plan

Prospect previously sponsored five defined contribution plans covering substantially all employees who meet certain eligibility requirements, of which one plan was sponsored by PCC. Effective May 1, 2018, the plans covering employees at Prospect's facilities in Connecticut and Pennsylvania were merged into the plan covering employees at CharterCARE, and Prospect's two remaining plans were renamed and segregated between union and non-union employees. Under these plans, employees can contribute up to 50% of their compensation up to the IRS deferred annual maximum. The Company may make discretionary matching contributions to the Plan. The Company's contributions to the Plan were $599,000 and $586,000 for the years ended September 30, 2019 and 2018, respectively, and are included in Employee Benefits in the accompanying statements of operations.

10. Equity Method Investments

RWMC 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. 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, 2019 and 2018, the Company's investments in RWRT, SNERCC, and other minor investments under the equity method were approximately $3,675,000 and $4,088,000, respectively, and are included in equity method investments in the accompanying consolidated balance sheet. For the year ended September 30, 2019 and 2018, the Company recognized approximately $560,000 and $589,000, respectively, as its share of the financial results of RWRT, SNERCC, and other minor investments and received $973,000 and $614,000, respectively, in distributions.

Summarized combined unaudited financial information for RWRT and SNERCC as of September 30, 2019 and September 30, 2018 is as follows (in thousands):

September 30,	2019	2018
Cash	$ 1,905	$ 2,515
Receivables and other current assets	1,683	3,756
Total current assets	3,588	6,271
Property, improvements and equipment, net	3,849	3,502
Goodwill	7,142	7,142
Intangible assets	821	851
Other long-term assets	1,532	1,569
Total assets	$ 16,932	$ 19,335
Accounts payable and accrued liabilities	$ 1,304	$ 1,052
Other long-term liabilities	948	420
Equity	14,680	17,863
Total liabilities and partner's capital	$ 16,932	$ 19,335

For the Year Ended September 30,		2019		2018
Revenues	$	16,678	$	17,278
Net income	$	2,461	$	2,953
RWMC's income from equity method investments	$	560	$	589

11. Subsequent Events

The Company has evaluated subsequent events through February 6, 2020, the date the Company's consolidated financial statements were available for issuance.