AUDITED FINANCIAL STATEMENTS AND OTHER SUPPLEMENTARY INFORMATION

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)
Year Ended September 30, 2014
With Report of Independent Auditors

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Audited Financial Statements and
Other Supplementary Information

Year Ended September 30, 2014

Contents

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Report of Independent Auditors

The Board of Directors
IASIS Healthcare Corporation, sole member of
IASIS Healthcare LLC

We have audited the accompanying financial statements of Health Choice Arizona, a division of Health Choice Arizona, Inc., which is a wholly owned subsidiary of IASIS Healthcare LLC, which comprise the balance sheet as of September 30, 2014, and the related statements of earnings, changes in equity of Parent and cash flows for the year then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity 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 audit. We conducted our audit 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 financial position of Health Choice Arizona at September 30, 2014, and the results of its operations and its cash flows for the year then ended in conformity with U.S. generally accepted accounting principles.

Restatement of 2014 Financial Statements

As discussed in Note 1A, the financial statements have been restated to correct errors in revenue recognition for the program settlement balances and for certain other errors. Our opinion is not modified with respect to this matter.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The details of the attached schedules (pages 18-24) of other supplementary information are presented for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management. The information has not been subjected to the auditing procedures applied in our audit of the financial statements and, accordingly, we express no opinion on it.

Ernst + Young LLP

Nashville, TN
January 27, 2015, except for Note 1A, as to
which the date is June 16, 2015

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Balance Sheet (Restated)

September 30, 2014

Assets	
Current assets:	
AHCCCS receivables, net	$ 22,666,658
Health insurer fee receivable	8,169,987
Due from affiliates	299,177,038
Other current assets	4,332,063
Total current assets	334,345,746
Goodwill	5,756,914
Other intangible assets, net of accumulated amortization of $30,000,000	15,000,000
Total assets	$ 355,102,660
Liabilities and equity of Parent	
Current liabilities:	
Accounts payable and accrued expenses	$ 92,681
Health insurer fee payable	7,027,622
Medical claims payable	67,379,775
Total current liabilities	74,500,078
Equity:	
Equity of Parent	280,602,582
Total liabilities and equity of Parent	$ 355,102,660

See accompanying notes.

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Statement of Earnings (Restated)

Year Ended September 30, 2014

Revenues	
Capitation premiums	$ 547,866,042
Delivery supplemental premiums	33,688,868
Health insurer fee revenue	8,169,987
Other revenue	100,324
Total revenues	589,825,221
Medical expenses	
Hospitalization, net	106,089,969
Medical compensation	131,199,337
Other medical, net	281,211,107
Total medical expenses	518,500,413
Administrative expenses	61,567,229
Total expenses	580,067,642
Earnings before income taxes	9,757,579
Income taxes	5,261,541
Net earnings	$ 4,496,038

See accompanying notes.

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Statement of Changes in Equity of Parent (Restated)

Year Ended September 30, 2014

	Contributed Capital	Retained Earnings	Total
Balance at September 30, 2013	$ 85,875,813	$ 190,230,731	$ 276,106,544
Net earnings	-	4,496,038	4,496,038
Balance at September 30, 2014	$ 85,875,813	$ 194,726,769	$ 280,602,582

See accompanying notes.

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Statement of Cash Flows (Restated)

Year Ended September 30, 2014

Operating activities	
Net earnings	$ 4,496,038
Adjustments to reconcile net earnings to net cash provided operating activities:	
Amortization	3,000,000
Changes in operating assets and liabilities:	
AHCCCS receivable, net	(15,669,876)
Health insurer fee receivable	(8,169,987)
Other current assets	194,415
Accounts payable and accrued expenses	(52,966)
Health insurer fee payable	7,027,622
Medical claims payable	16,676,111
Net cash provided by operating activities	7,501,357
Financing activities	
Change in due from affiliates	(7,501,357)
Net cash used in financing activities	(7,501,357)
Change in cash and cash equivalents	–
Cash and cash equivalents, beginning of year	–
Cash and cash equivalents, end of year	$ –

See accompanying notes.

Health Choice Arizona
(A Division of Health Choice Arizona, Inc.)

Notes to Financial Statements

September 30, 2014

1. Organization and Basis of Presentation

Health Choice Arizona (the Plan or Health Choice) is a division of Health Choice Arizona, Inc. (the Parent), which is a wholly owned subsidiary of IASIS Healthcare LLC (IASIS). The Parent is a provider-owned, managed care organization and insurer that delivers healthcare services to members through multiple health plans, accountable care networks and managed care solutions. IASIS provides high quality affordable healthcare services primarily in high-growth urban and suburban markets through 16 acute care hospital facilities and one behavioral health hospital facility with a total of 3,781 licensed beds, several outpatient service facilities and 134 physician clinics. The Plan is a prepaid Medicaid managed health plan that derives all of its revenue through a contract with the Arizona Health Care Cost Containment System (AHCCCS) to provide specified healthcare services to qualified Medicaid enrollees through contracts with providers, including affiliates of IASIS. AHCCCS is the state agency that administers Arizona's Medicaid program. The contract requires the Plan to arrange for healthcare services for enrolled Medicaid patients in exchange for fixed monthly premiums, based on negotiated per capita member rates, and supplemental payments from AHCCCS. These services are provided regardless of the actual costs incurred to provide these services. The Plan receives reinsurance and other supplemental payments from AHCCCS to cover certain costs of healthcare services that exceed certain defined thresholds.

On March 25, 2013, Health Choice was awarded a contract by AHCCCS. The contract commenced on October 1, 2013, which covers enrollees in Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pima and Pinal counties, and has an initial term of three years, and includes two-one year renewal options at the discretion of AHCCCS. The contract is terminable without cause on 90 days' written notice, or for cause upon written notice if the Plan fails to comply with any term or condition of the contract or fails to take corrective action as required to comply with the terms of the contract. Additionally, AHCCCS can terminate the contract in the event of the unavailability of state or federal funding.

1A. Restatement of Previously Issued Financial Statements

The Plan has restated its financial statements for the fiscal year ended September 30, 2014. The determination to restate its financial statements for the fiscal year ended September 30, 2014 occurred after IASIS' management, through an internal review of the program settlement process described below identified certain errors made by a former managed care division finance employee. Subject to restatement is the Plan's balance sheet as of September 30, 2014, and the related statements of earnings, changes in equity of Parent and cash flows for the fiscal year ended September 30, 2014, and affected footnotes. This restatement corrects errors for the fiscal year ended September 30, 2014 in the accounting for estimated program settlement amounts (the "program settlements") for the Plan, and corrects certain other errors determined to be immaterial individually and in the aggregate to the financial statements.

Estimates of future program settlements are calculated and recorded based on projected and known premium revenue, medical claims and member eligibility. The program settlement reconciliation process typically occurs in the 18 months post-plan year, when actual (rather than projected) medical claims and member eligibility information is fully available and a net settlement amount is either due to or from the state. During the fiscal year ended September 30, 2014, the Plan's revenue and receivables associated with these program settlements were overstated. These errors did not involve any cash payments, as actual program settlements are not paid until the end of the reconciliation process.

The impact of the correction of errors on the affected line items of the Plan's balance sheet as of September 30, 2014 and the statements of earnings and cash flows for the fiscal year ended September 30, 2014 is set forth below:

Balance Sheet
as of September 30, 2014

	As previously reported	Adjustments	As restated
AHCCCS receivables, net	$ 53,392,048	$ (30,725,390)	$ 22,666,658
Due from affiliates	288,423,152	10,753,886	299,177,038
Total current assets	354,317,250	(19,971,504)	334,345,746
Total assets	375,074,164	(19,971,504)	355,102,660
Equity of Parent	300,574,086	(19,971,504)	280,602,582
Total liabilities and equity of Parent	375,074,164	(19,971,504)	355,102,660

Statement of Earnings
For the Year Ended September 30, 2014

	As previously reported	Adjustments	As restated
Capitation premiums	$ 578,591,432	$ (30,725,390)	$ 547,866,042
Total revenues	620,550,611	(30,725,390)	589,825,221
Earnings before income taxes	40,482,969	(30,725,390)	9,757,579
Income taxes	16,015,427	(10,753,886)	5,261,541
Net earnings	24,467,542	(19,971,504)	4,496,038

Statement of Cash Flows
For the Year Ended September 30, 2014

	As previously reported	Adjustments	As restated
Net earnings	$ 24,467,542	$ (19,971,504)	$ 4,496,038
AHCCCS receivable, net	(46,395,266)	30,725,390	(15,669,876)
Net cash provided by (used in) operating activities	(3,252,529)	10,753,886	7,501,357
Change in due from affiliates	3,252,529	10,753,886	(7,501,357)
Net cash provided by (used in) financing activities	3,252,529	10,753,886	(7,501,357)

2. Summary of Significant Accounting Policies (Restated)

Due From Affiliates

Due from affiliates mostly represents the net excess of funds transferred to the centralized cash management account of IASIS over funds transferred to or paid on behalf of the Plan. Due from affiliates balances are readily available to the Plan for settlement of the Plan's current liabilities as they become due. Generally, this balance is decreased by automatic cash transfers from the IASIS accounts to the Plan's bank accounts to pay certain expenses. Generally, the balance is increased through transfers of daily cash deposits from the Plan's bank accounts to the centralized cash management account of IASIS. Interest income is not earned on outstanding balances due from affiliates.

Goodwill

Pursuant to accounting guidance related to goodwill and other intangible assets, goodwill is not amortized but is subject to annual impairment reviews or more often if events or circumstances indicate it may be impaired. An impairment loss is recorded to the extent that the carrying amount of goodwill exceeds its implied fair value. The Parent has completed its annual impairment test for the 2014 fiscal year, which resulted in no impairment.

Long-Lived Assets

The primary components of the Plan's long-lived assets are intangible assets. When events, circumstances or operating results indicate that the carrying values of certain long-lived assets (excluding goodwill) that are expected to be held and used might be impaired, the Plan considers the recoverability of assets to be held and used by comparing the carrying amount of the assets to the undiscounted value of future net cash flows expected to be generated by the assets. If assets are identified as impaired, the impairment is measured as the amount by which the carrying amount of the assets exceeds the fair value of the assets as determined by independent appraisals or estimates of discounted future cash flows.

Intangible Assets

Other intangible assets consist solely of the Plan's contract with AHCCCS, which is amortized over a period of 15 years, which approximates the contract's estimated useful life, including assumed renewal periods. Amortization of intangible assets totaled $3,000,000 for the year ended September 30, 2014, and is included in administrative expenses in the accompanying statement of earnings.

Revenue Recognition

Capitation premiums are recognized as revenue in the month that members of the Plan are entitled to healthcare services. Capitation premiums are subject to an episodic/diagnostic risk factor adjustment. Health Choice receives capitation payments for Prior Period Coverage (PPC) separately from its prospective capitation payments. PPC capitation payments are intended to cover those healthcare costs incurred by individuals while they are awaiting enrollment in the Plan. PPC revenues are recognized in the month in which the member is eligible for coverage under the Plan. AHCCCS limits the profitability and loss that health plans may recognize for both the Title XIX Waiver Group (TWG) and PPC member populations to 2%. All other prospective risk groups are subject to a tiered prospective profit reconciliation for the contract year ending September 30, 2014, based upon prospective expenses and prospective net capitation. As of September 30, 2014, the Plan had an estimated net receivable of approximately $22,667,000 for all risk groups.

Delivery supplemental premiums are payments received per newborn delivery and are intended by AHCCCS to cover the cost of maternity care for qualified pregnant women. Such premiums are billed and recognized in the month that delivery occurs.

Medical Expenses

Monthly capitation payments to primary care physicians and other healthcare providers are expensed in the month services are contracted to be performed. Claims expense for non-capitated arrangements is accrued as services are rendered by hospitals, physicians and other healthcare providers during the year. Monthly capitation payments and claims expense for non-capitated arrangements are recorded as hospitalization medical expense in the accompanying statement of earnings. Medical compensation includes primary care and specialty physician services. Other medical, net includes hospital outpatient services and other ancillary services such as radiology and lab and is net of Third Party Liability (TPL) recoveries received. TPL recoveries are payments received from a third party such as an individual, entity, or program that is, or may be, liable to pay for any medical services provided to an AHCCCS member. AHCCCS is the payor of last resort when there is another liable party.

Medical claims payable includes claims received but not paid and an estimate of claims incurred but not reported. Incurred but not reported claims are estimated using a combination of historical claims experience (including severity and payment lag time) and other actuarial analysis including number of enrollees, age of enrollees and certain enrollee health indicators to predict the cost of healthcare services provided to enrollees during any given period. While management believes that its estimation methodology effectively captures trends in medical claims costs, actual payments could differ significantly from estimates given changes in the healthcare cost structure or adverse experience. During the year ended September 30, 2014, the Plan recognized hospital medical claims expenses by increasing the medical claims payable related to estimates for prior periods by approximately $4,082,000. In order to evaluate the appropriateness of medical claims payable at September 30, 2014, the Plan engaged an actuary to provide an independent estimate of its medical claims payable.

Reinsurance

Reinsurance recoveries are recognized under the contract with AHCCCS when healthcare costs exceed stated amounts as provided under the contract, including estimates of such costs at the end of each accounting period. Contractually, the Plan is reimbursed by AHCCCS at a rate ranging from 75% to 100% for qualified healthcare costs for those members that exceed stated amounts of up to $25,000, depending on the case type of the member. Qualified costs must be incurred during the contract year and are the lesser of the amount paid by the Plan or the AHCCCS fee schedule. In the event that AHCCCS is unable to honor its reinsurance commitment, the Plan may be responsible for excess costs incurred. Reinsurance recoveries totaling approximately $14,737,000 were recognized during the year ended September 30, 2014,

and are included as a reduction of hospital medical expenses in the accompanying statement of earnings.

Health Insurer Fee

Effective January 1, 2014, the Plan began accounting for the mandated health insurer fee (HIF) to be paid to the federal government by health insurers, as part of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, which is imposed for calendar years beginning after December 31, 2013. The HIF is based on a company's share of the industry's net premiums written during the preceding calendar year, and is payable on September 30 of each year. The Plan's portion of the HIF for the 2014 calendar year is approximately $7,028,000. The HIF is non-deductible for federal income tax purposes. The Plan recorded the estimated liability for the HIF in full with a corresponding deferred asset that is being amortized to expense on a straight-line basis during the 2014 calendar year. The Plan's liability for the HIF is recorded as Health insurer fee payable on the accompanying balance sheet. The corresponding deferred asset is recorded within other current assets in the accompanying consolidated balance sheet. During the year ended September 30, 2014, the Plan recognized approximately $5,275,000 in other administrative expenses related to amortization of the HIF, with a remaining deferred cost asset balance of approximately $1,752,000. Because the Plan primarily serves individuals in government-sponsored programs, the Plan must secure additional reimbursement from state partners for this added cost. The Plan recognizes HIF revenue when there is a contractual commitment from the state to reimburse Health Choice for the full economic impact of the health insurer fee. HIF revenue is recognized ratably throughout the year. During the year ended September 30, 2014, HIF revenue totaling $8,170,000 was recognized as a result of the contractual commitment from Arizona, which included $2,915,000 related to a contractual commitment to reimburse Health Choice for the impact of the non-deductibility of the HIF for income tax purposes.

Administrative Expenses

The primary components of administrative expenses are management fees, HIF expense, premium taxes and amortization expense. Management fees are described further in Note 3.

Income Taxes

IASIS files consolidated federal and state income tax returns, which include the operating results of the Plan. IASIS allocates taxes to the Plan pursuant to the asset and liability method, as if the

Plan were a separate taxpayer. For balance sheet purposes, such allocations are included in due from affiliates in the accompanying balance sheet.

Fair Value of Financial Instruments

AHCCCS receivables, net, due from affiliates other current assets, accounts payable and accrued expenses, Health insurer fee receivable and payable and medical claims payable represent financial instruments. The carrying value of these financial instruments approximates their fair market value due to the short-term nature of these instruments.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates and are accounted for in the period identified.

Subsequent Events Consideration

The Plan evaluated events and transactions occurring subsequent to September 30, 2014 through June 16, 2015, the date these financial statements were available for issuance. During this period, there were no subsequent events that required recognition in the financial statements.

3. Transactions with Affiliates

The Plan is party to a management agreement with Health Choice Management Company (the Management Company), a wholly owned subsidiary of IASIS, which manages the general and administrative functions related to the Plan inclusive of payroll, advertising and related expenses. During the year ended September 30, 2014, the Plan recorded expenses of approximately $41,670,000 for services provided by the Management Company, which are included in administrative expenses in the accompanying statement of earnings.

The Plan remitted fee-for-service payments totaling approximately $8,663,000 during the year ended September 30, 2014, to facilities which are owned and operated by IASIS.

4. AHCCCS Receivable, net (Restated)

The AHCCCS receivable, net consists of the following at September 30, 2014:

Primary care provider payment parity receivable	$ 11,120,718
Payment reform initiative receivable	5,320,878
Reinsurance, net	2,391,360
Capitation receivable	3,001,822
Delivery supplement	594,061
PPC, TWG and prospective reconciliation settlements, net of risk adjustments	237,819
	$ 22,666,658

Primary Care Provider Payment Parity

Section 1902(a)(13)(C) of the Social Security Act, as amended by the Affordable Care Act, requires minimum levels of Medicaid payment for certain primary care services, provided by certain physicians. AHCCCS necessitates that contractors be funded for expected cost increases due to primary care rate parity. On a quarterly basis, AHCCCS gathers data to calculate the total payments that eligible providers were paid for eligible services in order to determine the mandated enhanced payment rates that cover the increased cost. Once such data is verified, AHCCCS then pays the contractor the calculated additional payment amounts. At September 30, 2014, the Plan's estimated receivable related to primary care provider parity was approximately $11,121,000.

Payment Reform Initiative

Effective October 1, 2013, AHCCCS began the Payment Reform Initiative (PRI) program. The PRI is an effort to encourage activity for AHCCCS contractors in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, and those related to child and adolescent health. To that end, AHCCCS has withheld a percentage of premium revenues from each AHCCCS contractor and will then distribute the withheld premiums to the contractors based on meeting certain quality performance measures. The initial measurement period for the PRI is October 1, 2013 through September 30, 2014. During the year ended September 30, 2014, AHCCCS withheld 1% of premium revenue from the Plan as part of the PRI program. The maximum payment to any one AHCCCS contractor will be limited to five percent of annual contractor revenues. At September 30, 2014, the Plan's estimated PRI receivable was approximately $5,321,000.

5. Leases

As a result of the Plan's management agreement with the Management Company, the Management Company assumed the remaining facility and equipment leases. The related rent expenses are included within the management fee charged by the Management Company, which is included in administrative expenses in the accompanying statement of earnings.

6. Commitments and Contingencies

Professional, General, and Other Liability Insurance

The Plan is subject to claims and lawsuits arising in the ordinary course of business, including, but not limited to, injuries arising from patient treatment and denials thereof.

The Plan's contract with AHCCCS requires the Plan to maintain professional liability insurance, comprehensive general insurance, and automobile liability insurance coverage of at least $1,000,000 for each occurrence. During the year ended September 30, 2014, the Plan was covered under IASIS' umbrella policy. IASIS, on behalf of the Plan, carries professional and general liability insurance in excess of self-insured retentions through an unrelated commercial insurance carrier in amounts that IASIS believes to be sufficient for the Plan, although some claims may exceed the scope of coverage in effect. IASIS maintains reserves for professional and general liability claims. Accordingly, no reserve for liability risks are recorded in the accompanying balance sheet. Professional and general liability insurance expense is included in the management fee charged by the Management Company for the year ended September 30, 2014, which is included in administrative expenses in the accompanying statement of earnings. The Plan is currently not a party to any such proceedings that, in the Plan's opinion, would have a material adverse effect on the Plan's business, financial condition or results of operations.

Performance Guarantee

If the Plan fails to effectively manage healthcare costs, these costs may exceed the premiums received by the Plan. The Plan believes the capitated premiums, together with reinsurance and other supplemental premiums, are sufficient to pay for the services the Plan is obligated to deliver. Pursuant to its contract with AHCCCS, the Plan is required annually to provide a performance bond or letter of credit, in an acceptable form, to guarantee performance of the Plan's obligations under its contract to provide and pay for the healthcare services. The amount of the performance guaranty that AHCCCS requires is generally based upon the membership in the Plan and the related capitation paid to the Plan. As of September 30, 2014, the Plan provided

a performance guarantee in the form of an irrevocable standby letter of credit for the benefit of AHCCCS totaling approximately $52,500,000.

State and Federal Laws and Regulations

The Plan is subject to state and federal laws and regulations. The Centers for Medicare and Medicaid Services (CMS) and AHCCCS have the right to audit the Plan to determine the Plan's compliance with such standards. The Plan is required to file periodic reports with AHCCCS and to meet certain financial viability standards. The Plan must also provide its enrollees with certain mandated benefits and must meet certain quality assurance and improvement requirements. The Plan believes it is in compliance with these CMS and AHCCCS requirements. The Plan must also comply with the electronic transactions regulations and privacy standards of the Health Insurance Portability and Accountability Act (HIPAA). The Plan believes it is in compliance with the HIPAA security standards as set forth in 45 CFR Part 164. The Plan has also complied with the requirements for health plans defined in 45 CFR Part 162.