Consolidated Financial Statements

As of and For the Years Ended
September 30, 2016 and 2015

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

Prospect Medical Holdings, Inc.

Contents

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, 2016 and 2015, and the related consolidated statements of operations, statements of comprehensive (loss) income, 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, 2016 and 2015, 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 29, 2016

Consolidated Financial Statements

Prospect Medical Holdings, Inc.

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

September 30,	**2016**	2015
Assets		
Current assets		
Cash and cash equivalents	**$ 29,587**	$ 65,899
Restricted cash	**6,117**	4,585
Restricted investments	**4,568**	1,266
Patient accounts receivable, net of allowance for doubtful accounts of $91,723 and $49,882	**262,497**	135,529
Due from government payers	**38,806**	38,460
Other receivables, prepaid expenses and other current assets	**99,228**	24,690
Income taxes receivable, net	**24,731**	-
Inventories	**25,590**	12,115
Hospital fee program receivable	**43,039**	32,285
Current assets held for sale	**10,494**	7,199
Total current assets	**544,657**	322,028
Property, improvements and equipment, net	**441,352**	238,205
Deferred income taxes, net	**25,294**	11,865
Goodwill	**341,488**	159,821
Intangible assets, net	**41,897**	28,820
Other assets	**42,560**	9,901
Long-term assets held for sale	**2,384**	4,978
Total assets	**$ 1,439,632**	$ 775,618

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,	**2016**	2015
Liabilities and Stockholder's Equity		
Current liabilities:		
Accrued medical claims and other healthcare costs payable	**$ 52,761**	$ 53,531
Accounts payable and other accrued liabilities	**205,946**	101,708
Accrued salaries, wages and benefits	**108,795**	56,694
Hospital fee program liability	**18,684**	15,022
Due to government payers	**23,002**	27,078
Income taxes payable, net	**-**	15,110
Revolving line of credit	**55,000**	20,000
Current portion of capital leases	**6,894**	2,900
Current portion of long-term debt	**6,951**	135
Other current liabilities	**10,293**	2,168
Current liabilities held for sale	**2,630**	1,972
Total current liabilities	**490,956**	296,318
Long-term debt, net of current portion	**613,005**	415,466
Malpractice reserves	**34,757**	6,632
Capital leases, net of current portion	**33,334**	9,296
Asset retirement obligations	**5,056**	4,583
Other long-term liabilities	**22,235**	6,754
Pension obligation	**209,658**	-
Long-term liabilities held for sale	**787**	129
Total liabilities	**1,409,788**	739,178
Commitments, contingencies and subsequent events		
Stockholder's equity:		
Common stock, $0.01 par value; 100 shares authorized, issued and outstanding at September 30, 2016 and 2015	**1**	1
Additional paid-in capital	**21,277**	20,037
Accumulated other comprehensive income	**11,338**	-
(Accumulated deficit) retained earnings	**(9,999)**	6,158
Total stockholder's equity attributable to Prospect Medical Holdings, Inc.	**22,617**	26,196
Non-controlling interests	**7,227**	10,244
Total stockholder's equity	**29,844**	36,440
Total liabilities and stockholder's equity	**$ 1,439,632**	$ 775,618

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Operations
(in thousands)

For the Years Ended September 30,	**2016**	2015
Revenues:		
Net Hospital Services revenues	**$ 1,273,038**	$ 1,021,038
Provision for bad debts	**(41,427)**	(42,042)
Net Hospital Services revenues less provision for bad debts	**1,231,611**	978,996
Medical Group revenues	**369,730**	333,238
Net Global Risk Management revenues	**19,635**	3,440
Other revenues	**9,582**	5,371
Total net revenues	**1,630,558**	1,321,045
Operating Expenses:		
Hospital operating expenses	**990,385**	768,863
Medical Group cost of revenues	**248,063**	224,028
Global Risk Management cost of revenues	**17,661**	3,119
General and administrative	**270,988**	188,956
Depreciation and amortization	**47,106**	34,128
Total operating expenses	**1,574,203**	1,219,094
Operating (loss) income from unconsolidated joint venture	**(931)**	6,400
Operating income	**55,424**	108,351
Other (income) expense:		
Interest expense and amortization of deferred financing costs, net	**48,616**	42,027
Loss on debt extinguishment	**26,561**	-
Adjustment to bargain purchase	**-**	319
Other (income) expense, net	**(315)**	230
Total other expense, net	**74,862**	42,576
(Loss) income before income taxes	**(19,438)**	65,775
Income tax (benefit) provision	**(4,750)**	31,279
Net (loss) income from continuing operations	**(14,688)**	34,496
Loss from discontinued operations:		
Loss from discontinued operations	**(8,277)**	(327)
Income tax benefit	**(3,373)**	(133)
Loss on discontinued operations	**(4,904)**	(194)
Net (loss) income before allocation to non-controlling interests	**(19,592)**	34,302
Net loss attributable to non-controlling interests	**(3,435)**	(337)
Net (loss) income attributable to Prospect Medical Holdings, Inc.	**$ (16,157)**	$ 34,639

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,	**2016**	2015
Net income attributable to Prospect Medical Holdings, Inc.	**$ (16,157)**	$ 34,639
Other comprehensive income, net of tax:		
Pension obligation and other post-retirement benefits adjustment (net of $7,800 tax)	**11,332**	-
Debt and equity securities, unrealized gain	**6**	-
Total other comprehensive income, net of tax	**11,338**	-
Total comprehensive (loss) income	**$ (4,819)**	$ 34,639

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 (Deficit)	Non-controlling Interests	Total Stockholder's Equity (Deficit)
Balance at October 1, 2014	100	$ 1	$ 18,457	$ -	$ (28,481)	$ (10,023)	$ 8,817	$ (1,206)
Options exercised	-	-	396	-	-	396	-	396
Stock-based compensation	-	-	1,184	-	-	1,184	-	1,184
Non-controlling interest attributed to PCC Seller	-	-	-	-	-	-	1,764	1,764
Net income (loss)	-	-	-	-	34,639	34,639	(337)	34,302
Balance at September 30, 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

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,	**2016**	2015
Operating activities		
Net (loss) income	**$ (19,592)**	$ 34,302
Adjustments to reconcile net (loss) income to net cash and cash equivalents provided by operating activities:		
Depreciation and amortization	**47,106**	34,128
Amortization of deferred financing costs, net	**2,245**	2,223
Gain on outlier settlement	**(5,741)**	-
Write-off of deferred financing costs	**5,587**	-
Amortization of original issue discount and premium, net	**1,200**	1,080
Write-off of original issue discount and premium	**3,030**	-
Provision for bad debts	**41,427**	42,042
Pension obligation net periodic benefit credit	**(1,356)**	-
Deferred income taxes, net	**20,863**	(14,008)
Stock-based compensation	**1,119**	1,184
Undistributed earnings from equity method investments	**(4)**	(135)
Loss on disposal of assets	**-**	271
Adjustment to (Gain on) bargain purchase	**-**	319
Gain on sale of equity method investment	**-**	(296)
Changes in operating assets and liabilities, net of business combinations:		
Patient accounts receivable	**(68,660)**	(59,985)
Due to/from government payers, net	**(9,942)**	2,389
Other receivables, prepaid expenses and other current assets	**(20,946)**	9,973
Hospital fee program receivable	**(10,754)**	(32,285)
Inventories	**(2,095)**	(1,809)
Hospital fee program liability and deferred revenue	**3,662**	12,216
Income taxes payable/receivable, net	**(39,841)**	9,289
Deposits and other assets	**(8,293)**	(636)
Accrued medical claims and other healthcare costs payable	**(769)**	14,217
Accounts payable and other accrued liabilities	**47,215**	21,935
Pension obligation	**(100,000)**	-
Net cash and cash equivalents used in operating activities from discontinued operations	**(583)**	(969)
Net cash and cash equivalents (used in) provided by operating activities	**(115,122)**	75,445
Investing activities		
Purchases of property, improvements and equipment	**(38,642)**	(37,231)
Cash paid for acquisitions, net of cash received and working capital adjustments	**(72,259)**	(1,740)
Cash in escrow for acquisitions (see Note 16)	**(22,854)**	-
Proceeds from sale of property and improvements	**-**	987
Proceeds from sale of equity method investment	**-**	1,233
Cash paid for equity method investments	**-**	(1,880)
Change in note receivable (net)	**42**	70
Increase in restricted investments	**(3,302)**	(624)
Net cash and cash equivalents used in investing activities from discontinued operations	**(150)**	(186)
Net cash and cash equivalents used in investing activities	**(137,165)**	(39,371)

Prospect Medical Holdings, Inc.

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

For the Years Ended September 30,	**2016**	2015
Financing activities		
Borrowings on Senior Secured Notes, net of original issue discount	**615,625**	-
Repayments on Senior Secured Notes	**(1,563)**	-
Repayment of Retired Senior Secured Notes	**(425,000)**	-
Borrowings on line of credit, net	**55,000**	-
Repayments on retired line of credit, net	**(20,000)**	-
Repayments of long-term debt, net	**(1,634)**	(133)
Proceeds from financing leases, net	**17,072**	-
Repayments of capital leases	**(4,350)**	(4,935)
Proceeds from exercise of stock options	**121**	396
Cash paid for deferred financing costs, net	**(12,251)**	-
Change in restricted cash	**(1,532)**	391
Repayments of insurance premium financing	**(5,513)**	(4,554)
Net cash and cash equivalents provided by (used in) financing activities	**215,975**	(8,835)
(Decrease) increase in cash and cash equivalents	**(36,312)**	27,239
Cash and cash equivalents, beginning of year	**65,899**	38,660
Cash and cash equivalents, end of year, continuing operations	**$ 29,587**	$ 65,899
Supplemental disclosure of cash flow information		
Interest paid (including cash paid on debt extinguishment)	**$ 54,688**	$ 38,099
Income taxes paid, net	**$ 12,255**	$ 35,778
Schedule of non-cash investing and financing activities		
Equipment acquired under capital leases	**$ 11,575**	$ 1,999
Insurance premium financed	**$ 5,513**	$ 4,472
Partial satisfaction of long-term liability assumed from acquisition of PCC	**$ 418**	$ 1,446

See accompanying notes to the consolidated financial statements.

1. Organization

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

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

Hospital Services Segment

The Company owns 18 acute care and behavioral hospitals and multi-level elder care facilities in Southern California, the Greater San Antonio, Texas region, Rhode Island, New Jersey and Pennsylvania with approximately 3,100 licensed beds, and a network of specialty and primary care clinics, through its subsidiaries, Southern California Healthcare System, Inc. ("SCHS"), Alta Los Angeles Hospitals, Inc. ("Alta Los Angeles Hospitals"), Alta Newport Hospital, Inc., Prospect Hospital Holdings, LLC ("Nix Health"), Prospect CharterCARE, LLC ("PCC" or "CharterCARE"), Prospect EOGH, Inc. ("East Orange"), and Prospect Crozer, LLC ("Crozer") (collectively, the "Hospital Services segment"). The Hospital Services segment subsidiaries are wholly-owned by Prospect, except for PCC, in which Prospect has an 85% interest.

The Company's three community hospitals in Hollywood, Los Angeles and Norwalk offer a comprehensive range of medical and surgical services, including general acute care hospital services, pediatrics, obstetrics and gynecology, pediatric sub-acute care, general surgery, medical-surgical services, orthopedic surgery, and diagnostic, outpatient, skilled nursing and urgent care services. The Company's psychiatric hospital in Van Nuys provides acute inpatient and outpatient psychiatric services on a voluntary basis. The Company's hospital in Culver City ("SCH Culver City") offers a comprehensive range of inpatient and outpatient services: including general surgery, orthopedic, spine, cardiology, diagnostic outpatient, rehabilitation, psychiatric and detox services. In addition, SCH Culver City has an active emergency room that plays an integral part in providing emergency services to the West Los Angeles area. Foothill Regional Medical Center ("Foothill"), located in Tustin, California, is a general acute care hospital and also operates pediatric sub-acute unit. Los Angeles Hospital at Bellflower ("Bellflower"), which opened in July 2015, operates a 32-bed voluntary adult behavioral health unit.

Nix Health provides comprehensive service offerings at various locations throughout the greater San Antonio, Texas region. These locations include Nix Medical Center, which provides inpatient acute care, geriatric psychiatry services, and emergency room services; Nix Specialty Health Center, which provides a full range of behavioral health and rehabilitation services for children, adolescents, and adults, and a range of health clinics and provider based clinics throughout San Antonio, Texas; and Nix Behavioral Health Center, which provides psychiatric emergency services and a crisis intervention unit. Nix Community General Hospital ("Nix CGH"), located in Dilley, Texas, ceased operations effective September 30, 2016 (see Note 5). Nix Physicians, Inc., a wholly-owned indirect subsidiary of Nix Health, commenced operations during the year ended September 30, 2016 and acquired a medical practice (see Note 4).

CharterCARE's operating subsidiaries include Prospect CharterCARE RWMC, LLC ("Roger Williams Medical Center"), Prospect CharterCARE SJHSRI, LLC ("St. Joseph Health Services of Rhode Island" or "SJHSRI"), Prospect CharterCARE Elmhurst, LLC ("Elmhurst Extended Care"), Prospect CharterCARE Physicians, LLC ("CharterCARE Physicians"), and New University Medical Group, LLC, which include hospitals, medical centers, a multi-level elder care facility, and a network of approximately 60 contracted primary care and specialist physicians located in Rhode Island with 785 licensed beds (collectively, "CharterCARE"). PCC is 85% owned by Prospect and 15% by CharterCARE Community Board (formerly known as CharterCARE Health Partners). Elmhurst Extended Care is included in discontinued operations in the accompanying consolidated financial statements (see Note 5).

East Orange, acquired March 1, 2016 (see Note 4), has 212 licensed beds and provides health care services, including a broad range of adult, psychiatric and intensive care services as well as outpatient ambulatory services and emergency care.

Crozer, acquired July 1, 2016 (see Note 4), provides medical services to Pennsylvania, Southern New Jersey and Northern Delaware including inpatient and outpatient acute care services, sub-acute care, emergency and trauma services, nursing and rehabilitative services, physician care services and other health care services. Crozer includes four hospitals including Crozer Chester Medical Center and Delaware County Memorial Hospital, a network of outpatient centers, a comprehensive physician network and a sports club.

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

Medical Group Segment

The Medical Group segment is a healthcare management services organization that provides management services to affiliated physician organizations that operate as independent physician associations ("Medical Groups" or "IPAs"). The affiliated physician organizations enter into agreements with HMOs to provide HMO enrollees with a full range of medical services in exchange for fixed, prepaid monthly fees known as "capitation" payments. The Medical Groups contract with physicians (primary care and specialist) and other healthcare providers to provide enrollees with medical services. Prospect currently manages the provision of prepaid healthcare services for its affiliated physician organizations in Southern California, Texas and Rhode Island. The network consists of the following physician organizations as of September 30, 2016 (individually referred to as an "Affiliate"):

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

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

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

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

In addition to the Affiliates and MSOs, the Medical Group segment includes Prospect Provider Group TX, Inc. ("PPGTX"), Prospect Provider Group RI, LLC ("PPGRI"), and Prospect Provider Group NJ, Inc. ("PPGNJ"), each of which are wholly-owned subsidiaries of Prospect Provider Groups, Inc. ("PPG"). PPG is a subsidiary of Prospect.

All of the Affiliates are wholly-owned by PMG, with the exception of Nuestra, which was 72.53% owned by PMG as of September 30, 2016 and 2015, and AMVI/Prospect which is a 50/50 Joint Venture between AMVI Care Health Network, Inc. ("AMVI") and PMG. The operations of all of these entities, with the exception of AMVI/Prospect, are consolidated in the accompanying consolidated financial statements. PMG is owned by a nominee physician shareholder pursuant to an assignable option agreement described below.

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

PMS has entered into an assignable option agreement with PMG and the nominee physician shareholder of PMG. Under the assignable option agreement, Prospect has an assignable option, obtained for a nominal amount from PMG and the nominee shareholder to designate the purchaser (successor physician) for all or part of PMG's issued and outstanding stock held by the nominee physician shareholder (the "Stock Option") in its sole discretion. The Company may also assign the assignable option agreement to any person. The assignable option agreement has an initial term of 30 years and is automatically extended for additional terms of 10 years each, as long as the term of the related management services agreement described below (the "Management Agreement") is automatically extended. Upon termination of the Management Agreement with PMG, the related Stock Option would be automatically and immediately exercised. The Stock Option may be exercised for a purchase price of $1,000. Under these nominee shareholder agreements, Prospect has the unilateral right to establish or effect a change of the nominee, at will, and without the consent of the nominee, on an unlimited basis and at nominal cost throughout the term of the Management Agreement. In addition to the Management Agreement with PMG, Prospect, through one of its management company subsidiaries, has a management agreement with each Affiliate. The term of the Management Agreements is generally 30 years. PMG is the sole shareholder of PHS, PPCM, Genesis, PNW, PSC, UMG, and PVMG. New Genesis Medical Associates, Inc. ("NGMA") is controlled through a nominee shareholder arrangement like the Stock Option structure utilized for PMG and discussed above.

The Company's Affiliates and NGMA have entered into Management Agreements with PMS or PHCA, as applicable. Each Affiliate has agreed to pay a management fee to PMS or PHCA, as applicable. The fee is based in part on the costs to the management company and on a percentage of revenues the Affiliate receives (i) for the performance of medical services by the Affiliate's employees and independent contractor physicians and physician extenders, and (ii) for all other services performed by the Affiliates. The revenue from which this fee is determined includes medical capitation (except for NGMA which provides professional and ancillary services), all sums earned from participation in any risk pools and all fee-for-service revenue earned. The management fee also includes a fixed amount for marketing and public relations services. Except in the case of Nuestra and AMVI/Prospect, the Management Agreements had initial terms of 30 years, renewable for successive 10-year periods thereafter, unless terminated by either party for cause. Effective September 1, 2013, the Managements Agreements for the ProMed Entities were consolidated under one new Management Agreement with PHCA. Effective October 1, 2013, the

Management Agreements for the rest of the Affiliates, other than Nuestra and AMVI/Prospect, were consolidated under one new Management Agreement with PMS. Those two new Management Agreements with PHCA and PMS include initial five year terms and are renewable for successive five year periods thereafter. In the case of Nuestra, its Management Agreement had an initial 10 year term renewable for successive one year terms, subsequently amended in January 15, 2009 to an initial 20 year term renewable for two 10 year periods. In the case of AMVI/Prospect, the Management Agreement has a one year term with successive one year renewal terms. The management agreement for NGMA was effective October 1, 2012 with an initial term of 30 years, renewable for successive 10-year periods thereafter, unless terminated by either party for cause. In return for payment of the management fee, Prospect (through PMS and PHCA) has agreed to provide financial management, information systems, marketing, advertising, public relations, risk management, and administrative support, including for utilization review and quality of care. At its cost, Prospect has assumed the obligations for all facilities, medical and non-medical supplies, and employment of non-physician personnel of its affiliated medical clinics.

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

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

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

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

The affiliated physician organizations provided medical services to a combined total of approximately 307,000 and 258,900 HMO enrollees as of September 30, 2016 and 2015, respectively. The enrollees include approximately 109,000 and 63,700 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, 2016 and 2015, respectively. The total paid member months including managed enrollees, for the fiscal years ended September 30, 2016 and 2015 was approximately 3,600,500 and 3,067,200, respectively.

On December 19, 2013, NGMA, an Affiliate of the Company, purchased stock of Chaparral Medical Group, Inc. ("CMG"), a California medical corporation. Consideration was composed of $1,100,000 in cash at the closing, $700,000 in future cash consideration to be used for the acquired company's general corporate purposes, and 3,750 shares of Ivy Holdings common stock issued at closing to the selling shareholders. As of December 19, 2013, NGMA owned 13.44% of the stock of CMG. During June 2015, CMG repurchased shares from a physician shareholder, which increased NGMA's ownership to 13.57%. After CMG's issuance of shares to physicians recruited to join CMG, NGMA's ownership decreased to 12.99%. After payment of the entire consideration, including the future cash consideration, NGMA will own 17.64% of the stock of

CMG. Pursuant to the terms of the stock purchase agreement, NGMA will have the right and option to make additional stock investments at the same share valuations and prices and upon the same applicable terms and conditions as the initially acquired shares, to bring its aggregate ownership up to 50%. CMG is a multi-specialty group serving communities primarily in the Los Angeles and San Bernardino counties. The Company accounts for NGMA's interest in CMG using the cost method as the Company does not have the ability to exercise significant influence over the operating and financial policies of CMG.

Global Risk Management Segment

The Global Risk Management segment commenced operations during the year ended September 30, 2015 and entered into global capitation arrangements with certain unrelated third-party health plans. The Global Risk Management segment also manages the provision of care for members in coordination with the Hospital and Medical Group segments. The Global Risk Management segment includes Prospect Health Plan, Inc. ("PHP") with operations in California, Prospect Health Services TX, Inc. ("PHSTX") with operations in Texas, Prospect Health Services RI, Inc. ("PHSRI") with operations in Rhode Island, and Coordinated Regional Care Group, Inc. ("CRCG") with operations in various states. The Company has also incorporated Prospect Health Services PA, Inc. Prospect Health Services CT, Inc. and Prospect Health Services NJ, Inc., in Pennsylvania, Connecticut and New Jersey, respectively. PHP, PHSTX, and PHSRI have entered into global capitation arrangements with certain third-party health plans and manage the provision of care for members in coordination with the Hospital Services and Medical Group segments.

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. During the current fiscal year, the Company established a captive insurance company, Prospect Medical Holding Risk Retention Group, Inc. ("RRG"), which was incorporated 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 organization. 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

Basis of Presentation

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

and assume the obligation to absorb losses. Although the Company has disproportionately few voting rights (based on the terms of the equity), the Company is considered to be the primary beneficiary of the activities of the Affiliates and NGMA and its subsidiaries. As a result, the Affiliates and NGMA and its subsidiaries are consolidated within the accompanying consolidated financial statements.

Operating results for the CharterCARE Physicians and Nix medical practices acquisitions, Primary and Multi-Specialty Clinics of Anaheim, Inc., East Orange and Crozer are consolidated with the Company's financial statements from their acquisition dates (various dates during the years ended September 30, 2015 and 2016, December 1, 2015, March 1, 2016, and July 1, 2016, respectively) (see Note 4). All significant intercompany balances and transactions have been eliminated in consolidation.

Reclassifications

Certain reclassifications were made to the 2015 consolidated financial statements in order to conform to the 2016 presentation.

Revenues

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

For the Years Ended September 30,	**2016** ***(a)***	2015 *(b)*
Net Hospital Services ***(c)***		
Inpatient	**$ 826,128**	$ 713,291
Outpatient	**332,243**	192,302
Capitation	**94,232**	98,964
Other	**20,435**	16,481
Total Hospital Services revenues	**1,273,038**	1,021,038
Less: Provision for bad debts	**(41,427)**	(42,042)
Total net Hospital Services revenues less provision for bad debts	**1,231,611**	978,996
Medical Group		
Capitation	**335,542**	312,031
Management fees	**10,760**	7,814
Other	**23,428**	13,393
Total Medical Group revenues	**369,730**	333,238
Global Risk Management ***(c)***		
Capitation	**19,635**	3,440
Other revenues	**9,582**	5,371
Total net revenues	**$ 1,630,558**	$ 1,321,045

(a) The revenues of Primary and Multi-Specialty Clinics of Anaheim, Inc., East Orange, Crozer and the medical practices acquired by CharterCARE Physicians and Nix Health have been included in the accompanying consolidated financial statements for the period from the acquisition date of December 1, 2015, March 1, 2016, July 1, 2016 and various dates during the year ended September 30, 2016 through September 30, 2016.

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

(c) Excluding 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 (Medi-Cal in California), managed care and other insurance programs that are paid at negotiated rates. These payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments, as further described below. Estimates of contractual allowances are based upon the payment terms specified in the related contractual agreements. The Company accrues for amounts that it believes may ultimately be due to or from the third-party payers. Normal estimation differences between final settlements and amounts accrued in previous years are reported as changes in estimates in the current year. Outstanding receivables, net of allowances for contractual discounts and bad debts, are included in patient accounts receivable in the accompanying consolidated balance sheets.

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

September 30,	**2016**	2015
Medicare	**$ 410,147**	$ 315,545
Medicaid	**437,968**	367,842
Managed Care	**231,146**	166,465
Self Pay/Other	**79,110**	55,741
Capitation	**94,232**	98,964
Total patient service revenue	**$ 1,252,603**	$ 1,004,557

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. Most inpatient hospital 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. 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 received final NPRs for SCH Culver City (formerly, Brotman Medical Center) through 2012, SCHS

through 2013, Alta Los Angeles Hospitals through 2013, Nix Health through 2013, Elmhurst through 2014, East Orange through 2012, Crozer Chester Medical Center through 2011, Delaware County Memorial Hospital through 2014. No NPR has been issued for Roger Williams Medical Center or St. Joseph's Health Services of Rhode Island since their acquisition by the Company during June 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 (if required by the respective facility's state) and adjusted for tentative and final settlements, if any. Medi-Cal is the version of the federal Medicaid program that is applicable to California residents. Inpatient services are reimbursed under prospectively determined rates based on diagnosis related groups, subject to outlier payments. Outpatient services are paid based on prospectively determined rates per procedure provided.

The SCHS and Alta Los Angeles Hospitals are eligible to participate in the State of California Medi-Cal Disproportionate Share ("DSH") programs, under which medical facilities that serve a disproportionate number of low-income patients receive additional reimbursements. Eligibility is determined annually based on prescribed guidelines. The Company accrues revenue based on the expected total annual DSH awards. Differences between the estimated and the actual awards are recorded in the period they become known. DSH amounts are subject to retrospective revision prior to finalization and such revisions could lead to material retractions. The Company records retrospective retractions when they are estimable and probable. Retrospective additional DSH revenues are recorded when the amounts are received. The Medi-Cal DSH receivable as of September 30, 2016 and 2015 was approximately $12,146,000 and $13,787,000, respectively, and were included in due from government payers in the accompanying consolidated balance sheets. For the fiscal years ended September 30, 2016 and 2015, total Medi-Cal DSH payments received by the SCHS and Alta Los Angeles Hospitals were approximately $21,566,000 and $15,690,000, respectively, and total Medi-Cal DSH revenues recorded were approximately $19,926,000 and $19,005,000, respectively. Additionally, pursuant to an audit of Medi-Cal cost reports and notification sent to the Company, the Company accrued a cost report liability payable to Medi-Cal of $1,764,000 and $1,743,000 as of September 30, 2016 and 2015, respectively.

Certain of the Company's California hospitals also participate in *the California Hospital Fee Program* (see Note 12).

In Texas, the Medicaid program reimburses under prospectively determined rates for inpatient services and based on costs for outpatient services. Medicaid reimbursement may be subject to periodic adjustment, as well as to changes in existing payment levels and rates, based on the amount of funding available to the Medicaid program. Nix Health has also been receiving payments from the Texas Health and Human Services Commission under the Section 1115 Waiver ("the waiver") that was recently granted to the state of Texas by CMS. Under the first year of the waiver ending September 30, 2012, a transition payment was paid to Nix Health based upon prior levels of payment under the "Upper Payment Limit" ("UPL") program, which the waiver replaced. Payments for years two through five under the waiver are based upon two pools. One pool is for payments for uncompensated care ("UCC") which includes the shortfall in Medicaid reimbursement as compared to cost and the cost of providing services to uninsured patients. The other pool is the Delivery System Reform Initiative Payments ("DSRIP"), where approved programs and services are undertaken to improve access and services provided. Programs are established by regions and approved by the Texas Health and Human Services Commission and CMS. These programs are assigned a value and milestones are established to measure success and the timing and level of payment from the DSRIP funds. Nix Health recorded revenue related to the UCC pool of $12,368,000 and $8,354,000 for the years ended September 30, 2016 and

2015, respectively. Revenue recorded related to the DSRIP pool was $11,356,000 for both of the years ended September 30, 2016 and 2015. At September 30, 2016 and 2015, amounts receivable under the Section 1115 Waiver totaled $20,974,000 and $20,536,000, respectively.

Nix Health also recorded $12,965,000 and $11,804,000 during the years ended September 30, 2016 and 2015, respectively, in costs for rural community provision of services. As of September 30, 2016 and 2015, prepaid expenses related to such costs of $3,565,000 and none, respectively.

The CharterCARE hospitals are participants in the State of Rhode Island's DSH program, which was established in 1995 to assist hospitals that provide a disproportionate amount of uncompensated care. Under the program, Rhode Island hospitals, including the CharterCARE hospitals, receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low income patients. The CharterCARE hospitals recognized revenue and received payments related to DSH and Upper Payment Limit ("UPL") reimbursement of $20,496,000 and $16,636,000 during the years ended September 30, 2016 and 2015, respectively. The State of Rhode Island also assesses a license fee to all hospitals in Rhode Island based on each hospital's net patient revenue. The CharterCARE hospitals recorded $16,199,000 and $15,058,000 of expense during the years ended September 30, 2016 and 2015, respectively, as a result of the license fee.

The New Jersey Health Care Reform Act of 1992 established the Health Care Subsidy Funds to provide certain hospitals in New Jersey, including East Orange, with funds necessary to provide charity care and other forms of uncompensated care. East Orange recognized $8,569,000 of revenue related to Hospital Relief Funds, charity care subsidies and mental health subsidies for the period from March 1, 2016 (inception) through September 30, 2016.

Pursuant to Pennsylvania Act 49 of 2010 ("Act 49"), the Pennsylvania Department of Public Welfare, as approved by the Centers for Medicare and Medicaid Services, established a revised inpatient hospital fee-for-service payment system utilizing All Patient Refined Diagnosis-Related Groups and provided an enhanced hospital reimbursement model. Act 49 imposes a statewide hospital assessment on net inpatient revenue of Pennsylvania licensed acute care hospitals for the periods July 1, 2010 through June 30, 2016. 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.

Under Pennsylvania's Medicaid Modernization Assessment ("MMA"), Crozer recognized $10,293,000 of revenue and received cash payments of $11,672,000 for the period from July 1, 2016 (inception) through September 30, 2016. Amounts receivable under the MMA were $7,388,000 as of September 30, 2016. Crozer also recognized $4,181,000 of expense for the period from July 1, 2016 (inception) through September 30, 2016, which are also accrued and are included in September 30, 2016 in the accompanying consolidated balance sheets.

Crozer also recognized $14,948,000 of revenue and received $4,029,000 of cash payments related to the Pennsylvania Community Access Fund Grant and Legislative Initiative for the period from July 1, 2016 (inception) through September 30, 2016. Amounts receivable under these programs was $17,809,000 and are included in September 30, 2016 in the accompanying consolidated balance sheets.

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

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

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

Similar to other hospital operators, the Company is subject to audits by Recovery Audit Contractors ("RAC") and other similar programs. As of September 30, 2016 and 2015, the Company accrued $1,879,000 and $262,000, respectively, in due to government payors in the accompanying consolidated balance sheets related to such programs.

SCH Culver City Outlier Liability

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

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

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

The Company filed an appeal of the outlier issue with the Provider Reimbursement Review Board for the 2006 cost reporting period after it received the notice of program reimbursement. Mediation was held with CMS and the U.S. Department of Justice in March 2015 for settlement of fiscal years 2005 and 2006. The terms of a final settlement were approved by CMS and the Health and Human Services Office of the General Counsel in December 2015. The Company received final approval of the settlement by the U.S. Department of Justice on January 19, 2016. Pursuant to the final agreement, CMS will receive $7,457,000 from SCH Culver City, including $5,357,000 from previously withheld reimbursement and $2,100,000 through recoupment from current payments to SCH Culver City of $60,000 per month over thirty-six months, accruing interest at the current Medicare Trust Fund rate. The final settlement resulted in a gain

of $5,741,000 recognized during the year ended September 30, 2016, which is included within Net Hospital Services revenues in the accompanying consolidated statements of operations.

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

September 30,	**2016**	2015
Due from government payers:		
Medicaid Disproportionate Share (DSH)	**$ 12,146**	$ 13,787
Medicare cost report settlements	**5,686**	3,906
Medicaid cost report settlements	**-**	231
Medicaid Section 1115 receivable	**20,974**	20,536
	$ 38,806	$ 38,460
Due to government payers:		
Outlier liability	**$ -**	$ 13,834
Medicare cost report settlements	**21,238**	11,501
Medicaid cost report settlements	**1,764**	1,743
	$ 23,002	$ 27,078

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's California facilities provide charity care to patients whose income level is below 300% of the Federal Poverty Level. Patients with income levels between 300% and 350% of the Federal Poverty Level qualify to pay a discounted rate under the requirements of California State Assembly Bill 774 (AB 774) based on various government program reimbursement levels. Patients without insurance are offered assistance in applying for Medicaid and other programs they may be eligible for, such as state disability. Patient advocates from the Company's Medical Eligibility Program ("MEP") screen patients in the Hospital and determine potential linkage to financial assistance programs. They also expedite the process of applying for these government programs. The Company's hospitals in other states provide care to patients who meet certain criteria under their respective financial assistance policies without charge. Key elements used to determine eligibility include a patient's demonstrated inability to pay based on family size and household income related to federal income poverty guidelines.

The approximate cost of providing charity care was $2,645,000 and $1,683,000 for the years ended September 30, 2016 and 2015, respectively. The Company has estimated the cost of charity care based on a ratio of the cost to charges, with cost consisting of operating expenses, excluding depreciation, interest and management fees.

Provisions for Contractual Allowances and Bad Debts

Collection of receivables from third-party payers and patients is the Company's primary source of cash and is critical to its operating performance. The Company closely monitors its historical collection rates, as well as changes in applicable laws, rules and regulations and contract terms, to assure that provisions for contractual allowances are made using the most accurate information available. However, due to the

complexities involved in these estimations, actual payments from payers may be materially different from the amounts management estimates and records. The Company's primary collection risks relate to uninsured patients and the portion of the bill which is the patient's responsibility, primarily co-payments and deductibles. Payments for services may also be denied due to issues over patient eligibility for medical coverage, the Company's ability to demonstrate medical necessity for services rendered and payer authorization of hospitalization.

Accounts receivable are reduced by an allowance for doubtful accounts. Valuation of the collectability of accounts receivable and provision for bad debts is based on historical collection experience, payer mix and the age of the receivables. Management routinely reviews accounts receivable balances in conjunction with these factors and other economic conditions which might ultimately affect the collectability of the patient accounts, and makes adjustments to the Company's allowances as warranted. For receivables associated with services provided to patients who have third-party coverage, management analyzes contractually due amounts and subsequently calculates an allowance for doubtful accounts and provision for bad debts once the age of the accounts reaches a specific age category based on historical experience. For receivables associated with self-pay patients, management records a significant provision for bad debts beginning in the period services were provided based on past experience that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The allowance for doubtful accounts as a percent of gross accounts receivable decreased from 27% at September 30, 2015 to 26% at September 30, 2016. The allowance for doubtful accounts was $91,723,000 and $49,822,000 as of September 30, 2016 and 2015, respectively. The decrease in the allowance for doubtful accounts as a percent of gross accounts receivable was due primarily to the acquisition of Crozer during the year ended September 30, 2016. Crozer's allowance for doubtful accounts as a percent of gross accounts receivable was 23% as of September 30, 2016.

Legislation

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

See Note 12 regarding the *Affordable Care Act*.

Other Revenues

Other revenues consist primarily of meaningful use incentive revenue, rental revenue from operating leases, tuition revenue, and Crozer Health Club and other revenues and totaled $9,582,000 and $5,371,000 for the years ended September 30, 2016 and 2015, respectively.

A summary of other revenues recorded during the years follows:

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

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

For the years ended September 30, 2016 and 2015, the Company recorded revenues of a nominal amount and $1,150,000, respectively, related to the Medicare and Medicaid Meaningful Use programs in the consolidated statements of operations. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria. Subsequent changes to these estimates will be recognized in the consolidated statement of operations in the period in which additional information is available. Such estimates are subject to audit by the federal government, the state, or its designee.

Rental Revenue: Rental revenue from operating leases is recorded based on the fixed, minimum required rents (base rents) per the lease agreements. Rental revenue from base rents is recorded on the straight-line method over the terms of the related lease agreements. During the years ended September 30, 2016 and 2015, the Company recorded rental revenues of $3,817,000 and $2,417,000.

Tuition Revenue: St. Joseph Health Services of Rhode Island operates the St. Joseph School of Nursing and recorded tuition revenue of $1,727,000 and $1,639,000 during the years ended September 30, 2016 and 2015, respectively.

Crozer Health Club and Other Revenues: In addition to rental revenues, Crozer recognized other revenues for the period from July 1, 2016 (inception) through September 30, 2016 of $1,238,000 for health club membership dues, $1,019,000 for outside contract revenue, and $1,599,000 for other health club and miscellaneous revenues.

Medical Group Segment

Medical Group Revenues

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

Capitation revenue (net of capitation withheld to fund risk share deficits discussed below) is recognized in the month in which the Affiliates are obligated to provide services. Minor ongoing adjustments to prior months' capitation, primarily arising from contracted HMOs' finalizing of monthly patient eligibility data for additions or subtractions of enrollees, are recognized in the month they are communicated to the Company. Additionally, Medicare pays capitation using a "Risk Adjustment model," which compensates managed care organizations and providers based on the health status (acuity) of each enrollee. Health

plans and providers with higher acuity enrollees will receive more and those with healthier enrollees will receive less. Under Risk Adjustment, capitation is determined based on health severity, measured using patient encounter data. Capitation is paid on an interim basis based on data submitted for the enrollee for the preceding year and is adjusted in subsequent periods (generally in the Company's fourth quarter) after the final data is compiled. Positive or negative capitation adjustments are made for Medicare enrollees with conditions requiring more or less healthcare services than assumed in the interim payments. Since the Company cannot reliably predict these adjustments, periodic changes in capitation amounts earned as a result of Risk Adjustment are recognized generally in the fourth quarter when those changes are communicated by the health plans to the Company. The Company received and recorded as additional revenue, approximately $13,601,000 and $17,503,000, respectively, in positive capitation risk adjustments for the Medical Group segment during the years ended September 30, 2016 and 2015, respectively.

HMO contracts also include provisions to share in the risk for hospitalization, whereby the Affiliate can earn additional incentive revenue or incur penalties based upon the utilization of hospital services. Typically, any shared risk deficits are not payable until and unless the Company generates future risk sharing surpluses, or if the HMO withholds a portion of the capitation revenue to fund any risk share deficits. At the termination of the HMO contract, any accumulated risk share deficit is typically extinguished. Due to the lack of access to information necessary to estimate the related costs, shared-risk amounts receivable from the HMOs are only recorded when such amounts are known. Risk pools for the prior contract years are generally final settled in the third or fourth quarter of the following fiscal year. For the years ended September 30, 2016 and 2015, Medical Group revenues included approximately $11,827,000 and $8,402,000, respectively, of additional revenues due to favorable settlements on prior year risk-sharing arrangements. At September 30, 2016 and 2015, contingent liabilities for carry-forward risk-pool deficits expected to be forgiven, or offset against future surpluses were approximately $7,953,000 and $6,422,000, 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, 2016 and 2015, the Company recognized $3,560,000 and $9,059,000, respectively, related to a shared savings incentive program with one health plan. Pay-for-performance revenues recorded during the years ended September 30, 2016 and 2015 were $6,263,000 and $11,387,000, 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, 2016 and 2015 were $10,760,000 and $7,814,000, respectively.

Medical Group Cost of Revenues

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

settlements are made or estimates adjusted, differences are reflected in current operations. See Note 14 for changes in claims estimates during the years ended September 30, 2016 and 2015.

In addition to contractual reimbursements to providers, the Company also makes discretionary incentive payments to physicians, which are in large part based on the pay-for-performance and shared risk revenues and favorable senior capitation risk adjustment payments received by the Company. Since the Company records these revenues generally in the third or fourth quarter of each fiscal year when the incentives and capitation adjustments due from the health plans are known, the Company also finalizes the discretionary physician bonuses in the same periods. During the years ended September 30, 2016 and 2015, the Company recorded discretionary physician incentives expense totaling approximately $16,311,000 and $14,082,000, respectively. As of September 30, 2016 and 2015, physician bonus accruals of approximately $9,665,000 and $9,021,000, respectively, were included in accounts payable and other accrued liabilities.

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

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

Global Risk Management Segment

Global Risk Management Revenues

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

Similar to the Medical Group segment, capitation revenue is recognized in the month in which the Global Risk Management segment is obligated to provide services. Minor ongoing adjustments to prior months' capitation, primarily arising from contracted HMOs' finalizing of monthly patient eligibility data for additions or subtractions of enrollees, are recognized in the month they are communicated to the Company. Additionally, Medicare pays capitation using a "Risk Adjustment model," which compensates managed care organizations and providers based on the health status (acuity) of each enrollee. Health plans and providers with higher acuity enrollees will receive more and those with healthier enrollees will receive less. Under Risk Adjustment, capitation is determined based on health severity, measured using patient encounter data. Capitation is paid on an interim basis based on data submitted for the enrollee for the preceding year and is adjusted in subsequent periods (generally in the Company's fourth quarter) after the final data is compiled. Positive or negative capitation adjustments are made for Medicare enrollees with conditions requiring more or less healthcare services than assumed in the interim payments. Since the Company cannot reliably predict these adjustments, periodic changes in capitation amounts earned as a result of Risk Adjustment are recognized generally in the fourth quarter when those changes are communicated by the health plans to the Company. During the years ended September 30, 2016 and 2015, the Global Risk Management Segment recognized capitation risk adjustments of $2,108,000 and $0.

Global Risk Management Cost of Revenues

The cost of health care services consists primarily of the transfer of capitation revenue to the Hospital and Medical Group segments under the Management Services Agreements, and capitation and claims

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

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

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

Property, Improvements and Equipment

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

As more fully described in Note 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 and Other Intangible Assets

Goodwill totaled $341,488,000 and $159,821,000 at September 30, 2016 and 2015, respectively, and arose as a result of the ProMed, Alta, SCH Culver City, Nix Health, Prospect CharterCARE Physicians medical practices, PMCA, East Orange, and Crozer acquisitions. Goodwill represents the excess of the consideration paid and liabilities assumed over the fair value of the net assets acquired, including identifiable intangible assets.

Goodwill is not amortized; rather it is reviewed annually for impairment for each reporting unit, or more frequently if impairment indicators arise. Impairment is the condition that exists when the carrying amount of goodwill exceeds its implied fair value. A two-step impairment test is used to identify potential goodwill impairment and to measure the amount of goodwill impairment loss to be recognized, if any. The Company has six reporting units with goodwill, consisting of the Southern California Hospitals (which includes SCH Hollywood, SCH Van Nuys, SCH Culver City, Los Angeles Community Hospital, Norwalk Community Hospital, Bellflower and Foothill), SCH Culver City, Nix Health, the MSOs and Medical Groups located in California ("California Medical Groups"), CharterCARE, East Orange and Crozer. The Southern California Hospitals reporting unit was a change in reporting units during the year ended September 30, 2016, and the California Medical Groups reporting unit was a change in reporting units during the year ended September 30, 2015; see Note 6.

The Company tests for goodwill impairment as of September 30 each year. In evaluating whether indicators of impairment exist, the Company considers adverse changes in market value, laws and regulations, profitability, cash flows, ability to maintain enrollment and renew payer contracts at favorable terms, among other factors. The goodwill impairment test is a two-step process. The first step consists of estimating the fair value of the reporting unit based on a weighted combination of (i) the guideline company method that utilizes revenue or earnings multiples for comparable publicly-traded companies, and (ii) a discounted cash flow model that utilizes expected future cash flows, the timing of those cash flows, and a discount rate (or weighted average cost of capital, which considers the cost of equity and cost of debt financing expected by a typical market participant) representing the time value of money and the inherent risk and uncertainty of the future cash flows. If the estimated fair value of the reporting unit is less than its carrying value, a second step is performed to compute the amount of the impairment by determining the "implied fair value" of the goodwill, which is compared to its corresponding carrying value. The Company recorded goodwill impairment related to the closure of Nix CGH 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, 2016 and 2015, resulted in no additional impairment charges.

Long-Lived Assets and Amortizable Intangibles

Amortizable intangible assets totaled $41,897,000 and $28,820,000, net of accumulated amortization at September 30, 2016 and 2015, respectively, and arose as a result of the ProMed, Alta, Nix Health, NGMA, PCC, CharterCARE Physicians medical practices, East Orange and Crozer acquisitions. Intangible assets include customer relationships, trade names, favorable leasehold, and physician guarantees. The Company reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying value of such assets may not be recoverable. The Company considers assets to be impaired and writes them down to fair value if estimated undiscounted cash flows associated with those assets are less than their carrying amounts. Fair value is based upon the present value of the associated cash flows. Changes in circumstances (for example, changes in laws or regulations, technological advances or changes in strategies) may also reduce the useful lives from initial estimates. Changes in planned use of intangibles may result from changes in customer base, contractual agreements, or regulatory requirements. In such circumstances, management will revise the useful life of the long-lived asset and amortize the remaining net book value over the adjusted remaining useful life. There were no impairments recorded during the years ended September 30, 2016 and 2015.

Medical Malpractice Liability Insurance

The individual physicians who contract with the Affiliates carry their own medical malpractice insurance. In the Hospital Services segment, the Company's hospitals carry professional and general liability insurance to cover medical malpractice claims under claims-made policies. Under the policies, insurance premiums cover only those claims actually reported during the policy term. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims related to occurrences during the policy term but reported subsequent to the policy's termination may be uninsured. The Company's hospitals have a consolidated policy for professional and general liability insurance with separate retentions for each entity. East Orange was fully insured for professional and general liability claims with no deductible from March 1, 2016 through September 30, 2016. Crozer was insured for professional and general liability claims through Prospect Medical Holding Risk Retention Group, Inc. for primary coverage from July 1, 2016 through September 30, 2016. 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 reserve for losses, which was determined with the assistance of a third party actuarial consulting firm, included estimates of claims incurred but not reported, was approximately $2,753,000 as of September 30, 2016.

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, 2016 and 2015, the total gross claims liability, was $14,591,000 and $6,632,000 and reinsurance recoverable on unpaid losses were $4,107,000 and $1,406,000, respectively, and were estimated using a discount factor of 4%. In addition, with the acquisitions of East Orange and Crozer during the current fiscal year, the Company recorded IBNR related to tail coverage for both East Orange and Crozer, which were determined with the assistance of a third party actuarial consulting firm. At September 30, 2016, IBNR reserves related to tail coverage for East Orange and Crozer was $2,223,000 and $15,190,000, respectively, using a discount factor of 4%.

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

Workers' Compensation Insurance

The workers' compensation coverage provides the statutory benefits required by law with a $250,000 deductible policy with limits of $1,000,000 per occurrence and aggregate for the Companies' entities located in California. Nix Health has opted out of the Texas Workers' Compensation system as a non-subscriber, and provides its employees with benefits for occupational injury or disease through an ERISA plan. Nix Health has an Employer's Excess Indemnity policy with a $25,000 deductible with limits of $10,000,000 per occurrence and $25,000,000 aggregate. CharterCARE was 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, 2016 and 2015, included in accrued salaries, wages and benefits are accruals for uninsured claims and claims incurred but not reported of approximately $17,675,000 and $14,110,000 and reinsurance recoverable on unpaid losses were $5,829,000 and $5,220,000, respectively. The amounts are estimated based upon an actuarial valuation of their claims experience, using a discount factor of 4%.

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

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

Asset Retirement Obligations

The Company recognizes the fair value of a liability for legal obligations associated with asset retirements in the period in which it is incurred, if a reasonable estimate of the fair value of the obligation can be made. Over time, the liability is accreted to its present value each period. Upon settlement of the obligation, any difference between the cost to settle the asset retirement obligation and the liability recorded is recognized as a gain or loss in the statement of operations. The Company has accrued $5,056,000 and $4,583,000 in other long-term liabilities related to asset retirement obligations for the CharterCARE and Crozer hospitals as of September 30, 2016 and 2015, respectively.

Stock Options

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

On June 30, 2015, the Board of Directors of Ivy Holdings adopted the First Amendment to the Ivy Plan and concurrently, on June 30, 2015, the stockholders of Ivy Holdings approved the First Amendment to the Ivy Plan (the "Amended Ivy Plan"). Pursuant to the Amended Ivy Plan, the Board of Directors authorized the issuance of options exercisable for an additional 13,972 shares of common stock of Ivy Holdings to employees, certain consultants and independent members of the boards of directors of Ivy Holdings and its subsidiaries (including the Company and its subsidiaries). These options granted under the Amended Ivy Plan are exercisable into Ivy Holdings stock and vest based on a number of criteria, including the same criteria as options granted under the Ivy Plan as well as the occurrence of certain corporate transactions, including a change in control of Ivy Holdings, as defined in the Incentive Stock Option Agreements; see Note 10.

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

Cash and Cash Equivalents

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

Restricted Cash

At September 30, 2016 and 2015, $1,725,000 and $1,277,000 was restricted for research at CharterCARE hospitals as of September 30, 2016 and 2015, respectively. An additional $4,392,000 and $1,308,000 was restricted for various other purposes including regulatory requirements and letters of credit as of September 30, 2016 and 2015, respectively.

Restricted Investments

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

Inventories

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

Deferred Financing Costs

Deferred financing costs are amortized over the period in which the related debt is outstanding using the effective interest method and are classified as a deduction from the carrying amount of the related debt.

Deferred financing costs at September 30, 2016 and 2015 are as follows (in thousands):

	2016			2015		
	Gross Book Value	**Accumulated Amortization**	**Net Book Value**	Gross Book Value	Accumulated Amortization	Net Book Value
Deferred financing costs	**$ 12,251**	**$ 602**	**$11,649**	$ 14,398	$ 7,165	$ 7,233

During the year ended September 30, 2016, the Company wrote off $5,587,000 of unamortized deferred financing costs and capitalized $12,251,000 related to Senior Secured Notes (see Note 9).

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, 2016 and 2015, the Company incurred $225,000 and $0 of interest and penalties related to incomes taxes.

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

Consolidated federal tax returns are filed, with the exception of PMG and NGMA, which file their own federal tax returns. The Company files separate state tax returns for California, Texas, Rhode Island, Pennsylvania, Connecticut and New Jersey. 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 (see Note 9).

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 (loss) income 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, 2016				
Certificates of deposit	**$ 1,302**	**$ 1,302**	**$ -**	**$ -**
Mutual funds	**3,266**	**3,266**	-	-
Total	**$ 4,568**	**$ 4,568**	**$**	**$**
As of September 30, 2015				
Certificates of deposit and money market mutual funds	$ 1,266	$ 1,266	$ -	$ -

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 fair values of the Company's current financial liabilities approximate their reported carrying amounts. The carrying values and the fair values of long term financial liabilities that qualify as financial instruments under the guidance are as follows (in thousands):

	2016		2015	
September 30,	**Carrying Amount**	**Fair Value**	Carrying Amount	Fair Value
Liabilities:				
Long-term debt	**$ 613,005**	**$ 613,005**	$ 415,466	$ 445,269

As of September 30, 2016, the Company's carrying amount of long-term debt approximated the fair value. The fair value of the Company's long-term debt was determined based on market prices as of September 30, 2015.

Nonfinancial Items Measured at Fair Value on a Nonrecurring Basis

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

Concentrations of Credit Risk

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

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

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

For the years ended September 30, 2016 and 2015, the Hospital Services segment received a total of 66% and 67% of its net patient revenues from Medicare and Medicaid programs, respectively, and the Medical Group segment received a total of 65% and 59%, respectively, of their capitation revenues from its five largest HMOs, as follows (in thousands):

Years Ended September 30,	**2016**	**% of Total Revenue**	2015	% of Total Revenue
Hospital Services:				
Government Payers:				
Medicare	**$ 410,147**	**32%**	$ 315,545	31%
Medicaid	**437,968**	**34%**	367,842	36%
Total	**$ 848,115**	**66%**	$ 683,387	67%
Medical Group:				
HMO A	$ 64,346	20%	HMO A 39,759	13%
HMO B	42,417	13%	HMO B 38,934	12%
HMO F	37,137	12%	HMO C 37,900	12%
HMO C	35,300	11%	HMO D 34,806	11%
HMO E	27,898	9%	HMO E 32,239	11%
Total	$ 207,098	65%	$ 183,638	59%

The Global Risk Management segment received 100% of their revenues from four health plans during the year ended September 30, 2016.

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.

Recently Adopted Accounting Pronouncements

In July 2013, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2013-11 that requires an unrecognized tax benefit or portion of an unrecognized tax benefit to be presented as a reduction to a deferred tax asset for a net operating loss carryforward, a similar tax loss, or a tax credit carryforward except when certain conditions exist. The amendment is effective for the Company for fiscal years beginning after December 15, 2014, including interim periods in 2014. The Company adopted this guidance effective October 1, 2015 with no material impact to its consolidated financial statements.

In April 2015, the FASB issued ASU No. 2015-03, "Simplifying the Presentation of Debt Issuance Costs." This ASU amends existing guidance to require the presentation of debt issuance cost on the balance sheet as a deduction from the carrying amount of the related debt, instead of an asset. This ASU is effective for reporting periods beginning after December 15, 2015 and early adoption is permitted. The Company elected early adoption of ASU No. 2015-03 effective October 1, 2014. The following table discloses the impact of the adoption of ASU No. 2015-03 on the amounts previously reported in the consolidated balance sheet (in thousands):

Balance Sheet as of September 30, 2015	As Previously Reported	Impact of ASU No. 2015-17	As Reported
Deferred financing costs, net	$ 7,233	$ (7,233)	$ -
Total assets	$ 782,851	$ (7,233)	$ 775,618
Long-term debt, net of current portion	$ 422,699	$ (7,233)	$ 415,466
Total liabilities	$ 746,411	$ (7,233)	$ 739,178

In November 2015, the FASB issued ASU No. 2015-17, "Income Taxes (Topic 740), Balance Sheet Presentation of Deferred Tax Assets and Liabilities". This ASU amends existing guidance by simplifying the presentation of deferred income taxes on a net basis as non-current deferred tax assets or liabilities. ASU No. 2015-17 did not modify the requirement that deferred tax assets and liabilities of a tax-paying component of an entity be offset and presented as a single amount. This ASU is effective for reporting reports beginning after December 15, 2017 with earlier adoption permitted. The Company elected early adoption of ASU No. 2015-17 effective October 1, 2013.

New Accounting Pronouncements

In May 2014, the FASB issued ASU No. 2014-09, "Revenue from Contracts with Customers (ASU 2014-09)," as amended by ASU 2015-14. The core principle of ASU 2014-09 is built on the contract between a vendor and a customer for the provision of goods and services, and attempts to depict the exchange of rights and obligations between the parties in the pattern of revenue recognition based on the consideration to which the vendor is entitled. To accomplish this objective, the standard requires five basic steps: (i) identify the contract with the customer, (ii) identify the performance obligations in the contract, (iii) determine the transaction price, (iv) allocate the transaction price to the performance obligations in the contract, (v) recognize revenue when (or as) the entity satisfies a performance obligation. Nonpublic entities will apply the new standard for annual periods beginning after December 15, 2018, including interim periods therein. Three basic transition methods are available — full retrospective, retrospective with certain practical expedients, and a cumulative effect approach. Under the third alternative, an entity would apply

the new revenue standard only to contracts that are incomplete under legacy U.S. GAAP at the date of initial application (e.g. January 1, 2019) and recognize the cumulative effect of the new standard as an adjustment to the opening balance of retained earnings. That is, prior years would not be restated and additional disclosures would be required to enable users of the financial statements to understand the impact of adopting the new standard in the current year compared to prior years that are presented under legacy U.S. GAAP. Early adoption is permitted for fiscal years beginning after December 15, 2016. The Company is currently evaluating the effect of this guidance on its consolidated financial statements.

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

In January 2016, the FASB issued ASU No. 2016-01, "Financial Instruments" ("ASU 2016-01"). 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 No. 2016-02, "Leases" ("ASU 2016-02"). 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 fiscal years beginning after December 15, 2018, 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 No. 2016-07, "Investments – Equity Method and Joint Ventures" ("ASU 2016-07"). 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)" ("ASU 2016-09"). 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)" ("ASU 2016-15"). 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 the Company's consolidated financial statements.

3. Property, Improvements and Equipment

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

September 30,	**2016**	2015
Property, improvements and equipment:		
Land and land improvements	**$ 73,675**	$ 53,327
Buildings and improvements	**277,292**	134,730
Leasehold improvements	**22,169**	20,009
Equipment	**185,045**	106,919
Furniture and fixtures	**6,926**	6,891
	565,107	321,876
Less: accumulated depreciation	**(123,755)**	(83,671)
Property, improvements and equipment, net	**$ 441,352**	$ 238,205

At September 30, 2016 and 2015, the Company had assets under capitalized leases of approximately $33,118,000 and $20,299,000, respectively, and related accumulated depreciation of $21,766,000 and $14,356,000, respectively.

Depreciation expense was approximately $40,128,000 and $27,538,000 for the years ended September 30, 2016 and 2015, respectively.

4. Acquisitions

Effective March 1, 2016, Prospect EOGH, Inc. acquired substantially all of the assets and associated real estate of East Orange General Hospital, located in East Orange, New Jersey. The acquisition of East Orange was accounted for as a business combination using purchase accounting. All assets acquired and liabilities assumed were at fair value in accordance with GAAP. The Company incurred $1,800,000 of transaction

costs during the year ended September 30, 2016, which are included in General and Administrative expenses in the accompanying consolidated statements of operations.

The following table summarizes the assets acquired and liabilities assumed in connection with the East Orange acquisition as of March 1, 2016 (in thousands):

		Purchase Price Allocation (Preliminary)
Patient accounts receivable and other receivables	$	10,064
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		(25,542)
Capital leases		(1,691)
Other long-term liabilities		(7,550)
Goodwill		3,531
Cash consideration, net of cash acquired	$	22,708

As asset purchases, the goodwill and intangible assets acquired are deductible for tax purposes. The purchase price allocation is preliminary as it may be adjusted for currently unknown assets or liabilities related to the pre-acquisition period, and adjustments to the fair value of property, plant and equipment, intangible assets, and goodwill for unknown factors related to the pre-acquisition period. These adjustments may be material.

Crozer

Effective July 1, 2016, Prospect Crozer, LLC acquired certain assets and assumed certain liabilities of Crozer-Keystone Health System, located in Delaware County, Pennsylvania and the surrounding areas. The acquisition of Crozer was accounted for as a business combination using purchase accounting. All assets acquired and liabilities assumed were at fair value with the exception of the defined benefit pension liability 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 a temporary difference 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 liability resulted in the recording of a deferred tax asset of approximately $40.7 million, which is reflected in the acquisition accounting. The Company incurred $4,200,000 of transaction costs during the year ended September 30, 2016, which are included in General and Administrative expenses in the accompanying consolidated statements of operations.

The following table summarizes the assets acquired (at fair value) and liabilities assumed (at fair value, except pension obligation, see above) in connection with the Crozer acquisition as of July 1, 2016 (in thousands):

		Purchase Price Allocation (Preliminary)
Patient accounts receivable	$	89,901
Other receivables, prepaid expenses and other current assets		57,147
Property, improvements and equipment		153,785
Deferred income taxes, long-term		40,746
Intangible assets		17,620
Other assets		1,272
Accounts payable and other current liabilities		(102,162)
Capital leases		(19,116)
Other long-term liabilities		(25,158)
Pension obligation		(330,331)
Goodwill		172,744
Cash consideration, net of cash acquired	$	56,448

As asset purchases, the goodwill and intangible assets acquired are deductible for tax purposes. The purchase price allocation is preliminary as it may be subject to further working capital and other adjustments under the asset purchase agreement due to currently unknown assets or liabilities related to the pre-acquisition period, income taxes, and adjustments to the fair value of property, plant and equipment, intangible assets, and goodwill for unknown factors related to the pre-acquisition period. These adjustments may be material. Of the total cash consideration of $56,488,000, $12,930,000 was accrued and included in accounts payable and other accrued liabilities in the accompanying consolidated balance sheets as of September 30, 2016.

Primary and Multi-Specialty Clinics of Anaheim

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 not yet paid as of September 30, 2016. The Company elected to treat the stock acquisition as a taxable asset acquisition under Internal Revenue Code Section 338.

The following table summarizes the assets acquired (at fair value) and liabilities assumed (at fair value) in connection with the PMCA acquisition as of December 1, 2015 (in thousands):

		Purchase Price Allocation
Property, improvements and equipment	$	169
Other assets		219
Accrued expenses		(11)
Goodwill		5,050
Cash consideration, net of cash acquired	$	5,427

Medical Practices Acquisitions

During the year ended September 30, 2016, CharterCARE Physicians and Nix Physicians, Inc., a subsidiary of Nix Health, entered into three asset purchase agreements to acquire medical practices with primary care physicians as well as specialties in general surgery and orthopedic services in Rhode Island and Texas for total cash consideration of $606,000. The Nix Health acquisition includes a second closing date to be mutually determined by the seller and Nix Physicians, Inc., at which time certain additional assets will be acquired.

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.

The following table summarizes the assets acquired (at fair value) and liabilities assumed (at fair value) in connection with the medical practices acquisitions during the year ended September 30, 2016 (in thousands):

	Purchase Price Allocation
Inventory	$ 11
Improvements and equipment	253
Goodwill	342
Net cash consideration	$ 606

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

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

The following table summarizes the assets acquired (at fair value) and liabilities assumed (at fair value) in connection with the CharterCARE Physician medical practices acquisitions during the year ended September 30, 2015 (in thousands):

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

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

University Medical Group

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

As of December 18, 2014, New UNMG acquired certain assets of the practice and assumed certain liabilities related to the administrative functions of UNMG ("Initial Close"). At a later date, New UNMG will acquire certain additional assets and assume certain additional liabilities ("Second Close"). Concurrent with the Initial Close, UNMG and New UNMG entered into an Interim Administrative Services Agreement, which is effective until the Second Close occurs. New UNMG also entered into the First Amendment to the Interim Administrative Services Agreement effective December 18, 2014. In addition, Prospect, RWMC and CharterCARE Physicians have receivables from various transactions of $5,297,000 and $4,345,000 due from UNMG as of September 30, 2016 and 2015, respectively, which are included in other assets in the accompanying consolidated balance sheet.

Because Second Close had not occurred as of September 30, 2016, the acquisition of UNMG is not reported in the accompanying consolidated financial statements. As a result of the Asset Purchase Agreement, Interim Administrative Services Agreement (as amended), and various transactions, New UNMG has the obligation to absorb certain losses of UNMG and the right to receive certain benefits from UNMG. However, New UNMG does not have the power to direct the activities of UNMG which most significantly impact its performance based on the terms of the Interim Administrative Services Agreement (as amended) and the governance of UNMG. As a result, New UNMG is not the primary beneficiary of UNMG, and the results of UNMG are not consolidated in the accompanying consolidated financial statements.

5. Discontinued Operations

During the year ended September 30, 2016, the Company determined the operations of Elmhurst Extended Care, 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. Elmhurst Extended Care was sold effective December 22, 2016 (see Note 16). The Company anticipates Nix CGH will be sold within the next twelve months. 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,	**2016**	2015
Carrying amounts of major classes of assets included as part of discontinued operations		
Cash	$ 910	$ (293)
Restricted cash	4,296	-
Patient accounts receivable, net of allowance for doubtful accounts and other receivables	3,039	4,118
Due from government payors	1,894	3,126
Other current assets	355	248
Total current assets	10,494	7,199
Property, plant and equipment, net	1,985	2,131
Other assets	399	2,847
Total assets of the disposal groups classified as held for sale in the consolidated balance sheets	$ 12,878	$ 12,177
Carrying amounts of major classes of liabilities included as part of discontinued operations		
Accounts payable and other accrued liabilities	$ 2,630	$ 1,972
Long-term liabilities	787	129
Total liabilities of the disposal groups classified as held for sale in the consolidated balance sheets	$ 3,417	$ 2,101

For the Year Ended September 30,	**2016**	2015
Major line items constituting pretax loss of discontinued operations		
Net Hospital Services revenues	$ 22,520	$ 24,498
Operating expenses	(28,009)	(24,544)
Depreciation and amortization	(276)	(246)
Loss on write-off of goodwill	(2,475)	-
Interest expense	(37)	(35)
Loss on discontinued operations before income taxes	(8,277)	(327)
Income tax benefit	(3,373)	(133)
Loss on discontinued operations	$ (4,904)	$ (194)

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, 2015.

6. Goodwill and Intangible Assets

As of September 30, 2016 and 2015, goodwill and intangible assets relate to the ProMed, Alta, SCH Culver City, Nix Health, NGMA, CharterCARE Physicians medical practices, East Orange and Crozer acquisitions. The Company performed its annual goodwill impairment analysis for each reporting unit that constitutes a business for which 1) discrete financial information is produced and reviewed by management, and 2) services that are distinct from the other reporting units.

During the year ended September 30, 2015, the Company reorganized its reporting structure for the Medical Group segment due to changes in financial information produced and reviewed by management and the convergence of the economic characteristics of the MSOs and Medical Groups located in California. Prior to the reorganization of the reporting structure, the Medical Group segment was comprised of two reporting units: PHCA and the ProMed Entities (collectively referred to as the "ProMed IPAs") as well as PMS and the other affiliated physician organizations, including NGMA (collectively, "Prospect IPAs"). As a result of the reorganization of reporting structure, the MSOs and Medical Groups located in California comprise a single reporting unit (collectively, "California Medical Groups").

During the year ended September 30, 2016, the Company reorganized its reporting structure for its hospitals located in Southern California. Prior to the year ended September 30, 2016, the reporting units for hospitals located in Southern California consisted of one reporting unit including the four hospitals located in Hollywood, Los Angeles, Norwalk, and Van Nuys and a second reporting unit for SCH Culver City. During the year ended September 30, 2016, the Company determined all seven hospitals located in Southern California (including the hospitals located in Tustin and Bellflower) represented a single reporting unit due to shared economic characteristics, geography and review of financial information.

During the year ended September 30, 2016, $2,475,000 of goodwill related to the Nix reporting unit was written off in conjunction with the classification of Nix CGH as discontinued operations (see Note 5).

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

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

September 30,	**2016**	2015
Southern California Hospitals	**$ 130,912**	$ 130,912
Nix Health	**3,138**	3,138 *(a)*
CharterCARE	**3,775**	3,432
California Medical Groups	**27,388**	22,339
East Orange	**3,531**	-
Crozer	**172,744**	-
	$ 341,488	$ 159,821 *(a)*

(a) Excludes $2,475,000 of goodwill related to the Nix Health reporting unit that is reflected in assets held for sale as of September 30, 2015 that was impaired during the year ended September 30, 2016 in connection with the closure of Nix CGH (see Note 5).

The following is a roll-forward of goodwill from October 1, 2014 to September 30, 2016 (in thousands):

	Amount
Balance, October 1, 2014	$ 156,389
Acquisition of CharterCARE Physicians medical practices (see Note 4)	3,432
Balance, September 30, 2015	159,821
Acquisitions of Nix Physicians and CharterCARE Physicians medical practices	342
Acquisition of PMCA	5,050
Acquisition of East Orange	3,531
Acquisition of Crozer	172,744
Balance, September 30, 2016	$ 341,488

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

	September 30, 2016								
	Alta	SCH Culver City	Nix Health	Charter CARE	Prospect	Promed	East Orange	Crozer	Total
HMO membership	$ -	$ -	$ -	$ -	$ -	$ 25,200	$ -	$ -	$ 25,200
Trade names, net of impairment	9,690	1,320	2,740	8,130	-	9,450	2,423	17,620	51,373
Favorable leasehold	-	-	20	-	-	-	-	-	20
Physician guarantees	-	-	547	-	-	-	-	-	547
Customer relationships	-	-	-	-	350	-	-	-	350
Other	-	-	-	97	-	-	-	-	97
Gross carrying value	9,690	1,320	3,307	8,227	350	34,650	2,423	17,620	77,587
Accumulated amortization	(4,432)	(1,320)	(2,965)	(3,728)	(200)	(22,444)	(141)	(460)	(35,690)
Intangible assets, net	$ 5,258	$ -	$ 342	$ 4,499	$ 150	$ 12,206	$ 2,282	$ 17,160	$ 41,897

	September 30, 2015						
	Alta	SCH Culver City	Nix Health	Charter CARE	Prospect	Promed	Total
HMO membership	$ -	$ -	$ -	$ -	$ -	$ 25,200	$ 25,200
Trade names, net of impairment	10,310	1,320	2,740	8,130	-	9,450	31,950
Favorable leasehold	-	-	20	-	-	-	20
Physician guarantees	-	-	1,530	-	-	-	1,530
Customer relationships	-	-	-	-	350	-	350
Other	-	-	-	97	-	-	97
Gross carrying value	10,310	1,320	4,290	8,227	350	34,650	59,147
Accumulated amortization	(4,361)	(880)	(2,964)	(2,082)	(150)	(19,890)	(30,327)
Intangible assets, net	$ 5,949	$ 440	$ 1,326	$ 6,145	$ 200	$ 14,760	$ 28,820

During the years ended September 30, 2016 and 2015, intangibles related to physician guarantees of $990,000 and $539,000, respectively, were fully amortized and removed from intangible assets.

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives and expense for the years ended September 30, 2016 and 2015 was $6,978,000 and $6,590,000, respectively.

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

Years ended September 30,	
2017	$ 6,854
2018	6,459
2019	5,957
2020	4,740
2021	4,721
Thereafter	13,166
Total	$ 41,897

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

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

The weighted-average remaining useful life for the intangible assets was 7.6 years as of September 30, 2016.

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 ProMed Entities, has ownership interests in physician medical groups that provide medical services to ProMed members, including CMG. For the years ended September 30, 2016 and 2015, the ProMed Entities paid these groups approximately $17,125,000 and $18,170,000, respectively. As of September 30, 2016 and 2015, the Company had accounts payable and other accrued liabilities due to these related parties of $392,000 and $531,000, 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, 2016 or 2015.

The Company is a wholly-owned indirect subsidiary of Ivy Holdings. Therefore, Ivy Holdings is the parent of an affiliated group of corporations within the meaning of Section 1504(a) of the Internal Revenue Code of 1986. On December 15, 2010, Ivy Holdings, Ivy Intermediate and the Company entered into a Tax Sharing Agreement. The Tax Sharing Agreement allows the Company to make payments to Ivy Holdings as necessary to fund their payment of any required taxes incurred due to such parent status. During the years ended September 30, 2016 and 2015, the Company made payments (net of refunds) under this arrangement of $7,460,000 and $24,977,000, 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,	**2016**	2015
Current:		
Federal	**$ (23,645)**	$ 35,578
State	**(1,968)**	9,709
	(25,613)	45,287
Deferred:		
Federal	**18,897**	(12,957)
State	**1,966**	(1,051)
	20,863	(14,008)
Total:		
Federal	**(4,748)**	22,621
State	**(2)**	8,658
	(4,750)	**$** 31,279

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

September 30,	**2016**	2015
Deferred tax assets:		
State tax benefit	**$ -**	$ 2,306
Allowances for bad debts	**21,294**	7,889
Vacation accrual and other	**9,693**	4,800
Workers compensation	**4,956**	3,991
Accrued bonuses	**3,783**	4,837
Malpractice reserves	**6,014**	2,546
Deferred rent	**125**	139
Tax credits	**2,002**	1,261
Net operating losses	**2,615**	302
Partnership outside basis difference	**6,310**	8,323
Transaction Cost	**4,519**	-
Claims Payable	**688**	-
Other	**229**	157
Deferred tax assets	**62,228**	36,551
Valuation allowance	**(742)**	(984)
Net deferred tax assets	**61,486**	35,567
Deferred tax liabilities:		
Intangible assets	**(5,998)**	(6,448)
Fixed assets	**(16,873)**	(17,035)
OCI-Pension liability	**(8,389)**	-
State tax	**(3,552)**	-
Other	**(1,380)**	(219)
Deferred tax liabilities	**(36,192)**	(23,702)
Net deferred tax assets (liabilities)	**$ 25,294**	$ 11,865

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

As of September 30, 2016, the Company maintains a valuation allowance of $742,000 on a certain portion of the California Enterprise credit and net operating losses of non-consolidated and separately filed entities for federal and state purposes, as it is more likely than not that the deferred tax asset will not be realized. As of September 30, 2015, valuation allowances were $984,000.

As of September 30, 2016, the Company has $1,261,000 of California Enterprise Zone credit carryforwards and $741,000 of federal and state AMT credit which can be carried over indefinitely. The Company has approximately $30,000,000 of state net operating loss carryforward for September 30, 2016, which expires through September 30, 2037.

The Company finalized an IRS examination for fiscal year 2012 during the year ended September 30, 2016 with no material impact on the consolidated financial statements. 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 2015 federal tax return.

Generally, the Company's tax years 2011 through 2014 are open for federal and state tax examination. As of September 30, 2016, the Company does not have material unrecognized tax benefits. The Company believes that it is reasonably possible that an increase in unrecognized tax benefits may be necessary within the coming year, and these unrecognized tax benefits would primarily impact deferred taxes and taxes payable, and the expected range of potential increase in the unrecognized tax benefits is not expected to be material to the balance sheet nor the income statement.

The FASB issued ASU No. 2015-17, which requires entities to offset deferred tax assets and liabilities for each tax paying jurisdiction within each tax paying component. The deferred taxes must be reported as non-current. The Company elected early adoption of the ASU (see Note 2 under New Accounting Pronouncements).

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

For the years ended September 30,	**2016**	2015
Tax provision at statutory rate	**35 %**	35%
State taxes, net of federal benefit	**0 %**	7%
Non-controlling interest	**(6)%**	0%
Other	**(4)%**	6%
	25 %	48%

9. Long-Term Debt

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

September 30,	**2016**	2015
Prospect's debt:		
Senior secured notes		
Term loan	**$ 623,438**	$ -
Less: discount, net	**(8,984)**	-
2019 Notes	**-**	325,000
Less: discount, net	**-**	(4,950)
	614,454	320,050
Additional 2019 Notes	**-**	100,000
Plus: premium, net	**-**	1,110
	-	101,110
East Orange medical arts building financing	**11,253**	-
Nix Alamo Heights building financing	**5,818**	-
	17,071	-
	631,525	421,160
Nix Health's debt:		
Mortgage debt	**-**	1,674
Other debt:	**80**	-
Less: Deferred financing costs, net	**(11,649)**	(7,233)
Total Debt *(1)*:	**619,956**	415,601
Less: current maturities	**(6,951)**	(135)
Long-term debt, net of current maturities *(1)*	**$ 613,005**	$ 415,466

(1) Net of discount, premium, and deferred financing costs

Prospect's Debt:

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 7.00% as of September 30, 2016. 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 ABL facility was amended in August 2016 to $115 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 2.31% as of September 30, 2016. The ABL Facility balance as of September 30, 2016 was $55,000,000. As of September 30, 2016, the Company had unused letters of credit of $9,200,000, which offset the Company's ability to borrow additional funds, and the ABL Facility had unused lender commitments of $50,800,000 as of September 30, 2016.

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, 2016, 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. 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 $12,251,000 related to the New Senior Secured Credit Facilities are being amortized over the term of the related debt using the straight line method, which approximates 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"). Interest is payable semi-annually in arrears on May 1 and November 1, commencing on November 1, 2012. The offering was executed in accordance with Rule 144A and Regulation S under the Securities Act of 1933. The terms of the PMH 2019 Notes are governed by an indenture among the Company, certain of its subsidiaries and affiliates (as "Guarantors"), and U.S. Bank National Association (as trustee) (the "Indenture"). The Indenture contains certain covenants that, among other things, limit the Company's ability, and the ability of its restricted subsidiaries (as such term is defined in the Indenture) to: retire and pay dividends or distributions on capital stock or equity interests, prepay subordinated indebtedness or make other restricted payments; incur additional debt; make investments; create liens on assets; enter into transactions with affiliates; engage in other businesses; sell or issue capital stock of restricted subsidiaries; merge or consolidate with another company; transfer and sell assets; create dividend and other payment restrictions affecting subsidiaries; and designate unrestricted subsidiaries. The Credit Agreement (defined below), executed in connection with the PMH Senior Secured Credit Facility (discussed below), contains a number of customary covenants as well as covenants requiring the Company to maintain a maximum consolidated secured leverage ratio and limiting the amount of capital expenditures.

Concurrent with the issuance of the PMH 2019 Notes, the Company entered into a five year $50 million revolving senior secured credit facility (the "PMH Senior Secured Credit Facility") which replaced the existing senior secured credit facility. The PMH Senior Secured Credit Facility provides, among other things, for borrowings up to the amount of the facility with sublimits of up to (i) $20 million to be available for the issuance of letters of credit and (ii) $10 million to be available for swingline loans. The commitment under the facility may be increased by up to $10 million upon the Company's request at the discretion of

the lenders and subject to certain customary requirements. The interest rate per annum applicable to loans under the PMH Senior Secured Credit Facility will be, at the Company's option, either a rate per annum equal to (i) LIBOR plus 3.50% or (ii) an alternate base rate, which will be the higher of the administrative agent's prime rate, the federal funds rate plus 0.50%, and the 1-month LIBOR rate plus 1.00%, plus in each case, 2.50%. In August 2013, the PMH Senior Secured Credit Facility limit was increased to $60 million. As of September 30, 2015, the Company had $20 million outstanding debt related to the PMH Senior Secured Credit Facility. As of September 30, 2015, the interest rate for the PMH Senior Secured Credit Facility was 3.95%.

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

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

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

In connection with the issuance of the Additional 2019 Notes, the Company entered into an amendment of its Credit Agreement governing the PMH Senior Secured Credit Facility that waived and amended certain provisions of the Credit Agreement, including certain restrictive covenants. 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 statement of operations for the year ended September 30, 2016.

Demand Notes

During the year ended September 30, 2012, the Company obtained a commitment from a bank for a $9.3 million equipment leasing facility to finance various equipment at the Company's hospital facilities. During January 2014, the commitment was increased to $15.0 million. As of September 30, 2016 and 2015, 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.

Other Debt:

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

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

During the year ended September 30, 2016, Nix SPE entered into a Purchase and Sale Agreement with a third party ("NAH Buyer") for the sale of Nix Alamo Heights for $6,300,000. Concurrently, the Company entered into a lease with the NAH Buyer to lease Nix Alamo Heights for 13 years, with 2% annual rent increases and four consecutive options to extend the lease term for five years each. Pursuant to the terms of the lease, the Company is required to repair, maintain and replace all aspects of the Nix Alamo Heights building. The Company's ability to lease the Nix Alamo Heights for up to 33 years and the requirement to fully maintain the property constitute continuing involvement for financial reporting purposes. As a result, the transaction has been accounted for as a financing transaction and is included within long-term debt as of September 30, 2016.

The Company also entered into an Agreement of Purchase and Sale effective September 14, 2016 to sell the East Orange medical arts building for a purchase price of $11,860,000 to a third party ("East Orange MAB Buyer"). Concurrently, the Company entered into a lease with the East Orange MAB Buyer to lease the East Orange medical arts building for 10 years, with 2% annual rent increases and four consecutive options to extend the lease term for five years each. East Orange sub-leases a significant portion of the building to third parties, resulting in continuing involvement for financial reporting purposes. As a result, the transaction has been accounted for as a financing transaction and is included within long-term debt as of September 30, 2016.

Scheduled payments under the Company's current and long-term debt as of September 30, 2016 are as follows (in thousands):

Years ending September 30,	
2017	$ 6,951
2018	7,067
2019	7,067
2020	7,140
2021	7,217
Thereafter	605,147
Total scheduled payments	640,589
Less: Senior Secured Notes discount, net	(8,984)
Less: Deferred financing costs, net	(11,649)
Total long-term debt	$ 619,956

Future amortization of the Company's debt discount and deferred financing costs as of September 30, 2016 are as follows (in thousands):

Years ending September 30,	
2017	$ 3,721
2018	3,721
2019	3,721
2020	3,721
2021	3,515
Thereafter	2,234
	$ 20,633

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, pursuant to which the Board of Directors authorized the issuance of options exercisable for an additional 13,972 shares of common stock of Ivy Holdings ("New Options") to employees, certain consultants and independent members of the boards of directors of Ivy Holdings and its subsidiaries (including the Company and its subsidiaries). Concurrently, the Compensation Committee granted 13,972

options to certain members of the Company's management and employees. The New Options are exercisable into Ivy Holdings stock and vest based on a number of criteria, including the same criteria as the Initial Options however, they only become exercisable on the occurrence of certain corporate transactions, including a change in control of Ivy Holdings, as defined in the Incentive Stock Option Agreements ("Corporate Transaction"). Because the occurrence and timing of a Corporate Transaction is not determinable as of September 30, 2016, no compensation cost has been recorded in the Company's consolidated financial statements.

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

Stock Options Activity

The following table summarizes information about Ivy Holdings stock options outstanding as of September 30, 2016 and 2015 and activity during the years then ended for the Initial Options and the New Options:

	Shares Subject to Options	Weighted Average Exercise Price	Weighted Average Aggregate Intrinsic Value	Weighted Average Remaining Contractual Term (Months)
Outstanding as of September 30, 2014	115,475	$ 45.37	$ 74.63	84.1
Granted *(1)*	51,786	176.00	—	—
Exercised	(12,620)	31.38	—	—
Canceled/Forfeited	(4,079)	46.24	—	—
Outstanding as of September 30, 2015	150,562	91.42	436.51	88.2
Granted	-	-	—	—
Exercised	(4,063)	30.00	—	—
Canceled/Forfeited	(3,093)	134.58	—	—
Outstanding as of September 30, 2016	143,406	$ 92.30	$ 445.70	76.2

(1) The options granted include 37,814 Initial Options and 13,972 New Options.

The aggregate intrinsic value is calculated as the difference between the exercise price of the underlying awards and the estimated fair value of the Company's common stock for those awards that have an exercise price currently below the estimated fair value. As of September 30, 2016, the aggregate intrinsic value of outstanding shares was approximately $64,000,000. As of September 30, 2016, there were 111,638 options that are exercisable at a weighted average exercise price of $68.91.

A summary of Ivy Holdings non-vested options and the changes during the fiscal years ended September 30, 2016 and 2015 is presented as follows for the Initial Options and New Options:

	Shares	Weighted Average Grant Date Fair Value
Ivy Holdings Stock Options:		
Nonvested at September 30, 2014	13,637	$ 70.47
Granted	51,786	98.65
Vested	(19,005)	89.73
Canceled/Forfeited	(1,672)	88.79
Nonvested at September 30, 2015	44,746	94.22
Vested	(15,991)	89.10
Canceled/Forfeited	(2,279)	91.45
Nonvested at September 30, 2016	26,476	$ 97.55

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, 2015 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,	2015
Weighted average fair value of option grants	$ 98.65
Estimated fair market value of the Company's common stock on the date of grant	$ 176.00
Weighted average expected life of the options	9.8 years
Risk-free interest rate	1.8%
Weighted average expected volatility	45.0%
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, 2016 and 2015 was $1,119,000 and $1,184,000, respectively. At September 30, 2016, there were 26,476 unvested options, which could potentially vest over the next six 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 $1,659,000. 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, 2016 and 2015.

11. Retirement Benefits

In conjunction with the acquisition of certain assets and the assumption of certain liabilities of Crozer-Keystone Health System, effective July 1, 2016 (the “Effective Date”), the Company became the sponsor and assumed the Crozer-Keystone Health System (“CKHS”) Employee Retirement Plan, an employee non-contributory, defined benefit pension plan (the “DB Plan”) covering certain full-time employees.

Pursuant to the Asset Purchase Agreement entered into by and among the Company, Prospect Crozer, LLC and Crozer’s wholly-owned subsidiary, CKHS, on January 8, 2015, as amended, (the “Agreement”) at Closing, CKHS agreed to pay out of the Purchase Price (Note 4) $100 million into an escrow, which funds was subsequently used by the Company upon becoming the sponsor of the DB Plan pursuant to IRS rules and regulations to fund in part the underfunded Plan liability then outstanding. Additionally, pursuant to the Agreement, within five years after the Effective Date and subject to applicable filing and authorization by the applicable Government Entity, the Company shall adopt a plan amendment to terminate the DB 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 DB Plan by providing lump sum distributions to participants, purchasing annuities for participants who do not elect a lump sum distribution.

Pursuant to an amendment to the DB Plan, effective July 1, 2016, the DB 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 will accrue on or after such date. Additionally, the DB 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).

Effective 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 transaction, on the Effective Date, 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.

Pursuant to an amendment to the OPEB Plan and SERP Plan, effective July 1, 2016, the Plans were frozen with all benefit accruals ceased as of July 1, 2016. No benefits will accrue on or after such 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.

The activity of the Pension Plan and the OPEB for the period from July 1, 2016 (Crozer inception) through September 30, 2016 is as follows (in thousands):

	Pension Plan	OPEB
Changes in benefit obligations		
Projected benefit obligations, beginning of period	$ 680,724	$ 6,888
Service cost	-	20
Interest cost	5,573	51
Actuarial (gain) loss	(3,616)	118
Benefits paid	(5,759)	(236)
Projected benefit obligation (Pension Plan) and Accumulated benefit obligation (OPEB), end of period	$ 676,922	$ 6,841
Changes in plan assets		
Fair value of plan assets, beginning of period	$ 350,393	$ -
Actual return on plan assets	22,630	-
Contributions by plan sponsor	100,000	236
Benefits paid	(5,759)	(236)
Fair value of plan assets, end of period	$ 467,264	$ -
Funded status of the plan, end of period	$ (209,658)	$ (6,841)
Accumulated benefit obligation, end of period	$ (209,658)	$ (6,841)

The funded status of the Pension Plan and OPEB as of September 30, 2016 and the components of net periodic benefit cost for the period from July 1, 2016 (Crozer inception) through September 30, 2016 were as follows (in thousands):

	Pension Plan	OPEB
Amounts recognized in the consolidated balance sheets consist of:		
Current liability	$ -	$ 1,050
Non-current liability	209,658	5,791
Amount recognized, end of year	$ 209,658	$ 6,841
Components of net periodic benefit cost:		
Service cost	$ -	$ 20
Interest cost	5,573	51
Expected return on plan assets	(7,000)	-
Total net periodic benefit (credit) cost	$ (1,427)	$ 71
Other change in benefit obligations recognized in accumulated other comprehensive income:		
Liability (gain) loss due to assumption change	$ 2,116	$ -
Liability (gain) loss due to participant experience	(5,732)	117
Asset return (gain) loss	(15,630)	-
Total recognized in other comprehensive income and accumulated other comprehensive income	$ (19,246)	$ 117

The assumptions used in determining the actuarial present value of the projected benefit obligations are as follows:

	Pension Plan	OPEB
Weighted average assumptions used to determine benefit obligations at end of period		
Discount rate	3.68%	3.27%
Rate of compensation increase	0.00 %	2.00%
Weighted average assumptions used to determine net periodic benefit cost for the period from July 1, 2016 (Crozer inception) through September 30, 2016		
Discount rate	3.68%	3.27%
Rate of compensation increase	0.00%	0.00%
Expected return on the plan assets	6.50%	0.00%

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:

	2016
Health care trend rate assumed for next year	**7.0%**
Rate to which the cost trend is assumed to decline (the ultimate rate)	**4.5%**
Year that the rate reaches the ultimate trend rate	**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	$ 6,934	$ 6,754
Effect on total of service and interest cost components	$ 312	$ 290

The asset allocation percentage by major asset class for the Plan and the target allocation for 2016 follows:

	Target	2016
Asset class:		
Cash and cash equivalents	0% – 20%	**- %**
Fixed income	10% – 100%	**87**
Domestic equity	0% – 100%	**-**
International equity	0% – 40%	**-**
Real estate	0% – 30%	**-**
Alternative investments and hedge funds	0% – 30%	**13**
		100 %

The investment objectives of the Plan 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 Plan 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 Plan is based on an aggregate of expected capital market returns within each asset category.

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

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	$ 62,396	$ 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 period from July 1, 2016 (inception) through September 30, 2016, there were no transfers in classification within the fair value hierarchy.

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

For the year ended September 30,	2016
July 1, 2016 (Crozer inception)	$ 69,528
Actual return on plan assets:	
Realized gain (loss)	282
Unrealized gain (loss)	1,367
Purchases	-
Sales	(8,780)
September 30, 2016	$ 62,397

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

	Pension Plan	OPEB
2017	$ 38,520	$ 1,050
2018	39,400	570
2019	39,800	440
2020	39,570	420
2021	38,900	400
2022 - 2026	192,290	1,850
	$ 388,480	$ 4,730

The Company also sponsors three defined contribution plans covering substantially all employees who meet certain eligibility requirements. Under these plans, employees can contribute up to 50% of their compensation up to the IRS deferred annual maximum. There is currently no company match offered under the plans, except at Nix Health, PCC, and Crozer, for which the expense for the employer match was $3,417,000 and $1,865,000 for the years ended September 30, 2016 and 2015, respectively. Total expenses under the plan were approximately $509,850 and $480,000 during the years ended September 30, 2016 and 2015, 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) required under leases in effect at September 30, 2016, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2017	$ 9,803	$ 20,330
2018	8,259	18,004
2019	6,413	15,291
2020	3,364	13,617
2021	3,343	10,722
Thereafter	29,919	43,722
Total minimum lease payments	61,101	$ 121,686
Less: amounts representing interest	(20,873)	
	40,228	
Less: current portion	(6,894)	
	$ 33,334	

Rent expense for the years ended September 30, 2016 and 2015 was approximately $22,481,000 and $15,258,000, respectively. Sublease rental income was not material to the consolidated financial statements for the years ended September 30, 2016 and 2015.

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

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

- Hospitals in California must conduct seismic evaluation and submit these evaluations to the Office of Statewide Health Planning and Development ("OSHPD"), Facilities Development Division for its review and approval;

- Hospitals in California must identify the most critical nonstructural systems that represent the greatest risk of failure during an earthquake and submit timetables for upgrading these systems to the OSHPD, Facilities Development Division for its review and approval; and

- Hospitals in California must prepare a plan and compliance schedule for each regulated building demonstrating the steps a hospital will take to bring the hospital buildings into substantial compliance with the regulations and standards.

The Company was required to conduct engineering studies at its hospitals to determine whether and to what extent modifications to the hospital facilities will be required. Management believes that SCH Culver City meets all current requirements; however, it may be required to make significant capital expenditures in the future to comply with the seismic standards, which could impact its earnings. The cost at September 30, 2016, is unknown at this time but could be material. In addition, such modifications to the hospital facilities could potentially result in environmental remediation liabilities which may be material to the Company.

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

In addition, in 2011, the California Legislature enacted Senate Bill 90, which permitted some hospitals to apply for up to an additional seven year extension to the seismic retrofit deadlines, not to extend beyond January 1, 2020. SB 90 also permits OSHPD to extend until January 1, 2018 the date by which the hospitals must obtain a building permit and commence the required retrofit project. 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 Hospitals both applied for the SB 90 extension from OSHPD. Two of the multi-story buildings owned by SCH Culver City were granted SB 90 extensions until January 1, 2019 or July 1, 2019. An additional single-story building is classified as SPC-2. Also, the facility operated by Los Angeles Community Hospital received an SB 90 extension until January 1, 2019.

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. Bellflower is not currently subject to the requirements of SB90 as the facility currently only provides psychiatric services.

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

Legislation and HIPAA

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

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

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

Affordable Care Act

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

Future changes to the Affordable Care Act 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.

California Hospital Fee Program

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

Governor Brown signed Senate Bill 239 ("SB 239") in October 2013. SB 239 enacted a hospital fee program for a program period beginning January 1, 2014 and ending December 31, 2016, contained language for the continuation of a hospital fee program thereafter, but provided that the program would terminate on December 31, 2016. In November 2016, the California voters approved Proposition 52, which made the hospital fee program permanent so that it continues after December 31, 2016. The hospital fee program is operated in cycles known as program periods. The next program period will begin on January 1, 2017

and end on June 30, 2019. Subsequent program periods will be of a duration not to exceed three years. The fee for service component of SB 239 for the period January 1, 2014 through December 31, 2016 was approved by CMS during December 2014, and the first cycle of the managed care component from January 2014 through June 2014 was approved by CMS during July 2015. In November 2016, Proposition 52 was approved in California, extending the existing hospital fee program and continuing the program on an on-going basis. Proposition 52 also prohibits lawmakers from diverting Medi-Cal funds to pay for anything other than their intended purpose.

Management of SCH Culver City estimated that SCH Culver City would be a "net" payer under the Program for AB 1383 and SB 90, since the fee assessments on SCH Culver City exceeded the supplemental payments by approximately $1,074,000 and $4,000,000, respectively. Accordingly, on October 6, 2010, the Company notified the California Department of Healthcare Services ("DHCS") that SCH Culver City was opting out of the Program.

SCH Culver City did not pay the required fee assessments under the Program. As of September 30, 2012, SCH Culver City recorded a liability of approximately $5,494,000, representing the accrued loss above, as well as deferred recognition of payments received from managed care plans. On November 15, 2012 the Company entered into a settlement agreement with DHCS with regards to SCH Culver City's liability under AB 1383, SB 90 and SB 335, as discussed above. Under the terms of the agreement, the DHCS agreed to forgive approximately $2,000,000 of the fees due under AB 1383, which was recorded by the Company during the year ended September 30, 2013. The remaining liability due to DHCS of $4,605,000 will be repaid by the Company monthly over a 10-year period without interest or penalties. The Company recorded a net liability of $3,233,000 as of the settlement date, which represents the net present value of the liability due to DHCS discounted at an effective interest rate of 7.5%. As of September 30, 2016 and 2015, the unamortized balance of the liability amounted to $2,268,000 and $2,547,000, respectively. The DHCS will no longer withhold against any other amounts due to SCH Culver City unless the Company is delinquent on payments owed under the agreement.

As of September 30, 2016 and 2015, the Company had a receivable related to the California Hospital Fee Program of $43,039,000 and $32,285,000, respectively, in the accompanying consolidated balance sheets. As of September 30, 2016 and 2015, the Company had a liability related to the California Hospital Fee Program of $18,684,000 and $15,022,000, respectively, in the accompanying consolidated balance sheets.

Total California Hospital Fee program revenues and expenses recognized during the years ended September 30, 2016 and 2015 were as follows (in thousands):

Years Ended September 30,	**2016**	2015
Hospital services revenues	**$ 91,929**	$ 134,604
Hospital operating expenses	**60,376**	91,325
Net pre-tax impact	**$ 31,553**	$ 43,279

Collective Bargaining Agreements

A small group of employees at SCH Hollywood, which is one of the hospitals under the consolidated group of Southern California Healthcare System, Inc., and Service Employees International Union, United Healthcare Workers-West ("SEIU") are currently parties to a collective bargaining agreement which expires May 2019. In addition, approximately 950 employees at SCH Culver City are part of a collective bargaining agreement with the SEIU or the California Nurses Association ("CNA"). SCH Culver City and CNA

are currently parties to a collective bargaining agreement which expires March 2019. SEIU and SCH Culver City are currently parties to a three-year term agreement that expires on April 27, 2017.

Approximately 300 employees at Our Lady of Fatima Hospital ("Fatima") are subject to a collective bargaining agreement with United Nurses and Allied Professionals ("UNAP"), which expired July 31, 2016. 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 30, 2017.

East Orange and the International Union of Operating Engineers are party to a collective bargaining agreement expiring December 2016 for the hospital's maintenance unit, consisting of approximately 15 employees.

Approximately 1,000 employees of Crozer are subject to seven collective bargaining agreements expiring on various dates from October 2017 through December 2019. Crozer is also negotiating certain new and expired collective bargaining agreements as of September 30, 2016.

Tangible Net Equity ("TNE") Requirement

The Company's affiliated physician organizations and PHP must comply with a minimum working capital requirement, Tangible Net Equity ("TNE") requirement, cash-to-claims ratio and claims payment requirements prescribed by the California Department of Managed Health Care ("DMHC"). Additionally, PHP has a TNE requirement as prescribed by the California Department of Managed Health Care. TNE is defined as net assets, less intangibles and amounts due from affiliates, plus subordinated obligations. As of September 30, 2016, PHP was in compliance with these regulatory requirements.

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

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

Employee Health Plans

Effective January 1, 2013 the Company offered self-insured EPO/HMO and PPO plans to all eligible employees. CharterCARE had a separate low-deductible employee health plan from the date of acquisition through December 31, 2014. Effective January 1, 2015, CharterCARE changed to self-insured EPO/HMO and PPO plans for all eligible employees. Effective March 1, 2016, East Orange offered self-insured EPO/HMO and PPO plans for all eligible employees. Effective July 1, 2016, Crozer offered self-insured EPO/HMO and PPO plans for all eligible employees.

Employee health benefits are administered by a third party claims administrator, based on plan coverage and eligibility guidelines determined by the Company, as well as by collective bargaining agreements (as reflected above). Commercial insurance policies cover per occurrence losses in excess of $750,000 for Crozer, $160,000 for East Orange, $275,000 for CharterCARE, $250,000 for all other hospitals and $175,000

for the Medical Group and Corporate segments. An actuarially and internally-estimated liability of approximately $4,157,000 and $3,850,000 for incurred but not reported claims has been included in accrued salaries, wages, and benefits as of September 30, 2016 and 2015, respectively. As of September 30, 2016, approximately $1,009,000 of the total liability for incurred but not reported claims was estimated using an internally-developed model.

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 fiscal years ended September 30, 2016 and 2015 (in thousands):

September 30,	**2016**	2015
IBNR as of beginning of year	**$ 53,531**	$ 39,314
Claim expenses incurred during the year:		
Related to current year	**226,431**	203,400
Related to prior year	**2,715**	1,606
Total incurred	**229,146**	205,006
Claims paid during the year:		
Related to current year	**(179,457)**	(156,485)
Related to prior year	**(50,459)**	(34,304)
Total paid	**(229,916)**	(190,789)
IBNR as of end of year	**$ 52,761**	$ 53,531

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,	**2016**	2015
Capitation expense	**$ 100,673**	$ 93,340
Fee-for-service claims expense	**142,674**	118,529
Other physician compensation	**20,436**	14,082
Other cost of revenues	**1,941**	1,196
Total cost of revenues	**$ 265,724**	$ 227,147

15. Joint Ventures and Unconsolidated Equity Investments

AMVI

The Company (through Prospect Medical Group, Inc.) and an unrelated third party, AMVI Care Health Network, Inc. ("AMVI") are partners in a joint venture initially formed to service Medi-Cal members under the CalOptima program in Orange County, California. Healthy Families and OneCare members were subsequently added to the joint venture arrangement. Effective January 1, 2013, all Healthy Family participants were transferred to the Company's Medi-Cal line of business and therefore no longer part of the joint venture. The Company does not consolidate the joint venture. The Company includes in its consolidated financial statements only the net results attributable to those enrollees specifically identified as assigned to it, together with the management fee that it charges the joint venture partner for managing those enrollees specifically assigned to AMVI. Costs incurred by the Company in managing the joint venture are included in general and administrative expenses in the accompanying consolidated financial statements. As of September 30, 2016 and 2015, the net liability balances of the Company investment in the joint venture under the equity method were approximately $181,000 and $1,944,000, respectively, and were included in accounts payable and other accrued liabilities in the accompanying consolidated financial statements.

Summarized unaudited financial information for the unconsolidated joint venture as of and for each of the years ended September 30, 2016 and 2015 is as follows (in thousands):

September 30,		**2016**		2015
Cash	**$**	**646**	$	(96)
Receivables		**626**		2,344
Total assets	**$**	**1,272**	$	2,248
Accrued medical claims	**$**	**144**	$	1,652
Other payables		**179**		158
Other partner's capital		**844**		437
Prospect's capital		**106**		1
Total liabilities and partner's capital	**$**	**1,273**	$	2,248

Years Ended September 30,		**2016**		2015
Revenues	**$**	**9,179**	$	19,817
(Loss) Income before income taxes	**$**	**(1,103)**	$	4,532
Prospect's equity (loss) income	**$**	**(1,303)**	$	5,867
Management fees earned by Prospect	**$**	**437**	$	1,106

RWRT and SNERCC

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

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

RWMC is not liable for any obligations insured by RWRT or SNERCC nor is it obligated to make any further capital contributions or lend funds to RWRT or SNERCC. As of September 30, 2016 and 2015, RWMC's investments in RWRT and SNERCC under the equity method were approximately $4,281,000 and $4,217,000, respectively, and are included in equity method investments in the accompanying consolidated balance sheets. For the years ended September 30, 2016 and 2015, the Company recognized approximately $448,000 and $455,000, respectively, as its share of the financial results of RWRT and SNERCC and received $320,000 and $423,000, respectively, in distributions.

Summarized combined unaudited financial information for RWRT and SNERCC as of September 30, 2016 and 2015 and for the year ended September 30, 2016 and for the period from June 20, 2014 (inception) through September 30, 2015 is as follows (in thousands):

September 30,	**2016**	2015
Cash	**$ 2,567**	$ 1,299
Receivables	**1,265**	1,547
Other current assets	**271**	274
Total current assets	**4,103**	3,120
Property, improvements and equipment, net	**6,495**	7,432
Goodwill	**7,142**	7,142
Intangible assets	**912**	943
Other long-term assets	**1,641**	1,663
Total assets	**$ 20,293**	$ 20,300
Accounts payable and accrued liabilities	**$ 1,251**	$ 1,618
Other long-term liabilities	**378**	345
Equity	**18,664**	18,337
Total liabilities and partner's capital	**$ 20,293**	$ 20,300

Years ended September 30,	**2016**	2015
Revenues	**$ 15,007**	$ 14,626
Net income	**$ 1,927**	$ 2,000
Roger Williams Medical Center's income from equity method investments	**$ 448**	$ 455

16. Subsequent Event (Unaudited)

The Company has evaluated subsequent events through December 29, 2016, the date the Company's consolidated financial statements were available for issuance.

Effective October 1, 2016, a wholly-owned subsidiary of the Company, Prospect ECHN, Inc. (and affiliated wholly-owned subsidiaries), acquired substantially all of the assets, and certain liabilities, of Eastern

Connecticut Health Network, Inc. and certain of its subsidiaries 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. Results of operations for the acquired assets will be included in the results of the Hospital Services segment from the date of acquisition and are not included in the results of operations for the year ended September 30, 2016.

Also effective October 1, 2016, a wholly-owned subsidiary of the Company, Prospect Waterbury, Inc. (and affiliated wholly-owned subsidiaries), acquired substantially all of the assets, and certain liabilities, of Greater Waterbury Health Network, Inc. and certain of its subsidiaries 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. Results of operations for the acquired assets will be included in the results of the Hospital Services segment from the date of acquisition and are not included in the results of operations for the year ended September 30, 2016.

Effective December 22, 2016, Prospect CharterCare RWMC, LLC and Prospect CharterCare Elmhurst, LLC ("Elmhurst") sold assets related to its Elmhurst Extended Care 206 bed nursing facility, including certain real property, to Valley Stream Property, LLC. (an affiliate of Tryko Partners, and its health care subsidiary, Marquis Health Services) for cash consideration of approximately $15 million. Results of operations of Elmhurst, and the related sold assets, are included in discontinued operations for the year ended September 30, 2016 and 2015.

Prospect CharterCARE, LLC

Consolidated Financial Statements

As of and for the Years Ended
September 30, 2016 and 2015

Prospect CharterCARE, LLC

Consolidated Financial Statements

As of and for the Years Ended September 30, 2016 and 2015

Prospect CharterCARE, LLC

Contents

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, 2016 and 2015, 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, 2016 and 2015, 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

March 29, 2017

Consolidated Financial Statements

Prospect CharterCARE, LLC

Consolidated Balance Sheets
(in thousands)

As of September 30,	**2016**	2015
Assets		
Current assets		
Cash and cash equivalents	**$ 4,091**	$ 13,288
Restricted cash	**2,198**	1,277
Patient accounts receivable, less allowance for doubtful accounts of $8,587 and $9,337	**38,511**	36,935
Other receivables	**8,883**	6,143
Due from government payers	**785**	871
Inventories	**6,196**	6,128
Prepaid expenses and other current assets	**3,372**	2,168
Current assets held for sale	**3,887**	3,894
Total current assets	**67,923**	70,704
Property, improvements and equipment, net	**55,592**	52,725
Goodwill	**3,774**	3,432
Intangible assets, net	**4,499**	6,145
Equity method investments	**4,611**	4,547
Other assets	**1,205**	1,727
Total assets	**$ 137,604**	$ 139,280

See accompanying notes to consolidated financial statements.

Prospect CharterCARE, LLC

Consolidated Balance Sheets
(in thousands)

As of September 30,	**2016**	2015
Liabilities and Members' Equity		
Current liabilities		
Accounts payable and other accrued liabilities	**$ 26,297**	$ 22,379
Accrued salaries, wages and benefits	**14,849**	14,378
Due to government payers	**125**	347
Due to affiliated companies, net	**28,006**	24,114
Current portion of capital leases	**1,439**	457
Current liabilities held for sale	**7,205**	3,759
Total current liabilities	**77,921**	65,434
Capital leases, net of current portion	**2,012**	538
Asset retirement obligations	**4,943**	4,583
Other long-term liabilities	**5,451**	1,265
Total liabilities	**90,327**	71,820
Commitments, contingencies, and subsequent events		
Members' equity:		
Member contributions	**71,645**	68,856
Accumulated deficit	**(24,368)**	(1,396)
Total members' equity	**47,277**	67,460
Total liabilities and members' equity	**$ 137,604**	$ 139,280

See accompanying notes to consolidated financial statements.

Prospect CharterCARE, LLC

Consolidated Statements of Operations
(in thousands)

For the Years Ended September 30,	**2016**	2015
Revenues:		
Net patient service revenues	**$ 338,440**	$ 323,795
Provision for bad debts	**(15,264)**	(15,782)
Net patient service revenues less provision for bad debts	**323,176**	308,013
Other revenues	**6,357**	10,307
Total net revenues	**329,533**	318,320
Operating Expenses:		
Salaries, wages and benefits	**189,529**	174,949
Supplies	**59,152**	56,099
Taxes and licenses	**20,459**	18,014
Purchased services	**19,629**	18,132
Depreciation and amortization	**12,376**	10,775
Professional fees	**11,774**	8,203
Other	**9,750**	7,348
Insurance	**8,141**	3,618
Management fees	**6,888**	6,717
Utilities	**4,506**	5,239
Lease and rental	**3,615**	3,423
Research grant expense	**2,424**	2,738
Repairs and maintenance	**1,624**	2,396
Registry	**788**	1,458
Total operating expenses	**350,655**	319,109
Operating income from unconsolidated equity method investments	**512**	455
Operating loss	**(20,610)**	(334)
Interest expense	**82**	104
Net loss from continuing operations	**(20,692)**	(438)
Loss from discontinued operations	**(2,280)**	(117)
Net loss	**$ (22,972)**	$ (555)

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 September 30, 2014	$ 65,219	$ (841)	$ 64,378
Member contributions	3,637	-	3,637
Net loss	-	(555)	(555)
Balance at September 30, 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

See accompanying notes to consolidated financial statements.

Prospect CharterCARE, LLC

Consolidated Statements of Cash Flows
(in thousands)

For the Years Ended September 30,	**2016**	2015
Operating activities		
Net loss	**$ (22,972)**	$ (555)
Adjustments to reconcile net loss to net cash used in operating activities:		
Depreciation and amortization	**12,376**	10,775
Provision for bad debts	**15,264**	15,782
Operating income from equity method investments, net of distributions	**(64)**	(57)
Gain on sale of equity method investment	**-**	(296)
Accretion of interest for asset retirement obligations	**360**	273
Changes in operating assets and liabilities, net of business combinations:		
Change in restricted cash	**(921)**	716
Patient accounts receivable and other receivables	**(19,580)**	(18,400)
Due to/from government payers, net	**(136)**	(406)
Inventories	**(57)**	(1,498)
Prepaid expenses and other current assets	**(1,204)**	(440)
Other assets	**522**	(401)
Accounts payable and other accrued liabilities	**8,576**	(9,676)
Net cash and cash equivalents provided by (used in) operating activities from discontinued operations	**573**	(459)
Net cash used in operating activities	**(7,263)**	(4,642)
Investing activities		
Purchases of property, improvements and equipment	**(10,324)**	(9,218)
Cash paid for acquisitions, net of cash received	**(374)**	(3,865)
Cash paid for equity method investments	**-**	(1,880)
Proceeds from sale of equity method investment	**-**	1,233
Net cash and cash equivalents used in investing activities from discontinued operations	**(146)**	(158)
Net cash used in investing activities	**(10,844)**	(13,888)
Financing activities		
Member contributions	**2,789**	3,637
Increase in due to affiliated companies, net	**3,892**	20,076
Repayments of capital leases	**(796)**	(431)
Net cash and cash equivalents provided by financing activities from discontinued operations	**3,025**	2,027
Net cash provided by financing activities	**8,910**	25,309
(Decrease) increase in cash and cash equivalents	**(9,197)**	6,779
Cash and cash equivalents, beginning of period	**13,288**	6,509
Cash and cash equivalents, end of period	**$ 4,091**	$ 13,288
Supplemental disclosure of cash flow information		
Interest paid	**$ 82**	$ 104
Schedule of non-cash investing and financing activities		
Equipment acquired under capital lease	**$ 3,252**	$ 244

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 (formerly known as CharterCARE Health Partners).

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, 2016 and 2015, the Company had a liability of $28,006,000 and $24,114,000, 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

CharterCARE Physicians Medical Practices

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.

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

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

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

For the Years Ended September 30,	**2016**	2015
Inventories	**$ 11**	$ 8
Improvements and equipment	**21**	328
Intangible assets	**-**	97
Goodwill	**342**	3,432
Net cash consideration	**$ 374**	$ 3,865

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

New University Medical Group

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

As of December 18, 2014, New UMG acquired certain assets of the practice and assumed certain liabilities related to the administrative functions of UMG ("Initial Close"). At a later date, New UMG will acquire certain additional assets and assume certain additional liabilities ("Second Close"). Concurrent with the Initial Close, UMG and New UMG entered into an Interim Administrative Services Agreement, which is effective until the Second Close occurs. New UMG also entered into the First Amendment to the Interim Administrative Services Agreement effective December 18, 2014. In addition, RWMC and CharterCARE Physicians have receivables from various transactions of $6,748,000 and $4,345,000 due from UMG as of September 30, 2016 and 2015, respectively, which are included in other receivables in the accompanying consolidated balance sheets.

Because the Second Close had not occurred as of September 30, 2016, the acquisition of UMG is not reported in the accompanying consolidated financial statements. As a result of the Asset Purchase Agreement, Interim Administrative Services Agreement (as amended), and various transactions, New UMG has the obligation to absorb certain losses of UMG and the right to receive certain benefits from UMG. However, New UMG does not have the power to direct the activities of UMG which most significantly impact its performance based on the terms of the Interim Administrative Services Agreement (as amended) and the governance of UMG. As a result, New UMG is not the primary beneficiary of UMG, and the results of UMG are not consolidated in the accompanying consolidated financial statements.

3. Discontinued Operations

During December 2016, the Company sold assets related to Elmhurst Extended Care (see note 12). 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 and 2015 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,	2016	2015
Carrying amounts of major classes of assets included as part of discontinued operations		
Cash	$ (129)	(344)
Restricted cash	22	-
Patient accounts receivable, net of allowance for doubtful accounts	2,555	3,149
Other current assets	301	32
Total current assets	2,749	2,837
Property, plant and equipment, net	739	685
Long-term assets	399	372
Total assets of the disposal groups classified as held for sale in the consolidated balance sheets	**$ 3,887**	$ 3,894
Carrying amounts of major classes of liabilities included as part of discontinued operations		
Accounts payable and other accrued liabilities	**$ 1,103**	$ 1,340
Due to affiliated companies, net	**5,315**	2,290
Long-term liabilities	**787**	129
Total liabilities of the disposal groups classified as held for sale in the consolidated balance sheets	**$ 7,205**	$ 3,759

For the Years Ended September 30,	**2016**	2015
Major line items constituting pretax loss of discontinued operations		
Net revenues	**$ 19,590**	$ 20,269
Operating expenses	**(21,870)**	(20,380)
Interest expense	**-**	(6)
Loss on discontinued operations	**$ (2,280)**	$ (117)

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, 2015.

4. Significant Accounting Policies

Basis of Presentation

The consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP") and include the accounts of all 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,	**2016**	2015
Medicare	**$ 151,015**	$ 144,583
Medicaid	**74,216**	62,993
Managed Care	**82,109**	81,677
Self-Pay/Other	**31,100**	34,542
Total	**$ 338,440**	$ 323,795

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 hospital 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. 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 revenues.

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.

The Company joined a second round of litigation relating to Medicare's settlement with providers relating to the manner in which the Centers for Medicare and Medicaid Services ("CMS") handled the budget neutrality adjustment associated with the rural floor wage index in setting the Medicare inpatient prospective system rates ("Rural Floor"). The Company entered into a settlement agreement with CMS and, as a result, recognized revenues of $1,858,000 and a net benefit of $1,672,000 during the year ended September 30, 2015 related to the Rural Floor litigation. There were no amounts recognized related to the Rural Floor litigation for the year ended September 30, 2016.

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 was established in 1995 to assist 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 $20,496,000 and $16,636,000 for the years ended September 30, 2016 and 2015, respectively. DSH and UPL payments received were $20,496,000 and $16,135,000 for the years ended September 30, 2016 and 2015, 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 $16,199,000 and $15,058,000 for the years ended September 30, 2016 and 2015, 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.

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

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

Charity Care

The Company provides charity care to patients whose income level is below 300% of the Federal Poverty Level. Patients without insurance are offered assistance in applying for Medicaid and other programs they may be eligible for, such as state disability. Patient advocates from the Company's Medical Eligibility Program ("MEP") screen patients in the hospital and determine potential linkage to financial assistance programs. They also expedite the process of applying for these government programs. The approximate cost of providing charity care was $1,225,000 and $990,000 for the years ended September 30, 2016 and 2015, respectively. The Company has estimated the cost of charity care based on a ratio of the cost to charges of operating expenses, excluding depreciation, interest and management fees.

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 18% and 20% of gross accounts receivable as of September 30, 2016 and 2015, respectively. The decrease was due to a self-pay discount which took effect during the year ended September 30, 2016, resulting in a decrease in the bad debt allowance required as of September 30, 2016.

Legislation

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

See Note 9 regarding the Affordable Care Act.

Other Revenues

Other revenues totaled $6,357,000 and $10,307,000 for the years ended September 30, 2016 and 2015, respectively. A summary of the principal components of other revenues is as follows:

Rural Floor settlement: The Company entered into a settlement agreement with CMS and recognized $1,858,000 of revenue during the year ended September 30, 2015 related to the Rural Floor litigation. No revenue related to this matter was recognized during the year ended September 30, 2016.

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

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

The Company recorded revenues, net of adjustments, of $(57,000) and $1,044,000 for the years ended
September 30, 2016 and 2015, respectively, related to the Medicare and Medicaid programs in the consolidated statements of operations. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria. Subsequent changes to these estimates will be recognized in the consolidated statement of operations in the period in which additional information is available. Such estimates are subject to audit by the federal government, the state, or its designee.

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 $1,727,000 and $1,639,000 for the years ended September 30, 2016 and 2015, 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 $1,479,000 and $1,767,000 for the years ended September 30, 2016 and 2015, 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 $670,000 and $581,000 for the years ended September 30, 2016 and 2015, 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 and Other Intangible Assets

Goodwill was $3,774,000 and $3,432,000 as of September 30, 2016 and 2015, respectively, and arose as a result of the Prospect CharterCARE Physicians medical practices acquisitions during the years ended September 30, 2016 and 2015. 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. In evaluating whether indicators of impairment exist, the Company considers adverse changes in market value, laws and regulations, profitability, cash flows, ability to maintain enrollment and renew payer contracts at favorable terms, among other factors. The goodwill impairment test is a two-step process. The first step consists of estimating the fair value of the reporting unit based on a weighted combination of (i) the guideline company method that utilizes revenue or earnings multiples for comparable publicly-traded companies, and (ii) a discounted cash flow model that utilizes expected future cash flows, the timing of those cash flows, and a discount rate (or weighted average cost of capital, which considers the cost of equity and cost of debt financing expected by a typical market participant) representing the time value of money and the inherent risk and uncertainty of the future cash flows. If the estimated fair value of the reporting unit is less than its carrying value, a second step is performed to compute the amount of the impairment by determining the "implied fair value" of the goodwill, which is compared to its corresponding carrying value. There were no impairments recorded for the years ended September 30, 2016 or 2015.

Long-Lived Assets and Amortizable Intangibles

Amortizable intangible assets, consisting primarily of trade names, were approximately $4,499,000 and $6,145,000, net of accumulated amortization at September 30, 2016 and 2015, respectively, and were a result of the Prospect CharterCARE and CharterCARE Physicians Medical Practices acquisitions. 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 for the years ended September 30, 2016 or 2015.

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 $5,083,000 and $879,000 as of September 30, 2016 and 2015, respectively, and insurance receivables were $806,000 and $594,000 as of September 30, 2016 and 2015, 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.

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

Workers' Compensation Insurance

The Company was fully insured for workers' compensation claims with no deductible during the years ended September 30, 2016 and 2015. Assets and liabilities related to workers' compensation insurance related to events prior to June 20, 2014 (inception) were not assumed by the Company.

Employee Health Plans

The Company had a low-deductible employee health plan from June 20, 2014 (inception) through December 31, 2014. Effective January 1, 2015, the Company changed to self-insured EPO/HMO and PPO plans for all eligible employees.

Employee health benefits are administered by a third party claims administrator, based on plan coverage and eligibility guidelines determined by the Company, as well as by collective bargaining agreements. Commercial insurance policies cover per occurrence losses in excess of $275,000. An actuarially estimated liability of approximately $1,557,000 and $1,856,000 for incurred but not reported claims due to Prospect has been included in due to affiliates, net as of September 30, 2016 and 2015, 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 statement of operations. The Company has accrued $4,943,000 and $4,583,000 related to asbestos remediation at RWMC and SJHSRI as of September 30, 2016 and 2015, 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 $2,198,000 and $1,277,000 as of September 30, 2016 and 2015, 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, 2016, 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, 2016	% of Net Patient Service Revenues	For the Year Ended September 30, 2015	% of Net Patient Service Revenues
Medicare	$ 151,015	45 %	$ 144,583	44%
Medicaid	74,216	22 %	62,993	21%
Total	$ 225,231	67 %	$ 207,576	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.

Recently Adopted Accounting Pronouncements

In July 2013, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2013-11 that requires an unrecognized tax benefit or portion of an unrecognized tax benefit to be presented as a reduction to a deferred tax asset for a net operating loss carryforward, a similar tax loss, or a tax credit carryforward except when certain conditions exist. The amendment is effective for the Company for fiscal years beginning after December 15, 2014, including interim periods in 2014. The Company adopted this guidance effective October 1, 2015 with no material impact to its consolidated financial statements.

New Accounting Pronouncements

In May 2014, the FASB issued ASU No. 2014-09, "Revenue from Contracts with Customers (ASU 2014-09)," as amended by ASU 2015-14. The core principle of ASU 2014-09 is built on the contract between a vendor and a customer for the provision of goods and services, and attempts to depict the exchange of rights and obligations between the parties in the pattern of revenue recognition based on the consideration to which the vendor is entitled. To accomplish this objective, the standard requires five basic steps: (i) identify the contract with the customer, (ii) identify the performance obligations in the contract, (iii) determine the transaction price, (iv) allocate the transaction price to the performance obligations in the contract, (v) recognize revenue when (or as) the entity satisfies a performance obligation. Nonpublic entities will apply the new standard for annual periods beginning after December 15, 2018, including interim periods therein. Three basic transition methods are available — full retrospective, retrospective with certain practical expedients, and a cumulative effect approach. Under the third alternative, an entity would apply the new revenue standard only

to contracts that are incomplete under legacy U.S. GAAP at the date of initial application (e.g. January 1, 2019) and recognize the cumulative effect of the new standard as an adjustment to the opening balance of retained earnings. That is, prior years would not be restated and additional disclosures would be required to enable users of the financial statements to understand the impact of adopting the new standard in the current year compared to prior years that are presented under legacy U.S. GAAP. Early adoption is permitted for fiscal years beginning after December 15, 2016. The Company is currently evaluating the effect of this guidance on its consolidated financial statements.

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

In January 2016, the FASB issued ASU No. 2016-01, "Financial Instruments" ("ASU 2016-01"). 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 No. 2016-02, "Leases" ("ASU 2016-02"). 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 fiscal years beginning after December 15, 2019, 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 No. 2016-07, "Investments – Equity Method and Joint Ventures" ("ASU 2016-07"). 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 August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230)" ("ASU 2016-15"). 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 the Company's 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,	**2016**	2015
Property, improvements and equipment:		
Land and land improvements	**$ 7,868**	$ 7,850
Buildings and improvements	**38,678**	31,855
Leasehold improvements	**3,280**	3,280
Equipment	**27,416**	20,498
Furniture and fixtures	**215**	736
	77,457	64,219
Less: accumulated depreciation	**(21,865)**	(11,494)
Property, improvements and equipment, net	**$ 55,592**	$ 52,725

At September 30, 2016 and 2015, the Company had assets under capitalized leases of approximately $4,095,000 and $860,000, respectively, and related accumulated depreciation of $610,000 and $228,000, respectively.

Depreciation expense, excluding discontinued operations, was $10,730,000 and $9,149,000 for the years ended September 30, 2016 and 2015, respectively.

6. Goodwill and Intangible Assets

Goodwill and intangible assets relate to the Prospect CharterCARE and CharterCARE Physicians medical practices acquisitions. The Company performed its annual goodwill impairment analysis for each reporting unit that constitutes a business for which 1) discrete financial information is produced and reviewed by management, and 2) services that are distinct from the other reporting units. Management has determined the Company consists of one reporting unit as of September 30, 2016. The following is a roll-forward of goodwill from September 30, 2014 to September 30, 2016 (in thousands):

	Amount
Balance, September 30, 2014	$ -
Acquisition of CharterCARE Physicians medical practices (see Note 2)	3,432
Balance, September 30, 2015	3,432
Acquisition of CharterCARE Physicians medical practices (see Note 2)	342
Balance, September 30, 2016	$ 3,774

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

	Amortization Period	**September 30, 2016**	September 30, 2015
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		**(3,728)**	(2,082)
Intangible assets, net		**$ 4,449**	$ 6,145

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 $1,646,000 and $1,626,000 for the years ended September 30, 2016 and 2015, respectively.

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

Years ended September 30,	
2017	$ 1,646
2018	1,646
2019	1,187
2020	20
Total	$ 4,499

The weighted-average remaining useful life for the intangible assets was 2.8 years as of September 30, 2016.

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.

Prospect contributed $2,789,000 and $3,637,000 for the years ended September 30, 2016 and 2015, 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 September 30, 2014	$ 54,721	$ 9,657	$ 64,378
Member contributions	3,091	546	3,637
Net loss	(472)	(83)	(555)
Balance at September 30, 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

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 $6,888,000 and $6,717,000 for the years ended September 30, 2016 and 2015, respectively, which is included within management fees expense in the accompanying consolidated statements of operations. As of September 30, 2016, the Company does not have a liability related to the MSA due PEHAS. As of September 30, 2015, $1,872,000 due to PEHAS is included in due to affiliates, net in the accompanying consolidated balance sheets.

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 2019. 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, 2016, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2017	$ 1,558	$ 764
2018	1,423	660
2019	706	605
2020	-	473
2021	-	391
Total minimum lease payments	3,687	$ 2,893
Less: amounts representing interest	(236)	
	3,451	
Less: current portion	(1,439)	
	$ 2,012	

Lease and rental expense was $3,615,000 and $3,423,000 for the years ended September 30, 2016 and 2015, 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, 2016 and 2015. 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, 2016 and 2015, as the borrowings are reflected in the separate consolidated financial statements of Prospect.

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Total borrowings outstanding as of September 30, 2016 and 2015, reflected in the consolidated financial statements of Prospect, but for which the Company is contingently liable as a guarantor, were (in thousands):

September 30,	**2016**	2015
Senior secured term loan	**$ 623,438**	$ -
Less: original issue discount, net	**(8,984)**	-
Senior secured 2019 Notes	**-**	325,000
Less: original issue discount, net	**-**	(4,950)
	614,454	320,050
Additional 2019 Notes	**-**	100,000
Plus: original issue premium, net	**-**	1,110
	-	101,110
	$ 614,454	$ 421,160

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 Prospect's existing 8.375% senior secured notes due during 2019; to repay $60 million for borrowings under Prospect's 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, 2016. 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. 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 2.31% as of September 30, 2016. The ABL Facility balance as of September 30, 2016 was $55,000,000. As of September 30, 2016, Prospect had unused letters of credit of $9,200,000, which offset Prospect's ability to borrow additional funds, and the ABL Facility had unused lender commitments of $50,800,000 as of September 30, 2016. 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, 2016, Prospect was in compliance with the financial covenants of the New Senior Secured Credit Facilities.

Letter of Credit

As of September 30, 2016, 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. 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") will substantially reform the United States health care system. The legislation impacts multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Starting in 2014, the legislation requires the establishment of health insurance exchanges, which will provide individuals without employer-provided health care coverage the opportunity to purchase insurance.

It is anticipated that some employers currently offering insurance to employees will opt to have employees seek insurance coverage through the insurance exchanges. It is possible that the reimbursement rates paid by insurers participating in the insurance exchanges may be substantially different than rates paid under current health insurance products. Another significant component of the PPACA is the expansion of the Medicaid program to a wide range of newly eligible individuals. In anticipation of this expansion, payments under certain existing programs, such as Medicare disproportionate share, will be substantially decreased. Each state's participation in an expanded Medicaid program is optional.

Future changes to the Affordable Care Act 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 300 employees at SJHSRI are subject to a collective bargaining agreement with United Nurses and Allied Professionals ("UNAP"), which expired July 31, 2016. 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 30, 2017.

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 $2,797,000 and $1,242,000 for the years ended September 30, 2016 and 2015, 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, 2016 and 2015, the Company's investments in RWRT, SNERCC, and other minor investments under the equity method were approximately $4,611,000 and $4,547,000, respectively, and are included in equity method investments in the accompanying consolidated balance sheets. For the years ended September 30, 2016 and 2015, the Company recognized approximately $512,000 and $455,000, respectively, as its share of the financial results of RWRT, SNERCC, and other minor investments and received $448,000 and $423,000, respectively, in distributions.

Summarized combined unaudited financial information for RWRT and SNERCC as of and for the years ended September 30, 2016 and 2015 is as follows (in thousands):

September 30,	**2016**	2015
Cash	**$ 2,567**	$ 1,299
Receivables and other current assets	**1,536**	1,821
Total current assets	**4,103**	3,120
Property, improvements and equipment, net	**6,495**	7,432
Goodwill	**7,142**	7,142
Intangible assets	**912**	943
Other long-term assets	**1,641**	1,663
Total assets	**$ 20,293**	$ 20,300
Accounts payable and accrued liabilities	**$ 1,251**	$ 1,618
Other long-term liabilities	**378**	345
Equity	**18,664**	18,337
Total liabilities and partner's capital	**$ 20,293**	$ 20,300

For the Years Ended September 30,	**2016**	2015
Revenues	**$ 15,007**	$ 14,626
Net income	**$ 1,927**	$ 2,000
RWMC's income from equity method investments	**$ 384**	$ 455

12. Subsequent Events (Unaudited)

The Company has evaluated subsequent events through March 29, 2017, the date the Company's consolidated financial statements were available for issuance.

On October 31, 2016, SJHSRI entered into a Purchase and Sale Agreement, pursuant to which SJHSRI granted and conveyed an exclusive easement to certain property utilized for telecommunications purposes for a 99 year term to a third party ("Grantee"). The Purchase and Sale Agreement also assigned certain of SJHSRI's telecommunications leases to the Grantee. The purchase price was approximately $2,057,000.

Effective December 22, 2016, RWMC and Elmhurst Extended Care sold assets related to the Elmhurst Extended Care 206 bed nursing facility, including certain real property, to Valley Stream Property, LLC. (an affiliate of Tryko Partners, and its health care subsidiary, Marquis Health Services) for cash consideration of approximately $15 million.

Effective November 28, 2016, SJHSRI entered into a Purchase Agreement ("MOB Purchase Agreement") to sell a medical office building for $100,000 to a third party ("Purchaser"). The purchaser has agreed to make certain required capital improvements pursuant to the terms of the MOB Purchase Agreement. On December 28, 2016, SJHSRI entered into a lease with the purchaser for a portion of the medical office building for specialty medical clinics for an initial base rent of $80,000 per month.

TAB 28B

Prospect CharterCARE SJHSRI, LLC

Financial Statements

As of and for the Years Ended
September 30, 2016 and 2015

Prospect CharterCARE SJHSRI, LLC

Financial Statements

As of and for the Years Ended September 30, 2016 and 2015

Prospect CharterCARE SJHSRI, LLC

Contents

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, 2016 and 2015, 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, 2016 and 2015, 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.

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 its 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 8 of the Company's calculation of its Title IV 90/10 revenue test ("Note 8 – Title IV 90/10") and Note 5 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 8 – Title IV 90/10 information and Note 11 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, 2017 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, 2017

Prospect CharterCARE SJHSRI, LLC

Balance Sheets
(in thousands)

September 30,	**2016**	2015
Assets		
Current assets		
Cash and cash equivalents	**$ -**	$ 11
Restricted cash	**462**	308
Patient accounts receivable, less allowance for doubtful accounts of $3,811 and $5,159	**16,321**	16,396
Other receivables	**821**	1,198
Due from government payers	**350**	565
Inventories	**1,971**	1,853
Prepaid expenses and other current assets	**1,073**	503
Total current assets	**20,998**	20,834
Property, improvements and equipment, net	**24,763**	25,796
Intangible assets, net	**1,953**	2,671
Other assets	**583**	645
Total assets	**$ 48,297**	$ 49,946

See accompanying notes to financial statements.

Prospect CharterCARE SJHSRI, LLC

Balance Sheets
(in thousands)

September 30,	**2016**	2015
Liabilities and Member's Equity		
Current liabilities		
Accounts payable and other accrued liabilities	**$ 8,847**	$ 8,316
Accrued salaries, wages and benefits	**4,276**	4,994
Due to government payers	**6**	166
Due to affiliated companies, net	**5,137**	3,796
Current portion of capital leases	**718**	130
Total current liabilities	**18,984**	17,402
Capital leases, net of current portion	**969**	104
Asset retirement obligations	**4,188**	3,883
Other long-term liabilities	**2,115**	451
Total liabilities	**26,256**	21,840
Commitments, contingencies, and subsequent events		
Member's equity:		
Member's contributions	**28,535**	28,535
Accumulated deficit	**(6,494)**	(429)
Total member's equity	**22,041**	28,106
Total liabilities and member's equity	**$ 48,297**	$ 49,946

See accompanying notes to financial statements.

Prospect CharterCARE SJHSRI, LLC

Statements of Operations
(in thousands)

For the Years Ended September 30,	**2016**	2015
Revenues:		
Net patient service revenues	**$ 144,754**	$ 144,741
Provision for bad debts	**(6,913)**	(7,897)
Net patient service revenues less provision for bad debts	**137,841**	136,844
Other revenues	**1,679**	3,406
Tuition revenues	**1,727**	1,639
Total net revenues	**141,247**	141,889
Operating Expenses:		
Salaries, wages and benefits	**82,417**	80,984
Supplies	**20,707**	19,302
Taxes and licenses	**9,544**	8,466
Purchased services	**7,260**	6,478
Depreciation and amortization	**6,784**	5,826
Professional fees	**4,849**	4,089
Other	**4,369**	3,191
Management fees	**2,915**	2,973
Utilities	**2,227**	2,786
Lease and rental	**1,957**	2,277
Insurance	**3,287**	1,851
Repairs and maintenance	**783**	1,260
Registry	**222**	1,071
Total operating expenses	**147,321**	140,554
Operating income from unconsolidated equity method investments	**64**	-
Operating (loss) income	**(6,010)**	1,335
Other expense:		
Interest expense	**55**	65
Total other expense	**55**	65
Net (loss) income	**$ (6,065)**	$ 1,270

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 September 30, 2014	$ 28,535	$ (1,699)	$ 26,836
Net income	-	1,270	1,270
Balance at September 30, 2015	28,535	(429)	28,106
Net loss	-	(6,065)	(6,065)
Balance at September 30, 2016	$ 28,535	$ (6,494)	$ 22,041

See accompanying notes to financial statements.

Prospect CharterCARE SJHSRI, LLC

Statements of Cash Flows
(in thousands)

For the Years Ended September 30,	**2016**	2015
Operating activities		
Net (loss) income	**$ (6,065)**	$ 1,270
Adjustments to reconcile net (loss) income to net cash and cash equivalents provided by operating activities:		
Depreciation and amortization	**6,784**	5,826
Provision for bad debts	**6,913**	7,897
Accretion of interest for asset retirement obligations	**305**	247
Changes in operating assets and liabilities:		
Change in restricted cash	**(154)**	(284)
Patient accounts receivable and other receivables	**(6,461)**	(8,083)
Due to/from government payers, net	**55**	(389)
Inventories	**(118)**	(283)
Prepaid expenses and other current assets	**(570)**	(1)
Other assets	**62**	(157)
Accounts payable and other accrued liabilities	**1,477**	(3,708)
Net cash provided by operating activities	**2,228**	2,335
Investing activities		
Purchases of property, improvements and equipment	**(3,148)**	(5,410)
Net cash used in investing activities	**(3,148)**	(5,410)
Financing activities		
Increase (decrease) in due to affiliated companies	**1,341**	(1,535)
Repayments of capital leases	**(432)**	(194)
Net cash provided by (used in) financing activities	**909**	(1,729)
Decrease in cash and cash equivalents	**(11)**	(4,804)
Cash and cash equivalents, beginning of period	**11**	4,815
Cash and cash equivalents, end of period	**$ -**	$ 11
Supplemental disclosure of cash flow information		
Interest paid	**$ 55**	$ 65
Schedule of non-cash investing activities		
Equipment acquired under capital lease	**$ 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 (formerly known as CharterCARE Health Partners). 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, 2016 and 2015, the Company had a net liability of $5,137,000 and $3,796,000, respectively, 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"). Operating results of the Company are presented as of and for the years ended September 30, 2016 and 2015.

Reclassifications

Certain reclassifications were made to the financial statements as of September 30, 2015 in order to conform to the presentation as of September 30, 2016.

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,	2016	2015
Medicare	$ 61,762	$ 60,072
Medicaid	36,447	33,551
Managed Care	33,124	34,815
Self-Pay/Other	13,421	16,303
Total	$ 144,754	$ 144,741

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.

The Company joined a second round of litigation relating to Medicare's settlement with providers relating to the manner in which the Centers for Medicare and Medicaid Services ("CMS") handled the budget neutrality adjustment associated with the rural floor wage index in setting the Medicare inpatient prospective system rates ("Rural Floor"). The Company entered into a settlement agreement with CMS and, as a result, recognized a net benefit of $677,000 during the year ended September 30, 2015 related to the Rural Floor litigation. There were no amounts recognized related to the Rural Floor litigation for the year ended September 30, 2016.

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 was established in 1995 to assist 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 $9,476,000 and $8,979,000 for the years ended September 30, 2016 and 2015, respectively. DSH and UPL payments received were $9,476,000 and $8,718,000 for the years ended September 30, 2016 and 2015, 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 $7,527,000 and $7,177,000, 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.

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

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 whose income level is below 300% of the Federal Poverty Level. Patients without insurance are offered assistance in applying for Medicaid and other programs they may be eligible for, such as state disability. Patient advocates from the Company's Medical Eligibility Program ("MEP") screen patients in the hospital and determine potential linkage to financial assistance programs. They also expedite the process of applying for these government programs. The approximate cost of providing charity care was $682,000 and $558,000 for the years ended September 30, 2016 and 2015, respectively. The Company has estimated the cost of charity care based on a ratio of the cost to charges of operating expenses, excluding depreciation and interest.

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 24% of gross accounts receivable as of September 30, 2016 and 2015, respectively. The decrease was due to a self-pay discount which took effect during the year ended September 30, 2016, resulting in a decrease in the bad debt allowance required as of September 30, 2016.

Legislation

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.

See Note 6 regarding the Affordable Care Act.

Other Revenues

Other revenues totaled $1,679,000 and $3,406,000 for the years ended September 30, 2016 and 2015, respectively. Management has evaluated the collectability of receivables related to other revenues and determined no allowance is necessary as of September 30, 2016 and 2015.

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

Rural Floor settlement: The Company entered into a settlement agreement with CMS and recognized $0 and $752,000 of revenue during the year ended September 30, 2016 and 2015, respectively, related to the Rural Floor litigation.

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

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

The Company recorded revenues, net of adjustments, of ($10,000) and $497,000 for the years ended September 30, 2016 and 2015, respectively, related to the Medicare and Medicaid programs in the statements of operations. These incentives have been recognized following the grant accounting model, recognizing income ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria. Subsequent changes to these estimates will be recognized in the statement of operations in the period in which additional information is available. Such estimates are subject to audit by the federal government, the state, or its designee.

Rental Revenue: Rental revenue from operating leases is recorded based on the fixed, minimum required rents (base rents) per the lease agreements. Rental revenue from base rent is recorded on the straight-line method over the terms of the related lease agreements. The Company recorded rental revenues of $441,000 and $262,000 for the years ended September 30, 2016 and 2015, 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 $1,727,000 and $1,639,000 for the years ended September 30, 2016 and 2015, respectively. Amounts receivable related to tuition revenues were $462,000 and $425,000 as of September 30, 2016 and 2015, respectively, which is included within other receivables in the accompanying balance sheets. The tuition receivable is net of an allowance for uncollectible tuition of $199,000 and $100,000 as of September 30, 2016 and 2015, 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 life of the lease if the lease does not provide for a transfer of ownership or bargain purchase or the useful life of the asset, if the lease does provide for a transfer of ownership or bargain purchase.

Long-Lived Assets and Amortizable Intangibles

Amortizable intangible assets, consisting of trade names, totaled approximately $1,953,000 and $2,671,000, net of accumulated amortization at September 30, 2016 and 2015. 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 for the years ended September 30, 2016 and 2015.

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 $2,096,000 and $431,000 as of September 30, 2016 and 2015, respectively, and insurance receivables were $409,000 and $276,000 as of September 30, 2016, and 2015, respectively, which are included within long term liabilities and long term assets, respectively, in the accompanying balance sheets. The gross claims liability and insurance receivables were estimated using a discount factor of 4%.

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

Workers' Compensation Insurance

The Company was fully insured for workers' compensation claims with no deductible for the years ended September 30, 2016 and 2015. Assets and liabilities related to workers' compensation insurance related to events prior to June 20, 2014 (inception) were not assumed by the Company.

Employee Health Plans

The Company had a low-deductible employee health plan from June 20, 2014 (inception) through December 31, 2014. Effective January 1, 2015, the Company changed to self-insured EPO/HMO and PPO plans for all eligible employees.

Employee health benefits are administered by a third party claims administrator, based on plan coverage and eligibility guidelines determined by the Company, as well as by collective bargaining agreements. Commercial insurance policies cover per occurrence losses in excess of $275,000. An actuarially estimated liability of approximately $653,000 and $839,000 for incurred but not reported claims due to Prospect has been included in due to affiliates, net as of September 30, 2016 and 2015, 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 statement of operations. The Company has accrued $4,188,000 and $3,883,000 related to asbestos remediation as of September 30, 2016 and 2015, 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 $462,000 and $308,000 as of September 30, 2016 and 2015, 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.

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, 2016, 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, 2016	**% of Net Patient Services Revenues**	For the Year Ended September 30, 2015	% of Net Patient Services Revenues
Medicare	**$ 61,762**	**43%**	$ 60,072	42 %
Medicaid	**36,447**	**25%**	33,551	23 %
Total	**$ 98,209**	**68%**	$ 93,623	65 %

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

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

In January 2016, the FASB issued ASU No. 2016-01, "Financial Instruments" ("ASU 2016-01"). 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 No. 2016-02, "Leases" ("ASU 2016-02"). 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 fiscal years beginning after December 15, 2019, 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 financial statements and footnote disclosures.

In March 2016, the FASB issued ASU No. 2016-07, "Investments – Equity Method and Joint Ventures" ("ASU 2016-07"). 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 financial statements and footnote disclosures.

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows (Topic 230)" ("ASU 2016-15"). 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 the Company's financial statements.

3. Property, Improvements and Equipment

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

September 30,	**2016**	2015
Property, improvements and equipment:		
Land and land improvements	**$ 4,931**	$ 4,914
Buildings and improvements	**15,677**	13,790
Leasehold improvements	**3,280**	3,280
Equipment	**12,241**	9,705
Furniture and fixtures	**299**	211
	36,428	31,900
Less: accumulated depreciation	**(11,665)**	(6,104)
Property, improvements and equipment, net	**$ 24,763**	$ 25,796

As of September 30, 2016 and 2015, the Company had assets under capitalized leases of $2,217,000 and $332,000, respectively, and related accumulated depreciation of $359,000 and $86,000, respectively.

Depreciation expense was $6,066,000 and $5,108,000 for the years ended September 30, 2016 and 2015, respectively.

4. Intangible Assets

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

	Amortization Period	**September 30, 2016**	September 30, 2015
Trade names	5 years	**$ 3,590**	$ 3,590
Total acquisition cost of intangible assets		**3,590**	3,590
Less accumulated amortization		**(1,637)**	(919)
Intangible assets, net		**$ 1,953**	$ 2,671

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 for each of the years ended September 30, 2016 and 2015.

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

Years ended September 30,	
2017	$ 718
2018	718
2019	517
Total	$ 1,953

The weighted-average remaining useful life for the intangible assets was 2.8 years as of September 30, 2016.

5. Related Party Transactions

Concurrent with the acquisition of the Company on June 20, 2014 (inception), Prospect East Hospital Advisory Services, LLC ("PEHAS"), a wholly-owned subsidiary of Prospect, entered into a Management Services Agreement ("MSA") with PCC and its Subsidiaries, 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 $2,915,000 and $2,973,000 for the years ended September 30, 2016 and 2015, respectively, which is included within management fee expense in the accompanying statements of operations. As of September 30, 2016 and 2015, $6,617,000 and $3,702,000, respectively, due pursuant to the MSA, is included in due to affiliates, net, in the accompanying balance sheets.

6. 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 4% to 8% per annum.

The future minimum annual lease payments (net of anticipated sublease income) required under leases in effect at September 30, 2016, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases
2017	$ 720	$ 369
2018	743	299
2019	339	286
2020	-	286
2021	-	286
Total minimum lease payments	1,802	$ 1,526
Less: amounts representing interest	(115)	
	1,687	
Less: current portion	(718)	
	$ 969	

Lease and rental expense was $1,957,000 and $2,277,000 for the years ended September 30, 2016 and 2015, 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, 2016 and 2015. The obligations and related interest expense related to these credit facilities are not reflected in the Company's financial statements as of September 30, 2016 and 2015, as the borrowings are reflected in the separate consolidated financial statements of Prospect.

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Total borrowings outstanding as of September 30, 2016 and 2015, reflected in the consolidated financial statements of Prospect, but for which the Company is contingently liable as a guarantor, were (in thousands):

September 30,	**2016**	2015
Senior secured term loan	**$ 623,438**	$ -
Less: original issue discount, net	**(8,984)**	-
Senior secured 2019 notes	**-**	325,000
Less: original issue discount, net	**-**	(4,950)
	614,454	320,050
Additional 2019 Notes	**-**	100,000
Plus: original issue premium, net	**-**	1,110
	-	101,110
	$ 614,454	$ 421,160

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 Prospect's existing 8.375% senior secured notes due during 2019; to repay $60 million for borrowings under our 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, 2016. 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. 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 2.31% as of September 30, 2016. The ABL Facility balance as of September 30, 2016 was $55,000,000. As of September 30, 2016, Prospect had unused letters of credit of $9,200,000, which offset Prospect's ability to borrow additional funds, and the ABL Facility had unused lender commitments of $50,800,000 as of September 30, 2016. 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, 2016, the Company was in compliance with the financial covenants of the New Senior Secured Credit Facilities.

Letter of Credit

As of September 30, 2016, 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 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") will substantially reform the United States health care system. The legislation impacts multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Starting in 2014, the legislation requires the establishment of health insurance exchanges, which will provide individuals without employer-provided health care coverage the opportunity to purchase insurance. It is anticipated that some employers currently offering insurance to employees

will opt to have employees seek insurance coverage through the insurance exchanges. It is possible that the reimbursement rates paid by insurers participating in the insurance exchanges may be substantially different than rates paid under current health insurance products. Another significant component of the PPACA is the expansion of the Medicaid program to a wide range of newly eligible individuals. In anticipation of this expansion, payments under certain existing programs, such as Medicare disproportionate share, will be substantially decreased. Each state's participation in an expanded Medicaid program is optional.

Future changes to the Affordable Care Act 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 300 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 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 30, 2017.

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.

7. 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 $1,894,000 and $1,016,000 for the years ended September 30, 2016 and 2015, respectively.

8. 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, 2016, 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.

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For the years ended September 30, 2016 and 2015, the Company's 90/10 cash basis revenue test percentages were computed as follows:

(in thousands)	**2016**	2015
Revenue by Source		
Student Title IV cash basis revenue		
Subsidized loan	**$ 340**	$ 380
Unsubsidized loan	**509**	471
Plus loan	**34**	28
Federal Pell grant	**273**	175
FSEOG	**-**	-
	$ 1,156	$ 1,054
Student Non-Title IV revenue		
Funds provided from private loans	**$ 91**	$ 60
State loans	**76**	101
Scholarships	**27**	8
State grants	**-**	17
Student payments	**422**	325
	$ 616	$ 511
Student Title IV cash basis revenue	**$ 1,156**	$ 1,054
Student title IV cash basis revenue + Student Non-Title IV cash basis revenue	**$ 1,772**	$ 1,565
	65.2%	67.3%

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 2016 federal fiscal year was 0.0%. Federal fiscal year 2016 is the most recent year for which this information is available.

9. Subsequent Events

The Company has evaluated subsequent events through March 29, 2017, the date the Company's financial statements were available for issuance.

Effective November 28, 2016, SJHSRI entered into a Purchase Agreement ("St. Joseph Purchase Agreement") to sell the former St. Joseph Hospital Campus (the "St. Joseph Hospital Campus") for $100,000 to a third party ("Purchaser"). The Purchaser has agreed to make certain required capital improvements pursuant to the terms of the St. Joseph Purchase Agreement. On December 28, 2016,

the sale closed, and SJHSRI entered into a seven year lease with the Purchaser for a portion of the St. Joseph Hospital Campus, where SJHSRI will continued to operate certain specialty medical clinics for an initial base rent of $80,000 per month. This lease may be extended for up to three additional seven year extension terms. The lease also provides for the payment of a portion of the property taxes for the St. Joseph Capital Campus by SJHSRI, consisting of $120,000 per year through 2020 and a pro rata portion of property taxes based on SJHSRI leased space after 2020.

On October 31, 2016, the Company entered into a Purchase and Sale Agreement, pursuant to which the Company granted and conveyed an exclusive easement to certain property utilized for telecommunications purposes for a 99 year term to a third party ("Grantee"). The Purchase and Sale Agreement also assigned certain of the Company's telecommunications leases to the Grantee. The purchase price was approximately $2,057,000.

Supplemental Report and Schedule

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, 2016, 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, 2017.

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*.

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, 2017

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 weakness(es) identified?	____	yes	X	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

There were no findings related to the financial statements which are required to be reported in accordance with generally accepted government auditing standards (GAGAS).

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).