Consolidated Financial Statements

Prime Healthcare Services, Inc. and Subsidiaries
Years Ended December 31, 2018, 2017, and 2016
With Report of Independent Auditors

Ernst & Young LLP

Building a better working world

Prime Healthcare Services, Inc. and Subsidiaries

Consolidated Financial Statements

Years Ended December 31, 2018, 2017, and 2016

Contents

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Report of Independent Auditors

The Board of Directors
Prime Healthcare Services, Inc. and Subsidiaries

We have audited the accompanying consolidated financial statements of Prime Healthcare Services, Inc. and Subsidiaries, which comprise the consolidated balance sheets as of December 31, 2018 and 2017, and the related consolidated statements of operations, comprehensive income (loss), stockholder's equity, and cash flows for each of the three years in the period ended December 31, 2018, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the 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 financial statements.

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

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Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Prime Healthcare Services, Inc. and Subsidiaries at December 31, 2018 and 2017, and the consolidated results of their operations and their cash flows for each of the three years in the period ended December 31, 2018, in accordance with U.S. generally accepted accounting principles.

Ernst & Young LLP

April 30, 2019

Prime Healthcare Services, Inc. and Subsidiaries

Consolidated Balance Sheets
(Dollars in Thousands)

	December 31 2018	December 31 2017
Assets		
Current assets:		
Cash and cash equivalents*	**$ 194,526**	$ 171,942
Restricted cash*	**869**	–
Patient accounts receivable, less allowances of $248,839 and $276,762 at December 31, 2018 and 2017, respectively*	**451,769**	486,031
Estimated third-party payor settlements	**55,778**	47,365
Provider fee receivable	**314,310**	312,330
Supplies inventory*	**62,290**	62,897
Prepaid expenses and other current assets*	**77,177**	78,015
Short-term investments	**1,138**	5,097
Related-party receivables*	**30,705**	6,075
Total current assets	**1,188,562**	1,169,752
Property and equipment, net of accumulated depreciation and amortization*	**1,254,356**	1,305,650
Insurance claims and reserves recoverable*	**148,577**	122,129
Goodwill	**40,809**	40,430
Other assets*	**27,985**	29,565
Total assets	**$ 2,660,289**	$ 2,667,526

*Account balances contain assets of the consolidated variable interest entities that can only be used to settle obligations of the variable interest entities (see Note 1).

See accompanying notes to consolidated financial statements.

Prime Healthcare Services, Inc. and Subsidiaries

Consolidated Balance Sheets (continued)
(Dollars in Thousands, Except Share Data)

	December 31 2018	December 31 2017
Liabilities and stockholder's equity		
Current liabilities:		
Accounts payable*	**$ 149,867**	$ 176,769
Accrued expenses*	**252,965**	242,350
Medical claims payable	**13,878**	6,533
Current portion of related-party payables*	**58,786**	40,249
Estimated third-party payor settlements	**29,011**	57,707
Provider fee payable	**152,779**	169,900
Current portion of capital leases*	**66,208**	67,062
Current portion of long-term debt*	**63,546**	20,612
Total current liabilities	**787,040**	781,182
Long-term liabilities:		
Revolving credit facility	**299,776**	336,139
Sale leaseback liability	**651,933**	651,229
Insurance claims liabilities and reserves*	**192,326**	165,967
Related-party payables, net of current portion*	–	30,000
Pension liabilities	**25,722**	25,832
Capital leases, net of current portion*	**93,186**	136,089
Long-term debt, net of current portion*	**477,342**	494,216
Other long-term liabilities	**43,457**	33,830
Total long-term liabilities	**1,783,742**	1,873,302
Stockholder's equity:		
Common stock, $0.01 par value, 3,000 shares authorized, 30 shares issued and outstanding	–	–
Additional paid-in capital	**3**	3
Accumulated other comprehensive loss	**(8,739)**	(7,536)
Accumulated deficit	**(264,284)**	(350,700)
Noncontrolling interest	**362,527**	371,275
Total stockholder's equity	**89,507**	13,042
Total liabilities and stockholder's equity	**$ 2,660,289**	$ 2,667,526

*Account balances contain liabilities of the consolidated variable interest entities for which creditors do not have recourse to the general credit of the Company (see Note 1).

See accompanying notes to consolidated financial statements.

Prime Healthcare Services, Inc. and Subsidiaries

Consolidated Statements of Operations

(Dollars in Thousands)

	Year Ended December 31		
	2018	**2017**	**2016**
Revenue			
Patient service revenue (net of contractual allowances and discounts)	**$ 4,089,204**	$ 4,232,340	$ 4,028,093
Provision for doubtful accounts	**(693,656)**	(866,378)	(698,780)
Net patient service revenue, less provision for doubtful accounts	**3,395,548**	3,365,962	3,329,313
Premium revenue	**18,939**	20,593	19,909
Other operating revenue	**212,758**	222,879	137,971
	3,627,245	3,609,434	3,487,193
Operating expenses			
Compensation and employee benefits	**1,744,245**	1,741,264	1,823,128
General and administrative	**458,938**	503,325	487,333
Supplies	**437,979**	486,217	535,941
Professional services	**412,105**	410,974	462,677
Depreciation and amortization	**172,388**	167,864	156,042
Rent and lease	**75,844**	70,109	69,274
Medical claims	**65,919**	53,318	5,105
Intangible and goodwill impairments	**50**	44,879	32,961
	3,367,468	3,477,950	3,572,461
Income (loss) from operations	**259,777**	131,484	(85,268)
Interest expense	**(147,557)**	(149,270)	(171,740)
Other nonoperating income (loss)	**4,076**	1,535	(63)
Income (loss) before income taxes	**116,296**	(16,251)	(257,071)
Income tax	**(1,513)**	(1,985)	(2,645)
Net income (loss)	**114,783**	(18,236)	(259,716)
Net income attributable to noncontrolling interest	**(24,939)**	(15,866)	(93,539)
Net income (loss) attributable to controlling interest	**$ 89,844**	$ (34,102)	$ (353,255)

See accompanying notes to consolidated financial statements.

Prime Healthcare Services, Inc. and Subsidiaries

Consolidated Statements of Comprehensive Income (Loss)

(Dollars in Thousands)

	Year Ended December 31		
	2018	**2017**	**2016**
Net income (loss)	**$ 114,783**	$ (18,236)	$ (259,716)
Unrealized gain in foreign translations	**116**	–	–
Unrealized loss in defined benefit pension plan	**(1,319)**	(716)	(918)
Comprehensive income (loss)	**113,580**	(18,952)	(260,634)
Less comprehensive income attributable to noncontrolling interest	**(24,939)**	(15,866)	(93,539)
Comprehensive income (loss) attributable to controlling interest	**$ 88,641**	$ (34,818)	$ (354,173)

See accompanying notes to consolidated financial statements.

Prime Healthcare Services, Inc. and Subsidiaries

Consolidated Statements of Stockholder's Equity

(Dollars in Thousands, Except Share Data)

	Shares	Common Stock	Additional Paid-In Capital	Accumulated Other Comprehensive Loss	Retained Earnings (Accumulated Deficit)	Noncontrolling Interest	Total
Balance, December 31, 2015	30	$ –	$ 3	$ (5,902)	$ 107,624	$ 296,563	$ 398,288
Distribution of Landmark Medical Center, Rehabilitation Hospital of Rhode Island, and Landmark Physician Office Services	–	–	–	–	(66,652)	–	(66,652)
Unrealized loss in defined benefit pension plan	–	–	–	(918)	–	–	(918)
Cash distributions	–	–	–	–	(1,642)	(26,329)	(27,971)
Controlling interest in net loss	–	–	–	–	(353,255)	–	(353,255)
Noncontrolling interest in net income	–	–	–	–	–	93,539	93,539
Balance, December 31, 2016	30	–	3	(6,820)	(313,925)	363,773	43,031
Unrealized loss in defined benefit pension plan	–	–	–	(716)	–	–	(716)
Cash distributions	–	–	–	–	(2,861)	(8,988)	(11,849)
Other	–	–	–	–	188	624	812
Controlling interest in net loss	–	–	–	–	(34,102)	–	(34,102)
Noncontrolling interest in net income	–	–	–	–	–	15,866	15,866
Balance, December 31, 2017	30	–	3	(7,536)	(350,700)	371,275	13,042
Unrealized gain in foreign translations	–	–	–	**116**	–	–	**116**
Unrealized loss in defined benefit pension plan	–	–	–	**(1,319)**	–	–	**(1,319)**
Cash distributions	–	–	–	–	**(1,270)**	**(33,990)**	**(35,260)**
Other	–	–	–	–	**(2,158)**	**303**	**(1,855)**
Controlling interest in net income	–	–	–	–	**89,844**	–	**89,844**
Noncontrolling interest in net income	–	–	–	–	–	**24,939**	**24,939**
Balance, December 31, 2018	**30**	**$ –**	**$ 3**	**$ (8,739)**	**$ (264,284)**	**$ 362,527**	**$ 89,507**

See accompanying notes to consolidated financial statements.

Prime Healthcare Services, Inc. and Subsidiaries

Consolidated Statements of Cash Flows

(Dollars in Thousands)

	Year Ended December 31		
	2018	**2017**	**2016**
Operating activities			
Net income (loss)	**$ 114,783**	$ (18,236)	$ (259,716)
Adjustments to reconcile net income (loss) to net cash provided by operating activities:			
Depreciation and amortization	**172,388**	167,864	156,042
(Gain) loss on sale of assets	**(4,076)**	(1,535)	63
Provision for doubtful accounts	**693,656**	866,378	698,780
Other intangible and goodwill impairment	**50**	44,879	32,961
Other	–	(2,942)	–
Loss on extinguishment and amortization of deferred debt issuance costs	**3,716**	2,584	11,924
Net realized and unrealized loss (gain) on investments	**223**	(555)	(165)
Changes in assets and liabilities, net of hospital acquisitions/distributions:			
Patient accounts receivable	**(659,394)**	(823,095)	(530,010)
Supplies inventory	**607**	5,505	(592)
Prepaid expenses and other current assets	**838**	26,205	(11,463)
Other assets	**(4,696)**	3,290	5,332
Related-party receivables/payables	**(26,093)**	(8,157)	16,930
Accounts payable	**(30,711)**	(85,233)	(37,268)
Accrued expenses, insurance claims liabilities and reserves, and other long-term liabilities	**3,647**	52,282	44,941
Medical claims payable	**7,345**	3,243	992
Estimated third-party payor settlements and provider fee	**(56,210)**	(62,706)	9,494
Net cash provided by operating activities	**216,073**	169,771	138,245
Investing activities			
Purchase of property and equipment	**(77,192)**	(93,571)	(112,457)
Proceeds from sale of assets	**3,035**	–	–
Purchases of investments	**(2,492)**	(4,286)	(11,135)
Proceeds from sale of investments	**6,698**	7,225	3,821
Cash assumed with acquisitions, net of cash acquired	–	–	2,841
Net cash used in investing activities	**(69,951)**	(90,632)	(116,930)
Financing activities			
Payments of loan issuance costs	**(2,188)**	–	(12,661)
Proceeds from borrowings on sale leaseback	–	–	15,000
Repayments on line of credit	–	–	(175,454)
(Repayments) borrowings on revolving credit facility	**(36,378)**	12,418	323,721
Payments on long-term debt	**(22,405)**	(40,181)	(250,841)
Payments on capital lease obligations	**(67,307)**	(47,714)	(45,610)
Proceeds from long-term debt borrowing	**50,000**	8,142	212,035
Payments on related-party note	**(10,000)**	–	–
Cash distributions	**(35,260)**	(11,849)	(27,971)
Cash distributed with distributions of hospitals	–	–	(808)
Net cash (used in) provided by financing activities	**(123,538)**	(79,184)	37,411
Net increase (decrease) in cash and cash equivalents	**22,584**	(45)	58,726
Cash and cash equivalents, beginning of year	**171,942**	171,987	113,261
Cash and cash equivalents, end of year	**$ 194,526**	$ 171,942	$ 171,987

Prime Healthcare Services, Inc. and Subsidiaries

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	Year Ended December 31		
	2018	**2017**	**2016**
Supplemental cash flow information			
Cash paid during the year for:			
Interest	**$ 140,253**	$ 151,887	$ 156,264
Income taxes	**$ 1,457**	$ 5,456	$ 1,600
Supplemental disclosure of noncash investing and financing activities			
Financing obligations incurred for the acquisition of property and equipment	**$ 25,047**	$ 47,692	$ 68,162
Property, plant, and equipment included in accounts payable	**$ 3,809**	$ 4,943	$ 2,216
Noncash distribution of hospital to stockholder	**$ –**	$ –	$ 66,652
Financed asset under construction	**$ 14,324**	$ –	$ –
Sale leaseback of facilities	**$ –**	$ –	$ 63,000
Conversion of debt to sale leaseback	**$ –**	$ –	$ 100,000

See accompanying notes to consolidated financial statements.

1. Basis of Presentation and Significant Accounting Policies

Nature of Business

Prime Healthcare Services, Inc. and Subsidiaries (collectively, the "Company" or "PHSI") owns and operates general acute care hospitals in communities across the United States. The Company is a wholly owned subsidiary of Prime Healthcare Holdings, Inc. ("PHHI").

As of December 31, 2018, the Company wholly owned and operated 30 acute care hospitals, with 6,073 licensed beds located in various communities in 11 states. The Company's operations also include medical groups and other operations related to its hospital business.

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 ("U.S. GAAP") and include the accounts of the Company, and its subsidiaries, all of which are controlled by the Company through majority voting control and variable interest entities for which the Company is the primary beneficiary.

The Company has a variable interest in certain medical groups and other entities. The other entities primarily consist of Prime Healthcare Management, Inc. ("PHM") and Prime Healthcare Management II, Inc. ("PHM II"). PHM provides management services to certain PHSI hospitals. PHM II provides management services to certain PHSI hospitals and Prime Healthcare Foundation ("PHF") hospitals. The Company has determined that certain medical groups are variable interest entities ("VIE"s) due to the equity interest holder's lack of ability to exercise control. The Company has determined that the other entities are variable interest entities due to a lack of sufficient equity at risk. The Company has also determined that it is the primary beneficiary of the medical groups and other entities because the Company has both of the following: (1) the power to direct the activities of the VIE that most significantly impact the VIE's economic performance and (2) the obligation to absorb losses of, or the right to receive benefits from, the VIE that could potentially be significant to the VIE. Accordingly, the Company has consolidated these entities. The creditors of these variable interest entities do not have recourse to the general credit of the primary beneficiary.

All intercompany accounts and transactions have been eliminated upon consolidation. Noncontrolling 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 noncontrolling owners.

(Dollars in Thousands)

1. Basis of Presentation and Significant Accounting Policies (continued)

The equity of the VIEs has been reflected as a noncontrolling interest as of December 31, 2018 and 2017. The consolidation of these entities does not change any legal ownership, and does not change the assets or the liabilities and equity of PHSI as a stand-alone entity. These entities had total revenues of approximately $238,374, $273,667 and $289,379 (including revenues of $122,079, $163,050, $204,991 related to PHSI) for the years ended December 31, 2018, 2017, and 2016, respectively. The 2017 decrease in revenues is the result of PHMI and PHMII changing the method of calculating management fees charged to PHSI hospitals.

Total assets and total liabilities of VIEs are as follows:

	December 31	
	2018	**2017**
Assets		
Current assets:		
Cash and cash equivalents	**$ 9,497**	$ 4,377
Restricted cash	**254**	–
Patient accounts receivable, net	**3,702**	4,738
Supplies inventory	**208**	95
Related-party receivables	**364,696**	395,301
Notes receivable	**263**	93
Prepaid expenses and other current assets	**3,622**	3,658
Total current assets	**382,242**	408,262
Property and equipment, net	**59,263**	61,636
Insurance claims and reserves recoverable	**1,818**	4,330
Other assets	**3,845**	3,761
Total assets	**$ 447,168**	$ 477,989
Liabilities		
Current liabilities:		
Accounts payable	**$ 5,440**	$ 10,813
Accrued expenses	**19,180**	17,047
Current portion of related-party payables	**20,000**	–
Current portion of capital lease	**4,113**	3,300
Current portion of long-term debt	**8,431**	10,664
Total current liabilities	**57,164**	41,824
Insurance claims liabilities and reserves	**3,157**	5,917
Related-party payables, net of current portion	–	30,000
Capital leases, net of current portion	**1,660**	4,046
Long-term debt, net of current portion	**23,893**	20,654
Total liabilities	**$ 85,874**	$ 102,441

(Dollars in Thousands)

1. Basis of Presentation and Significant Accounting Policies (continued)

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Revenues are recorded during the period the health care services are provided, based upon the estimated amounts due from the patients and third-party payors. In some cases, reimbursement is based on formulas which cannot be determined until cost reports are filed and audited or otherwise settled by the various programs. See Note 2 for further discussion of the Company's payment arrangements with its third-party payors.

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

	Year Ended December 31		
	2018	**2017**	**2016**
Medicare	**$ 1,464,123**	$ 1,561,204	$ 1,412,950
Medicare Managed Care	**549,019**	499,043	437,128
Medicaid	**258,396**	266,890	254,934
Medicaid Managed Care	**478,600**	492,700	428,527
Commercial – contracted	**926,275**	988,747	992,177
Commercial – non-contracted	**321,223**	293,344	285,593
Self-pay/other	**91,568**	130,412	216,784
	$ 4,089,204	$ 4,232,340	$ 4,028,093

Charity Care

The Company provides 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 $47,187, $36,281, and $54,838 for the years ended December 31, 2018, 2017, and 2016, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges

1. Basis of Presentation and Significant Accounting Policies (continued)

associated with providing care to charity patients. In addition, the Company provides services to other medically indigent patients under various state Medicaid programs. Depending on the state, such programs pay amounts that are less than the cost of the services provided to the recipients.

Allowance for Contractual Adjustments and Doubtful Accounts

The Company's patient accounts receivable are reduced by allowances for contractual adjustments and doubtful accounts. In evaluating the collectability of patient accounts receivable, the Company analyzes its historical collections and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowances for contractual adjustments and doubtful accounts. Management regularly reviews data from these major payor sources of revenue in evaluating the sufficiency of these allowances. For receivables associated with self-pay patients, the Company records a provision for doubtful accounts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the expected rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

Premium Revenue and Medical Claims Expense

The Company has agreements with various Health Maintenance Organizations ("HMO"s) to provide medical services to enrollees. Under these agreements, the Company receives monthly premium revenue based on the number of each HMO's enrollees, regardless of services actually performed by the Company. Premium revenue under HMO contracts is recognized during the period in which the Company is obligated to provide services. Certain HMO contracts also contain shared-risk provisions, whereby the Company can earn additional incentive revenue or incur penalties based upon the utilization of inpatient hospital services by assigned HMO enrollees. The Company estimates shared-risk revenue and expenses based upon inpatient and outpatient utilization.

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.

1. Basis of Presentation and Significant Accounting Policies (continued)

Other Operating Revenue

Other operating revenue consists of fees earned by the Company for management services provided to PHF, equipment procurement services, outsourced business office, information technology support services, coding and other revenue cycle services provided to PHF (see Note 9).

Supplies Inventory

Supplies inventory is stated at the lower of cost, determined by the average cost method, or net realizable value. Inventories consist primarily of medical and surgical supplies and pharmaceuticals.

Property and Equipment

Property and equipment is stated at cost or, in the case of acquisitions, at their acquisition date fair values. Depreciation is computed using the straight-line method over the estimated useful lives of the assets, which range from 3 to 30 years. Amortization of leasehold improvements is computed over the lesser of the lease term or the estimated useful lives of the assets and is included in depreciation and amortization expense. Equipment capitalized under capital lease obligations is amortized over the lesser of the life of the lease term or the useful life of the asset.

Long-Lived Assets

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 the planned use of intangible assets 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

1. Basis of Presentation and Significant Accounting Policies (continued)

remaining net book value over the adjusted remaining useful life. The Company recorded a $50 impairment related to a noncompete agreement during the year ended December 31, 2018. There were no impairments of long-lived assets recorded during the years ended December 31, 2017, and 2016.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Principal areas requiring the use of estimates include third-party settlements; allowances for contractual discounts and doubtful accounts; impairment of goodwill; impairment and useful lives of long-lived assets; professional liability, general liability, and medical claims reserves; and reserves for legal contingencies.

Income Taxes

The Company has elected to be taxed under the provisions of subchapter S of the Internal Revenue Code ("IRC"). Under these provisions, the Company does not pay federal corporate income taxes on its taxable income. However, the Company is subject to a 1.5% California franchise tax along with applicable income taxes in the states where the Company has operations. The stockholder of PHSI is taxed on their proportionate share of the Company's taxable income as defined by the IRC. The Company distributes funds necessary to satisfy the stockholder's tax liability. Based on tax positions taken, or to be taken, by the applicable stockholder, $164,000 and $7,000 of income previously taxed as of December 31, 2018 and 2017, respectively, could, if available, be distributed to the stockholder of PHSI and $315,000 and $363,000, respectively, of income previously taxed could, if available, be distributed to the stockholder of PHM and PHM II.

The literature related to uncertain tax positions prescribes a recognition threshold and measurement process for accounting for uncertain tax positions and also provides guidance on various related matters such as derecognition, interest, penalties, and disclosures required. The Company does not have any entity-level uncertain tax positions. The Company files income tax returns in the U.S. federal jurisdiction and various state and local jurisdictions. Generally, the

1. Basis of Presentation and Significant Accounting Policies (continued)

Company is subject to examination by federal tax authorities for three years from the filing of a tax return and state and local tax authorities for four years from the filing of the state tax return. The Company is currently under examinations by U.S. federal for 2012 tax year and by the California Franchise Tax Board for tax years 2009 to 2016.

Deferred tax assets ("DTAs") and liabilities are recorded for differences between the financial statement and tax basis of the assets and liabilities that will result in taxable or deductible amounts in the future based on enacted laws and rates applicable to the periods in which the differences are expected to affect taxable income. The company has recorded a full valuation allowance over its deferred tax assets and liabilities based on the weight of available evidence that it is more likely than not that its DTAs will be realized. The major components of the Company's DTAs relate to the allowance for doubtful accounts and fixed assets.

Cash and Cash Equivalents

The Company considers all highly liquid investments with an original maturity of three months or less when purchased to be cash equivalents.

Other Assets

Other assets primarily consist of intangible assets arising from business combinations (see Note 4) and equity method investments.

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.

Management evaluates goodwill for impairment on an annual basis (October 1) and whenever events and changes in circumstances suggest that the carrying amount may not be recoverable. 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 values of the reporting units are estimated using a combination of the income or discounted cash flow approach and the guideline merged and acquired company approach, which uses comparable market data.

1. Basis of Presentation and Significant Accounting Policies (continued)

On January 1, 2017, the Company early adopted Financial Accounting Standards Board ("FASB") Accounting Standards Update ("ASU") 2017-04, *Simplifying the Test for Goodwill Impairment*. Prior to the adoption of ASU 2017-04, there was a two-step method for determining goodwill impairment. Step one was to compare the fair value of the reporting unit with the unit's carrying amount, including goodwill. If this test indicated the fair value was less than the carrying value, then step two was required to compare the implied fair value of the reporting unit's goodwill utilizing a hypothetical purchase price allocation with the carrying value of the reporting unit's goodwill. The new guidance eliminates the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment charge. Instead, entities record an impairment charge based on the excess of a reporting unit's carrying amount over its fair value. The Company performed its last annual goodwill evaluation on October 1, 2018.

During the year ended December 31, 2017, the Company determined that goodwill related to Lower Bucks Hospital, Saint Mary's Regional Medical Center and Medical Group, and St. Mary's General Hospital was fully impaired. Accordingly, the Company recorded a charge to the consolidated statements of operations of $44,879.

During the year ended December 31, 2016, the Company determined that goodwill related to Dallas Medical Center, Dallas Regional Medical Center, Riverview Regional Medical Center, North Vista Hospital, Lehigh Regional Medical Center, and High Desert Heart Vascular Institute was fully impaired. Accordingly, the Company recorded a charge to the consolidated statements of operations of $32,961.

The impairments recorded in 2017 and 2016 were the result of lower projected future earnings of the impaired reporting units and were calculated under the two-step method mentioned above. No impairments related to goodwill were recognized in 2018, as the fair values exceeded the carrying amounts of each reporting unit.

1. Basis of Presentation and Significant Accounting Policies (continued)

Fair Value of Financial Instruments

The Company's consolidated balance sheets include the following financial instruments: cash and cash equivalents, restricted cash, patient accounts receivable, short-term investments, related-party receivables and payables, accounts payable, accrued expenses, and long-term debt. The Company considers the carrying amounts of current assets and current liabilities in the consolidated balance sheets to approximate the fair value of these financial instruments and their expected realization. As long-term debt has variable interest rates, the carrying value approximates fair value in the consolidated balance sheets.

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.

Financial Items Measured at Fair Value on a Recurring Basis

The Company sponsors the Garden City Hospital Osteopathic Employee Pension Plan (the "Plan"). The Plan includes investments which are measured at fair value on a recurring basis. The majority of the Plan's investments are recorded at net asset value as a practical expedient for fair value. The remaining investments are measured using Level 3 inputs (see Note 11).

1. Basis of Presentation and Significant Accounting Policies (continued)

Concentration of Credit Risk

Cash and cash equivalents are maintained at financial institutions and, generally, balances may exceed federally insured limits of $250 per depositor at each financial institution. The Company has not experienced any losses to date related to these balances. Management monitors the financial condition of these institutions on an ongoing basis and does not believe any significant credit risk exists as of December 31, 2018.

At December 31, 2018 and 2017, patient accounts receivable were comprised of the following government programs; Medicare 39% and 41%, respectively; Medicaid 17% and 17%, respectively; health maintenance and preferred provider organizations (managed care programs) 25% and 23%, respectively; and private pay and commercial insurance patients 19% and 19%, respectively. Management believes there are minimal credit risks associated with receivables from government programs. Receivables from managed care programs and others are from various payors who are subject to differing economic conditions and do not represent concentrated risks to the Company. Management continually monitors and adjusts the reserves associated with receivables.

Recent Accounting Pronouncements

In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers*, which outlines a single comprehensive model for recognizing revenue and supersedes most existing revenue recognition guidance, including guidance specific to the health care industry. ASU 2014-09 will require new and enhanced disclosures. Companies can adopt the new standard either using the full retrospective approach, a modified retrospective approach with practical expedients, or a cumulative effect upon adoption approach. In July 2015, the FASB issued a final ASU (ASU 2015-14, *Revenue from Contracts with Customers (Topic 606): Deferral of Effective Date*), that defers the effective date by one year, with early adoption permitted. This update is effective on January 1, 2019 for the Company. The Company will adopt the new standard effective January 1, 2019, and will use the modified retrospective approach. The Company is currently evaluating the impact of its pending adoption of the new standard on its consolidated financial statements.

1. Basis of Presentation and Significant Accounting Policies (continued)

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842)*. ASU 2016-02 establishes a right-of-use ("ROU") model that requires a lessee to record a ROU asset and a lease liability on the balance sheet for all leases with terms longer than 12 months. Leases will be classified as either finance or operating, with classification affecting the pattern of expense recognition in the income statement. The new standard will become effective for annual reporting periods beginning December 15, 2019. A modified retrospective transition approach is required for lessees for capital and operating leases existing at, or entered into after, the beginning of the earliest comparative period presented in the financial statements, with certain practical expedients available. The Company is currently evaluating the impact of its pending adoption of the new standard on its consolidated financial statements.

In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows (Topic 230)*: *Restricted Cash (a consensus of the FASB Emerging Issues Task Force)*, which provides guidance on the presentation of restricted cash or restricted cash equivalents on the statement of cash flows. ASU 2016-18 is effective for nonpublic business entities in fiscal years beginning after December 15, 2018, and interim periods within fiscal years beginning after December 15, 2019. The Company is in the process of evaluating the impact of this update on its consolidated financial condition, results of operations, and liquidity.

Reclassifications

Certain prior-year amounts on the balance sheet and cash flows related to accrued expenses, medical claims payable, related-party payables, long-term debt, other long-term liabilities, and capital leases and certain prior-year amounts on the income statement related to employee benefits and medical claims were reclassified to conform to the current year presentation. There was no change in reported net income/(loss), comprehensive income/(loss), stockholder's equity, or classifications within the statement of cash flows related to these reclassifications.

2. Revenue Recognition

The Company has arrangements with third-party payors that provide for payments to the Company at amounts different from its established rates. A summary of the payment arrangements with major third-party payors is as follows:

Medicare

Inpatient acute-care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Medicare reimburses the Company for covered outpatient services rendered to Medicare beneficiaries by way of an outpatient prospective payment system based on ambulatory payment classifications. The Company's classification of patients under the Medicare program and the appropriateness of their admissions are subject to an independent review. The Company is also paid for services rendered to Medicare managed care program beneficiaries, also known as Medicare Part C, or Medicare Advantage, where the federal government contracts with private insurers to provide members with Medicare benefits.

Inpatient non-acute services, certain outpatient services, medical education costs, and defined capital costs related to Medicare beneficiaries are paid based, in part, on a cost reimbursement methodology. The Company is reimbursed for cost reimbursable items at a tentative rate, with final settlement determined after the submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. 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. These differences decreased net patient revenue by approximately $11,706 and $14,241, respectively, for the years ended December 31, 2018 and 2017, and increased net patient service revenue by approximately $1,499 for the year ended December 31, 2016. The Company does not believe that there are significant credit risks associated with this government agency.

Medicaid

Inpatient services rendered to Medicaid program beneficiaries in the states in which the Company operates are reimbursed under a prospective payment system. Outpatient services are reimbursed based on a mixture of fee schedules and a cost reimbursement methodology. The Company is reimbursed for cost reimbursable services at tentative rates, with final settlement determined after

2. Revenue Recognition (continued)

submission of annual cost reports and audits thereof by the Medicaid state auditors. The Company also participates in Medicaid managed care arrangements. Payments for services of Medicaid beneficiaries that participate in those programs include prospectively determined rates and fee schedule payments. The estimated amounts due to or from the Medicaid state audits 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 examination is substantially complete. These differences decreased net patient service revenue by approximately $1,157, $1,963, and $5,544 for the years ended December 31, 2018, 2017, and 2016, respectively. The Company does not believe that there are significant credit risks associated with these government agencies.

Insurance, Health Maintenance Organizations, and Preferred Provider Organizations

The Company has also entered into agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the Company under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Other

The Company also provides its services to patients enrolled in programs of commercial insurance carriers, health maintenance organizations, and preferred provider organizations under which the Company does not have agreements. The Company recognizes revenue for these patients based on usual and customary rates for these services, adjusted for historical trends in the Company's reimbursement for similar services.

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. These differences did not materially affect net patient service revenue for the years ended December 31, 2018 and 2017, but decreased net patient service revenue by $124,000 for the year ended December 31, 2016, primarily due to the Company's strategy of migrating to a common information technology platform and consolidating many of the individual hospital business offices into regional business offices, which resulted in a significant decrease in cash collections.

2. Revenue Recognition (continued)

Meaningful Use Incentives

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

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

The Company recorded estimated incentive payments of $5,853, and $4,958 for fiscal years 2017 and 2016, respectively, and no incentive payments were recorded in 2018 related to the Medicare and Medicaid programs. These incentives have been recognized following the grant accounting model, recognizing revenue ratably over the applicable reporting period as management becomes reasonably assured of meeting the required criteria. Subsequent changes to these estimates will be recognized in the consolidated statements of operations in the period in which additional information is available. Such estimates are subject to audit by the federal government, the state, or its designee.

Hospital Fee Programs

The Company recognizes revenues related to supplemental Medi-caid payments under California Hospital Quality Assurance ("CHQA") programs. These programs are funded by quality assurance fees paid by participating hospitals and matching federal funds.

Legislation approved by the State of California in October 2013 created the framework for the provider fee to continue in perpetuity without requiring further legislation by the State. Proposition 52 was passed in November 2016, which made permanent the current provider fee program and places limits on the ability of the State of California to reallocate funds for non-health care purposes.

(Dollars in Thousands)

2. Revenue Recognition (continued)

Two CHQA programs had activity in 2016, 2017, and 2018: a 36-month hospital fee program covering the period from January 1, 2014 through December 31, 2016, and a 30-month hospital fee program covering the period from January 1, 2017 through June 30, 2019. Prior to 2017, the timing of revenue and expense recognition of the CHQA program was based on the timing of CMS approval, which did not consistently match the timing of the various hospital fee programs due to delays in approvals. With the passage of time and the administration of the CHQA programs, it has been determined that there is persuasive evidence that an arrangement exists despite whether CMS has finalized the actual amounts paid. Effective December 31, 2017, the Company determined the supplemental payments and quality assurance fees met all criteria related to revenue and expense recognition, respectively. Accordingly, in 2017, all previously unrecognized supplemental payments and related quality assurance fees relating to 2014 to 2017 were recognized as patient service revenue and as provider fee expense, respectively. The Company recorded a net benefit of $175,600 during 2017, with $110,300 from the 36-month program and $65,300, from the 30-month program. During 2018, the Company recorded a net benefit of $74,100, all of which was from the 30-month program.

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:

	Year Ended December 31		
	2018	**2017**	**2016**
Net patient service revenue	**$ 204,100**	$ 338,709	$ 180,503
General and administrative expense	**(129,952)**	(163,081)	(137,064)
Net pretax impact of California hospital fee program	**$ 74,148**	$ 175,628	$ 43,439

Amounts recorded on the balance sheets with respect to the California hospital fee program are included in provider fee receivable and provider fee payable.

(Dollars in Thousands)

2. Revenue Recognition (continued)

Other states have programs that are similar in nature to California, with amounts concentrated in New Jersey, Michigan, Missouri, Alabama, and Texas. For the years ended December 31, 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 for states other than California:

	December 31, 2018						
	Total	**NJ**	**MI**	**MO**	**AL**	**TX**	**Other States**
Net patient service revenue	**$ 103,158**	**$ 21,695**	**$ 20,602**	**$ 21,771**	**$ 10,592**	**$ 12,309**	**$ 16,189**
General and administrative expenses	**(45,400)**	**–**	**(5,740)**	**(13,570)**	**(4,543)**	**(12,818)**	**(8,729)**
Net impact of hospital fee programs	**$ 57,758**	**$ 21,695**	**$ 14,862**	**$ 8,201**	**$ 6,049**	**$ (509)**	**$ 7,460**

	December 31, 2017						
	Total	**NJ**	**MI**	**MO**	**AL**	**TX**	**Other States**
Net patient service revenue	$ 78,977	$ 17,986	$ 15,485	$ 18,434	$ 10,500	$ 9,188	$ 7,384
General and administrative expenses	(35,410)	(1,020)	(5,364)	(13,751)	(4,759)	(4,320)	(6,196)
Net impact of hospital fee programs	$ 43,567	$ 16,966	$ 10,121	$ 4,683	$ 5,741	$ 4,868	$ 1,188

	December 31, 2016						
	Total	**NJ**	**MI**	**MO**	**AL**	**TX**	**Other States**
Net patient service revenue	$ 69,943	$ 10,948	$ 15,348	$ 16,307	$ 8,278	$ 9,215	$ 9,847
General and administrative expenses	(35,181)	(82)	(3,460)	(14,366)	(7,093)	(3,002)	(7,178)
Net impact of hospital fee programs	$ 34,762	$ 10,866	$ 11,888	$ 1,941	$ 1,185	$ 6,213	$ 2,669

3. Acquisitions and Distributions

Acquisitions

There were no acquisitions made in 2018 and 2017. During the year ended December 31, 2016, the Company entered into the acquisitions listed below. 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. The goodwill arising from these acquisitions 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.

(Dollars in Thousands)

3. Acquisitions and Distributions (continued)

During 2016, the Company acquired two hospitals:

Facility	Acquisition Date	Type
Lehigh Regional Medical Center[1]	February 1, 2016	Asset
St. Michael's Medical Center[1]	May 1, 2016	Asset

[1] Acquisition includes hospital along with physician group.

The following table presents the allocation of the aggregate purchase price for each of the hospitals purchased in 2016:

	Lehigh Regional Medical Center	St. Michael's Medical Center	Total
Cash	$ –	$ 12,996	$ 12,996
Patient accounts receivable	–	14,220	14,220
Supplies inventory	864	4,466	5,330
Prepaid expenses	237	817	1,054
Property and equipment	9,492	46,810	56,302
Intangible assets	990	5,160	6,150
Goodwill	1,300	9,559	10,859
Other assets	–	929	929
Liabilities	(290)	(34,425)	(34,715)
Consideration	$ 12,593	$ 60,532	$ 73,125

Distributions

Effective December 31, 2018, PHM II distributed intercompany management fee receivables (due from PHSI hospitals) with a carrying value of $48,000 to PHF on behalf of PHM II's controlling stockholder, subject to a subordination agreement the Company and PHF entered into with Wells Fargo, which stipulates that the Company's term loan borrowings are required to be paid off before the payment of such management fees to PHF can be made. Such distribution will be recorded if and when the applicable management fees are paid to PHF.

(Dollars in Thousands)

3. Acquisitions and Distributions (continued)

Effective December 31, 2016, the Company distributed its ownership interests in Landmark Medical Center, Rehabilitation Hospital of Rhode Island, and Landmark Physician Office Services (collectively, the “Rhode Island businesses”) to PHF on behalf of its controlling stockholder.

The following table summarizes the carrying amounts of the components of assets and liabilities distributed:

	Rhode Island Businesses
Cash	$ 808
Patient accounts receivable, net	22,917
Supplies inventory	2,012
Prepaid expenses	1,375
Estimated third-party payor settlements	(1,002)
Property and equipment	41,558
Other assets	9
Insurance claims liabilities and reserves	(1,025)
	$ 66,652

In conjunction with the distributions, all liabilities of the facilities that were distributed were retained by PHSI, except for the estimated third-party settlements and insurance claims liabilities and reserves of the Rhode Island businesses, which liabilities were assumed by PHF. Operating results for the distributions have been included in the accompanying consolidated financial statements through the date of distribution.

(Dollars in Thousands)

4. Goodwill and Intangible Assets

Goodwill

The changes in the carrying amount of goodwill are as follows:

	Year Ended December 31	
	2018	**2017**
Balance, beginning of year	**$ 40,430**	$ 82,727
Reclassifications from other assets related to acquisitions of medical groups in prior years	**379**	2,582
Impairment	**–**	(44,879)
Balance, end of year	**$ 40,809**	$ 40,430

Gross goodwill as of December 31, 2018 and 2017 was $118,649 and $118,270, respectively for each year. Accumulated impairment losses as of the same balance sheet dates were $77,840 respectively.

Intangible Assets

The Company's intangible assets consist of trade names, which were acquired in connection with acquisitions, and are amortized over 10–15 years.

The gross carrying amount of the Company's trade names was $32,282 at December 31, 2018 and 2017, and the net carrying amount was $20,565 and $23,637 at December 31, 2018 and 2017, respectively, and are recorded in other assets (non-current).

The weighted average remaining amortization period for intangible assets subject to amortization is approximately 11 years. There are no expected residual values related to these intangible assets.

(Dollars in Thousands)

4. Goodwill and Intangible Assets (continued)

Amortization expense on these intangible assets was $2,924, $3,588, and $3,268 during the years ended December 31, 2018, 2017, and 2016, respectively. Expected amortization expense on intangible assets for the five years subsequent to December 31, 2018, and thereafter, are as follows:

Years ending December 31:	
2019	$ 2,414
2020	1,938
2021	1,938
2022	1,938
2023	1,758
Thereafter	10,579
	$ 20,565

5. Property and Equipment

Property and equipment consist of the following at December 31:

	2018	2017
Land	**$ 150,903**	$ 150,346
Buildings and building improvements	**911,733**	860,324
Equipment	**987,759**	919,614
	2,050,395	1,930,284
Less: Accumulated depreciation and amortization	**(891,021)**	(721,522)
	1,159,374	1,208,762
Construction in progress	**94,982**	96,888
	$ 1,254,356	$ 1,305,650

Depreciation expense was $169,464, $164,276, and $152,774 for the years ended December 31, 2018, 2017, and 2016, respectively.

5. Property and Equipment (continued)

Gross property and equipment includes approximately $367,046 and $324,908 of equipment under capital lease arrangements as of December 31, 2018 and 2017, respectively. Related accumulated amortization totaled approximately $172,137 and $115,240 as of December 31, 2018 and 2017, respectively. Amortization of equipment held under capital leases is included in the depreciation and amortization amounts disclosed above.

6. Long-Term Debt and Revolving Credit Facility

On January 26, 2016, the Company closed a $700,000 senior secured credit facility (the "Facility") lead jointly by Wells Fargo Bank, N.A. and Barclays Bank, PLC. Of the $700,000, $400,000 is a revolving facility, $200,000 is a term loan, and $100,000 is an accordion feature. The Facility matures on January 26, 2021. The term loan requires payments of $5,000 on a quarterly basis, with the remaining outstanding balance due at maturity. The Facility bears interest at either the London Interbank Offered Rate ("LIBOR") plus a margin, or the Base Rate, which is the greater of (a) the Federal Funds Rate plus 0.5%; (b) LIBOR plus 1%; or (c) the rate of interest announced by Wells Fargo as its "prime rate," plus a margin. The margins vary from 1% to 3% and are based upon the amount which has been borrowed under the revolving facility as compared to the amount that is currently available, based on a formula.

The Company recognized a loss on the extinguishment of the prior credit facility of approximately $9,400 in January 2016, representing the write off of unamortized loan costs, which is reflected in interest expense in the accompanying consolidated statements of comprehensive loss.

On August 30, 2018, the Company and Wells Fargo Bank, N.A. entered into a second amendment to the Facility, which included an additional $50,000 first-in, last-out revolving facility (the "FILO loan") to provide additional liquidity following the United States Department of Justice settlement (refer to Note 12 for further details). Debt financing costs related to the FILO loan approximated $2,188. The Company concluded in accordance with ASC 470-50, *Modifications and Extinguishments*, that the second amendment to the Facility included a partial extinguishment as a result of certain changes in participating lenders, which resulted in $600 of previously deferred financing costs being recorded as a loss on extinguishment included within interest expense for the year ended December 31, 2018. The FILO loan matures on August 30, 2020, and requires monthly interest payments and quarterly principal payments of $5,000, starting on March 1, 2019, with the remaining outstanding balance due at maturity. At December 31, 2018, $299,700, $140,000, and $50,000 were outstanding on the revolving credit facility, the term loan, and the

(Dollars in Thousands)

6. Long-Term Debt and Revolving Credit Facility (continued)

FILO credit facility, respectively. Interest rates on $290,000 of the revolving credit facility approximated 5.5% (LIBOR of 2.5% plus a margin of 3.0%) and 4.6% (LIBOR of 1.6% plus a margin of 3.0%) as of December 31, 2018 and 2017, respectively. Interest rates on the remaining amounts outstanding amounts on the revolving credit facility of $4,700 and $5,000 approximated 7.5% (prime rate of 5.5% plus a margin of 2.0%) and 9.5% (prime rate of 5.5% plus a margin of 4.0%) as of December 31, 2018. Interest rates on the remaining amounts outstanding amounts on the revolving credit facility of $46,100 approximated 6.5% (prime rate of 4.5% plus a margin of 2.0%). The Facility requires the Company to maintain certain financial and nonfinancial covenants. The Company was in compliance with all covenants at December 31, 2018 and 2017.

Long-term debt consists of the following as of December 31:

	Maturity	Terms	Interest Rates (4)	Interest Rates (5)	2018	2017
Loan with MPT, secured by Desert Valley Hospital and Chino Valley Medical Center facilities (owned by Prime A – See below)	February 2022	(1) (2)	**11.2%**	11.1%	**$ 140,000**	$ 140,000
Loan with MPT, secured by real property of Desert Valley Hospital	January 2020	(1) (2)	**11.0%**	11.0%	**12,500**	12,500
Loan with MPT, secured by real property of Centinela Hospital Medical Center	June 2022	(1) (2)	**11.6%**	11.4%	**100,000**	100,000
Note payable with MPT, secured by certain property and equipment and lease deposits of Paradise Valley Hospital	May 2022	(1) (2)	**11.0%**	10.7%	**25,000**	25,000
Note payable with MPT, secured by certain property and equipment and lease deposits of Monroe Hospital	July 2022	(1) (2)	**10.0%**	8.8%	**2,966**	5,000
Note payable with MPT, secured by certain property and equipment and lease deposits of St. Joseph Medical Center and St. Mary's Medical Center	February 2025	(1) (2)	**9.0%**	8.8%	**40,000**	40,000
Note payable with MPT, secured by certain property and equipment and lease deposits of Lake Huron Medical Center	August 2020	(1) (2)	**9.0%**	8.8%	**10,000**	10,000

(Dollars in Thousands)

6. Long-Term Debt and Revolving Credit Facility (continued)

	Maturity	Terms	Interest Rates (4)	Interest Rates (5)	2018	2017
Term loan with BBVA Compass, secured by certain real property	June 2019	Principal and interest of $153 payable monthly(2)	**5.0%**	5.0%	**$ 24,853**	$ 26,694
Term loan agented by Wells Fargo, secured by certain real property of the Company	January 2021	Principal and interest of $5,000 paid quarterly(2)	**7.5%**	6.6%	**140,000**	160,000
FILO Revolving Credit agented by Wells Fargo, secured by accounts receivable and related assets of the Company	August 2020	Principal and interest of $5,000 paid quarterly(2) (3)	**7.5%**	–	**50,000**	–
Other					**1,145**	1,420
Total debt, before deferred financing costs					**546,464**	520,614
Less: deferred financing costs					**(5,576)**	(5,786)
Total debt, net of deferred financing costs					**540,888**	514,828
Less: current portion of long-term debt					**(63,546)**	(20,612)
					$ 477,342	$ 494,216

(1) Monthly payments of interest are due; the interest rates are subject to annual escalation increases of the greater of 2% or the consumer price index. The interest rates related to the loan with MPT secured by the real property of Chino Valley Medical Center ("Chino") and Desert Valley Hospital ("DVH") are disclosed on a weighted average. Original mortgages of Chino's $50 million and DVH's $70 million are capped at 11%.

(2) Subject to financial and nonfinancial covenants. The Company was in compliance with these covenants at December 31, 2018.

(3) Principal repayment of FILO revolving credit shall commence on March 1, 2019.

(4) Interest rates as of December 31, 2018

(5) Interest rates as of December 31, 2017

(Dollars in Thousands)

6. Long-Term Debt and Revolving Credit Facility (continued)

Prime A, a company which is under common ownership with the Company, has title to and leases the Desert Valley Hospital and Chino Valley Medical Center facilities to the Company. As it relates to debt due to Medical Properties Trust, Inc. ("MPT") for these two facilities, the Company and Prime A are co-borrowers on the loan. Because the Company pays on behalf of itself and Prime A, the entire loan is reflected on the financial statements of the Company under accounting literature that requires an entity to measure obligations that it expects to pay on behalf of its co-obligors.

Aggregate annual principal maturities of long-term debt for the five years subsequent to December 31, 2018, and thereafter, are as follows, excluding deferred financing costs:

Years ending December 31	
2019	$ 65,896
2020	73,347
2021	100,954
2022	265,624
2023	–
Thereafter	40,643
	$ 546,464

7. Leases

On July 3, 2012, the Company entered into a master lease agreement with subsidiaries of MPT, which replaced the existing leases for various real estate and hospital buildings that had been acquired as part of various historical acquisitions. All of the legal entities that are parties to the master lease agreement (which are the hospital entities themselves, as well as PHSI and Prime A) provide cross guarantees on the obligations to MPT, with the guarantees including both lease payments under the master lease as well as indebtedness due to MPT. Prime A's guarantee is limited to the indebtedness for which it is a co-borrower ($140,000, see Note 6 and below). In connection with the master lease agreement, the then-existing leases were reset to new 10-year terms with options to extend the term by two 60-month periods. Monthly rent is defined as 10.75% of the lease base, subject to annual escalation of the greater of 2% or the consumer price index. The Company has the option to buy the properties at a price that is fixed at the time of entering into the lease. Due to the guarantee and option to purchase included in the lease, this transaction was recognized as a finance obligation.

7. Leases (continued)

In 2012 and 2013, the Company entered into additional transactions with MPT. The Company sold to MPT real estate and hospital buildings that had been acquired as part of the acquisitions of Roxborough Memorial Hospital, Saint Mary's Regional Medical Center, Providence Medical Center, and Saint John's Hospital. Concurrent with these agreements, the Company entered into an amendment to the master lease agreement, whereby the hospital properties and related medical office buildings were added to the master lease, and, accordingly, the terms of these transactions (and the accounting treatment) are the same as described above.

During 2015 and 2016, in connection with the acquisitions of St. Joseph Medical Center in Kansas City, MO, and St. Mary's Medical Center in Blue Springs, MO (February 2015), Lake Huron (September 2015), and St. Michael's Medical Center (May 2016), the Company sold the related real estate and hospital buildings to MPT. The Company then leased back the real estate and hospital buildings for periods of ten years, with options to extend the term of the lease for two additional five-year periods. Monthly rent is defined as 8.50% of the lease base, subject to annual escalation of the greater of 2% or the consumer price index. The Company has the right of first refusal to purchase the properties for the price that a third party offers. These transactions do not qualify for sale leaseback accounting because of the Company's deemed continuing involvement with the buyer-lessor, including the requirement to pay reserves for major repairs, which is considered a form of contingent collateral and results in the transaction being recorded under the financing method. Additionally, during 2016, the Company entered into a sale leaseback transaction with respect to St. Clare's Health System. Due to continuing involvement, this transaction was recognized as a finance obligation. Later in 2016, an additional $15,000 in financing was provided to St Clare's LLC Boonton property.

(Dollars in Thousands)

7. Leases (continued)

The Company's sale leaseback liabilities consist of the following as of December, before unamortized loan costs:

Hospital	2018(1) Monthly Rent	2017(2) Monthly Rent	2018	2017	Maturity Date
Paradise Valley Hospital	**$ 223**	$ 219	**$ 23,000**	$ 23,000	Jul 2022
Alvarado Hospital Medical Center	**679**	665	**70,000**	70,000	Jul 2022
San Dimas Community Hospital	**126**	124	**13,000**	13,000	Jul 2022
San Dimas Medical Office Building	**68**	67	**7,000**	7,000	Jul 2022
Garden Grove Hospital Medical Center	**158**	154	**16,250**	16,250	Jul 2022
Garden Grove Medical Office Building	**85**	83	**8,750**	8,750	Jul 2022
Roxborough Memorial Hospital	**291**	285	**30,000**	30,000	Jul 2022
St. Mary's Regional Medical Center	**776**	760	**80,000**	80,000	Jul 2022
Dallas Medical Center	**243**	238	**25,000**	25,000	Jun 2023
Providence Medical Center	**582**	570	**60,000**	60,000	Jun 2023
St. John Hospital	**146**	143	**15,000**	15,000	Jun 2023
St. Joseph Medical Center	**602**	590	**80,000**	80,000	Feb 2025
St. Mary's Medical Center	**226**	221	**30,000**	30,000	Feb 2025
Lake Huron Hospital	**150**	147	**20,000**	20,000	Feb 2025
St. Michael's Medical Center	**464**	455	**63,000**	63,000	May 2031
St. Clare's Health System	**865**	847	**115,000**	115,000	May 2031
	$ 5,684	$ 5,568	**$ 656,000**	$ 656,000	

(1) Monthly base rent to MPT for year ending December 2018
(2) Monthly base rent to MPT for year ending December 2017

7. Leases (continued)

The Company leases the hospital properties and related other medical office buildings for West Anaheim Medical Center and Shasta Regional Medical Center from MPT. All leases under this master lease agreement have a 10-year term (through July 2022), with options to extend the term by two 60-month periods. Monthly rent is defined as 10.75% of the lease base, subject to annual escalation of the greater of 2% or the consumer price index. These leases are accounted for as operating leases. The West Anaheim Medical Center facility includes monthly rent payments of approximately $242 and $238 at December 31, 2018 and 2017, respectively. The Shasta Regional Medical Center facility includes monthly rent payments of approximately $611 and $599 at December 31, 2018 and 2017, respectively.

On January 1, 2015, the Company entered into a lease agreement with MPT, in connection with the acquisition of Monroe Hospital. The Company concluded in accordance with ASC 840-30-30, *Capital Leases Initial Measurement,* that the capital lease asset and obligation should be recorded at fair value, as the present value of the minimum lease payments exceeded the fair value of the leased property. Therefore, the lease was recorded as a capital lease on the consolidated balance sheets, with an initial value of approximately $9,300 maturing in July 2022. The total monthly lease payments paid to MPT for the lease were approximately $226 and $221 at December 31, 2018 and 2017, respectively. Of these monthly payments, approximately $79 and $77 were applied against Monroe's $5,000 note payable due to MPT at December 31, 2018 and 2017, respectively (see Note 6).

The Company leases medical office buildings under master lease agreements with subsidiaries of Prime A (see Note 9).

Lease expense, consisting primarily of building rent and equipment leases, amounted to approximately $75,844, $70,109, and $69,274 for the years ended December 31, 2018, 2017, and 2016, respectively, net of sublease income of $14,140, $18,268, and $16,323 for the years ended December 31, 2018, 2017, and 2016, respectively.

Capital leases bear interest (stated and/or implied) at rates ranging from 1.02% to 11.37% for all capital leases, and have maturity dates through March 1, 2025.

Involvement in Asset Constructed by Landlord – Under ASC 840, *Leases*, a build-to-suit arrangement exists when a lessee, among other things, is financially involved during the asset construction period. In 2017, Prime A began construction of a new corporate office building for

(Dollars in Thousands)

7. Leases (continued)

PHMI. In May 2017, Prime A, as landlord, entered into a date-certain lease with PHMI, as lessee, obligating PHMI to make lease payments regardless of whether construction was completed. Although, PHMI is not obligated to pay construction costs, PHMI, in substance, is the owner of assets during the construction period. As construction of the corporate office building progresses, the Company will record the costs paid by the landlord to construct the building as construction in progress and a related long-term financing obligation. As of December 31, 2018, the Company has recorded $14,323 of construction in progress costs within property and equipment and a related other long-term liability.

Future minimum lease payments, under this noncancelable lease, approximate $278 per month, adjusted annually for the change in CPI, for a term of 240 months through November 2038, totaling $66,720 throughout the duration of the agreement.

As of December 31, 2018, future minimum lease payments under noncancelable operating leases (with initial or remaining lease terms in excess of one year) and future minimum capital lease payments are as follows:

	Capital Leases	Operating Lease Commitments	Sale Leaseback Commitments
Years ending December 31:			
2019	$ 72,507	$ 50,266	$ 69,550
2020	52,964	44,917	70,941
2021	33,651	41,489	72,359
2022	10,071	35,261	308,789
2023	3,908	17,836	136,990
Thereafter	1,677	88,513	463,881
	174,778	278,282	1,122,510
Less: noncancellable subleases	–	(25,057)	–
Total minimum payments	174,778	$ 253,225	1,122,510
Less: amounts representing interest	(15,384)		(466,510)
	159,394		656,000
Less: current portion	(66,208)		–
Less: deferred financing cost	–		(4,067)
	$ 93,186		$ 651,933

8. Professional Liability, Workers' Compensation, and Healthcare Insurance

Desert Valley Insurance Limited ("DVIL") provides workers' compensation, professional liability, and earthquake insurance coverage to the Company. DVIL is owned by Prime A.

Workers' Compensation Insurance

DVIL provides workers' compensation insurance on an occurrence basis. Under the terms of the policies, DVIL is obligated to insure each workers' compensation claim up to a maximum of $1,000 per claim. Losses in excess of $1,000 per claim are insured by the Safety National Insurance Company with no general aggregate limit.

Professional Liability Insurance

DVIL provides professional liability insurance on a claims-made basis. Under this policy, insurance premiums cover only those claims 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 after the policy's termination may be uninsured. Under the current policy, the medical groups of PHSI are covered up to $1,000 per claim and a $3,000 general aggregate limit with no deductible. The hospitals of PHSI are covered up to $6,000 per claim with no deductible. Excess losses up to an additional $25,000 per incident and general aggregate are insured by Illinois Union Insurance Company and excess losses up to an additional $10,000 per incident and general aggregate are insured by Endurance American Specialty Insurance Company.

U.S. GAAP requires that a healthcare facility recognize the estimated costs of 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 claims reserve is based on the best data available to the Company; however, the estimate 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 professional liability is dependent on future developments, management is of the opinion that the associated liabilities relating to the amounts incurred but not reported before the policy's termination date, recognized in the accompanying consolidated financial statements within insurance claims liabilities and reserves of $42,500 and $39,500 as of December 31, 2018 and 2017, respectively, are adequate to cover such claims. Management is not aware of any professional liability claims whose settlement, if any, would have a material adverse effect on the Company's consolidated financial position.

(Dollars in Thousands)

8. Professional Liability, Workers' Compensation, and Healthcare Insurance (continued)

Medical Insurance

Effective January 1, 2017, the Company self-insures each employee medical claim. Claims are adjudicated by an independent third-party administrator. Losses in excess of $350 are covered by a reinsurance agreement with Desert Valley Insurance Ltd. at 90% of covered costs up to a maximum of $3,000 per covered member per incident, with no general aggregate limit.

9. Related-Party Transactions

Related-party receivables are unsecured, non-interest-bearing, due on demand, and consist of the following:

	Year Ended December 31 2018	2017
Prime A Investments, LLC and subsidiaries	**$ 1,407**	$ 1,095
Prime Healthcare Foundation, Inc. and subsidiaries	**29,298**	4,980
	$ 30,705	$ 6,075

Related-party payables, current portion, consist of the following:

	Year Ended December 31 2018	2017
Desert Valley Insurance Limited	**$ 38,786**	$ 36,522
Prime Healthcare Foundation, Inc. and subsidiaries	**–**	3,727
Prime A Investments, LLC and subsidiaries, promissory note, unsecured, bears interest at 6% per annum, principal and interest due on maturity (June 30, 2019)	**20,000**	–
	$ 58,786	$ 40,249

(Dollars in Thousands)

9. Related-Party Transactions (continued)

Long-term related-party payables consist of the following:

	Year Ended December 31	
	2018	**2017**
Prime A Investments, LLC and subsidiaries, promissory note, unsecured, bears interest at 6% per annum, principal and interest due on maturity (June 30, 2019)	$ –	$ 30,000
	$ –	$ 30,000

The Company recorded interest expense of $1,719, $1,800, and $5,124 for the years ended December 31, 2018, 2017, and 2016, respectively, related to the Prime A promissory note described above. Accrued interest was $0 and $1,800 as of December 31, 2018 and 2017, respectively.

The Company has entered into certain agreements with PHF, a related party. Under these agreements, (i) PHM II provides management services to PHF; (ii) Bio-Med, Inc. provides asset management services, including, but not limited to, repairs and maintenance of medical equipment, to PHF; (iii) Hospital Business Services, Inc. provides outsourced business office services to PHF; fees relating to these agreements totaled approximately $86,403, $77,827, and $52,635 for the years ended December 31, 2018, 2017, and 2016, respectively. The Company, through its wholly owned subsidiary, PrimEra Technologies, Inc. provides outsourced IT, coding, and other revenue cycle functions to PHF. Fees relating to these agreements totaled $4,248 for the year ended December 31, 2018. Prior to 2018, such services were provided at no charge to PHF. These fees are included in other operating revenues in the consolidated statements of operations and comprehensive income.

Effective January 1, 2017, PHSI insures PHF's employee medical claims. Claims are adjudicated by an independent third-party administrator. Losses in excess of $350 are covered by reinsurance agreement with DVIL at 90% of the covered costs up to a maximum of $3,000 per covered member per incident. The Company recorded billings to PHF of $68,200 and $62,700 for years ended December 31, 2018 and 2017, respectively, which amounts are included in other operating revenue. Related claim payments to PHF approximated $57,900 and $46,400 for the years ended December 31, 2018 and 2017, respectively, and are recorded as medical claims expense in the consolidated statements of operations.

9. Related-Party Transactions (continued)

The Company has entered into agreements with DVIL to provide workers' compensation, earthquake insurance coverage, commercial malpractice liability insurance, and healthcare insurance for employees (see Note 8). Premiums paid to DVIL for workers' compensation, professional and general liability, earthquake and flood, and medical stop loss insurances totaled approximately $67,533 and $71,978 for the years ended December 31, 2018 and 2017, respectively. Prior to 2017, in addition to workers' compensation, professional and general liability, earthquake and flood, the Company also had a medical insurance program with DVIL for healthcare coverage for employees. Premiums paid to DVIL totaled approximately $223,933 for the year ended December 31, 2016.

The Company leases certain medical office buildings, and parking facilities under master lease agreements with subsidiaries of Prime A. The leases are for five-year terms. Rent expense incurred under these leases was approximately $18,633, $21,408, and $23,579 for the years ended December 31, 2018, 2017, and 2016, respectively. The Company subleases some of the office space under the master lease agreements to third party-tenants.

On December 29, 2017, Prime A donated two medical office buildings, the Centinela MOBs, to PHF. Rent expense for the Centinela MOBs was $3,307 for the year ended December 31, 2018, paid to PHF. Rent expense for these MOBs was $3,133 for the year ended December 31, 2017, paid to Prime A.

The Company leases a medical office building under a master lease agreement with a subsidiary of PHF. The lease provides an option to extend three additional periods of five years each. Rent expense incurred under this master lease was approximately $1,095 and $1,034 for the years ended December 31, 2018 and 2017, respectively.

10. Retirement Savings Plan

The Company has a defined contribution retirement plan covering substantially all of its employees. The Company's contribution to the plan is at the Company's discretion but limited to the maximum amount deductible for federal income tax purposes under the applicable Internal Revenue Code. During the years ended December 31, 2018, 2017, and 2016, the Company incurred contribution costs of approximately $16,527, $16,073, and $15,275, respectively, to the plan.

(Dollars in Thousands)

11. Defined Benefit Pension Plan

The Company sponsors the Garden City Hospital Osteopathic Employee Pension Plan (the "Plan"). The Plan covers substantially all eligible employees of Garden City Hospital hired prior to 2003, as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), with at least 1,000 hours worked in each Anniversary Year (as defined). Entry into the Plan was frozen effective May 15, 2003, and benefit accruals were frozen effective May 15, 2004.

The Company recognizes the funded status (i.e., the difference between the fair value of plan assets and the projected benefit obligations) of this pension plan in the consolidated balance sheets. For the years ended December 31, 2018, 2017, and 2016, the unrealized losses related to this pension plan were approximately $1,319, $716, and $918 respectively.

Benefit Obligations, Fair Value of Plan Assets, and Funded Status

The following table provides a reconciliation of the changes in the benefit obligation and fair value of plan assets, and a statement of funded status:

	Year Ended December 31	
	2018	**2017**
Change in projected benefit obligation:		
Benefit obligation at beginning of year	**$ 79,340**	$ 76,107
Interest cost	**2,697**	2,929
Actuarial (gain) loss	**(4,280)**	4,042
Benefits paid	**(3,901)**	(3,738)
Projected benefit obligation at end of year	**73,856**	79,340
Change in plan assets:		
Fair value of plan assets at beginning of year	**53,508**	50,601
Actual (loss) return on plan assets	**(3,106)**	5,589
Employer contributions	**1,633**	1,056
Benefits paid	**(3,901)**	(3,738)
Fair value of plan assets at end of year	**48,134**	53,508
Underfunded status at end of year	**$ (25,722)**	$ (25,832)

(Dollars in Thousands)

11. Defined Benefit Pension Plan (continued)

The change in the actuarial loss for the years ended December 31, 2018 and 2017, is attributable to the change in the discount rate utilized to determine the benefit obligation amount. During the year ended December 31, 2018, net actuarial gains decreased the benefit obligation by approximately $4,280. During the year ended December 31, 2017, net actuarial losses increased the benefit obligation by approximately $4,042. These losses/gains are recorded in accumulated other comprehensive income.

The Company has a total accumulated other comprehensive loss related to the pension plan of $9,147 and $7,828 as of December 31, 2018 and 2017, respectively.

The Company will make a contribution to the Plan of $2,378 in 2019.

Information for the pension plan, which has a projected and accumulated benefit obligation in excess of plan assets, is as follows:

	Year Ended December 31	
	2018	**2017**
Projected benefit obligation	**$ 73,856**	$ 79,340
Accumulated benefit obligation	**$ 73,856**	$ 79,340
Fair value of plan assets at measurement date	**$ 48,134**	$ 53,508

Net Periodic Costs

A summary of the components of net pension expense is as follows:

	Year Ended December 31	
	2018	**2017**
Interest cost	**$ 2,697**	$ 2,929
Expected return on plan assets	**(2,489)**	(2,304)
Net pension expense	**$ 208**	$ 625

(Dollars in Thousands)

11. Defined Benefit Pension Plan (continued)

Assumptions

The assumptions used to determine the benefit obligations are as follows:

	Year Ended December 31	
	2018	**2017**
Weighted average discount rate	**4.05%**	3.49%
Rate of compensation increase	**N/A**	N/A

The assumptions used to determine the net pension expense, are as follows:

	Year Ended December 31	
	2018	**2017**
Weighted average discount rate	**3.49%**	3.95%
Weighted average expected long-term rate of return on plan assets	**6.25%**	6.25%

Basis Used to Determine Expected Long-Term Return on Plan Assets

The expected long-term return on plan assets assumption was developed as a weighted average rate based on the target asset allocation of the plan and the Long-Term Capital Market Assumptions ("CMA") 2014. The capital market assumptions were developed with a primary focus on forward-looking valuation models and market indicators. The key fundamental economic inputs for these models are future inflation, economic growth, and interest rate environment. Due to the long-term nature of the pension obligations, the investment horizon for the CMA 2014 is 20 to 30 years. In addition to forward-looking models, historical analysis of market data and trends was reflected, as well as the outlook of recognized economists, organizations, and consensus CMA from other credible studies.

Benefit Payments

Benefit payments in the table below are based on the same assumptions used to measure the related benefit obligations and are paid from both funded benefit plan trusts and current assets. Actual benefit payments may vary significantly from these estimates.

(Dollars in Thousands)

11. Defined Benefit Pension Plan (continued)

The following table summarizes the expected benefit payments to be paid over the next ten years:

Years ending December 31:		
2019	$	4,310
2020		4,510
2021		4,640
2022		4,730
2023		4,840
Years 2024–2028		24,270
	$	47,300

Benefit Plan Assets Measured at Fair Value on a Recurring Basis

The fair values of the pension plan assets, by asset class, are as follows:

	Fair Value Measurements Using			
	Level 1	**Level 2**	**Level 3**	**Total Fair Value**
December 31, 2018				
Guaranteed investment contract	**$ –**	**$ –**	**$ 662**	**$ 662**
Total assets in the fair value hierarchy	**$ –**	**$ –**	**$ 662**	**662**
Investments measured at net asset value				**47,472**
Investments at fair value				**$ 48,134**

	Fair Value Measurements Using			
	Level 1	**Level 2**	**Level 3**	**Total Fair Value**
December 31, 2017				
Guaranteed investment contract	$ –	$ –	$ 742	$ 742
Total assets in the fair value hierarchy	$ –	$ –	$ 742	742
Investments measured at net asset value				52,766
Investments at fair value				$ 53,508

11. Defined Benefit Pension Plan (continued)

Guaranteed Investment Contract. The Plan is party to a contract with the John Hancock Life Insurance Company ("John Hancock"), under which the Plan previously contributed a specified amount, and John Hancock maintains the contributions in an unallocated annuity fund to which the contributions earn interest at market rate. The balance in the fund is guaranteed never to be less than the aggregate contributions made to the accumulation fund, less all expenses, taxes, and amounts withdrawn to pay benefits. There are no guarantees as to the amount of interest.

Investments measured at net asset value. Net asset value per share is based on the fair value of the underlying investments within these pooled separate accounts, consisting of common stock valued at the closing price reported on the active market on which the individual securities are traded, and corporate bonds, government bonds, collateralized mortgage obligations, and other asset-backed securities valued at the bid price or the average of the bid and ask price using pricing models, quoted prices of securities with similar characteristics, or broker quotes. Certain of these investments have redemption restrictions for 30 days, and the remainder of the investments do not have any redemption restrictions.

Plan Assets

The Company has adopted and implemented investment policies for the Plan that incorporate strategic asset allocation mixes intended to best meet the Plan's long-term obligations, while maintaining an appropriate level of risk and liquidity. The asset portfolio employs a diversified mix of investments, which are reviewed periodically. Active management strategies are utilized where feasible in an effort to realize investment returns in excess of market indices. The Plan's investment policies allow for investments in stable portfolios (consisting of short-term, high-quality debt securities), fixed-income portfolios (primarily consisting of debt securities issued by the U.S. government, foreign governments, and U.S. and foreign corporations), real assets (consisting largely of owned real estate and real estate investment trusts), U.S. stocks, and non-U.S. stocks. The investment strategy currently targets a mix of 42% fixed-income assets, 48% U.S. equities, and 10% foreign equities.

12. Contingencies and Commitments

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.

On May 23, 2016, the United States Department of Justice ("USDOJ") filed a motion and notice of its intent to partially intervene in the False Claims Act ("FCA") action filed by a former employee of Alvarado Hospital. Pursuant to its notice, USDOJ only intervened on the relator's FCA claim that California PHSI hospitals submitted claims for unnecessary inpatient admissions of patients who allegedly could have been treated on an outpatient basis, including through observation care. The USDOJ did not intervene on the relator's other FCA claims, including the allegation that PHSI hospitals submitted claims with false diagnoses of medical complications and comorbidities but were ultimately settled with case as mentioned below. In 2016, the Company established an accrual of approximately $27,000 with regard to the potential settlement of this case and a payable to PHF for approximately $4,300 in accordance with the indemnification provisions of the hospital transfer agreements. On March 28, 2018, the Company reached an agreement in principle to resolve all claims raised in this case, which resulted in an increase of the accrual established in 2016 to $65,300 as of December 31, 2017, and an increase of the payable established in 2016 to PHF to approximately $11,700 as of December 31, 2017. On August 3, 2018, the parties finalized the settlement agreement, and the accrual for the Company was reduced by approximately $3,500 based on this final settlement. Pursuant to that agreement, the Company issued a payment of $61,800 on August 31, 2018, settling the case and the payable to PHF.

In 2008, the Company sued a major health plan, seeking payment of underpaid or unpaid claims for healthcare services provided to members of the health plan. In March 2014, the Company filed an amended complaint, narrowing the scope of the lawsuit. The health plan responded by filing cross-complaints asserting claims against the Company. The health plan asserted that the Company, among other things, improperly determined that patients were unstable for transfer,

12. Contingencies and Commitments (continued)

improperly coded the claims on the bills, and charged unreasonable amounts. The health plan also alleged entitlement to reimbursement on some amounts it alleged were overpaid but limited its claims to those in which the Company had claimed it was underpaid. On February 9, 2015, the Company and the health plan agreed to dismiss their respective lawsuits against each other and instead to resolve their disputes through confidential and binding arbitration. On March 19, 2018, the arbitration panel issued a final award ("Award") of approximately $42,000 against the Company, for which the Company established an accrual as of December 31, 2017. Following this ruling, the Company increased the accrual as of December 31, 2018, by approximately $2,000 for interest incurred. As of December 31, 2018, the total accrual was approximately $44,000 (including a payable to PHF, which was increased by approximately $200 during 2018 to $3,500, related to this case in accordance with the indemnification provisions of the hospital transfer agreements). On February 26, 2019, the Los Angeles County Superior Court confirmed the Award against the Company and entered a judgment in the approximate amount of $44,000.

The Company vigorously disputes the basis for the Award and has filed an appeal of the Award and judgment. Execution of the judgment is stayed during the appeal because the Company has obtained a surety bond as assurance of payment of the judgment depending on the outcome of the appeal. Interest in the amount of $6 per day continues to accrue on the judgment until it is either vacated or paid.

The Company was a plaintiff and cross-defendant in a civil action initiated by the Company in October 2015 related to the Company's termination of its agreement to purchase the Daughters of Charity Health System ("DCHS") (now known as Verity). Under its agreement, the Company was entitled to terminate, but under certain circumstances was required to pay a termination fee to DCHS of either $5,000 or $40,000, depending on the basis for its decision to terminate.

Following termination, a dispute arose as to the actual basis for the Company's termination and, thus, which, if any, termination fee was owed. In 2016, the Company established a reserve of $17,000 related to this case. In August 2017, both sides entered into a Settlement Agreement and Mutual General Release. Under the terms of this settlement, both parties agreed to dismiss their respective claims against each other, and, in 2017, the Company paid DCHS/Verity $5,000 and made an unrestricted donation of $12,000 to the St. Vincent Foundation in 2017, satisfying the settlement agreement.

12. Contingencies and Commitments (continued)

Legislation and HIPAA

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. 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. These laws and regulations include, but are not limited to, accreditation, licensure, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by health care providers. Violations of these laws and regulations could result in exclusion from government health care program participation, together with the imposition of significant fines and penalties, as well as significant repayment of past reimbursement received for patient services. While the Company is subject to similar regulatory review, management believes that the outcome of any potential regulatory review will not have a material adverse effect on the Company's consolidated financial position.

Management believes that the Company is in compliance with government laws and regulations related to fraud and abuse and other applicable areas. Compliance with such laws and regulations can be subject to future governmental 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 expanded upon HIPAA in a number of ways, including establishing notification requirements for certain breaches of protected health information. In addition to these federal rules, California has also developed strict standards for the privacy and security of health information as well as for reporting certain violations and breaches. The Company may be subject to significant fines and penalties if found not to be compliant with these state or federal provisions.

(Dollars in Thousands)

12. Contingencies and Commitments (continued)

Labor Relations

As of December 31, 2018, the Company had approximately 25,000 employees, of whom approximately 22% are represented by various labor organizations.

The table below shows the Company's employees who are represented by unions as of December 31, 2018:

Facility	**Employee Group**	**Union**	**Date on Which Collective Bargaining Agreement Expires**
Alvarado Hospital Medical Center	Registered Nurses	California Nurses Association	In negotiations
Centinela Hospital Medical Center	Registered Nurses	California Nurses Association	In negotiations
Centinela Hospital Medical Center	Service, Maintenance, Technical, Skilled Maintenance and Business Office Clerical Employees	SEIU United Healthcare Workers	April 18, 2020
Chino Valley Medical Center	Registered Nurses	United Nurses Associations of California	In negotiations
Garden Grove Hospital Medical Center	Registered Nurses	United Nurses Associations of California	September 30, 2019
Garden Grove Hospital Medical Center	Professional, Service, Maintenance, Technical, Skilled Maintenance and Business Office Clerical Employees	SEIU United Healthcare Workers	April 18, 2020
Lower Bucks Hospital	Engineers and Maintenance	International Union of Engineers Local 835	October 15, 2021
Lower Bucks Hospital	Registered Nurses	Pennsylvania Association of Staff Nurses and Allied Professionals	November 1, 2019
Saint Mary's Regional Medical Center – Reno	Registered Nurses	California Nurses Association/ National Nurses United	March 31, 2019
Saint Mary's Regional Medical Center – Reno	Service and Technical Employees	Communication Workers of America	March 9, 2020

(Dollars in Thousands)

12. Contingencies and Commitments (continued)

Facility	Employee Group	Union	Date on Which Collective Bargaining Agreement Expires
Saint Michael's Medical Center	Professional Employees	1199J (Guild)	In negotiations
Saint Michael's Medical Center	Service Employees	1199J (Service)	In negotiations
Saint Michael's Medical Center	Residents	Committee of Interns and Residents	August 29, 2019
Saint Michael's Medical Center	Boiler Room and Maintenance Dept. Employees	International Union of Engineers Local 68	In negotiations
Saint Michael's Medical Center	All Registered Nurses and Nurse Anesthetists. Technical Employees in certain departments only.	JNESO	In negotiations
St. Joseph Medical Center	Engineers and Maintenance Employees	International Union of Engineers Local 101S	March 31, 2021
St. Mary's Hospital – Passaic	Skilled Maintenance Employees	International Union of Engineers Local 68-68A-68B	August 14, 2020
St. Mary's Hospital – Passaic	Registered Nurses	JNESO	August 14, 2020
St. Mary's Hospital – Passaic	Technical Employees	JNESO	August 14, 2020
West Anaheim Medical Center	Technical Employees	The National Union of Healthcare Workers	October 10, 2021
West Anaheim Medical Center	Registered Nurses	California Nurses Association	June 30, 2021
Shasta Regional Medical Center	Registered Nurses	California Nurses Association	June 30, 2021
Shasta Regional Medical Center	Technical Employees	Caregiver and Healthcare Employees Union	In negotiations

The following summarizes the status of the other collective bargaining agreements:

As of December 31, 2018, the Chino Valley Medical Center collective bargaining agreements with UNAC, as well as the Shasta Regional Medical Center collective bargaining agreement with CHEU, were under negotiation. During negotiation, the Company is following the previously existing contracts until a new contract is finalized.

12. Contingencies and Commitments (continued)

Provider Contracts

Many of the Company’s payor 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.

Capital Commitments

In connection with the acquisitions of various hospitals, such acquisition agreements require the Company to make certain capital expenditures before a specified date, such as facility renovations, medical equipment, and information systems. As of December 31, 2018, remaining capital commitments of $3,500 and $8,731 are required by December 31, 2019, and December 31, 2021, respectively.

13. Subsequent Events

Subsequent events are events or transactions that occur after the consolidated balance sheet date but before consolidated financial statements are available to be issued. The Company recognizes in the consolidated financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the consolidated balance sheet, including the estimates inherent in the process of preparing the consolidated financial statements. The Company’s consolidated financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the consolidated balance sheet but arose after the consolidated balance sheet date and before consolidated financial statements are available to be issued. The Company has evaluated subsequent events through April 30, 2019, which is the date the consolidated financial statements were available to be issued.

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