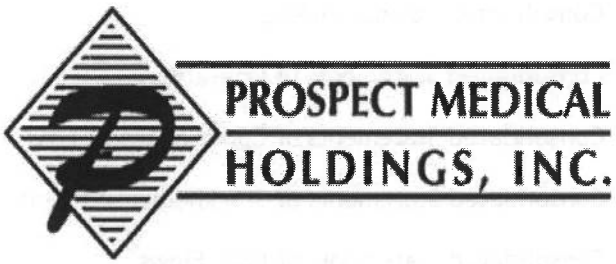

Consolidated Financial Statements

As of and for the Years Ended
September 30, 2019 and 2018

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

BDO

Prospect Medical Holdings, Inc.

Contents

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Independent Auditor's Report

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

We have audited the accompanying consolidated financial statements of Prospect Medical Holdings, Inc. (the "Company"), which comprise the consolidated balance sheets as of September 30, 2019 and 2018, and the related consolidated statements of operations, statements of comprehensive loss, statements of stockholder's deficit, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Prospect Medical Holdings, Inc. and its subsidiaries as of September 30, 2019 and 2018, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

BDO USA, LLP

December 20, 2019

Prospect Medical Holdings, Inc.

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

September 30,	2019	2018
Assets		
Current assets		
Cash and cash equivalents	$ 52,091	$ 7,694
Cash held in escrow	70,000	-
Restricted cash	1,485	1,742
Restricted investments	29,540	23,779
Patient accounts receivable, net of allowance for doubtful accounts of $165,719 and $151,279 at September 30, 2019 and 2018, respectively	306,587	317,412
Due from government payers	20,270	21,409
Other receivables, prepaid expenses and other current assets	118,000	117,026
Income tax receivable	-	2,737
Inventories	34,229	32,624
Hospital fee program receivable	167,530	211,454
Current assets held for sale	37,277	60,990
Total current assets	837,009	796,867
Property, improvements and equipment, net	538,471	513,690
Deferred income taxes, net	823	1,975
Goodwill	302,377	301,988
Intangible assets, net	25,545	31,822
Other assets	118,022	56,922
Long term assets held for sale	44,120	115,369
Total assets	$ 1,866,367	$ 1,818,633

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

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

September 30,	2019	2018
Liabilities and Stockholder's Deficit		
Current liabilities:		
Accrued medical claims and other healthcare costs payable	$ 72,508	$ 62,887
Accounts payable and other accrued liabilities	264,252	298,996
Accrued salaries, wages and benefits	179,997	167,705
Hospital fee program liability	24,362	65,966
Due to government payers	28,606	29,137
Income taxes payable	7,395	-
Revolving line of credit, net	70,000	207,645
Current portion of capital leases	10,238	12,933
Current portion of long-term debt	18,983	18,429
Current portion of MPT liabilities	43,145	-
Other current liabilities	25,249	27,831
Current liabilities held for sale	33,939	42,224
Total current liabilities	778,674	933,753
Long-term debt, net of current portion	187,367	1,098,441
Malpractice reserves	133,300	73,532
Capital leases, net of current portion	30,372	29,230
Asset retirement obligations	5,602	6,179
Other long-term liabilities	48,706	32,949
Pension obligations	302,372	254,121
MPT liabilities, net of current portion	1,338,040	-
Long term liabilities held for sale	11,994	12,777
Total liabilities	2,836,427	2,440,982
Commitments and contingencies		
Stockholder's deficit:		
Common stock, $0.01 par value; 100 shares authorized, issued and outstanding at September 30, 2019 and 2018	1	1
Additional paid-in capital	64,961	23,961
Accumulated other comprehensive (loss) income	(23,236)	21,303
Accumulated deficit	(1,019,073)	(676,930)
Total stockholder's deficit attributable to Prospect Medical Holdings, Inc.	(977,347)	(631,665)
Non-controlling interests	7,287	9,316
Total stockholder's deficit	(970,060)	(622,349)
Total liabilities and stockholder's deficit	$ 1,866,367	$ 1,818,633

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Operations
(in thousands)

For the Years Ended September 30,	2019	2018
Revenues:		
Net Hospital Segment patient services revenues	$ 2,487,156	$ 2,576,844
Provision for bad debts	(98,306)	(100,026)
Net Hospital segment patient services revenues less provision for bad debts	2,388,850	2,476,818
Other non-patient Hospital revenues	49,377	45,828
Net Hospital Segment revenues	2,438,227	2,522,646
Medical Group revenues	353,954	334,408
Global Risk Management revenues	49,696	33,863
Corporate revenues	7,321	2,971
Total net revenues	2,849,198	2,893,888
Operating Expenses:		
Hospital operating expenses	1,966,380	2,029,219
Medical Group cost of revenues	259,631	267,376
Global Risk Management cost of revenues	33,444	20,430
General and administrative	501,586	486,543
Depreciation and amortization	92,011	85,051
Total operating expenses	2,853,052	2,888,619
Operating income from unconsolidated joint ventures	5,889	2,599
Operating income	2,035	7,868
Other expense:		
Interest expense and amortization of deferred financing costs, net	127,835	100,190
Loss on early extinguishment of debt	30,052	18,422
Goodwill impairment	-	14,228
Other expense, net	2,858	2,231
Total other expense, net	160,745	135,071
Loss before income taxes	(158,710)	(127,203)
Income tax provision	16,455	62,786
Net loss from continuing operations	(175,165)	(189,989)
Loss from discontinued operations:		
Loss from discontinued operations	(141,539)	(59,914)
Income tax benefit	18,234	1,289
Loss on discontinued operations, net of taxes	(123,305)	(58,625)
Loss before allocation to non-controlling interests	(298,470)	(248,614)
Net loss attributable to non-controlling interests	(734)	(4,449)
Net loss attributable to Prospect Medical Holdings, Inc.	$ (297,736)	$ (244,165)

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

Consolidated Statements of Comprehensive Loss
(in thousands)

For the Years Ended September 30,	2019	2018
Net loss attributable to Prospect Medical Holdings, Inc.	**$ (297,736)**	$ (244,165)
Other comprehensive (expense) income, net of tax:		
Pension obligation and other post-retirement benefits adjustment (net of $251 and $6,833 tax)	**(45,796)**	12,995
Debt and equity securities, unrealized gain	**1,257**	160
Total other comprehensive (loss) income, net of tax	**(44,539)**	13,155
Total comprehensive loss	**$ (342,275)**	$ (231,010)

See accompanying notes to the consolidated financial statements.

Prospect Medical Holdings, Inc.

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

	Number of Common Shares	Common Stock	Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings (Accumulated Deficit)	Prospect Medical Holdings, Inc. Stockholder's (Deficit) Equity	Non-controlling Interests	Total Stockholder's (Deficit) Equity
Balance at October 1, 2017	100	$ 1	$ 22,398	$ 8,148	$ 24,165	$ 54,712	$ 12,604	$ 67,316
Options exercised	-	-	853	-	-	853	-	853
Stock-based compensation	-	-	710	-	-	710	-	710
Non-controlling interest attributed to minority shareholders	-	-	-	-	-	-	1,161	1,161
Net loss	-	-	-	-	(244,165)	(244,165)	(4,449)	(248,614)
Dividend paid to stockholder	-	-	-	-	(456,930)	(456,930)	-	(456,930)
Other comprehensive income, net of tax	-	-	-	13,155	-	13,155	-	13,155
Balance at September 30, 2018	100	1	23,961	21,303	(676,930)	(631,665)	9,316	(622,349)
Non-controlling interest attributed to minority shareholders	-	-	-	-	-	-	(1,295)	(1,295)
Net loss	-	-	-	-	(297,736)	(297,736)	(734)	(298,470)
Capital contribution from stockholder	-	-	41,000	-	-	41,000	-	41,000
Dividend paid to stockholder	-	-	-	-	(44,407)	(44,407)	-	(44,407)
Other comprehensive loss, net of tax	-	-	-	(44,539)	-	(44,539)	-	(44,539)
Balance at September 30, 2019	100	$ 1	$ 64,961	$ (23,236)	$ (1,019,073)	$ (977,347)	$ 7,287	$ (970,060)

See accompanying notes to the consolidated financial statements.

CIIH16-000949

Prospect Medical Holdings, Inc.

Consolidated Statements of Cash Flows
(in thousands)

For the Years Ended September 30,	2019	2018
Operating activities		
Net loss	$ (298,470)	$ (248,614)
Adjustments to reconcile net loss to net cash and cash equivalents used in operating activities:		
Depreciation and amortization	92,011	85,051
Amortization of deferred financing costs, net	4,484	2,702
Goodwill impairment	-	14,228
Write-off of deferred financing costs	13,444	11,411
Amortization of original issue discount and premium, net	3,478	2,976
Write-off of original issue discount and premium	16,608	6,713
Provision for bad debts	98,306	100,026
Pension obligation net periodic benefit cost	17,411	12,403
Excess contribution to pension plan	(15,939)	(41,667)
Deferred income taxes, net	1,152	97,782
Stock-based compensation	-	710
Undistributed earnings from unconsolidated joint ventures	(5,889)	(2,599)
Gain on sale of equity method investments	-	280
Loss (gain) on disposal of assets	3,398	(976)
Changes in operating assets and liabilities, net of business combinations:		
Patient accounts receivable	(87,481)	(93,310)
Due to/from government payers, net	608	11,668
Other receivables, prepaid expenses and other current assets	(974)	57,185
Hospital fee program receivable	43,924	(152,242)
Hospital fee program liability	(41,604)	63,999
Inventories	(1,605)	(93)
Income taxes payable/receivable, net	10,132	(45,530)
Other assets	(36,325)	1,580
Accrued medical claims and other healthcare costs payable	9,621	8,175
Accounts payable, other accrued liabilities and other long term liabilities	2,399	51,482
Net cash and cash equivalents used in operating activities from discontinued operations	99,863	50,698
Net cash and cash equivalents used in operating activities	(71,448)	(5,962)
Investing activities		
Purchases of property, improvements and equipment	(52,075)	(70,543)
Cash paid for acquisitions, net of cash received and working capital adjustments	(390)	(5,780)
Proceeds from sale of property and improvements	-	726
Distribution received from equity and cost method investments	2,355	2,150
Increase in investments	(4,253)	(7,315)
Net cash and cash equivalents used in investing activities from discontinued operations	(11,224)	(28,037)
Net cash and cash equivalents used in investing activities	(65,587)	(108,799)

Prospect Medical Holdings, Inc.

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

For the Years Ended September 30,	2019	2018
Financing activities		
Borrowings on Senior Secured Notes, net of original issue discount	-	1,097,600
Repayments on Senior Secured Notes	(1,114,400)	(622,788)
Borrowings on line of credit	290,000	385,000
Repayments on line of credit	(429,000)	(176,000)
Repayments on retired line of credit, net	-	(115,300)
Proceeds of other long-term debt	175,538	-
Repayments of long-term debt	(7,346)	(1,380)
Repayment of financing leases	(2,082)	(2,450)
Repayments of capital leases	(14,509)	(11,318)
Proceeds from exercise of stock options	-	853
Cash paid for deferred financing costs	(526)	(19,536)
Change in restricted cash	257	29,019
Change in cash held in escrow	(70,000)	-
Capital contribution from stockholder	41,000	-
Dividend paid to stockholder	(44,407)	(456,930)
Repayments of insurance premium financing	(37)	(10,026)
Cash paid for deferred financing costs related to MPT liability transaction	(21,781)	-
Proceeds from MPT liability transactions	1,385,796	-
Repayment of MPT liability transactions	(5,447)	-
Net cash and cash equivalents used in financing activities from discontinued operations	(1,624)	(1,398)
Net cash and cash equivalents provided by financing activities	181,432	95,346
Increase (decrease) in cash and cash equivalents	44,397	(19,415)
Cash and cash equivalents, beginning of year	7,694	27,109
Cash and cash equivalents, end of year	$ 52,091	$ 7,694
Supplemental disclosure of cash flow information		
Interest paid (including cash paid on debt extinguishment)	$ 101,251	$ 53,070
Income taxes received	$ 343	$ 3,485
Schedule of non-cash investing and financing activities		
Equipment acquired under capital leases	$ 15,213	$ 16,849
Accrual of property, improvements and equipment	$ 47,113	$ 19,249
Insurance premium financed	$ -	$ 9,900
Partial satisfaction of long-term liability assumed from acquisition of PCC	$ -	$ 1,195
Acquisition of NUMG	$ -	$ 7,452

See accompanying notes to the consolidated financial statements.

1. Organization

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

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

Hospital Services Segment

As of September 30, 2019, through its subsidiaries, the Company owns 16 acute care and behavioral hospitals and multi-level elder care facilities in Southern California, Rhode Island, Pennsylvania and Connecticut with approximately 3,100 licensed beds, and a network of specialty and primary care clinics. The Hospital Services segment subsidiaries are wholly-owned by Prospect, except for the facilities in Rhode Island, in which Prospect has an 85% interest in the subsidiary that owns such facilities.

Additionally, at September 30, 2019, through its subsidiaries the Company owns 4 acute care and behavioral health hospitals in Texas and New Jersey, which are in the process of being closed or sold. According, and as further discussed in Note 5, for all periods presented the assets and liabilities of these businesses have been classified as "held for sale," and the operations (as it relates to revenues and expenses that will no longer continue post sale) have been shown within discontinued operations. All of the footnotes in these financial statements refer to continuing operations unless otherwise stated.

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

Medical Group Segment

The Medical Group segment is a healthcare management services organization that provides management services to affiliated physician organizations that operate as independent physician associations ("Medical Groups" or "IPAs"). The affiliated physician organizations enter into agreements with HMOs to provide HMO enrollees with a full range of medical services in exchange for fixed monthly fees ("Capitation"). The Medical Groups contract with physicians (primary care and specialist) and other healthcare providers to provide enrollees with medical services. Prospect currently manages the provision of healthcare services for its affiliated physician organizations in California, Texas, Rhode Island, Connecticut, Pennsylvania and New Jersey. The California network consists of various IPAs that are generally wholly-owned by Prospect Medical Group, Inc. ("PMG") and managed by the two medical management company subsidiaries that are wholly-owned by Prospect. The Company's networks in its other states consist of IPA subsidiaries of Prospect Provider Groups, Inc. The Medical Group segment also owns clinic facilities in California, Rhode Island, Pennsylvania and Connecticut that operate by employing physicians to serve their patients. In California, the clinic facilities are owned through New Genesis Medical Association ("NGMA"). PMG and NGMA are owned by a nominee physician shareholder pursuant to an assignable option agreement, under which Prospect has an assignable option, obtained for a nominal amount from PMG and the nominee shareholder, to designate the purchaser (successor physician) for all or part of PMG's issued and outstanding stock held by the nominee physician shareholder (the "Stock Option") in its sole discretion.

Most of the physician organizations in California and Texas have entered into Management Service Agreements ("MSA") with Prospect Medical Systems Inc., ("PMS"), and have agreed to pay a management fee to PMS, which is based in part on the costs to the management company and on a percentage of revenues. In Rhode Island, Pennsylvania, Connecticut and New Jersey, the physician organizations have entered into Administrative Services Agreements ("ASA") with PMS pursuant to which they have agreed to reimburse PMS for the costs of certain administrative services provided by PMS on their behalf. In return for payment of the management fee, PMS has agreed to provide financial management, information systems, marketing, advertising, public relations, risk management, and administrative support, including for utilization review and quality of care. At its cost, PMS has assumed the obligations for all facilities and employs physician and non-physician personnel for administrative services. The management fee is earned based on a combination of percentage of revenue and share of pre-tax income. The management fees fluctuate based on the revenue and profitability of each physician organization. The MSAs are not terminable by the physician organization except in the case of gross negligence, fraud or other illegal acts, or bankruptcy, of PMS. The services provided under an ASA are more limited than those provided under an MSA and each ASA is terminable by either party upon the delivery of 90 days prior written notice thereof.

Prospect consolidates the revenues and expenses of all the physician organizations (except for one entity that is a 50/50 joint venture, which is accounted for under the equity method) from the respective dates of execution of the Management Agreements. All significant inter-entity balances have been eliminated in consolidation. In the case of the joint venture, only that portion of the results which are contractually identified as Prospect's are recognized in the consolidated financial statements, together with the management fee that the Company charges the joint venture for managing the other owners' share of the joint venture operations.

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

The affiliated physician organizations provided medical services to a combined total of approximately 445,000 and 442,000 enrollees as of September 30, 2019 and 2018, respectively. The enrollees include approximately 237,000 and 255,000 enrollees that the Company manages for the economic benefit of certain independent third parties, and for which the Company earns management fee income as of September 30, 2019 and 2018, respectively. The total paid member months including managed enrollees, for the years ended September 30, 2019 and 2018 was approximately 5,435,000 and 5,360,000, respectively.

Global Risk Management Segment

The Global Risk Management segment exists in pursuit of the Company coordinated regional care ("CRC") operating model and risk management platform. CRC has subsidiaries in California, Texas, Rhode Island, Pennsylvania, Connecticut and New Jersey, and has accountable care organizations operating in Rhode Island, Pennsylvania and New Jersey. These entities contract with third-party health plans and the Centers for Medicare and Medicaid Services ("CMS") on progressive risk reimbursement models leading to global risk contracts for physicians, other medical services and institutional services including hospital inpatient and outpatient services, home health, skilled nursing facility and other institutional services. In turn, the global risk management entities contract with owned and third-party independent physician associations, owned and third-party hospitals and other health care providers to assume and manage this global risk. Through these contracts, the Company manages health plan member populations with a focus

on delivering coordinated care to members across our network of physicians and providers under risk and value-based contracts. This segment also includes Coordinated Regional Care Group, Inc. ("CRCG"). CRCG incurs development and operating costs related to the Global Risk Management segment for new markets and strategic initiatives.

Corporate Segment

The Company has two captive insurance companies, Prospect Medical Holding Risk Retention Group, Inc. ("RRG"), based in Vermont, and Connecticut Healthcare Insurance Company ("CHIC"), based in the Cayman Islands. RRG was formed to provide primary insurance coverage for hospital and physician professional and general liability risks for the Company's subsidiary health care organizations located in Pennsylvania on a claims-made basis. CHIC provides hospital and physician professional and general liability coverage to all of the Company's hospitals and affiliated subsidiaries except for Prospect Crozer, LLC ("Crozer") and its Pennsylvania subsidiaries. CHIC is an exempted Company with limited liability under the Companies Law of the Cayman Islands and it holds a Class "B(i)" Insurer's License under Section 4(3)(b) of the Cayman Islands Insurance Law 2010. CHIC's principal activity is to issue primary policies for hospital liabilities covering Prospect, its subsidiaries and employees, on a claims-made basis. The Company procured excess healthcare professional liability and umbrella liability insurance policy on a claims-made basis covering healthcare professional liability, general liability, automobile liability, employer's liability, helipad liability and non-owned aircraft liability of the Company and its affiliates. This excess coverage is purchased entirely from unrelated commercial insurers. CHIC also provides a deductible reimbursement policy for workers compensation to the Company's facilities all of which have high deductible program structures or are qualified self-insureds.

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

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

2. Significant Accounting Policies

Principles of Consolidation and Basis of Presentation

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

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

The consolidation of these entities does not change any legal ownership, and does not change the assets or the liabilities and equity of the Parent Entity as a stand-alone entity. These entities had total revenues of approximately $330,930,000 and $310,720,000 and total net income of approximately $14,245,000 and net loss of approximately $2,184,000 for the years ended September 30, 2019 and 2018, respectively. The assets and liabilities of the variable interest entities are as follows (in thousands):

September 30,	2019	2018
Assets		
Total current assets	$ 86,966	$ 89,882
Total non-current assets	89,049	90,465
Total assets	$ 176,015	$ 180,347
Liabilities		
Total current liabilities	$ 52,120	$ 69,097
Total long-term liabilities	730	730
Total liabilities	$ 52,850	$ 69,827

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Revenues

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

For the Years Ended September 30,	2019	2018
Net Hospital Services		
Inpatient	$ 1,392,340	$ 1,497,923
Outpatient	926,645	902,122
Capitation	148,800	157,968
Other	19,371	18,831
Total Hospital Segment patient service revenues	2,487,156	2,576,844
Less: Provision for bad debts	(98,306)	(100,026)
Total Net Hospital Segment patient service revenues less provision for bad debts	2,388,850	2,476,818
Other non-patient revenues	49,377	45,828
Total Hospital Segment revenues	2,438,227	2,522,646
Medical Group		
Capitation	302,734	297,965
Management fees	15,044	10,501
Other	36,176	25,942
Total Medical Group revenues	353,954	334,408
Global Risk Management		
Capitation	37,018	23,095
Other	12,678	10,768
Total Global Risk Management revenue	49,696	33,863
Corporate Segment revenues	7,321	2,971
Total net revenues	$ 2,849,198	$ 2,893,888

Hospital Services Segment

Net Patient Service Revenues

Operating revenue of the Hospital Services segment consists primarily of net patient service revenue. The Company reports net patient service revenue at the estimated net realizable amounts from patients and third-party payers and others in the period in which services are rendered. The Company has agreements with third-party payers, including Medicare, Medicaid, managed care and other insurance programs that are paid at negotiated rates. These payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments, as further described below. Estimates of contractual allowances are based upon the payment terms specified in the related contractual agreements. The Company accrues for amounts that it believes may ultimately

be due to or from the third-party payers. Normal estimation differences between final settlements and amounts accrued in previous years are reported as changes in estimates in the current year. Outstanding receivables, net of allowances for contractual discounts and bad debts, are included in patient accounts receivable in the accompanying consolidated balance sheets.

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

Years ended September 30,	2019	2018
Medicare	$ 822,407	$ 801,222
Medicaid	750,909	874,865
Managed Care	579,141	559,463
Self-Pay/Other	166,528	164,495
Capitation	148,800	157,968
Other	19,371	18,831
Total patient service revenue	$ 2,487,156	$ 2,576,844

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

Medicare: Medicare is a federal program that provides certain hospital and medical insurance benefits to persons aged 65 and over, some persons with end-stage renal disease and certain other beneficiary categories, including eligible disabled persons. Most inpatient hospital services rendered to Medicare program beneficiaries are paid on a fee-for-service basis at prospectively determined rates per discharge, according to a patient classification system based on clinical, diagnostic, and other factors. Most outpatient services also are paid on a fee-for-service basis generally using prospectively determined rates. The Company receives, as appropriate, Medicare disproportionate share hospital ("DSH") and bad debt payments at tentative rates, with final settlement determined after submission of the annual Medicare cost report and audit thereof by the Medicare Administrative Contractor. The Company also receives, as appropriate, Medicare uncompensated care DSH payments, which are generally not subject to cost report audit except to determine eligibility for Medicare DSH. The Company also receives Medicare outlier payments on an ongoing basis during the year for cases that are unusually costly, and under certain circumstances these payments may be reconciled to more closely reflect the costs in excess of outlier thresholds after the submission and audit of the annual Medicare cost report. Normal estimation differences between filed settlements and amounts accrued are reflected in net patient service revenue.

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

Although services for most Medicare beneficiaries are paid by the Federal government on a fee-for-service basis, approximately one-third of Medicare beneficiaries are enrolled in a "Medicare Advantage" plan, which is a type of health plan that contracts with the Medicare program to provide hospital and medical benefits to Medicare beneficiaries. Medicare Advantage Plans include Health

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

Medicaid: Medicaid is a joint federal-state funded healthcare benefit program that is administered by states to provide benefits to qualifying individuals who are unable to afford care. The Company receives reimbursements under the fee-for-service component of Medicaid programs in each state in which it operates at prospectively determined rates for inpatient services and a mixture of fee schedules and cost reimbursement methodologies for outpatient services depending on the specific state regulations. Cost report settlements are recorded based upon as-filed cost reports (if required by the respective facility's state) and adjusted for tentative and final settlements, if any. In addition, in California, Rhode Island, and Pennsylvania, a substantial portion of Medicaid beneficiaries are enrolled in Medicaid managed care organizations. The Company received payments for services furnished to these beneficiaries based on negotiated contract rates or non-contract payment methodologies where the Company does not have a contract with the managed care organization.

The various states in which the Company operates have additional programs in which certain of the Company's facilities participate in, related to medical facilities serving a disproportionate number of low-income patients. The following table shows the revenues generated by these programs during the years ended September 30, 2019 and 2018 (in thousands), which are reflected in Net Hospital Services revenues in the accompanying consolidated statements of operations:

For the years ended September 30,	2019	2018
California Medi-Cal Disproportional Share ("CA DSH") *(a)*	$ 28,967	$ 13,761
Rhode Island DSH and Upper Payment Limit ("UPL") *(b)*	20,456	19,035
Pennsylvania State Programs *(c)*	68,831	40,344
Connecticut Medicaid DSH revenue *(d)*	26,338	33,152
	$ 144,592	$ 106,292

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

(b) Rhode Island hospitals receive federal and state Medicaid funds as additional reimbursement for treating a disproportionate share of low-income patients. The State of Rhode Island also assesses a license fee to all hospitals in Rhode Island based on each hospital's net patient revenue. The Company recorded $17,565,000 and $16,925,000 of expense during the years ended September 30, 2019 and 2018, respectively, as a result of the license fee.

(c) The Company's Pennsylvania hospitals are participants in Pennsylvania statewide hospital assessment, Medicaid Modernization Assessment ("MMA"), which has been extended through June 30, 2023. The assessments have enabled the Commonwealth of Pennsylvania to maintain

the updated inpatient payment system, make changes to existing disproportionate share/supplemental payments, and to create new payments where applicable. The Company has also recognized revenues from the Pennsylvania Community Access Fund ("CAF").

(d) The Company's hospitals in Connecticut participate in its Medicaid DSH program and receive additional reimbursement for treating a disproportionate share of low-income patients. Connecticut assesses a provider tax based on total net revenue received by a hospital for the provision of inpatient hospital services and outpatient hospital services. The state's 2020/2021 budget eliminated a scheduled reduction in the hospital's tax rates on inpatient and outpatient services by maintaining the rates at fiscal year 2019 levels but requiring the base year for calculating the tax to be adjusted each biennium. The State has made a Medicaid supplemental payment to hospitals for the first quarter of the State's 2020-21 fiscal year prior to obtaining federal approval, and has announced that this payment would be recovered if federal approval was not obtained. The amount of the provider tax has also been the subject of litigation, which was recently settled. However, the final settlement is contingent on federal approval of the state's tax waiver and proposed Medicaid State Plan Amendments, as well as on the state's General Assembly approval and adoption of implementing legislation. The proposed settlement agreement is estimated to have a financial impact on hospitals of approximately $1.8 billion in state and federal funds between now and 2026. The agreement includes a one-time payment or refund of approximately $79 million to hospitals, along with declining taxes on hospitals and corresponding increasing state payments to facilities during the applicable time period. The state can ask the court to modify the agreement if the state's overall costs are between $50 and $100 million, and the state can terminate the agreement if the state's overall costs rise by $100 million.

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

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

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

The following is a summary of due from and due to governmental payers at September 30, 2019 and 2018 (in thousands):

September 30,	2019	2018
Due from government payers:		
Medicaid Disproportionate Share	$ 19,301	$ 16,545
Medicare cost report settlements	969	4,691
Medicaid Section 1115 receivable	-	173
	$ 20,270	$ 21,409
Due to government payers:		
Medicare cost report settlements	$ 19,464	$ 20,323
Medicaid cost report settlements	9,142	8,814
	$ 28,606	$ 29,137

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

California Hospital Fee Program

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

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

Years Ended September 30,	2019	2018
Hospital services revenues	$ 122,976	$ 284,122
General and administrative expenses	53,775	123,996
Net pre-tax impact	$ 69,201	$ 160,126

As of September 30, 2019 and 2018, the Company had receivables related to the California Hospital Fee Program of approximately $167,530,000 and $211,454,000, respectively, and had liabilities related to the California Hospital Fee Program of approximately $24,362,000 and $65,996,000, respectively, in the accompanying consolidated balance sheets.

Legislation approved by the State of California in October 2013 created the framework for the hospital fee program to continue in perpetuity without requiring further legislation from California. In November 2016, California voters approved Proposition 52, which made the hospital fee program permanent and prohibits lawmakers from diverting Medi-Cal funds to pay for anything other than their intended purpose.

In December 2017, CMS approved the fee-for-service inpatient and outpatient payments and taxes for the period from January 1, 2017 to June 30, 2019 ("QAF 5"). CMS has not yet approved the amended Health Plan contracts. During the year ended September 30, 2018, the Company recorded revenues under the QAF 5 program of $111.9 million related to periods prior to the current fiscal year. Additionally, the Company recorded revenues related to previous hospital fee programs prior to QAF 5 of $14.6 million during the year ended September 30, 2018. The current cycle of the California Hospital Fee Program relates to the period from July 1, 2019 through December 31, 2021 ("QAF 6"). This cycle has not yet been approved by CMS and accordingly the Company has not recorded any revenues or expenses related to QAF 6 (or any prior program) during the fourth quarter of the year ended September 30, 2019.

Charity Care

The Company provides charity care to patients who lack financial resources and are deemed to be medically indigent based on criteria established under the Company's charity care policy. This care is provided without charge or at amounts less than the Company's established rates. Because the Company does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The direct and indirect costs related to this care totaled approximately $7,559,000 and $8,787,000 for the years ended September 30, 2019 and 2018, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. In addition, the Company provides services to other medically indigent patients under various state Medicaid programs. Such programs pay amounts that are less than the cost of the services provided to the recipients. The Company has not changed its charity care or uninsured discount policies during the years ended September 30, 2019 and 2018.

Provisions for Contractual Allowances and Bad Debts

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

Accounts receivable are reduced by an allowance for doubtful accounts. Valuation of the collectability of accounts receivable and provision for bad debts is based on historical collection experience, payer mix and the age of the receivables. Management routinely reviews accounts receivable balances in conjunction with these factors and other economic conditions which might ultimately affect the collectability of the patient accounts, and makes adjustments to the Company's allowances as warranted. For receivables associated with services provided to patients who have third-party coverage, management analyzes contractually due amounts and subsequently calculates an allowance for doubtful accounts and provision for bad debts once the age of the accounts reaches a specific age category based on historical experience. For receivables associated with self-pay patients, management records a significant provision for bad debts beginning in the period services were provided based on past experience that many patients are unable or unwilling to pay the portion of their bill for which they are

financially responsible. The allowance for doubtful accounts as a percent of gross accounts receivable was 35% and 32% at September 30, 2019 and September 30, 2018, respectively. The allowance for doubtful accounts was approximately $165,719,000 and $151,279,000 as of September 30, 2019 and 2018, respectively, and the increase results from a determination at September 30, 2019 to fully reserve for all patient accounts receivable over 365 days old.

Legislation

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

Medical Group Segment

Medical Group Revenues

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

Capitation revenue (net of capitation withheld to fund risk share deficits discussed below) is recognized in the month in which the physician organizations are obligated to provide services. Minor ongoing adjustments to prior months' capitation, primarily arising from contracted HMOs' finalizing of monthly patient eligibility data for additions or subtractions of enrollees, are recognized in the month they are communicated to the Company. Additionally, Medicare pays capitation using a "Risk Adjustment model," which compensates managed care organizations and providers based on the health status (acuity) of each enrollee. Health plans and providers with higher acuity enrollees will receive more and those with healthier enrollees will receive less. Under Risk Adjustment, capitation is determined based on health severity, measured using patient encounter data. Capitation is paid on an interim basis based on data submitted for the enrollee for the preceding year and is adjusted in subsequent periods (generally in the Company's fourth quarter) after the final data is compiled. Positive or negative capitation adjustments are made for Medicare enrollees with conditions requiring more or less healthcare services than assumed in the interim payments. Since the Company cannot reliably predict these adjustments, periodic changes in capitation amounts earned as a result of Risk Adjustment are recognized generally in the fourth quarter when those changes are communicated by the health plans to the Company. During the years ended September 30, 2019 and 2018, the Company returned and recognized as a reduction in revenue,

approximately $1,749,000 and $3,220,000, respectively, as a result of the final Hierarchical Condition Category ("HCC") reconciliation.

HMO contracts also include provisions to share in the risk for hospitalization, whereby the physician organization can earn additional incentive revenue or incur penalties based upon the utilization of hospital services. Typically, any shared risk deficits are not payable until and unless the Company generates future risk sharing surpluses, or if the HMO withholds a portion of the capitation revenue to fund any risk share deficits. At the termination of the HMO contract, any accumulated risk share deficit is typically extinguished. Due to the lack of access to information necessary to estimate the related costs, shared-risk amounts receivable from the HMOs are only recorded when such amounts are known. Risk pools for the prior contract years are generally final settled in the third or fourth quarter of the following fiscal year. For the years ended September 30, 2019 and 2018, Medical Group revenues included approximately $10,482,000 and $7,125,000, respectively, relating to risk-sharing profit. At September 30, 2019 and 2018, contingent liabilities for carry-forward risk-pool deficits expected to be forgiven, or offset against future surpluses were approximately $88,991,000 and $92,700,000, respectively, based on the available information from the health plans.

The Company also receives incentives under "pay-for-performance" programs for quality medical care based on various criteria. These incentives, which are included in other revenues within Medical Group revenues, are generally recorded in the third and fourth quarters of the fiscal year when such amounts are known. Performance and incentive revenues recorded during the years ended September 30, 2019 and 2018 were $11,221,000 and $5,751,000, respectively.

Management fee revenue is earned in the month the services are rendered. Management fee arrangements with unaffiliated entities provide for compensation ranging from 6.5% to 10% of revenues. Management fee revenues recorded during the years ended September 30, 2019 and 2018 were $10,248,000 and $5,656,000, respectively. Management fees for revenue for entities that are consolidated are eliminated on consolidation.

Medical Group Cost of Revenues

The cost of health care services consists primarily of capitation and claims payments, pharmacy costs and incentive payments to contracted providers. These costs are recognized in the period incurred, or when the services are provided. Claims costs also include an estimate of the cost of services which have been incurred but not yet reported to the Company. The estimate for accrued medical costs is based on projections of costs using historical studies of claims paid and adjusted for seasonality, utilization and cost trends. These estimates are subject to trends in loss severity and frequency. Although considerable variability is inherent in such estimates, management records its best estimate of the amount of medical claims incurred at each reporting period. Estimates are continually monitored and reviewed and, as settlements are made or estimates adjusted, differences are reflected in current period. See Note 14 for changes in claims estimates during the years ended September 30, 2019 and 2018.

The Company has contractual reimbursement obligations to providers and discretionary incentive payment obligations to physicians. These payments are in large part predicated on the pay-for-performance, shared risk revenues, and favorable senior capitation risk adjustment payments received by the Company from the health plans. The Company records these revenues generally in the third or fourth quarter of each fiscal year when the incentives and capitation adjustments due from the health plans are known. During this period, the Company also finalizes the physician discretionary incentive.

The Company recorded physician incentives expense of approximately $17,643,000 and $21,669,000 for the years ended September 30, 2019 and 2018, respectively. As of September 30, 2019 and 2018, physician incentive accruals of approximately $14,351,000 and $17,396,000, respectively, were included in accounts payable and other accrued liabilities in the accompanying consolidated financial statements.

The Company also periodically evaluates the need to establish premium deficiency reserves for the probability that anticipated future health care costs could exceed future capitation payments from HMOs under capitated contracts and, where appropriate, records a premium deficiency reserve. There were no such premium deficiencies recorded at September 30, 2019 and 2018, respectively.

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

Global Risk Management Segment

Global Risk Management Revenues

Operating revenue of the Global Risk Management segment consists primarily of payments for medical services procured under global capitation arrangements from third-party health plans. Capitation revenue under these global capitation contracts is prepaid monthly to the Global Risk Management segment based on the number of enrollees. Entities within the Global Risk Management segment entered into Management Services Agreements with the Hospital Services and Medical Group segments, under which up to 98% of capitation revenue received is transferred to these segments. During the years ended September 30, 2019 and 2018, capitation revenue received from health plans was $267,300,000 and $254,795,000, respectively, of which $105,755,000 and $101,563,000, and $120,119,000 and $116,957,000 was transferred to our Hospital Services segment and Medical Group segment, respectively.

Similar to the Medical Group segment, capitation revenue is recognized in the month in which the Global Risk Management segment is obligated to provide services. Minor ongoing adjustments to prior months' capitation, primarily arising from contracted HMOs' finalizing of monthly patient eligibility data for additions or subtractions of enrollees, are recognized in the month they are communicated to the Company. Additionally, Medicare pays capitation using a "Risk Adjustment model," which compensates managed care organizations and providers based on the health status (acuity) of each enrollee. Health plans and providers with higher acuity enrollees will receive more and those with healthier enrollees will receive less. Under Risk Adjustment, capitation is determined based on health severity, measured using patient encounter data. Capitation is paid on an interim basis based on data submitted for the enrollee for the preceding year and is adjusted in subsequent periods (generally in the Company's fourth quarter) after the final data is compiled. Positive or negative capitation adjustments are made for Medicare enrollees with conditions requiring more or less healthcare services than assumed in the interim payments. Since the Company cannot reliably predict these adjustments, periodic changes in capitation amounts earned as a result of Risk Adjustment are recognized generally in the fourth quarter when those changes are communicated by the health plans to the Company. During the years ended September 30, 2019 and 2018, the Global Risk Management Segment recognized capitation risk adjustments of $4,552,000 and $5,155,000, respectively.

Global Risk Management Cost of Revenues

The cost of health care services consists primarily of the transfer of capitation revenue to the Hospital Services and Medical Group segments under the Management Services Agreements, and capitation and claims payments. These costs are recognized in the period incurred, or when the services are provided.

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

The Company also periodically evaluates the need to establish premium deficiency reserves for the probability that anticipated future health care costs could exceed future capitation payments from HMOs under capitated contracts and, where appropriate, record a premium deficiency reserve. There were no such premium deficiencies recorded at September 30, 2019 or 2018.

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

Property, Improvements and Equipment

Property, improvements and equipment are stated on the basis of cost or, in the case of acquisitions, at their acquisition date fair values. Depreciation is provided using the straight-line method over the estimated useful lives of the assets, and amortization of leasehold improvements is provided using the straight-line basis over the shorter of the remaining lease period or the estimated useful lives of the leasehold improvements. Leasehold improvements are generally depreciated over 5 to 40 years, buildings are depreciated over 5 to 40 years, equipment is depreciated over 2 to 15 years and furniture and fixtures are depreciated over 2 to 20 years. Equipment capitalized under capital lease obligations are amortized over the lesser of the life of the lease or the useful life of the asset.

As more fully described in Note 13, the Company is required to comply with certain seismic standards as required by the state of California by dates ranging from February 2021 through June 2022. The useful life of buildings subject to seismic retrofit requirements may be limited if the Company does not make the necessary upgrades by the required compliance date.

Goodwill

Goodwill represents the excess of the consideration paid and liabilities assumed over the fair value of the net assets acquired, including identifiable intangible assets.

Goodwill is not amortized; rather it is reviewed annually for impairment for each reporting unit, or more frequently if impairment indicators arise. Impairment is the condition that exists when the carrying amount of goodwill exceeds its implied fair value. The Company's annual goodwill impairment test is conducted on July 1. Impairment of goodwill is tested at the reporting unit level, by comparing the reporting unit's carrying amount, including goodwill, to the fair value of the reporting unit. The fair value of the reporting units are estimated. In evaluating whether indicators of impairment exist, the Company considers adverse changes in market value, laws and regulations, profitability, cash flows, ability to maintain enrollment and renew payer contracts at favorable terms, among other factors. The goodwill impairment test is a one-step process which consists of estimating based on a weighted combination of (i) the guideline company method that utilizes revenue or earnings multiples for comparable publicly-traded companies, and (ii) a discounted cash flow model. If the estimated fair value of the reporting unit is less than its carrying value, this indicates that goodwill is impaired, and impairment is recorded based on the deficiency of fair value compared to the carrying value. The

Company's impairment test related to goodwill during the year ended September 30, 2018 resulted in a full impairment of goodwill related to the Rhode Island facilities. There were no impairment charges during the year ended September 30, 2019.

Intangible Assets

Intangible assets include customer relationships, trade names, and favorable leaseholds. The Company reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying value of such assets may not be recoverable. The Company considers assets to be impaired and writes them down to fair value if estimated undiscounted cash flows associated with those assets are less than their carrying amounts. Fair value is based upon the present value of the associated cash flows. Changes in circumstances (for example, changes in laws or regulations, technological advances or changes in strategies) may also reduce the useful lives from initial estimates. Changes in planned use of intangibles may result from changes in customer base, contractual agreements, or regulatory requirements. In such circumstances, management will revise the useful life of the long-lived asset and amortize the remaining net book value over the adjusted remaining useful life. There were no impairments recorded during the years ended September 30, 2019 and 2018.

Insurance Reserves

Medical Malpractice Liability Insurance

The individual physicians who contract with the physician organizations carry their own medical malpractice insurance, some of which may be purchased from RRG or CHIC. In the Hospital Services segment, the Company's hospitals carry professional and general liability insurance to cover medical malpractice claims under claims-made policies. Under the policies, insurance premiums cover only those claims actually reported during the policy term. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims related to occurrences during the policy term but reported subsequent to the policy's termination may be uninsured. The Company's hospitals have a consolidated policy for professional and general liability insurance with separate retentions for each entity. The Pennsylvania MCARE fund provides the $500,000 in excess of $500,000 RRG malpractice coverage for Crozer.

For the current fiscal year, RRG provided primary malpractice insurance ($500,000 per occurrence and $2,500,000 in the aggregate) and general liability ($1,000,000 per occurrence and $2,000,000 in the aggregate). In addition, the RRG provided coverage for losses of $4,000,000 in excess of $1,000,000 for each hospital professional liability claim with no aggregate limit. RRG also provides additional layers of excess coverage over $5,000,000 up to $20,000,000, which are 100% reinsured by third party insurance carriers through multiple layers. The excess coverage provided for general liability is over $10,000,000 up to $50,000,000, which is also 100% reinsured by third party carriers. Additionally, there is $1,000,000 per occurrence and $3,000,000 in the aggregate) coverage for non-healthcare provider professional liability.

During the year ended September 30, 2018, CHIC provided malpractice and general liability ($2,000,000 per occurrence) coverage for all facilities except Crozer and Prospect ECHN, Inc. ("ECHN"). During the year ended September 30, 2019, CHIC provided malpractice and general liability ($5,000,000 per occurrence and $37 million in the aggregate) coverage for all facilities, except Crozer. CHIC also provided an excess healthcare professional liability and umbrella liability insurance policy on a claims-made basis covering healthcare professional liability, general liability, automobile liability, employers' liability, helipad liability and non-owned aircraft liability. The limit provided was $80,000,000 and $60,000,000

(during the years ended September 30, 2019 and 2018, respectively) for each loss event and in the annual aggregate excess of the primary coverage layers described above. This coverage was fully reinsured by third party carriers.

GAAP requires that a health care organization record and disclose the estimated costs of medical malpractice claims in the period of the incident of malpractice, if it is reasonably possible that liabilities may be incurred and losses can be reasonably estimated. The Company has recognized an estimated liability for incurred but not reported claims and the self-insured risks (including deductibles and potential claims in excess of policy limits) based upon an actuarial valuation of the Company's historical claims experience of its hospitals. At September 30, 2019 and 2018, the total gross claims liability, was $133,300,000 and $73,532,000 and reinsurance recoverable on unpaid losses were $49,552,000 and $12,834,000, respectively, included in other assets on the accompanying consolidated balance sheets, and were estimated using a discount factor ranging from 3.50% to 4.00%.

Workers' Compensation Insurance

The workers' compensation coverage provides the statutory benefits required by law with a $500,000 deductible reimbursement policy provided by CHIC for the Company's entities located in California and Connecticut, and for the year ended September 30, 2019, Pennsylvania (covered in fiscal 2018 for the first $500,000 with a third party carrier). The facilities in Rhode Island were fully insured for workers' compensation claims with no deductible. At September 30, 2019 and 2018, included in accrued salaries, wages and benefits are accruals for uninsured claims and claims incurred but not reported of approximately $29,182,000 and $27,776,000 and reinsurance recoverable on unpaid losses of $3,134,000 and $8,557,000, respectively, included in other assets on the accompanying consolidated balance sheets. The amounts are estimated based upon an actuarial valuation of claims experience, using a discount factor of 4%.

Reserve Methodology

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

Stock Options

Ivy Holdings has a stock option plan (the "Ivy Plan"), which is administered by the Compensation Committee of the Ivy Holdings Board. The plan includes an Incentive Stock Option Agreement and a Non-Qualified Stock Option Agreement to be used in connection with the grant of options under the plan. These options granted under the Ivy Plan are exercisable into Ivy Holdings stock and vest based on a number of criteria.

Compensation costs for option awards are measured and recognized in the consolidated financial statements based on their grant date fair value, net of estimated forfeitures over the awards' service period. Options subject to variable accounting treatment are subject to revaluation at the end of each reporting period. The Company uses the Black-Scholes option pricing model and a single option award

approach to estimate the fair value of stock options granted. The fair value of restricted stock grants are determined on the date of grant, based on the number of shares granted and the quoted price or estimated fair market value of the Company's common stock. Equity-based compensation is classified within the same line items as cash compensation paid to employees. Compensation costs related to stock options that vest or are exercisable when certain corporate transactions occur, including a change in control, are recognized at the time that such an event occurs.

Cash and Cash Equivalents

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

Restricted Cash

Some of the Company's cash is restricted for various purposes including research, regulatory requirements and letters of credit. The Company is also required to keep restricted deposits by certain HMOs for the payment of claims. Such restricted deposits are classified as a current asset in the accompanying consolidated balance sheets, as they are restricted for payment of current liabilities. Restricted cash also include certificates of deposit with maturity dates of more than 90 days when purchased.

Cash Held in Escrow

The Company holds $70 million of the cash at September 30, 2019 which is held in in escrow and is expected to be contributed to the Company's pension plans during the year ending September 30, 2020.

Restricted Investments

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

Inventories

Inventories of supplies are valued at the lower of amounts that approximate the weighted average cost or net realizable value, which approximates market value, and are expensed as incurred. Inventories consist primarily of medical and surgical supplies and pharmaceuticals.

Internal Use Software

Included within other receivables, prepaid expenses and other current assets are hosting arrangements related to the Oracle suite of products, which are accounted for as service contracts. The gross carrying amount of capitalized service costs was approximately $12,100,000 and $149,000 at September 30, 2019 and 2018, respectively. There is no expected residual value for capitalized costs. At September 30, 2019 and 2018, there was approximately $12,100,000 and $149,000, respectively, of capitalized costs for hosting arrangements accounted for as service contracts that is was in the development stage and amortization is scheduled to commence once the project is complete and ready for its intended use. The

estimated amortization period is 5 years. There was no amortization expense for the years ended September 30, 2019 and 2018, respectively.

Deferred Financing Costs

Deferred financing costs are amortized over the period in which the related debt is outstanding using the effective interest method and are classified as a deduction from the carrying amount of the related debt. As it relates to MPT liabilities, deferred financing costs are classified in other assets in the accompanying consolidated balance sheets.

Income Taxes

Deferred income tax assets and liabilities are recognized for differences between financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. To the extent a deferred tax asset cannot be recognized under the preceding criteria, allowances must be established. The impact on deferred taxes of changes in tax rates and laws, if any, are applied to the years during which temporary differences are expected to be settled and reflected in the financial statements in the period of enactment. The Company recognizes interest and penalties associated with income tax matters and unrecognized tax benefits in the income tax expense line item of the statements of operations. For the year ended September 30, 2018, the Company incurred $2,405,000 of interest and penalties related to income taxes, which were reversed during the year ended September 30, 2019.

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

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

Sale-Leaseback Transactions

The Company evaluates sale-leaseback transactions by determining whether the transaction meets the qualifying criteria to be recognized as a sale-leaseback, including the transfer of risk and rewards of ownership as well as the absence of continuing involvement of the Company. When the qualifying criteria for a sale-leaseback transaction are not met, the Company accounts for the transaction as a financing (see Notes 9 and 10).

Comprehensive Income

Comprehensive income consists of net income and other gains and losses affecting stockholder's equity that, under generally accepted accounting principles, are excluded from net income (loss) attributable to the Company. For the Company, such items consist primarily of unrealized gains or losses on debt and equity securities as well as changes related to pension and other postretirement liabilities that are not recognized immediately in net periodic benefit costs (see Note 12).

Fair Value of Financial Instruments

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

Fair Value Measurement

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

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

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

Financial Items Measured at Fair Value on a Recurring Basis

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

September 30, 2019	Total	Level 1	Level 2	Level 3
Mutual funds	$ 29,540	$ 29,540	$ -	$ -
September 30, 2018				
Mutual funds	$ 23,779	$ 23,779	$ -	$ -

The Company's investments are classified within Level 1 of the fair value hierarchy because they are valued using quoted market prices. The Company's defined benefit pension plan assets are also measured at fair value (see Note 12).

The Company's carrying amount of long-term debt approximated fair value as of September 30, 2019 and 2018, respectively.

Nonfinancial Items Measured at Fair Value on a Nonrecurring Basis

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

During the year ended September 30, 2018, the Company recorded approximately $14,228,000 of impairment relating to goodwill, which is reflected in the accompanying consolidated statements of operations.

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

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

Residual Value of Goodwill	Valuation Technique	Unobservable Input	Rates
$ -	Discounted Cash Flow	Weighted average cost of capital	9.3%
		Revenue growth rate	2.1% - 2.5%
	Guideline Public Company	LTM revenue multiple	0.5x
		NTM EBITDA multiple	7.0x

There were no nonrecurring measurements as of September 30, 2019.

Concentrations of Credit Risk

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

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

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

For the years ended September 30, 2019 and 2018, the Hospital Services segment received a total of 63% and 65% of its net patient revenues from Medicare and Medicaid programs, respectively, and the Medical Group segment received a total of 65% and 62% for the years ended September 30, 2019 and 2018, respectively, of their capitation revenues from its five largest HMOs, as follows (in thousands):

Years Ended September 30,	2019	% of Total Revenue		2018	% of Total Revenue
Hospital Services:					
Government Payers:					
Medicare	$ 822,407	33%		$ 801,222	31%
Medicaid	750,909	30%		874,865	34%
Total	$ 1,573,316	63%		$ 1,676,087	65%
Medical Group:					
HMO A	$ 61,087	20%	HMO A	60,506	20%
HMO B	35,674	12%	HMO B	35,705	11%
HMO E	34,684	11%	HMO F	32,934	11%
HMO F	34,207	11%	HMO D	32,357	11%
HMO D	32,617	11%	HMO C	27,051	9%
Total	$ 198,269	65%		$ 188,553	62%

The Global Risk Management segment received all of their revenues from seven health plans during the years ended September 30, 2019 and 2018.

Use of Estimates

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

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, "Revenue from Contracts with Customers (Topic 606)" with an effective date deferred by ASU 2015-14. The core principle of ASU 2014-09 is built on the contract between a vendor and a customer for the provision of goods and services, and attempts to depict the exchange of rights and obligations between the parties in the pattern of revenue recognition based on the consideration to which the vendor is entitled. To accomplish this objective, the standard requires five basic steps: (i)

identify the contract with the customer, (ii) identify the performance obligations in the contract, (iii) determine the transaction price, (iv) allocate the transaction price to the performance obligations in the contract, (v) recognize revenue when (or as) the entity satisfies a performance obligation. Nonpublic entities will apply the new standard for annual periods beginning after December 15, 2018, and interim periods within fiscal years beginning after December 15, 2019. Three basic transition methods are available – full retrospective, retrospective with certain practical expedients, and a cumulative effect approach. Under the third alternative, an entity would apply the new revenue standard only to contracts that are incomplete under legacy U.S. GAAP at the date of initial application and recognize the cumulative effect of the new standard as an adjustment to the opening balance of retained earnings. That is, prior years would not be restated and additional disclosures would be required to enable users of the financial statements to understand the impact of adopting the new standard in the current year compared to prior years that are presented under legacy U.S. GAAP. The Company is currently evaluating the effect of this guidance on its consolidated financial statements.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)". The core principle of ASU 2016-02 is that a lessee should recognize the assets and liabilities that arise from leases, including operating leases. Under the new requirements, a lessee will recognize in the statement of financial position a liability to make lease payments (the lease liability) and the right-of-use asset representing the right to the underlying asset for the lease term. For leases with a term of 12 months or less, the lessee is permitted to make an accounting policy election by class of underlying asset not to recognize lease assets and lease liabilities. The recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee have not significantly changed from previous GAAP. The standard was originally scheduled to effective for nonpublic entities for fiscal years beginning after December 15, 2019. In November 2019 the FASB issued ASU 2019-10, "Financial Instruments—Credit Losses (Topic 326), Derivatives and Hedging (Topic 815), and Leases (Topic 842)" which delay the effective date by one year to December 2020. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

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

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

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

Reclassifications

Certain reclassifications were made to the prior year consolidated financial statements in order to conform to the current year presentation, and primarily relate to presentation of discontinued operations (see Note 5).

3. Property, Improvements and Equipment

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

September 30,	2019	2018
Land and land improvements	$ 68,403	$ 75,801
Buildings and improvements	359,570	316,217
Leasehold improvements	12,097	8,758
Equipment	373,153	283,008
Furniture and fixtures	5,288	4,705
	818,511	688,489
Less: accumulated depreciation	(342,106)	(248,162)
	476,405	440,327
Construction in Progress	62,066	73,363
Property, improvements and equipment, net	$ 538,471	$ 513,690

At September 30, 2019 and 2018, the Company had assets under capitalized leases of approximately $53,861,000 and $31,784,000, respectively, and related accumulated depreciation of $10,771,000 and $12,433,000, respectively.

Depreciation expense was approximately $83,683,000 and $78,153,000 for the years ended September 30, 2019 and 2018, respectively.

Included within equipment is capitalized software costs, which relate to significant system conversions. The estimated amortization period is 5 years. The gross carrying amount of capitalized software for internal use (related to the Cerner suite of products) was approximately $39,538,000 and $14,557,000 at September 30, 2019 and 2018, respectively, and the net carrying amount considering accumulated amortization was approximately $37,449,000 and $14,557,000 at September 30, 2019 and 2018, respectively. There is no expected residual value for capitalized internal-use software. At September 30, 2019 and 2018, there was approximately $28,355,000 and $7,914,000, respectively, of capitalized costs for internal-use software that is in the development stage and amortization is scheduled to commence once the software project is complete and ready for its intended use. Amortization expense was $2,050,000 and $0 for the years ended September 30, 2019 and 2018, respectively.

4. Acquisitions

For the years ended September 30, 2019 and 2018, the Company entered into the following material acquisitions. All business combinations were consistent with the Company's strategic growth plan and were accounted for using the acquisition method of accounting. Operating results for each of the acquisitions have been included in the accompanying consolidated financial statements from the date of acquisition. Goodwill arising is primarily attributable to the synergies expected to arise after the acquisitions, and is expected to be deductible for tax purposes for entities that were asset acquisitions, but is not is expected to be deductible for tax purposes for entities that were stock acquisitions.

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

Transaction costs incurred during the years ended September 30, 2019 and 2018 were immaterial.

2019 acquisitions

The Company completed the acquisitions of 10 physician practices in Connecticut and Pennsylvania for an aggregate purchase price of approximately $400,000. All acquisitions were asset acquisitions.

2018 acquisitions

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

The Company completed the acquisitions of four physician practice acquisitions in Connecticut for an aggregate purchase price of approximately $2.6 million, one physician multi-specialty practice in Pennsylvania for a purchase price of $1.6 million (net of working capital adjustments), three physician medical practices in California for an aggregate purchase price of approximately $800,000, and one physician family practice in Rhode Island for $180,000. All acquisitions were asset acquisitions, except for one stock purchase acquisition in Connecticut for a purchase price of $800,000.

5. Discontinued Operations

During the year ended September 30, 2019, the Company made the determination to sell the operations of Nix Hospital System ("Nix Health") in Texas and East Orange General Hospital ("EOGH") in New Jersey. The initial plan as approved by the Company's Board of Directors in March 2019 was to sell both Nix Health and EOGH as "going concern" businesses. Subsequent to the initial plan, the plans for Nix Health changed as a result of interest in the market place. The decision to sell the acute hospital building as a real estate transaction was made in August 2019. The hospital closed to patient admissions in September 2019 and as of September 30, 2019 had no patients "in-house". The building is under contract for sale for $28.5 million and the sale is expected to close in the second quarter of fiscal 2020. The decision was made in October 2019 to initially consolidate, and then close, the behavioral business. The two behavioral health businesses were closed in November 2019. Efforts are underway to sell the building that is owned and sublease the building that is leased. Negotiations continue with a number of potential buys with respect to the sale of EOGH. The Company's decision to discontinue the operations of each of these entities was based on the strategy of the Company's management in their respective markets and financial results.

Accordingly, as of September 30, 2019 and 2018, the assets and liabilities of these businesses have been classified as "held for sale," and the operations (as it relates to revenues and expenses that will no longer continue post sale) have been shown within discontinued operations.

In connection with the presentation of discontinued operations, the Company was required to test the long lived assets for impairment as of September 30, 2019. As part of that impairment test: (i) goodwill at Nix Health was fully impaired; (ii) property, plant and equipment at EOGH was impaired by approximately $55.9 million and at Nix Health was impaired by $17.8 million, respectively.

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

September 30,	2019	2018
Patient accounts receivable, net of allowance for doubtful accounts and other receivables	$ 26,037	$ 33,377
Due from government payors	2,022	11,424
Other receivables, prepaid expenses and other current assets	7,732	11,352
Inventories	1,486	4,837
Total current assets	37,277	60,990
Property, improvements and equipment, net	42,401	110,273
Goodwill	-	3,138
Intangible assets, net	1,555	1,797
Other assets	164	161
Total assets of the disposal groups classified as held for sale in the consolidated balance sheets	$ 81,397	$ 176,359

September 30,	2019	2018
Accrued medical claims and other healthcare costs payable	$ 53	$ 46
Accounts payable and other accrued liabilities	23,325	29,436
Accrued salaries, wages and benefits	7,929	9,849
Due to government payers	855	1,478
Current portion of capital leases	1,777	1,415
Total current liabilities	33,939	42,224
Long-term debt, net of current portion	946	1,000
Malpractice reserves	2,677	3,748
Capital leases, net of current portion	7,310	6,623
Other long-term liabilities	1,061	1,406
Total liabilities of the disposal groups classified as held for sale in the consolidated balance sheets	$ 45,933	$ 55,001

For the Years Ended September 30,	2019	2018
Net patient service revenues	$ 189,063	$ 190,085
Provision for bad debts	(19,953)	(19,388)
Net patient service revenues	169,110	170,697
Other non-patient revenues	4,762	5,049
Total revenues	173,872	175,746
Hospital operating expenses	181,145	174,058
General and administrative	47,829	42,651
Depreciation and amortization	7,224	12,763
Total operating expenses	236,198	229,472
Net operating loss	(62,326)	(53,726)
Interest expense, net	1,708	1,699
Goodwill impairment	3,138	4,572
Property, improvement and equipment impairment	73,682	-
Other expense (income), net	685	(83)
Total other expense, net	79,213	6,188
Loss on discontinued operations before income taxes	(141,539)	(59,914)
Income tax benefit	18,234	1,289
Loss on discontinued operations, net of taxes	$ (123,305)	$ (58,625)

6. Goodwill and Intangible Assets

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

September 30,	2019	2018
Southern California Hospitals	$ 130,912	$ 130,912
California Medical Groups	28,222	28,222
Crozer	140,216	140,216
ECHN	535	483
Waterbury	2,492	2,155
Total	$ 302,377	$ 301,988

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

September 30,	2019	2018
Balance, beginning of year	$ 301,988	$ 302,985
Acquisitions	389	13,231
Impairment	-	(14,228)
Balance, end of year	$ 302,377	$ 301,988

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

September 30,	Useful lives	2019	2018
HMO membership	14 years	$ 25,200	$ 25,200
Trade names, net of impairment	3 - 20 years	42,030	50,160
Customer relationships	7 years	-	350
Other	5 - 6 years	97	97
Gross carrying value		67,327	75,807
Accumulated amortization		(41,782)	(43,985)
Intangible assets, net		$ 25,545	$ 31,822

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives and expense for the years ended September 30, 2019 and 2018 was $6,278,000 and $6,898,000, respectively. There are no expected residual values related to these intangible assets.

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

Years ending September 30,	
2020	$ 5,108
2021	5,088
2022	3,299
2023	2,780
2024	2,780
Thereafter	6,490
	$ 25,545

The weighted-average remaining useful life for the intangible assets was approximately 7 years as of September 30, 2019.

7. Related Party Transactions

Jeereddi Prasad, M.D., a shareholder of Ivy Holdings, a director of Ivy Holdings and the Company, and an officer of the Upland Medical Group, a Professional Medical Group and Pomona Valley Medical Group, Inc (collectively "ProMed Entities"), has ownership interests in physician medical groups that provide medical services to ProMed members, including Chaparral Medical Group, Inc., (in which the Company beneficially owns a 13.2% interest). For the years ended September 30, 2019 and 2018, the ProMed Entities paid these groups approximately $21,922,000 and $19,760,000, respectively. As of September 30, 2019 and 2018, the Company had accounts payable and other accrued liabilities due to these related parties of $806,000 and $1,266,000, respectively.

Pursuant to a Management Services Agreement, dated December 15, 2010 and amended on May 3, 2012 (the "LGP Management Agreement"), between the Company and Leonard Green & Partners, L.P. ("LGP"), a private equity fund with affiliated funds that collectively constitute the majority shareholder of Ivy Holdings, LGP provides to the Company, (a) certain investment banking services, (b) management, consulting and financial planning services and (c) financial advisory and investment banking services in connection with major financial transactions from time to time. In consideration for the services provided by LGP under the LGP Management Agreement, the Company pays LGP an annual fee of $1,000,000, payable in monthly installments, and reimburses LGP for its related expenses up to $50,000 annually. If approved by the unanimous consent of the Board of Directors of the Company, additional customary fees may be due to LGP pursuant to the terms of the LGP Management Agreement for services rendered in connection with major transactions from time to time. As of September 30, 2019 and 2018, there was approximately $500,000 and $0 payable, respectively, included in accounts payable and other accrued liabilities on the accompanying consolidated balance sheets.

During the year ended September 30, 2019, the Company received a capital contribution from Ivy Intermediate of $41.0 million and paid a dividend of approximately $44.4 million (see Note 11).

The Company is a wholly-owned indirect subsidiary of Ivy Holdings. Therefore, Ivy Holdings is the parent of an affiliated group of corporations within the meaning of Section 1504(a) of the Internal Revenue Code of 1986. On December 15, 2010, Ivy Holdings, Ivy Intermediate and the Company entered into a Tax Sharing Agreement. The Tax Sharing Agreement allows the Company to make payments to Ivy Holdings as necessary to fund their payment of any required taxes incurred due to such parent status. Under this agreement, the Company received refunds (net of payments) of $(343,000) and $5,463,000 for the years ended September 30, 2019 and September 30, 2018, respectively.

8. Income Taxes

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

For the years ended September 30,	2019	2018
Current:		
Federal	$ 11,940	$ (41,703)
State	3,353	(8,549)
	15,293	(50,252)
Deferred:		
Federal	1,162	100,529
State	-	12,509
	1,162	113,038
Total:		
Federal	13,102	58,826
State	3,353	3,960
	$ 16,455	$ 62,786

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

September 30,	2019	2018
Deferred tax assets:		
Accrued medical claims	$ 3,443	$ 4,265
Malpractice reserves	3,254	3,202
Accounts receivable	26,596	22,136
Accrued salaries & wages	13,478	10,530
Pension obligation	65,919	81,847
Net operating losses	44,026	51,567
Tax Credits	1,719	2,870
Outside basis differences	7,244	755
Lease liability	132,400	-
UTP & other	-	7,730
Deferred tax assets	298,079	184,902
Valuation allowance	(203,335)	(105,909)
Net deferred tax assets	94,744	78,993
Deferred tax liabilities:		
Property, plant & equipment	(72,053)	(54,863)
Intangible assets	(6,642)	(8,626)
Prepaid expenses	(2,969)	(2,222)
Other comprehensive income	(11,585)	(11,307)
UTP & other	(672)	-
Deferred tax liabilities	(93,921)	(77,018)
Net deferred tax assets	$ 823	$ 1,975

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

Management assesses the available positive and negative evidence to estimate whether sufficient future pretax income will be generated to permit use of the existing deferred tax assets. A significant piece of objective negative evidence evaluated was the cumulative pretax losses incurred over the three year period ended September 30, 2019. Such objective evidence limits the ability to consider other subjective evidence, such as the Company's projections for future growth. On the basis of this evaluation, at September 30, 2019 and 2018, a valuation allowance of approximately $203.3 million and $105.9 million, respectively, was recorded to recognize only the portion of the deferred tax asset that is more likely than not to be realized. The amount of the deferred tax asset considered realizable, however, could be adjusted if estimates of future taxable income during the carryforward period are reduced or increased or if negative objective evidence in the form of cumulative losses is no longer present and additional weight is given to subjective evidence such as the Company's projections for growth.

During fiscal 2019, the Company completed an IRS examination for Ivy Holdings, Inc. & Subsidiaries fiscal 2014 through 2016 federal income tax returns without any adjustment to reported taxable income The Company is under examinations by the California Franchise Tax Board for tax years ended September 30, 2014 through 2016. The Company does not currently anticipate any changes to our unrecognized tax benefits for the next twelve months related to these examinations.

The Company's tax years 2016 and 2017 are open for federal tax examination, and generally the states are open for tax years 2015 through 2017. During the year ended September 30, 2018, the Company recorded a liability in the amount of $12.7 million related to uncertain tax positions ("UTP") with respect to impermissible accounting methods for federal income tax purposes, which was recorded in other long-term liabilities in the accompanying consolidated balance sheets. During the year ended September 30, 2019, The Company has removed the UTP liability due to filing with IRS for a change from an improper to a proper accounting method change.

On December 22, 2017, the Tax Cuts and Jobs Act of 2017 (the "Act") was signed into law making significant changes to the Internal Revenue Code. Changes include, but are not limited to, a corporate tax rate decrease from 35% to 21% effective for tax years beginning after December 31, 2017, limitations on various business deductions such as executive compensation under Internal Revenue Code §162(m), the transition of U.S international taxation from a worldwide tax system to a territorial system, and a one-time transition tax on the mandatory deemed repatriation of cumulative foreign earnings as of December 31, 2017. The United States federal income tax rate reduction was effective as of January 1, 2018. As a result, the Company reduced net U.S. deferred tax assets by $25,660,000 during the year ended September 30, 2018. As the Company does not have profitable foreign subsidiaries, it does not anticipate any impacts as a result of the mandatory deemed repatriation of cumulative foreign earnings.

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

For the years ended September 30,	**2019**	2018
Tax provision at statutory rate	**21%**	25%
State taxes, net of federal benefit	**16%**	15%
Impact of US Tax Reform	**0%**	(16)%
Valuation allowance	**(56)%**	(77)%
UTP	**8%**	(2)%
Other	**1%**	4%
	(10)%	(51)%

9. Long-Term Debt

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

September 30,	2019	2018
Senior secured credit facility (net of discount of $0 and $20,085, respectively)	$ -	$ 1,094,315
Other debt *(1)*	206,350	38,769
Less: Deferred financing costs, net ("DFC")	-	(16,214)
Total Debt, net of discount and DFC	206,350	1,116,870
Less: current maturities	(18,983)	(18,429)
Long-term debt, net of current maturities	$ 187,367	$ 1,098,441

(1) Other debt includes (i) financing obligations related to sales-leaseback transactions. The financing obligations related to sales-leaseback transactions were $23,152,000 and $24,614,000 for years ended September 30, 2019 and 2018, respectively, excluding the sale leaseback transaction in entered into in fiscal 2019 with MPT (see Note 10) and (ii) debt related to the Foothill ($51,267,000) and TRS Notes ($112,937,000) entered into in fiscal 2019 with MPT (see Note 10).

Senior Secured Credit Facilities

On June 30, 2016, the Company entered into a six-year $625,000,000 senior secured term loan B (the "Original Term Loan"). The Original Term Loan was issued with an original discount of 1.50%, or $9,375,000. Additionally, the Company refinanced the previous revolver with a new $100,000,000 asset-based revolving credit facility ("Original ABL Facility" and together with the Original Term Loan, the "New Senior Secured Credit Facilities"). Pursuant to various amendments from August 2016 through October 2017, the aggregate commitment amount under the Original ABL facility was increased in stages to $175,000,000. The original maturity date for the Original ABL Facility was June 30, 2021, and the original maturity date for the Term Loan was June 30, 2022.

On February 22, 2018, the Company refinanced and replaced both the Original Term Loan and the Original ABL Facility, and entered into an Amended and Restated Term Loan Credit Agreement (the "Amended TL Agreement"), by and among the Company (as the borrower), the lenders party thereto and JPMorgan Chase Bank, N.A. ("JPMorgan"), as administrative agent and collateral agent. The Amended TL Agreement replaced the Original Term Loan with a new Term B-1 Loan ("Term B-1 Loan"). The principal amount of the Term B-1 Loan was $1,120,000,000 and such loan incurred interest at LIBOR (subject to a 1.00% floor) plus 5.50%. The Term B-1 Loan was issued with an original discount of 2.00% and was originally scheduled to mature on February 22, 2024. The Term B-1 Loan was repaid on August 23, 2019 (see Note 10).

Additionally, on February 22, 2018, the Company entered into an Amended and Restated ABL Credit Agreement (the "Amended ABL Agreement"), by and among the Company (as the borrower), the lenders party thereto and JPMorgan, as administrative agent and collateral agent. The Amended ABL Agreement replaced the Original ABL Facility. Under the Amended ABL Agreement, the maximum revolving commitment was $250,000,000 with ability to expand the facility to $325,000,000, and the new ABL

facility (the "New ABL Facility") bears interest at a variable base rate plus an applicable spread that is based on excess availability under the New ABL Facility, as further described in the Amended ABL Agreement, which was 6.0% as of September 30, 2019. From January 2019 through July 2019 the Company entered into various amendments to the Amended ABL Agreement. Such amendments (i) waived certain events of default at September 30, 2018; (ii) increased the maximum revolving commitment from $250.0 million to $280.0 million, and further to $285.0 million, while simultaneously reducing and removing future expansion of the facility; (iii) introduced $40.0 million of a first in last out ("FILO") revolving facility, which incurred interest at either 2.5% or 3.5% per annum depending on whether they are Eurodollar loans or ABR loans (which were repaid on August 23, 2019); (iv) provides for a reduction in the maximum revolving commitment by $20.0 million and $10.0 million upon the future planned closure or disposition of Nix Health and EOGH, respectively. The New ABL Facility matures on February 22, 2023. As of September 30, 2019, the outstanding balance and the available balance on the New ABL facility was approximately $70.0 million and $175.6 million, respectively.

The proceeds of the Term B-1 Loans and the New ABL Facility (the "New Senior Secured Credit Facilities") were used to refinance the Original Term Loan and the Original ABL Facility, to pay a dividend of $457,000,000 to the Company's stockholders, to pay certain expenses associated with the refinancing, to prefund approximately $40,000,000 of pension liabilities of the Company's subsidiaries, to make payments to certain option holders as a result of the referenced dividend, and to finance certain working capital and other operational needs of the Company and its subsidiaries.

Under applicable accounting literature, during the year ended September 30, 2018, deferred financing costs of $11,700,000 and outstanding debt discount of $6,700,000 as of February 22, 2018 were expensed and presented within loss on debt extinguishment in the accompanying consolidated statements of operations, and new costs of approximately $18,000,000 incurred in connection with the refinancing were capitalized to offset the new long-term debt in the accompanying consolidated balance sheets, and are being amortized over the term of the related debt using the effective interest method. In connection with the repayment of the Term B-1 Loan (see Note 10), and under applicable accounting literature, during the year ended September 30, 2019, deferred financing costs of $13,444,000 and outstanding debt discount of $16,608,000 were expensed and are presented within loss on debt extinguishment in the accompanying consolidated statements of operations.

The New ABL Facility is secured by a first priority security interest on the working capital assets of the Company and its wholly-owned subsidiaries except Prospect Health Plan, Inc., CHIC, RRG, Prospect Health Access Network, Inc. and certain immaterial subsidiaries and a second priority security interest on their fixed assets. The Amended ABL Agreement does not have any financial maintenance covenants. The Amended ABL Agreement has a "springing" fixed charge ratio covenant that applies if excess availability is less than the greater of 10% of the maximum borrowing amount and $22,000,000. The fixed charge ratio covenant was not required to be tested for the fiscal quarter ended September 30, 2019.

Demand Notes

The Company has a commitment from a bank for a $15,000,000 equipment leasing facility to finance various equipment at the Company's hospital facilities. As of September 30, 2019 and 2018, draws under the facility are classified as capital lease arrangements. Draws represent demand notes until conversion to capital leases, and interest accrues on such draws at the bank prime rate plus 1.50% with a floor of 4.50% and payable monthly. As of September 30, 2019, approximately $15,000,000 had been drawn under the line.

Scheduled payments under the Company's current and long-term debt as of September 30, 2019 are as follows (in thousands):

Years ending September 30,	
2020	$ 18,983
2021	15,289
2022	13,140
2023	13,106
2024	13,412
Thereafter	132,420
Total scheduled payments	206,350
Less: Current maturities	(18,983)
Total long-term debt	$ 187,367

10. Transactions with MPT

On August 23, 2019, the Company closed a series of transactions with affiliates of Medical Properties Trust, Inc. ("MPT"), a publicly traded Real Estate Investment Trust ("REIT"). Under these transactions, the Company sold to MPT the Company's hospital buildings in California (excluding Foothill Regional Medical Center ("Foothill"), Connecticut and Pennsylvania for an aggregate purchase price of $1,386,000,000. Concurrent with the sale transactions, the Company entered into two master lease agreements whereby the hospital properties and related medical office buildings were leased back for an initial 15 year term, with options to extend twice for an additional 5 years each and for a further 4.75 year extension. Monthly rent is defined as 7.5% of the lease base, subject to annual escalation of consumer price index, limited to a minimum of 2% and a maximum of 4%. For the first master lease, the Company has the option to buy the properties at their fair value at the end of the lease term. For the second master lease, the Company has the option to purchase at a price that is fixed at the time of entering into the lease (the "Option Price"). If the Company chooses not to exercise this option, and the fair value at the end of the lease is below the Option Price, then the Company must pay MPT a sum equal to the difference between the fair value and the Option Price. These transactions do not qualify for sale leaseback accounting because of the Company's deemed continuing involvement with the buyer-lessor, including the requirements to pay reserves for major repairs, and the option to purchase included in the lease, which are considered a form of contingent collateral and results in the transaction being recorded under the financing method. All of the legal entities that are parties to the master lease agreement (which are the hospital entities themselves) provide cross guarantees on all of the obligations to MPT, which guarantees include both lease payments under the master lease as well as indebtedness due to MPT. The balance due under the leases is reflected in MPT liabilities in the accompanying consolidated financial statements.

Further, the Company obtained a mortgage on the Foothill property. This mortgage is secured by the buildings at Foothill. The interest on this mortgage is 7.5% per annum and is subject to annual escalation of consumer price index, limited to a minimum of 2% and a maximum of 4%. The maturity date of this loan is in August 2034. MPT can purchase the property on event of default or at end of term, or if Company does not exercise purchase rights for the aforementioned leased properties. Additionally, if the Foothill property is no longer used as collateral for a promissory note payable to Prospect Medical Group, Inc. ("PMG"), one of the Company's California Medical Groups, then MPT shall have the right to purchase the Foothill property and lease it back to the Company under the second master lease

agreement, for an amount equal to the outstanding principal balance. The referenced promissory note payable to PMG has been included in the calculation of PMG's Tangible Net Equity in connection with requirements of the California Department of Managed Health Care. The balance due under the promissory note payable to MPT is reflected in long term debt in the accompanying consolidated financial statements (see Note 9).

Additionally, the Company entered into a promissory note (the "TRS Note"), under which MPT has advanced to the Company $112,937,000 related to and secured by the value of the properties in Rhode Island. The interest on this note is 7.5% per annum and is subject to annual escalation of consumer price index, limited to a minimum of 2% and a maximum of 4%. The maturity date of this note is the earlier of August 2022 or the conversion to and sale-leaseback of the properties in Rhode Island. The balance due under this note is reflected in long term debt in the accompanying consolidated financial statements (see Note 9).

All of the agreements referenced in this footnote are cross-collateralized and cross defaulted. Based on annualized Adjusted EBITDAR (as defined) achieved over the three years from the transaction date, additional amounts between $50 million to $250 million will be payable to the Company. As of September 30, 2019, there has been no accounting for these amounts in the consolidated financial statements. The proceeds from these transactions were used to pay off in full the Term B-1 Loan and to pay down the amounts outstanding under the Amended ABL Agreements (see Note 9) and the FILO facility, as well as fund a restricted cash account for the future paydown of the Company's pension liabilities and to provide working capital.

The MPT transaction documents contain certain customary covenants and restrictions and a financial covenant based on EBITDAR performance.

Interest expense under these agreements was $6,649,000 for the year ended September 30, 2019.

See Note 13 for future minimum lease payments related to sale leaseback commitments as of September 30, 2019.

11. Stockholder's Equity

Equity Based Compensation Plans

Effective December 15, 2010, the Board of Directors of Ivy Holdings adopted the Ivy Plan that initially authorized the issuance of options exercisable for up to 155,110 shares of the common stock of Ivy Holdings ("Initial Options") to employees, certain consultants and independent members of the boards of directors, of Ivy Holdings and its subsidiaries (including the Company and its subsidiaries). These options are exercisable into Ivy Holdings stock and vest based on a number of criteria, including time, Company and Business Unit performance based on EBITDA targets and CEO and Compensation Committee discretion. Since the Ivy Holdings stock options were granted to Company employees for their services related to the Company, the related compensation cost has been recorded in the Company's consolidated financial statements. Effective June 30, 2015, the Board of Directors of Ivy Holdings adopted the First Amendment to the Ivy Plan. Under the First Amendment, and subsequent amendments, a further 63,704 shares of common stock of Ivy Holdings ("New Options") can be issued.

The New Options are exercisable into Ivy Holdings stock and vest based on a number of criteria, including the same criteria as the Initial Options. However, they only become exercisable on the occurrence of certain corporate transactions, including a change in control of Ivy Holdings, as defined in the Incentive Stock Option Agreements ("Corporate Transaction"). Because the occurrence and timing of a Corporate Transaction is not determinable as of September 30, 2019 and 2018, no compensation cost has been recorded in the Company's consolidated financial statements for the years then ended. See Note 16 for Merger Agreement that was entered into subsequent to year-end.

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

Stock Options Activity

The following table summarizes information about Ivy Holdings stock options outstanding as of September 30, 2019 and 2018 and activity during the years then ended for the Initial Options and the New Options:

	Shares Subject to Options	Weighted Average Exercise Price	Weighted Average Aggregate Intrinsic Value	Weighted Average Remaining Contractual Term (Months)
Outstanding as of October 1, 2017	168,875	$ 174.91	$ 663.09	73.4
Granted	26,516	418.21	–	–
Exercised	(22,608)	37.74	–	–
Canceled/Forfeited	(9,530)	322.72	–	–
Outstanding as of September 30, 2018 (1)	163,253	140.47	156.53	70.5
Granted	–	–	–	–
Exercised	–	–	–	–
Canceled/Forfeited	(14,233)	231.42	–	–
Outstanding as of September 30, 2019	149,020	$ 131.79	$ –	56.2

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

The aggregate intrinsic value is calculated as the difference between the exercise price of the underlying awards and the estimated fair value of the Company's common stock for those awards that have an exercise price currently below the estimated fair value. As of September 30, 2019, the outstanding shares had no aggregate intrinsic value. As of September 30, 2019, there were 101,448 options that are exercisable at a weighted average exercise price of $47.23.

A summary of Ivy Holdings non-vested options and the changes during the fiscal years ended September 30, 2019 and 2018 is presented as follows for the Initial Options and New Options:

	Shares	Weighted Average Grant Date Fair Value
Ivy Holdings Stock Options:		
Nonvested at October 1, 2017	34,364	$ 225.09
Granted	26,516	188.98
Vested	(17,054)	269.50
Canceled/Forfeited	(9,530)	206.09
Nonvested at September 30, 2018	34,296	181.07
Granted	–	–
Vested	–	–
Canceled/Forfeited	(1,876)	200.11
Nonvested at September 30, 2019	32,420	$ 179.97

Stock-Based Compensation Expense

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

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

There were no options granted during the year ended September 30, 2019. Fair value for options granted during the year ended September 30, 2018 was estimated with the following assumptions for Ivy Holdings:

September 30,	2018
Weighted average fair value of option grants	$ 188.98
Estimated fair market value of the Company's common stock on the date of grant	$ 390.14
Weighted average expected life of the options	5 years
Risk-free interest rate	0.85%
Weighted average expected volatility	60.0%
Dividend yield	0.00%

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

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

Expected Volatility - The Company estimates the volatility of the common stock at the date of grant based on the average of the historical volatilities of a group of peer companies. The Company has identified a group of comparable companies to calculate historical volatility from publicly available data for sequential periods approximately equal to the expected terms of the option grants. In selecting comparable companies, Management considered several factors including industry, stage of development, size and market capitalization.

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

Stock-based compensation expense for the Ivy Holdings stock options recognized by the Company during the years ended September 30, 2019 and 2018 was $0 and $710,000, respectively. At September 30, 2019, there were no unvested options, which could potentially vest over the next nine fiscal years, subject to meeting the vesting requirements noted above. There were no remaining maximum estimated stock compensation expense to be amortized to expense in future periods. Options which are expected to vest based on CEO and Compensation Committee discretion are treated as variable stock options and are subject to revaluation at each reporting period. Management determined the fair value of the discretionary vested options using a Black Scholes calculation but determined that the change in compensation expense was not material to the consolidated financial statements for the years ended September 30, 2019 and 2018.

Contributions

On January 25, 2019 and on February 6, 2019, Ivy Holdings made equity contributions in the amount of $40,000,000 and $1,000,000, respectively, to Ivy Intermediate Holding Inc., which was then contributed as equity to the Company.

Dividends

On February 22, 2018, the Board of Directors of Ivy Holdings, Inc. (the "Board") approved special cash in the amount of approximately $33,000,000 in bonus payments were made ("the Bonuses") to Option Holders in connection with the dividend provided that any Bonus with respect to an unvested portion of an option shall be payable upon the date such unvested portion becomes vested and exercisable, subject to the Optionee's continued employment with Prospect through such date. At September 30, 2019 and 2018, approximately $2,300,000 was accrued for bonuses in connection with this. To reflect the Dividend and pursuant to the terms of the Option Plan, the Board further resolved to equitably adjust the Options by reducing the per-share exercise price of the Options to an amount determined with reference to the Bonus amount payable by Prospect Medical with respect to such Option (the "Adjusted Exercise Price").

The Company distributed approximately $456,930,000 in connection with the issuance of "New Senior Secured Credit Facilities" during the year ended September 30, 2018, which was recorded against retained earnings, and was ultimately paid to the common stockholders of Ivy Holdings, Inc. (see Note 9).

The Company distributed approximately $44,407,000 during the year ended September 30, 2019, which was recorded against accumulated deficit.

12. Retirement Benefits

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

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

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

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

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

ECHN has a defined benefit pension plan that covered substantially all of its employees. The benefits were based upon years of service and compensation for the five highest years during the employee's last 10 years of service. Effective December 31, 2013, ECHN froze the defined-benefit for all remaining participants. During September 2013, the Board passed a resolution to freeze all benefits related to the

Defined benefit pension plan. On December 31, 2008, ECHN implemented a soft freeze on the defined benefit pension plan. All qualified employees were eligible to enter into the defined contribution plan, ECHN contributed 3% of eligible employees' salaries. This contribution was non-guaranteed for all employees, except certain union workers covered under a collective bargaining agreement.

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

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

The activity of the pension plans for the years ended September 30, 2019 and 2018 is as follows (in thousands):

September 30,	*2019*	*2018*
Changes in benefit obligations		
Projected benefit obligations, beginning of period	$ 660,176	$ 864,293
Service cost	181	194
Interest cost	28,432	27,695
Plan participant contributions	918	461
Actuarial loss	115,016	(48,654)
Benefits paid	(20,482)	(134,185)
Lump sum benefits paid and annuity purchase	(15,606)	(49,628)
Plan changes	(21)	-
Projected benefit obligation, end of year	$ 768,614	$ 660,176
Changes in plan assets		
Fair value of plan assets, beginning of year	$ 400,468	$ 556,590
Actual return on plan assets	80,668	(14,437)
Contributions by plan sponsor	15,939	41,667
Plan participant contributions	327	461
Benefits paid	(21,108)	(134,185)
Lump sum benefits paid and annuity purchase	(15,606)	(49,628)
Fair value of plan assets, end of year	$ 460,688	$ 400,468
Funded status of the plan, end of year	$ (307,926)	$ (259,708)
Accumulated benefit obligation, end of year	$ (307,926)	$ (259,708)

The funded status of the pension plans as of September 30, 2019 and 2018 is as follows (in thousands), split between the pension plans and the post retirement plans:

	2019 Pensions	2019 OPEBs	2019 Total	2018 Pensions	2018 OPEBs	2018 Total
Current liability	$ -	$ 500	$ 500	$ -	$ 600	$ 600
Non-current liability	302,372	5,054	307,426	254,121	4,987	259,108
	$ 302,372	$ 5,554	$ 307,926	$ 254,121	$ 5,587	$ 259,708

The components of net periodic benefit cost for the years ended September 30, 2019 and 2018 are as follows (in thousands):

September 30,	2019	2018
Components of net periodic benefit cost:		
Service cost	$ 181	$ 194
Interest cost	28,432	27,695
Expected return on plan assets	(11,154)	(16,045)
Effect of settlement	-	1,457
Amortization of prior service credit	(48)	(48)
Total net periodic benefit cost	$ 17,411	$ 13,253
Other change in benefit obligations recognized in accumulated other comprehensive income:		
(Gain) Loss due to assumption change	$ 111,382	$ (64,429)
Loss due to participant experience	4,849	14,118
Amortization of net loss	63	-
Asset return (gain) loss	(70,275)	30,483
Prior service cost	28	-
Total recognized in other comprehensive loss (income) and accumulated other comprehensive loss (income)	$ 46,047	$ (19,828)

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The assumptions used in determining the actuarial present value of the projected benefit obligations for pension plans as of September 30, 2019 and 2018 and for the years ended September 30, 2019 and 2018 are as follows:

	2019	2018
Weighted average assumptions used to determine benefit obligations at end of period		
Discount rate	**2.92-3.31%**	3.23-4.48 %
Rate of compensation increase	**0.00-2.00%**	0.00-2.00 %
Weighted average assumptions used to determine net periodic benefit cost for the period ended		
Discount rate	**4.24-4.48%**	3.49-4.41 %
Rate of compensation increase	**0.00-2.00%**	0.00-2.00 %
Expected return on the plan assets	**0.00-4.50%**	0.00-4.50 %

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

	2019	2018
Health care trend rate assumed for next year	**6.75%**	7.00%
Rate to which the cost trend is assumed to decline (the ultimate rate)	**4.50%**	4.50%
Year that the rate reaches the ultimate trend rate	**2027**	2026

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

	1% Increase	1% Decrease
Effect on other postretirement benefit obligations	$95	$87
Effect on total of service and interest cost components	$3	$3

The asset allocation percentage by major asset class for the plans and the target allocation for 2019 follows:

	Target	2019
Asset class:		
Cash and cash equivalents	0% - 20%	1 %
Fixed income	10% - 100%	95 %
Domestic equity	0% - 100%	
International equity	0% - 40%	
Real estate	0% - 30%	
Alternative investments and hedge funds	0% - 30%	4 %
		100 %

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

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

September 30, 2019	Level 1	Level 2	Level 3	Net asset value	Total
Fixed income securities:					
Short-Term Duration	$ -	$ 36,534	$ -	$ -	$ 36,534
Extended Duration	-	172,610	-	-	172,610
Interim Duration	-	48,328	-	-	48,328
Long-Term Duration	-	181,570	-	-	181,570
Real estate	-	-	1,056	-	1,056
Alternative investments	-	-	17,809	-	17,809
Cash and cash equivalents	-	-	-	2,781	2,781
Total	$ -	$ 439,042	$ 18,865	$ 2,781	$ 460,688

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

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

On an annual basis, the Company assesses the valuation hierarchy for pension assets recorded at fair value. From time to time, assets will be transferred within the fair value hierarchy as a result of changes in, among other things, inputs used, liquidity, or valuation methodologies. During the years ended September 30, 2019 and 2018, there were no transfers in classification within the fair value hierarchy.

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

September 30,	2019	2018
Balance, beginning of year	$ 21,555	$ 23,742
Actual return on plan assets:		
Realized loss	-	-
Unrealized (loss) gain	(2,690)	(2,187)
Purchases	-	-
Sales	-	-
Balance, end of year	$ 18,865	$ 21,555

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

2020	$ 44,970
2021	40,450
2022	41,940
2023	42,760
2024	43,750
2025 - 2029	216,990
	$ 430,860

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

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

The following table presents Waterbury's participation in these plans as of and for the years ended September 30, 2019 and 2018.

Pension Trust Fund	EIN / Pension Plan	Pension Protection Act ("PPA") Certified Zone Status *(1)*		FIP / RP Status Pending / Implemented *(2)*	Contributions		Surcharge Imposed	Exp. Date of CBA
		2019	2018		2019	2018		
Connecticut Health Care Associates Pension Fund	06-1313462	Red	Red	Implemented	$2,122,000	$2,140,000	No	7/1/22
New England Health Care Employees Pension Fund	22-3071963	Green	Green	NA	754,000	821,000	No	3/15/21
Total contributions					$2,876,000	$2,961,000		

(1) The most recent PPA zone status available in 2019 is for the plan's year-ending during 2018. The zone status is based on information received from the plan and is certified by the plan's actuary. Among other factors, plans in the red zone are generally less than 65 percent funded, plans in the orange zone are less than 80 percent funded and have an accumulated funding deficiency in the current year or projected in the next six years, plans in the yellow zone are less than 80 percent funded, and plans in the green zone are at least 80 percent funded.

(2) The "FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan ("FIP") or a rehabilitation plan ("RP") is either pending or has been implemented. As it relates to the Connecticut Health Care Associates ("CHCA") Pension Plan, the trustees adopted a Rehabilitation Plan on May 7, 2018. The Rehabilitation Period, as defined, commenced on January 1, 2019 and ends on December 31, 2028. The trustees updated the Rehabilitation Plan on December 12, 2019 which reflects various reductions to plan benefits effective January 1, 2020.

During the years ended September 30, 2019 and 2018, Waterbury's contributions to the CHCA Pension Plan and the New England Health Care Employees Pension Plan represented 98.1% and 2.4% and 98.2% and 2.6% of the total contributions made to the plans by all participating employers, respectively.

Governmental regulations impose certain requirements relative to union-sponsored pension plans. In the event of plan termination or employer withdrawal, an employer may be liable for a portion of the plan's unfunded vested benefits. As of September 30, 2019, Waterbury has not recorded any liabilities for future withdrawal obligations related to the multi-employer plans.

Defined contribution plans

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

plans, employees can contribute up to 50% of their compensation up to the IRS deferred annual maximum. There is currently no company match offered under the plans, except at certain facilities in Rhode Island and Pennsylvania, for which the expense for the employer match was $18,863,000 and $19,723,000 for the years ended September 30, 2019 and 2018, respectively.

13. Commitments and Contingencies

Leases

The Company leases various office facilities and equipment from third parties under non-cancelable operating and capital lease arrangements expiring at various dates through 2034. Certain operating leases contain rent escalation clauses and renewal options, which have been factored into determining rent expense on a straight-line basis over the lease terms. Capital leases bear interest at rates ranging from 2.5% to 41.0% per annum.

The future minimum annual lease payments required under leases in effect at September 30, 2019, are as follows (in thousands):

For the Years ending September 30,	Capital Leases	Operating Leases	MPT Liability*
2020	$ 12,661	$ 22,455	$ 103,935
2021	9,157	18,685	106,273
2022	4,903	16,987	109,461
2023	4,018	14,195	112,745
2024	2,889	12,887	116,128
Thereafter	19,855	56,273	1,358,111
Total minimum lease payments	53,483	$ 141,482	1,906,653
Less: amounts representing interest	(12,873)		(572,644)
Add: amounts representing land	-		47,176
	40,610		1,381,185
Less: current portion	(10,238)		(43,145)
	$ 30,372		$ 1,338,040

* *Excludes debt related to the Foothill and TRS Notes entered into in fiscal 2019 with MPT (see Note 10).*

Rent expense related to operating leases for the years ended September 30, 2019 and 2018 was approximately $44,959,000 and $46,124,000, respectively. Sublease rental income was not material to the consolidated financial statements for the years ended September 30, 2019 and 2018.

Litigation

The Company is subject to a variety of claims and suits that arise from time to time in the ordinary course of its business, acquisitions, or other transactions. While the Company's management currently believes that resolving all of these matters, individually or in the aggregate, will not have a material adverse impact on the Company's consolidated financial position or results of operations, the litigation

and other claims that the Company faces are subject to inherent uncertainties and management's view of these matters may change in the future. Should an unfavorable final outcome occur, there exists the possibility of a material adverse impact on the Company's consolidated financial position, results of operations and cash flows for the period in which the effect becomes probable and reasonably estimable.

Seismic Standards

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

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

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

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

Recently enacted Assembly Bill 2190 (AB-2190) was utilized to request additional extension. OSHPD granted extensions to 06/01/2022, 10/01/2021, and 02/01/2021 for Tower Building (at SCH Culver City), Pavilion Building (at SCH Culver City), and LACH respectively. For all three buildings, the construction must start by April 1, 2020 for AB-2190 extensions to be valid. SCH-Culver City is evaluating pursuing an alternate "replacement" scheme that would relocate the Emergency department into the adjoining One-Story Building which currently classified as an SPC-2 structure. The Tower Building would be retained as a 'non-hospital' OSHPD building useable for lower acuity services such as behavioral health and subacute/skilled nursing services.

The Company will also be required to make significant capital expenditures in the future to comply with 2030 seismic standards (i.e., upgrade to SPC-4D and NPC-4D/5) for any buildings that will be utilized for hospital facilities beyond January 1, 2030. Such modifications to the hospital facilities could potentially result in environmental remediation liabilities which may be material to the Company.

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

Legislation and HIPAA

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

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

The Health Insurance Portability and Accountability Act ("HIPAA") assures health insurance portability, reduces healthcare fraud and abuse, guarantees security and privacy of health information, and enforces standards for health information. The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") expanded upon HIPAA in a number of ways, including establishing notification requirements for certain breaches of protected health information. In addition to these federal rules, states have also developed their own standards for the privacy and security of health information as well as for reporting certain violations and breaches (for example, California's Confidentiality of Medical Information Act and Lanterman-Petris Short Act) which in some cases are more stringent. Other federal privacy laws may also apply to certain services provided by the Company, including 42 C.F.R. Part 2, which addresses the confidentiality of substance use disorder records. The Company may be subject to significant fines and penalties if found not to be compliant with these state or federal provisions.

Affordable Care Act

The Patient Protection and Affordable Care Act ("PPACA") has made significant changes to the United States health care system. The legislation impacted multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Under this legislation, 33 states have expanded their Medicaid programs to cover previously uninsured childless adults, and four additional states voted in 2018 to expand Medicaid or to elect a governor that pledged to expand Medicaid. In addition, many uninsured individuals have had the opportunity to purchase health insurance via state-based marketplaces, state-based marketplaces using a federal platform, state-partnership marketplaces or the federally-facilitated marketplace. PPACA also implemented a number of health insurance market reforms, such as allowing children to remain on their parents' health insurance until age 26 or prohibiting certain plans from denying coverage based on pre-existing conditions. Nationally, these reforms have reduced the number of uninsured individuals.

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

Collective Bargaining Agreements

As of September 30, 2019, the Company had approximately 17,800 employees, of whom approximately 5,500 employees or 31% are represented by various labor organizations. Of those, approximately 1,300 employees or 7% of the Company's employees are employed under union contracts that have expired or will expire before September 30, 2020.

Tangible Net Equity ("TNE") Requirement

The Company's affiliated California physician organizations and licensed healthcare service plans may be subject to one or more of the following requirements: minimum working capital, Tangible Net Equity, cash-to-claims ratio and claims payment requirements as prescribed by the California Department of Managed Health Care ("DMHC"). TNE is defined as net assets, less intangibles and amounts due from affiliates, plus subordinated obligations. As of September 30, 2019, the Company's affiliated California physician organizations were in compliance with these regulatory requirements.

Employee Health Plans

The Company offers self-insured EPO/HMO and PPO plans to all eligible employees.

Employee health benefits are administered by a third party claims administrator, based on plan coverage and eligibility guidelines determined by the Company, as well as by collective bargaining agreements (as reflected above). Prior to January 1, 2018, commercial insurance policies covered per occurrence losses. Effective January 1, 2018, all locations were covered by insurance policies with CHIC for per occurrence losses in excess of $350,000, except for Crozer for which the limit is $750,000. CHIC maintains reinsurance coverage above $500,000 for all locations except for Crozer, for which the limit is $750,000. An actuarially and internally-estimated liability of approximately $12,808,000 and $16,566,000 for incurred but not reported claims has been included in accrued salaries, wages, and benefits as of September 30, 2019 and 2018, respectively.

Provider Contracts

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

14. Accrued Medical Claims and Other Healthcare Costs Payable

The following table presents the roll-forward of incurred but not reported ("IBNR") claims reserves (Medical Group segment, Global Risk Management segment, and full risk contracts) as of and for each of the years ended September 30, 2019 and 2018 (in thousands):

September 30,	2019	2018
IBNR as of beginning of year	$ 62,887	$ 53,510
Claim expenses incurred during the year:		
Related to current year	296,817	301,598
Related to prior year	4,523	8,667
Total incurred	301,340	310,265
Claims paid during the year:		
Related to current year	(229,417)	(246,369)
Related to prior year	(62,302)	(54,519)
Total paid	(291,719)	(300,888)
IBNR as of end of year	$ 72,508	$ 62,887

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

Years Ended September 30,	2019	2018
Capitation expense	$ 98,254	$ 96,027
Fee-for-service claims expense	167,702	171,443
Other physician compensation	24,561	15,097
Other cost of revenues	2,558	5,239
Total cost of revenues	$ 293,075	$ 287,806

15. Joint Ventures and Unconsolidated Equity Investments

The Company has invested in several joint ventures with unrelated third parties, which are accounted for under the equity method of accounting. As of September 30, 2019 and 2018, CharterCARE owned: 20% of Roger Williams Radiation Therapy and 20% of Southern New England Regional Cancer Center, LLC. ECHN owned: 50% of NRRON, LLC; 50% of Aetna Ambulance Service, Inc.; 50% of Ambulance Service of Manchester, LLC; and 50% of Evergreen Endoscopy Center, LLC. Waterbury owned: 50% of Harold Leever Regional Cancer Center Inc. Crozer owned: 50% of University Technology Park, Inc. and 21.25% of Delaware Valley Sleep Management Company, LLC. Prospect Medical Group, Inc. owned: 50% of AMVI/Prospect Medical Group. These joint ventures under the equity method are included in the other assets in the accompanying consolidated balance sheets as of September 30, 2019 and 2018 are $28,119,000 and $24,627,000, respectively. For the years ended September 30, 2019 and 2018, the Company received $1,828,000 and $1,746,000, respectively, in distributions for equity method investments, and $527,000 and $404,000, respectively, for cost method investments.

Summarized combined unaudited financial information for the Company's joint ventures as of September 30, 2019 and 2018 and for the years then ended is as follows (in thousands):

September 30,	2019	2018
Cash	$ 18,976	$ 17,226
Receivables	10,096	8,060
Other current assets	21,329	23,654
Total current assets	50,401	48,940
Property, improvements and equipment, net	32,972	33,757
Goodwill	7,142	7,142
Intangible assets	821	852
Other long-term assets	2,904	3,094
Total assets	94,240	93,785
Accounts payable and accrued liabilities	5,827	5,563
Other long-term liabilities	6,116	5,334
Equity	82,297	82,888
Total liabilities and partner's capital	$ 94,240	$ 93,785

Years ended September 30,	2019	2018
Revenues	$ 74,095	$ 67,554
Net income	$ 12,178	$ 5,039
PMH's income from equity method investments	$ 5,358	$ 1,332

16. Subsequent Events

The Company has evaluated subsequent events through December 20, 2019, the date the Company's consolidated financial statements were available for issuance.

Effective October 2, 2019, Ivy Holdings entered into an Agreement and Plan of Merger ("Merger Agreement") with Chamber, Inc. ("Chamber"), Chamber Merger Sub, Inc. and affiliates of LGP. Chamber is owned by two individuals who hold the largest individual shareholdings in Ivy Holdings. The Merger Agreement contemplates, among other things, (i) the purchase of Ivy Holdings by and merger into by Chamber Merger Sub, Inc. (ii) the buyout of all of the other current stockholders of Ivy Holdings, (iii) the termination of all options that have not previously been exercised. The Merger Agreement is subject to regulatory approval by various state agencies and is expected to close during the year ended September 30, 2020.