Prospect EOGH, Inc.

Consolidated Financial Statements

As of and for the Years Ended
September 30, 2020 and 2019

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Contents

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Independent Auditor's Report

Board of Directors
Prospect EOGH, Inc.
East Orange, New Jersey

We have audited the accompanying consolidated financial statements of Prospect EOGH, Inc. (the "Company"), which comprise the consolidated balance sheets as of September 30, 2020 and 2019, and the related consolidated statements of operations, member's deficit, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Prospect EOGH, Inc. as of September 30, 2020 and 2019, and the results of their operations and their cash flows for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

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

Emphasis of Matter Regarding Covid-19 and the CARES Act

As more fully described in Note 1 to the consolidated financial statements, the Company has been negatively impacted by the outbreak of a novel coronavirus (COVID-19), which was declared a global pandemic by the World Health Organization in March 2020. Furthermore, on March 27, 2020, the President signed into law the Coronavirus Aid, Relief, and Economic Security ("CARES Act") to provide certain relief funds as a result of the COVID-19 outbreak. The application for these relief funds requires the Company to among other things, meet certain conditions as defined, in order for them to be used to support the ongoing operations of the Company. The COVID-19 pandemic and the recognition of the relief funding under CARES Act has impacted the financial position, results of operations, and cash flows of the Company. Our opinion is not modified with respect to this matter.

BDO USA, LLP

March 26, 2021

Prospect EOGH, Inc.

Consolidated Balance Sheets
(in thousands)

September 30,	**2020**	2019
Assets		
Current assets		
Cash	**$ 171**	$ 706
Patient accounts receivable, less allowance for doubtful accounts of $42,191 and $40,771, at September 30, 2020 and 2019, respectively	**11,771**	19,211
Due from government payers	**877**	877
Other receivables, prepaid expenses and other current assets	**2,670**	6,655
Inventories	**1,379**	1,486
Total current assets	**16,868**	28,935
Property, improvements and equipment, net	**158**	9,432
Intangible assets, net	**1,313**	1,555
Other assets	**164**	164
Total assets	**$ 18,503**	$ 40,086

See accompanying notes to consolidated financial statements.

Prospect EOGH, Inc.

Consolidated Balance Sheets
(in thousands)

September 30,	**2020**	2019
Liabilities and Member's Deficit		
Current liabilities		
Accounts payable and other accrued liabilities	**$ 11,137**	$ 12,002
Accrued salaries, wages and benefits	**4,784**	4,469
Due to affiliated companies, net	**84,990**	102,223
Due to government payers	**670**	855
Refund liability, current portion	**2,284**	-
Capital leases, current portion	**448**	656
Total current liabilities	**104,313**	120,205
Note payable	**922**	946
Malpractice reserves	**1,550**	1,992
Refund liability, net of current portion	**7,868**	-
Capital leases, net of current portion	**250**	671
Other long-term liabilities	**-**	1,061
Total liabilities	**114,903**	124,875
Commitments, contingencies and subsequent events		
Member's deficit:		
Member contributions	**32,719**	32,719
Accumulated deficit	**(129,119)**	(117,508)
Total member's deficit	**(96,400)**	(84,789)
Total liabilities and member's deficit	**$ 18,503**	$ 40,086

See accompanying notes to consolidated financial statements.

Prospect EOGH, Inc.

Consolidated Statements of Operations
(in thousands)

For the years ended September 30,	**2020**	2019
Revenues:		
Net patient service revenues	**$ 77,397**	$ 86,570
Provision for bad debts	**(5,648)**	(6,018)
Net patient service revenues less provision for bad debts	**71,749**	80,552
Other non-patient Hospital revenues	**9,173**	3,417
Total net revenues	**80,922**	83,969
Operating expenses:		
Salaries, wages and benefits	**52,034**	57,841
Supplies	**9,359**	10,533
Purchased services	**7,748**	8,876
Impairment of property, improvements and equipment and net current assets	**8,857**	51,991
Depreciation and amortization	**5,163**	7,153
Professional fees	**11,137**	12,464
Other operating expenses	**13,447**	14,931
Total operating expenses	**107,745**	163,789
Pandemic relief grant income	**15,659**	-
Operating loss	**(11,164)**	(79,820)
Other expense (income):		
Interest expense	**446**	745
Other expense (income), net	**8**	(82)
Total other expense, net	**454**	663
Loss before income tax benefit	**(11,618)**	(80,483)
Income tax benefit	**(7)**	(109)
Net loss	**$ (11,611)**	$ (80,374)

See accompanying notes to consolidated financial statements.

Prospect EOGH, Inc.

Consolidated Statements of Member's Deficit
(in thousands)

	Member Contributions	Accumulated Deficit	Total Member's Deficit
Balance at October 1, 2018	$ 32,719	$ (37,134)	$ (4,415)
Net loss	-	(80,374)	(80,374)
Balance at September 30, 2019	32,719	(117,508)	(84,789)
Net loss	-	(11,611)	(11,611)
Balance at September 30, 2020	$ 32,719	$ (129,119)	$ (96,400)

See accompanying notes to consolidated financial statements.

Prospect EOGH, Inc.

Consolidated Statements of Cash Flows
(in thousands)

For the years ended September 30,	**2020**	2019
Operating activities		
Net loss	**$ (11,611)**	$ (80,374)
Adjustments to reconcile net loss to net cash provided by (used in) operating activities:		
Depreciation and amortization	**5,163**	7,153
Impairment of property, improvements and equipment and net current assets	**8,857**	51,991
Provision for bad debts	**5,648**	6,018
Loss on disposal of property, improvements and equipment	**-**	146
Changes in operating assets and liabilities:		
Patient accounts receivable	**1,792**	(8,917)
Due (to)/from government payers, net	**(185)**	(1,302)
Refund liability	**10,152**	-
Other receivables, prepaid expenses and other current assets	**375**	(4,558)
Inventories	**107**	(32)
Accounts payable and other accrued liabilities	**(2,062)**	(4,087)
Net cash provided by (used in) operating activities	**18,236**	(33,962)
Investing activities		
Purchases of property, improvements and equipment	**(885)**	(6,990)
Net cash used in investing activities	**(885)**	(6,990)
Financing activities		
Change in payable due to affiliated companies, net	**(17,233)**	41,562
Repayments of note payable	**(24)**	(6)
Repayments of capital leases	**(629)**	(493)
Net cash (used in) provided by financing activities	**(17,886)**	41,063
Change in cash	**(535)**	111
Cash, beginning of year	**706**	595
Cash, end of year	**$ 171**	$ 706
Supplemental disclosure of cash flow information		
Interest paid	**$ 420**	$ 676
Schedule of non-cash investing and financing activities		
Equipment acquired under capital leases	**$ -**	$ 805
Accrual of property, improvements and equipment	**$ 9**	$ 8

See accompanying notes to consolidated financial statements.

1. Organization

Prospect EOGH, Inc. ("EOGH" or the "Company") is a wholly-owned subsidiary of Prospect NJ, Inc. ("PNJ"). PNJ is wholly owned by Prospect Medical Holdings, Inc. ("Prospect" or "PMH"). EOGH operates a 201-bed acute care general hospital which provides healthcare services in East Orange, New Jersey and surrounding communities.

During the year ended September 30, 2019, Prospect made the determination to sell the operations of the Company. Prospect's decision to sell the operations of the Company was based on its historical financial results. In connection with this decision, under applicable accounting literature, the Company was required to test the long-lived assets for impairment as of September 30, 2020 and 2019. Under this test, the Company recorded impairment of property, improvements and equipment, net of $51,991,000, at September 30, 2019 and as a result the assets have been brought down to their net realizable value at that date. At September 30, 2020, the Company recorded further impairment of property, improvements and equipment, net of $5,247,000 and impairment to net current assets of $3,610,000, for total impairment of $8,857,000 for the year ended September 30, 2020.

In October 2020, Prospect entered into an Asset Purchase Agreement to sell the majority of the assets of the Company to an unrelated third party, for a purchase price of $6.2 million. The transaction requires approval by the Attorney General in the state of New Jersey, and is expected to close in the fourth quarter of fiscal year 2021.

COVID-19 Pandemic

In January 2020, the Secretary of the U.S. Department of Health and Human Services ("HHS") declared a national public health emergency due to a novel strain of coronavirus. In March 2020, the World Health Organization declared the outbreak of COVID-19, a disease caused by this coronavirus strain, a pandemic. The resulting measures to contain the spread and impact of COVID-19 have adversely affected the Company's results of operations. Where applicable, the impact resulting from the COVID-19 pandemic during the year ended September 30, 2020, has been considered, including updated assessments of the recoverability of assets and evaluation of potential credit losses. As a result of the COVID-19 pandemic, federal and state governments have passed legislation, promulgated regulations and taken other administrative actions intended to assist healthcare providers in providing care to COVID-19 and other patients during the public health emergency. Sources of relief include the Coronavirus Aid, Relief and Economic Security Act (the "CARES Act"), which was enacted on March 27, 2020, and the Paycheck Protection Program and Health Care Enhancement Act (the "PPPHCE Act"), which was enacted on April 24, 2020. Together, the CARES Act and the PPPHCE Act include $175 billion in funding to be distributed to eligible providers through the Public Health and Social Services Emergency Fund (the "Provider Relief Fund" or "PRF"). HHS has allocated Provider Relief Fund among eligible health care providers through two completed phases of general distributions and a number of targeted distributions beginning in April 2020. In October 2020, HHS announced an additional $20 billion general distribution from the Provider Relief Fund that considers financial losses and changes in operating revenues and expenses, including expenses attributable to COVID-19, and payments already received through PRF distributions.

CARES Act and PPPHCE Act Funds (included Medicare Advanced Payments)

The CARES Act also alleviates some of the financial strain on hospitals, physicians, other healthcare providers and states through a series of Medicare and Medicaid payment policies that temporarily increase Medicare and Medicaid reimbursement and allow for added flexibility, as described below.

(1) Effective May 1, 2020 through March 31, 2021, the 2% sequestration reduction on Medicare fee for service ("FFS") and payments to hospitals, physicians and other providers is suspended and will resume effective April 2021 as authorized by the Sequestration Transparency Act of 2020 and amended by the Consolidated Appropriations Act of 2021. The estimated impact of this change on the Company's operations is an increase of approximately $263,000 of revenues in fiscal 2020. The suspension is financed by a one-year extension of the sequestration adjustment through 2030.

(2) The CARES Act instituted a 20% increase in the Medicare Severity Diagnosis Related Groups ("MS-DRG") payment for confirmed COVID-19 hospital admissions for the duration of the public health emergency as declared by the Secretary of HHS.

(3) The CARES Act eliminated the scheduled nationwide reduction of $4 billion in federal Medicaid Disproportionate Share Hospital ("DSH") allotments to States in federal fiscal year ("FFY") 2020 mandated by the Affordable Care Act and decreased the FFY 2021 Medicaid DSH reduction from $8 billion to $4 billion effective December 1, 2020. Legislation passed in October 2020 delayed the 2021 reduction through December 11, 2020. The reduction mandated by the Patient Protection and Affordable Care Act ("PPACA") is set to be terminated at the end of FFY 2025.

(4) The CARES Act expanded the Medicare Accelerated and Advance Payments Program, which provides prepayment of claims to providers in certain circumstances, such as national emergencies or natural disasters. Under this measure, providers could request accelerated and advance payments during which time providers continue to receive payments for services. Under the CARES Act, accelerated and advance payments could be retained for 120 days; at the end of the 120-day period, the accelerated payment would be repaid via an offset of payments on claims that would otherwise be paid. Generally, repayments of the accelerated and advance payments the Company received were to commence during August 2020; however, under legislation passed in October 2020, providers may retain the accelerated payments for one year from the date of receipt before the Centers for Medicare and Medicaid Services ("CMS") commences recoupment, which will be effectuated by a 25% offset of claims payments for 11 months, followed by 50% offset for the succeeding six months. At the end of the 29-month period, interest on the unpaid balance will be assessed at 4% per annum. As of September 30, 2020, the Company had received Medicare accelerated and advance payments of approximately $10 million, which are reflected in refund liability, current and long term, in the accompanying consolidated balance sheets.

(5) A 6.2% increase in the Federal Medical Assistance Percentage ("FMAP") matching funds was instituted to help states respond to the COVID-19 pandemic. The additional funds are available to states from January 1, 2020 through the quarter in which the public health emergency period ends, provided that states meet certain conditions. An increase in states' FMAP leverages Medicaid's existing financing structure, which allows federal funds to be provided to states more quickly and efficiently than establishing a new program or allocating

money from a new funding stream. Increased federal matching funds support states in responding to the increased need for services, such as testing and treatment during the COVID-19 public health emergency, as well as increased enrollment as more people lose income and qualify for Medicaid during the economic downturn.

On September 19, 2020, HHS issued a Post-Payment Notice of Reporting Requirements for the PRF that were disbursed under the CARES Act. This notice changed guidance that had been previously communicated during June and July 2020. Key differences include introduction of the concept of calendar year measurement as opposed to quarterly measurement, the requirement to first apply stimulus monies received to healthcare related expenses attributable to COVID-19 (net of reimbursements from other sources), and change (negative change comparing calendar year 2020 over calendar year 2019) from lost revenues, as defined to net patient care operating income as defined, net of healthcare related expenses previously applied. The notice also allowed for an additional six months through June 30, 2021, for companies to use the remaining amounts toward expenses attributable to COVID-19 that have not been reimbursed by other sources, or apply toward lost net patient care operating income in an amount not to exceed the calendar 2019 net gain. Also, on October 22, 2020, HHS issued a notice that amended the September 19, 2020 guidance, to replace the comparison of operating income to lost revenues. On January 7, 2021, HHS issued further guidance for the PRF that were disbursed under the CARES Act by allowing the use for the calculation of lost revenues to use budgeted revenues as an alternative to comparing with prior year budgets, and allowing for targeted distributions to be used in the same way as general distributions. The definitions included in the Post-Payment Notice of Reporting Requirements may be subject to change or further interpretation. Management will continue to evaluate and monitor compliance with the terms and conditions through June 30, 2021.

The following table shows the funds that the Company received through the PRF in both general and targeted distributions during the year ended September 30, 2020 (in thousands):

	PRF Funds	Hotspot Funds	Other funds	Total
Funds received during the year ended September 30, 2020	$ 1,683	$ 12,350	$ 14,835	$ 28,868
Funds transferred to affiliated companies	-	(7,572)	-	(7,572)
Funds applied to lost revenues	(1,683)	(4,778)	(9,198)	(15,659)
Funds applied to incremental expenses	-	-	(5,635)	(5,635)
Funds applied to incremental capital assets	-	-	(2)	(2)
Funds unused at September 30, 2020	$ -	$ -	$ -	$ -

The amount of lost revenues (represented as a negative change in year-over-year net revenues from patient care related sources) was recorded in "pandemic relief grant income" and incremental expenses were recognized as a reduction to operating expense within the accompanying consolidated statements of operations for the year ended September 30, 2020. The recognition of amounts received is conditioned upon the provision of care for individuals with possible or actual cases of COVID-19 after January 31, 2020, certification that payment will be used to prevent, prepare for and respond to coronavirus and shall reimburse the recipient only for healthcare related expenses or lost revenues that are attributable to coronavirus, and receipt of the funds. Amounts are recognized as a reduction to operating costs and expenses only to the extent the Company is reasonably assured that underlying conditions are met. These monies have been recognized following the grant accounting model, recognizing income or reduction to expenses over the applicable reporting period as management becomes reasonably assured of meeting the required criteria. As of September 30, 2020, the Company had accounted for all such funds.

HHS has also used funds appropriated to the Provider Relief Fund and the Families First Coronavirus Response Act ("FFCRA") to provide claims reimbursement to health care providers for testing uninsured individuals for COVID-19, treating uninsured individuals with a primary COVID-19 diagnosis, and administering a COVID-19 vaccine to uninsured individuals. The COVID-19 uninsured program is administered through HHS's Health Resources & Services Administration ("HRSA") and began providing reimbursement in May of 2020. Generally, reimbursements under this program are set at Medicare FFS rates, exclusive of the 20% increase in the MS-DRG payment for confirmed COVID-19 hospital admissions under the CARES Act.

Liquidity

The Company is dependent on Prospect to fund ongoing operations. As of September 30, 2020, the Company had a liability of $84,990,000 due to Prospect, which is payable on demand, does not bear interest, and is included in due to affiliated companies, net in the accompanying consolidated balance sheets. Prospect does not intend to have the Company repay the liability in a manner which would impair the Company's ability to maintain sufficient liquidity to sustain ongoing operations.

2. Significant Accounting Policies

Principles of Consolidation and Basis of Presentation

The consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP") and include the accounts of EOGH's wholly-owned subsidiary, Prospect EOGH Hospital Properties Urban Renewal, LLC, but do not include the accounts of PNJ or Prospect. All significant intercompany balances and transactions have been eliminated in consolidation.

Net Patient Service Revenues

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

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

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

For the years ended September 30,	**2020**	2019
Medicare	**$ 33,917**	$ 32,113
Medicaid	**20,863**	25,782
Managed Care	**17,114**	17,517
Self-Pay/Other	**5,503**	11,158
Total	**$ 77,397**	$ 86,570

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

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

Cost report settlement estimates are recorded based upon as-filed cost reports and are adjusted for tentative settlements, if any, and when a final Notice of Program Reimbursement ("NPR") is issued in the year the settlement occurs.

Medicaid: Medicaid is a joint federal-state funded healthcare benefit program that is administered by states to provide benefits to qualifying individuals who are unable to afford care. The Company receives reimbursements under the fee-for-service component of Medicaid programs at prospectively determined rates for both inpatient and outpatient services. Similar to Medicare, cost report settlements are recorded based upon as-filed cost reports and adjusted for tentative and final settlements, if any, in the year the settlement occurs.

The New Jersey Health Care Reform Act of 1992 established Health Care Subsidy Funds to provide certain hospitals in New Jersey with funds necessary to provide charity care and other forms of uncompensated care. EOGH recognized revenue related to this program of $4,222,000 and $2,001,000 for the years ended September 30, 2020 and 2019, respectively.

Managed Care: The Company has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations ("HMOs"), and preferred

provider organizations ("PPOs"). The basis for payment under these agreements is in accordance with negotiated contracted rates or at the Company's standard charges for services provided.

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

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

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

Charity Care

The Company provides charity care to patients who lack financial resources and are deemed to be medically indigent based on criteria established under the Company's charity care policy. This care is provided without charge or at amounts less than the Company's established rates. Because the Company does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue. The direct and indirect costs related to this care totaled $3,181,000 and $4,733,000 for the years ended September 30, 2020 and 2019, respectively. Direct and indirect costs for providing charity care are estimated by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. In addition, the Company provides services to other medically indigent patients under various state Medicaid programs. Such programs pay amounts that are less than the cost of the services provided to the recipients. The Company has not changed its charity care or uninsured discount policies during the years ended September 30, 2020 or 2019.

Provisions for Contractual Allowances and Bad Debts

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

Accounts receivable are reduced by an allowance for doubtful accounts. Valuation of the collectability of accounts receivable and provision for bad debts is based on historical collection experience, payer mix and the age of the receivables. Management routinely reviews accounts receivable balances in conjunction with these factors and other economic conditions which might ultimately affect the collectability of the patient accounts, and makes adjustments to the Company's allowances as warranted. For receivables associated with services provided to patients who have third-party coverage, management analyzes contractually due amounts and subsequently calculates an allowance for doubtful accounts and provision for bad debts once the age of the accounts reaches a specific age category based on historical experience. For receivables associated with self-pay patients, management records a significant provision for bad debts beginning in the period services were provided based on past experience that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. During the year ended September 30, 2020, the Company transitioned from trended models based on a payment to charge ratios ("PCR") to models which primarily consider contractual rates for billed claims, but retained the PCR model for unbilled accounts receivable. Under the new models, net patient revenue was reduced by approximately $6,856,000. The allowance for doubtful accounts as a percent of gross patient accounts receivable was 78% and 68% at September 30, 2020 and 2019, respectively.

Other Non-Patient Hospital Revenues

Other non-patient Hospital revenues totaled $9,173,000 and $3,417,000 for the years ended September 30, 2020 and 2019, respectively, which includes grant revenues. In July 2019, a grant was received from the State of New Jersey that provides other non-patient hospital revenues of approximately $625,000 per month through June 2021. Management has evaluated the collectability of other receivables consisting primarily of other revenues and grant revenues and determined no allowance is necessary as of September 30, 2020 and 2019, respectively.

Legislation

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

Property, Improvements and Equipment, Net

Property, improvements and equipment are stated on the basis of cost or, in the case of acquisitions, at their acquisition date fair values less accumulated depreciation. Depreciation is provided using the straight-line method over the estimated useful lives of the assets, and amortization of leasehold improvements is provided using the straight-line basis over the shorter of the remaining lease period or the estimated useful lives of the leasehold improvements. Leasehold improvements are generally depreciated over seven years, buildings are depreciated over ten years, equipment is depreciated over three to seven years and furniture and fixtures are depreciated over five to seven years. Equipment capitalized under capital lease obligations are amortized over the lesser of the life of the lease or the useful life of the asset. During the years ended September 30, 2020 and 2019, the Company recorded impairment to property, improvements and equipment (see Notes 1 and 3).

Intangible Assets

Intangible assets include trade names. The Company reviews long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying value of such assets may not be recoverable. The Company considers assets to be impaired and writes them down to fair value if estimated undiscounted cash flows associated with those assets are less than their carrying amounts. Fair value is based upon the present value of the associated cash flows. Changes in circumstances (for example, changes in laws or regulations, technological advances or changes in strategies) may also reduce the useful lives from initial estimates. Changes in planned use of intangibles may result from changes in customer base, contractual agreements, or regulatory requirements. In such circumstances, management will revise the useful life of the long-lived asset and amortize the remaining net book value over the adjusted remaining useful life. In March 2020, the COVID-19 pandemic was identified as a triggering event. In evaluating whether indicators of impairment exist, the Company considered adverse changes in market value, laws and regulations, profitability, cash flows, ability to maintain enrollment and renew payer contracts at favorable terms, among other factors. There was no impairment of intangible assets recorded during the years ended September 30, 2020 and 2019.

Insurance Reserves

Medical Malpractice Liability Insurance

The individual physicians who contract with the physician organizations carry their own medical malpractice insurance, some of which may be purchased from Prospect's captive insurance company. The Company's hospital carries professional and general liability insurance to cover medical malpractice claims under claims made policies. Under the policies, insurance premiums cover only those claims actually reported during the policy term. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims related to occurrences during the policy term but reported subsequent to the policy's termination may be uninsured. Prospect's hospitals have a consolidated policy for professional and general liability insurance with separate retentions for each entity.

During the years ended September 30, 2020 and 2019, Prospect's captive insurance company provided malpractice and general liability ($5,000,000 per occurrence and $37,000,000 in the aggregate), along with excess healthcare professional liability and umbrella liability insurance policy on a claims-made basis covering healthcare professional liability, general liability, automobile liability, employers' liability, helipad liability and non-owned aircraft liability. The limit provided

was $80,000,000 during the years ended September 30, 2020 and 2019 for each loss event and in the annual aggregate excess of the primary coverage layers described above. This coverage was fully reinsured by third party carriers.

GAAP requires that a health care organization record and disclose the estimated costs of medical malpractice claims in the period of the incident of malpractice, if it is reasonably possible that liabilities may be incurred and losses can be reasonably estimated. The Company has recognized an estimated liability for incurred but not reported claims and the self-insured risks (including deductibles and potential claims in excess of policy limits) based upon an actuarial valuation of the Company's historical claims experience of the Company's hospitals. The Company's gross claims liability was $1,550,000 and $1,992,000 as of September 30, 2020 and 2019, respectively. The gross claims liability for September 30, 2020 and 2019 was estimated using a discount factor of 4% and is included within malpractice reserves in the accompanying consolidated balance sheets.

Workers' Compensation Insurance

The Company was fully insured for workers' compensation claims with no deductible during the years ended September 30, 2020 and 2019.

Reserve Methodology

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

Cash

Cash is primarily comprised of deposits with banks. The Company maintains its cash at banks with high credit-quality ratings.

Inventories

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

Income Taxes

Deferred income tax assets and liabilities are recognized for differences between financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. To the extent a deferred tax asset cannot be recognized under the preceding criteria, allowances must be established. The impact on deferred taxes of changes in tax rates and laws, if any, are applied to the years during which temporary differences are expected to be settled and reflected in the financial statements in the period of enactment. The Company recognizes interest and penalties

associated with income tax matters and unrecognized tax benefits in the income tax expense line item of the consolidated statements of operations.

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

Applicable accounting literature requires that the current and deferred tax expense for a group that files a consolidated return be allocated among the group members when those members issue separate financial statements. While the literature does not require the use of any particular allocation method, it does require the method to be systematic, rational, and consistent with GAAP. It goes on to indicate that the separate return method meets those criteria.

Under the separate return method, the carve-out entity calculates its tax provision as if it were filing its own separate tax return based on the pre-tax accounts included in the carve-out entity. This can result in perceived inconsistencies between the tax provision of the carve-out entity and the tax provision of the consolidated group. This is acceptable, as the literature acknowledges that if the separate return method is used, the sum of the amounts allocated to individual members of the group may not equal the consolidated amount.

Fair Value of Financial Instruments

Financial instruments consist primarily of cash, patient and other accounts receivables, accounts payable and other accrued liabilities, accrued salaries, wages and benefits, amounts due from(to) government payers, capital lease obligations, note payable, malpractice reserves and other liabilities. The carrying amounts of current assets and liabilities approximate their fair value due to the relatively short period of time between the origination of the instruments and their expected realization.

Concentrations of Credit Risk

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

Financial instruments that potentially subject the Company to concentrations of credit risk consist of receivables due from Medicare and Medicaid. The Company received revenues from Medicare and Medicaid as follows (in thousands):

For the years ended September 30,	**2020**	**% of Net Patient Services Revenues**	2019	% of Net Patient Services Revenues
Medicare	**$ 33,917**	**44%**	$ 32,113	37%
Medicaid	**20,863**	**27%**	25,782	30%
Total	**$ 54,780**	**71%**	$ 57,895	67%

Use of Estimates

The preparation of consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses, and the disclosure of contingent assets and liabilities at the dates, and for the periods, that the consolidated financial statements are prepared. Actual results could materially differ from those estimates. Principal areas requiring the use of estimates include third party settlements, amounts due from (to) government payers, allowances for contractual discounts and doubtful accounts, malpractice reserves, and impairment of long-lived assets and intangible assets.

New Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, "Revenue from Contracts with Customers (Topic 606)" with effective dates deferred for all entities by ASU 2015-14, and further deferred for nonpublic entities by ASU 2020-05. The core principle of ASU 2014-09 is built on the contract between a vendor and a customer for the provision of goods and services, and attempts to depict the exchange of rights and obligations between the parties in the pattern of revenue recognition based on the consideration to which the vendor is entitled. To accomplish this objective, the standard requires five basic steps: (i) identify the contract with the customer, (ii) identify the performance obligations in the contract, (iii) determine the transaction price, (iv) allocate the transaction price to the performance obligations in the contract, (v) recognize revenue when (or as) the entity satisfies a performance obligation. Nonpublic entities will apply the new standard for annual periods beginning after December 15, 2019, and interim periods within fiscal years beginning after December 15, 2020. Three basic transition methods are available — full retrospective, retrospective with certain practical expedients, and a cumulative effect approach. Under the third alternative, an entity would apply the new revenue standard only to contracts that are incomplete under legacy GAAP at the date of initial application and recognize the cumulative effect of the new standard as an adjustment to the opening balance of retained earnings. That is, prior years would not be restated and additional disclosures would be required to enable users of the financial statements to understand the impact of adopting the new standard in the current year compared to prior years that are presented under legacy GAAP. The Company has evaluated the effect of this guidance on its consolidated financial statements and does not expect the impact to be material to the consolidated financial statements.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)" with effective dates deferred for all entities by ASU 2019-10, and further deferred for nonpublic entities by ASU 2020-05. The core principle of ASU 2016-02 is that a lessee should recognize the assets and liabilities that arise from leases, including operating leases. Under the new requirements, a lessee will recognize in the statement of financial position a liability to make lease payments (the lease liability) and the right-of-use asset representing the right to the underlying asset for the lease term. For leases with a term of 12 months or less, the lessee is permitted to make an accounting policy election by class of underlying asset not to recognize lease assets and lease liabilities. The recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee have not significantly changed from previous GAAP. Nonpublic entities will apply the new standard for annual periods beginning after December 15, 2021, and interim periods within fiscal years beginning after December 15, 2022. The Company is currently evaluating the standard and the impact on its consolidated financial statements and footnote disclosures.

Reclassifications

Certain reclassifications were made to prior year consolidated financial statements in order to conform to the current year presentation. These reclassifications did not have a material impact on previously reported consolidated financial statements.

3. Property, Improvements and Equipment

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

September 30,	**2020**	2019
Property, improvements and equipment:		
Land and land improvements	**$ 341**	$ 341
Buildings and improvements	**13,242**	14,614
Equipment	**8,087**	10,992
	21,670	25,947
Less: accumulated depreciation	**(21,522)**	(16,601)
	148	9,346
Construction in Progress	**10**	86
Property, improvements and equipment, net	**$ 158**	$ 9,432

At September 30, 2020 and 2019, the Company had assets under capitalized leases of $2,165,000 and $2,165,000 and related accumulated depreciation of $1,901,000 and $1,813,000, respectively.

Depreciation expense was $4,921,000 and $6,911,000 for the years ended September 30, 2020 and 2019, respectively.

In connection with Prospect's decision to sell East Orange General Hospital, the Company was required to test the long-lived assets for impairment as of September 30, 2020 and 2019, under applicable accounting literature. Under this test, the Company recorded impairment of property, improvements and equipment, net of $5,247,000 and $51,991,000, respectively, along with impairment of net current assets of $3,610,000 as of September 30, 2020, for total impairment of $8,857,000 for the year ended September 30, 2020, which is included in the consolidated statements of operations.

4. Intangible Assets

Identifiable intangible assets are comprised of tradenames (in thousands):

September 30,	Amortization Period	**2020**	2019
Total acquisition cost of intangible assets	10 years	**$ 2,039**	$ 2,039
Less accumulated amortization		**(726)**	(484)
Intangible assets, net		**$ 1,313**	$ 1,555

Amortization is recognized on a straight-line basis (management's best estimate of the period of economic benefit) over the respective useful lives. Amortization expense was approximately $242,000 for each of the years ended September 30, 2020 and 2019.

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

Years ending September 30,	
2021	$ 242
2022	242
2023	242
2024	242
2025	242
Thereafter	103
Total	$ 1,313

The weighted-average remaining useful life for the intangible assets was approximately 6 years as of September 30, 2020.

5. Related Party Transactions

The Company has transactions with Prospect and fellow subsidiaries of Prospect related to payments that may be made on behalf of the Company, and vice versa. At September 30, 2020 and 2019, the Company had a net payable due to Prospect in the amount of $84,990,000 and $102,223,000, respectively, which is reflected in due to affiliated companies, net on the accompanying consolidated balance sheets.

6. Income Taxes

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

For the years ended September 30,	**2020**	2019
Current:		
Federal	**$ -**	$ (129)
State	**(7)**	20
	(7)	(109)
Total:		
Federal	**-**	(129)
State	**(7)**	20
	$ (7)	$ (109)

Temporary differences and carry forward items that result in deferred income tax balances as of September 30, 2020 and 2019 are as follows (in thousands):

September 30,	**2020**	2019
Deferred tax assets:		
Net operating loss	**$ 25,696**	$ 24,962
Allowances for bad debts	**78**	14
Charitable contribution	**2**	-
Deferred revenue	**1,771**	-
Deferred FICA taxes	**395**	-
Vacation accrual	**657**	324
Fixed assets	**10,403**	9,027
Interest expense limitation	**-**	224
Prepaid	**-**	2
State taxes	**1**	24
Deferred tax assets	**39,003**	34,577
Valuation allowance	**(38,458)**	(34,154)
Net deferred tax assets	**545**	423
Deferred tax liabilities:		
Prepaids	**(238)**	(263)
Intangibles	**(307)**	(160)
Deferred tax liabilities	**(545)**	(423)
Net deferred tax assets	**$ -**	$ -

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

The difference between the reported amount of income tax expense and the expected amount of income tax expense applying the federal statutory tax rate is predominately due to the state and local income taxes net of federal benefit, deferred true-up and valuation allowance.

The Company is a wholly-owned indirect subsidiary of Ivy Holdings, Inc. ("Ivy Holdings"). Ivy Holdings files consolidated federal and combined state tax returns, which includes Prospect EOGH, Inc. The Company files a separate state return for New Jersey.

During fiscal year 2019, the Company completed an Internal Revenue Service ("IRS") examination for Ivy Holdings, Inc. & Subsidiaries for fiscal year 2014 through 2016 federal income tax returns without any adjustment to reported taxable income. The Company's tax years 2016 through 2018 are open for federal income tax examination, and generally, the states are open for tax years 2015 through 2018. The Company does not currently anticipate any changes to our unrecognized tax benefits for the next twelve months related to these examinations.

The Company has evaluated the CARES Act and does not expect the legislation to have a significant impact on the effective tax rate of the Company.

7. Commitments and Contingencies

Leases

The Company leases various office facilities and equipment from third parties under non-cancelable operating and capital lease arrangements expiring at various dates through November 2021. Capital leases bear interest at rates ranging from 4.45% to 11.48% per annum.

The future minimum annual lease payments required under leases in effect at September 30, 2020, are as follows (in thousands):

For the years ending September 30,	Capital Leases	Operating Leases
2021	$ 473	$ 33
2022	254	-
Total minimum lease payments	727	$ 33
Less: amounts representing interest	(29)	
	698	
Less: current portion	(448)	
	$ 250	

Rent expense was $338,000 and $342,000 for the years ended September 30, 2020 and 2019, respectively.

Contingent Liability for Borrowings by Prospect Under Credit Facility

The Company is contingently liable as a guarantor, among others, for amounts that may from time to time be borrowed by PMH on a credit facility. The obligations and related interest expense related to the credit facility is not reflected in the Company's consolidated financial statements as of and for the years ended September 30, 2020 and 2019, as the borrowings are reflected in the separate consolidated financial statements of PMH.

On February 22, 2018, PMH entered into an ABL Credit Agreement (the "ABL Agreement"), by and among PMH (as the borrower), the lenders party thereto and JPMorgan, as administrative agent and collateral agent. Under the ABL Agreement, the maximum revolving commitment was $250.0 million with ability to expand the facility to $325.0 million (the "ABL Facility"), and the ABL facility bears interest at a variable base rate plus an applicable spread that is based on excess availability under the ABL Facility, as further described in the ABL Agreement, which was 4.0% and 6.0% as of September 30, 2020 and 2019, respectively. From January 2019 through July 2019 PMH entered into various amendments to the ABL Agreement. Such amendments (i) waived certain events of default at September 30, 2018; (ii) increased the maximum revolving commitment from $250.0 million to $280.0 million, and further to $285.0 million, while simultaneously reducing and removing future expansion of the facility; (iii) introduced $40.0 million of a first in last out ("FILO") revolving

facility, which incurred interest at either 2.5% or 3.5% per annum depending on whether they are Eurodollar loans or ABR loans (which were repaid on August 23, 2019); (iv) provides for a reduction in the maximum revolving commitment by $20.0 million and $10.0 million upon the future planned closure or disposition of PMH's hospital facilities in Texas and New Jersey, respectively. In January 2020, the maximum revolving commitment under the ABL Agreement decreased by $10.0 million to $275.0 million in connection with the sale of one of the acute care building at Nix Health in Texas in December 2019. The ABL Facility matures on February 22, 2023. As of September 30, 2019, the outstanding balance and the available balance on the New ABL facility was approximately $70.0 million and $175.6 million, respectively. As of September 30, 2020, no amounts were borrowed under the ABL Facility and the available balance to borrow was approximately $210.8 million. The ABL Facility is secured by a first priority security interest on all assets of PMH and most of its wholly owned subsidiaries, including the Company, except for certain assets of some hospital tenants pledged as security for obligations owed to their landlord, Medical Properties Trust ("MPT"). No assets of the Company, or its subsidiaries, are pledged as collateral for MPT. The ABL Agreement does not have any financial maintenance covenants. The ABL Agreement has a "springing" fixed charge ratio covenant that applies if excess availability is less than the greater of 10% of the maximum borrowing amount and $22.0 million. The fixed charge ratio covenant was not required to be tested for the fiscal quarter ended September 30, 2020 because no amounts were borrowed as of September 30, 2020.

Litigation

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

Legislation and HIPAA

Numerous state and federal laws and regulations govern the collection, dissemination, use, privacy, confidentiality, security, availability and integrity of personally identifiable information, including protected health information. These laws and regulations include the Health Insurance Portability and Accountability Act, as amended, and its implementing regulations, as well as The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") (collectively, "HIPAA"). HIPAA establishes a set of basic national privacy and security standards for the protection of protected health information, or PHI, by health plans, healthcare clearinghouses and certain healthcare providers, referred to as covered entities, and the business associates with whom such covered entities contract for services, which includes us.

HIPAA requires the Company to develop and maintain policies and procedures with respect to PHI that is used or disclosed, including the adoption of administrative, physical and technical safeguards to protect such information. HIPAA also implemented the use of standard transaction code sets and standard identifiers that covered entities must use when submitting or receiving certain electronic healthcare transactions, including activities associated with the billing and collection of healthcare claims.

HIPAA imposes mandatory penalties for certain violations. Penalties for violations of HIPAA and its implementing regulations start at $100 per violation and are not to exceed $50,000 per violation, subject to a cap of $1.5 million for violations of the same standard in a single calendar year. However, a single breach incident can result in violations of multiple standards. HIPAA also authorizes state attorneys general to file suit on behalf of their residents. Courts will be able to award damages, costs and attorneys' fees related to violations of HIPAA in such cases. Although HIPAA does not create a private right of action allowing individuals to sue the Company in civil court for violations of HIPAA, its standards have been used as the basis for duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI.

In addition, HIPAA mandates that HHS conduct periodic compliance audits of HIPAA covered entities or business associates for compliance with the HIPAA Privacy and Security Standards. It also tasks HHS with establishing a methodology whereby harmed individuals who were the victims of breaches of unsecured PHI may receive a percentage of the Civil Monetary Penalty fine paid by the violator.

HIPAA further requires that patients be notified of any unauthorized acquisition, access, use or disclosure of their unsecured PHI that compromises the privacy or security of such information, with certain exceptions related to unintentional or inadvertent use or disclosure by employees or authorized individuals. HIPAA specifies that such notifications must be made "without unreasonable delay and in no case later than 60 calendar days after discovery of the breach." If a breach affects 500 patients or more, it must be reported to HHS without unreasonable delay, and HHS will post the name of the breaching entity on its public web site. Breaches affecting 500 patients or more in the same state or jurisdiction must also be reported to the local media. If a breach involves fewer than 500 people, the covered entity must record it in a log and notify HHS at least annually.

In addition to these HIPAA laws, states have also developed their own standards for the privacy and security of health information as well as for reporting certain violations and breaches (for example, California's Confidentiality of Medical Information Act and Lanterman-Petris Short Act). When these state laws provide greater patient privacy protection, they are considered more stringent than HIPAA and are not preempted by HIPAA (HIPAA preempts state privacy laws that provide lesser patient privacy protection than HIPAA's Privacy Rule and state security laws that are contrary to HIPAA's Security Rule). Other federal privacy laws may also apply to certain services provided by the Company, including 42 C.F.R. Part 2, which addresses the confidentiality of substance use disorder records.

Numerous other federal and state laws protect the confidentiality, privacy, availability, integrity and security of personally identifiable information ("PII"), including protected health information ("PHI") governed by HIPAA. These PII laws in many cases are more restrictive than, and may not be preempted by, HIPAA and may be subject to varying interpretations by courts and government agencies, creating complex compliance issues for us and potentially exposing the Company to additional expense, adverse publicity and liability.

New health information standards, whether implemented pursuant to HIPAA, congressional action or otherwise, could have a significant effect on the manner in which the Company must handle healthcare related data, and the cost of complying with standards could be significant. If the Company does not comply with existing or new laws and regulations related to PHI, the Company could be subject to criminal or civil sanctions.

Because of the extreme sensitivity of the PII that is stored and transmitted, the security features of the Company's information systems are very important. If the security measures are breached or fail, unauthorized persons may be able to obtain access to PII and PHI. As a result, the Company's

reputation could be severely damaged, the Company could face litigation, damages for contract breach, penalties and regulatory actions for violation of HIPAA and other applicable laws or regulations and significant costs for remediation, notification to individuals and for measures to prevent future occurrences. Any potential security breach could also result in increased costs associated with liability for stolen assets or information, repairing system damage that may have been caused by such breaches, implementing measures to prevent future occurrences, and engaging third-party experts and consultants. While the Company maintains insurance covering certain security and privacy damages and claim expenses, the Company may not carry insurance or maintain coverage sufficient to compensate for all liability and in any event, insurance coverage would not address the reputational damage that could result from a security breach of PHI or PII.

The Company outsources important aspects of the storage and transmission of client and patient information, and thus rely on third parties to manage functions that have material cyber-security risks. The Company attempts to address these risks in part by requiring outsourcing subcontractors who handle client and patient information to sign business associate agreements contractually requiring those subcontractors to adequately safeguard personal health data to the same extent that applies to the Company. However, it cannot be assured that these contractual measures and other safeguards will adequately protect the Company from the risks associated with the storage and transmission of client and patients' proprietary and protected health information.

The Company also publishes statements to patients that describe how the Company handles and protects personal information. If federal or state regulatory authorities or private litigants consider any portion of these statements to be untrue, the Company may be subject to claims of deceptive practices, which could lead to significant liabilities and consequences, including, without limitation, costs of responding to investigations, defending against litigation, settling claims and complying with regulatory or court orders.

Affordable Care Act

The PPACA has made significant changes to the United States health care system. The legislation impacted multiple aspects of the health care system, including many provisions that change payments from Medicare, Medicaid and insurance companies. Under this legislation, 36 states and the District of Columbia have expanded their Medicaid programs to cover previously uninsured childless adults, and voters in two additional states (Missouri and Oklahoma) approved ballot measures in 2020 to add Medicaid expansion to the state's constitution with expansion coverage to begin no later than July 1, 2021. In addition, many uninsured individuals have had the opportunity to purchase health insurance via state-based marketplaces, state-based marketplaces using a federal platform, state-partnership marketplaces or the federally-facilitated marketplace. PPACA also implemented a number of health insurance market reforms, such as allowing children to remain on their parents' health insurance until age 26 or prohibiting certain plans from denying coverage based on pre-existing conditions. Nationally, these reforms have reduced the number of uninsured individuals.

It is unclear what changes may be made to PPACA, if any, given the new Biden Administration following the results of the presidential and congressional races and the pending decision from the Supreme Court in the consolidated matter entitled California v Texas, addressing the validity of the Act. The Tax Cuts and Jobs Act ("TCJA"), passed in December 2017, eliminated the individual mandate shared responsibility payment (penalty) under PPACA, effective January 1, 2019. The individual mandate penalty was included in PPACA to address concerns that other market reforms expanding access to coverage might produce adverse selection and higher premiums. Although data

suggests that some reduction in enrollment occurred in 2019 following elimination of the individual mandate penalty and that premium rates also dropped slightly nationally, the extent to which the repeal of the individual mandate penalty will impact the uninsured rate and future premiums are unclear at this juncture.

On December 14, 2018, the United States District Court for the Northern District of Texas ruled that the individual mandate without the penalty is unconstitutional and that PPACA is therefore invalid in its entirety. On December 18, 2018, a panel of the United States Court of Appeals for the Fifth Circuit largely affirmed, concluding that the plaintiffs have standing to challenge the law and that the individual mandate without the penalty is unconstitutional, but remanded the matter to the district court for further analysis of the extent to which the individual mandate is severable from some, all, or none of PPACA's other provisions. Litigation in this matter is ongoing, with the Supreme Court scheduled to hear oral arguments on November 10, 2020. The outcome of this appeal is uncertain following the passing of Justice Ruth Bader Ginsburg and the confirmation of Judge Amy Coney Barrett to fill her seat on the Court. In addition, following the change in Administration, the United States, on February 10, 2021, filed a letter with the Supreme Court indicating it has reconsidered its position. It is now the position of the United States that: (1) 26 U.S.C. section 5000A as amended to eliminate the monetary penalty remains constitutional; and (2) should the Court nevertheless determine that 26 U.S.C. section 5000A as amended is unconstitutional, the remainder of the PPACA is severable from that provision. The Court is scheduled to issue its ruling by June 2021. This litigation along with any future legislative changes to PPACA or other federal and state legislation could have a material impact on the operations of the Company. The Company is continuing to monitor the legislative environment and developments in pending litigation for risks and uncertainties.

Employee Health Plans

The Company offers self-insured exclusive provider organization ("EPO")/HMO and PPO plans to all eligible employees.

Employee health benefits are administered by a third-party claims administrator, based on plan coverage and eligibility guidelines determined by the Company, as well as by collective bargaining agreements. Commercial insurance policies cover per occurrence losses in excess of $160,000. An actuarially estimated liability of approximately $676,000 and $474,000 as of September 30, 2020 and 2019, respectively, for incurred but not reported claims is included in due to affiliated companies, net on the consolidated balance sheets.

Provider Contracts

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

8. Defined Contribution Plan

Prospect sponsors defined contribution plans (the "Plans") covering substantially all employees of Prospect who meet certain eligibility requirements, including the Company. Under the Plans, employees can contribute up to 100% of their compensation up to the IRS deferred annual maximum.

The Company may make discretionary matching contributions to the Plan. The Company did not make any contributions to the Plan for the years ended September 30, 2020 or 2019.

9. Subsequent Events

The Company has evaluated subsequent events through March 26, 2021, the date the Company's consolidated financial statements were available for issuance.

In October 2020, Prospect entered into an Asset Purchase Agreement to sell the majority of the assets of the Company to an unrelated third party, for a purchase price of $6.2 million. The transaction requires approval by the Attorney General in the state of New Jersey, and is expected to close in the fourth quarter of fiscal 2021.

Subsequent to year-end, through a commutation agreement certain policies and reinsurance amendments were revised, which transferred risk for self-insured layers of coverage for the hospital and physician professional and general liability, medical stop loss and certain buffer layer excess programs from PMH's captive insurance company to the Company's hospitals and affiliated subsidiaries.