

VHS Phoenix Health Plan, LLC

Consolidated Financial Statements and Other
Supplementary Information as of and for the
Year Ended June 30, 2014, and
Independent Auditors' Report

VHS PHOENIX HEALTH PLAN, LLC

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INDEPENDENT AUDITORS' REPORT

To the Members of
VHS Phoenix Health Plan, LLC:

We have audited the accompanying consolidated financial statements of VHS Phoenix Health Plan, LLC, and subsidiaries (the "Company"), which comprise the consolidated balance sheet as of June 30, 2014, and the related consolidated statements of operations, members' equity, and cash flows for the year 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.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We conducted our audit 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 Company'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 Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the 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 consolidated financial position of the Company as of June 30, 2014, and the results of its operations and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information listed in the table of contents is presented for the purpose of additional analysis and is not a required part of the consolidated financial statements. This supplementary information is the responsibility of the Company's management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. Such information has been subjected to the auditing procedures applied in our audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, such information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Deloitte & Touche LLP

November 6, 2014

VHS PHOENIX HEALTH PLAN, LLC

CONSOLIDATED BALANCE SHEET

AS OF JUNE 30, 2014

ASSETS

CURRENT ASSETS:

Cash and cash equivalents	\$ 161,078
Reinsurance and other receivables	7,058,653
Parity receivables	16,753,534
Prepaid expenses and other current assets	644,936
Due from affiliates — net	<u>294,062,443</u>

Total current assets 318,680,644

PROPERTY AND EQUIPMENT:

Furniture and equipment	5,319,696
Software	2,971,544
Less accumulated depreciation and amortization	<u>(7,766,533)</u>

Net property and equipment 524,707

TOTAL ASSETS \$ 319,205,351

LIABILITIES AND MEMBER'S EQUITY

CURRENT LIABILITIES:

Accounts payable	1,294,672
Medical claims payable	22,603,110
Program settlements and other accrued expenses	<u>19,797,176</u>

Total current liabilities 43,694,958

LONG-TERM LIABILITIES 535,817

MEMBER'S EQUITY:

Members capital	157,035,173
Retained earnings	<u>117,939,403</u>

Total member's equity 274,974,576

TOTAL LIABILITIES AND MEMBER'S EQUITY \$ 319,205,351

See notes to consolidated financial statements.

VHS PHOENIX HEALTH PLAN, LLC

CONSOLIDATED STATEMENT OF OPERATIONS FOR THE YEAR ENDED JUNE 30, 2014

REVENUE:	
Capitation	\$ 290,469,104
Supplemental revenue	23,191,458
Other revenue	<u>3,509,871</u>
Total revenue	<u>317,170,433</u>
EXPENSES:	
Hospital	48,499,317
Medical compensation	96,938,232
Other medical	<u>147,157,426</u>
	292,594,975
Less reinsurance and third-party liability	<u>3,908,390</u>
Total medical expenses	288,686,585
Administrative expenses	<u>20,372,606</u>
Total expenses	<u>309,059,191</u>
INCOME BEFORE IMPAIRMENT EXPENSE, PREMIUM TAXES AND HEALTH INSURER FEES AND INCOME TAXES	8,111,242
IMPAIRMENT EXPENSE, NET OF TAXES	(76,920,628)
PREMIUM TAXES AND HEALTH INSURER FEES	(9,972,725)
INCOME TAX EXPENSE	<u>(503,030)</u>
NET LOSS	<u>\$ (79,285,141)</u>

See notes to consolidated financial statements.

VHS PHOENIX HEALTH PLAN, LLC

CONSOLIDATED STATEMENT OF MEMBER'S EQUITY FOR THE YEAR ENDED JUNE 30, 2014

	Member's Capital	Retained Earnings	Member's Equity
BALANCE — July 1, 2013, as previously reported (unaudited)	\$ 157,035,173	\$ 214,639,516	\$ 371,674,689
Prior-period adjustment (see Note 1) (unaudited)	<u>-</u>	<u>(17,414,972)</u>	<u>(17,414,972)</u>
BALANCE — July 1, 2013, as restated	157,035,173	197,224,544	354,259,717
Net loss	<u>-</u>	<u>(79,285,141)</u>	<u>(79,285,141)</u>
BALANCE — June 30, 2014	<u>\$ 157,035,173</u>	<u>\$ 117,939,403</u>	<u>\$ 274,974,576</u>

See notes to consolidated financial statements

VHS PHOENIX HEALTH PLAN, LLC

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED JUNE 30, 2014

OPERATING ACTIVITIES:

Net loss	\$ (79,285,141)
Prior period adjustment	(17,414,972)
Adjustments to reconcile net loss to net cash used in operating activities:	
Impairment expense, net of taxes	76,920,628
Depreciation and amortization	1,524,513
Deferred income taxes	223,093
Changes in assets and liabilities:	
Increase in receivables and other current assets	(562,188)
Decrease in medical claims payable	(44,207,590)
Decrease in accounts payable	(3,625,428)
Increase in accrued expenses and other liabilities	<u>17,826,440</u>
Net cash used in operating activities	<u>(48,600,645)</u>

INVESTING ACTIVITIES:

Capital expenditures	(97,169)
Decrease in due from affiliates	<u>(1,588,926)</u>
Net cash provided by investing activities	<u>(1,686,095)</u>

DECREASE IN CASH AND CASH EQUIVALENTS (50,286,740)

CASH AND CASH EQUIVALENTS — Beginning of year 50,447,818

CASH AND CASH EQUIVALENTS — End of year \$ 161,078

See notes to consolidated financial statements.

VHS PHOENIX HEALTH PLAN, LLC

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS AS OF AND FOR THE YEAR ENDED JUNE 30, 2014

1. ORGANIZATION AND OPERATIONS

VHS Phoenix Health Plan, LLC (the “Company”) is a wholly owned subsidiary of VHS Phoenix Health Plans, Inc., and an indirect wholly owned subsidiary of Tenet Healthcare Corporation (“Tenet”). Tenet acquired Vanguard Health Systems, Inc. (“Vanguard”), the former parent of the Company.

The Company is a prepaid Medicaid managed health plan that derives substantially all of its revenue through a contract with the Arizona Health Care Cost Containment System (“AHCCCS”) to provide specified health services to qualified Medicaid enrollees through contracts with providers. AHCCCS is the state agency that administers Arizona’s Medicaid program. The contract requires the Company to arrange for health care services for enrolled Medicaid patients in exchange for fixed monthly premiums, which are based on negotiated per capita member rates, reinsurance, and other supplemental payments from AHCCCS.

The Company subcontracts with hospitals, physicians, and other medical providers in Arizona to provide services to its enrollees in Maricopa County. These services are provided regardless of the actual costs incurred to provide the services. The Company receives reinsurance and other supplemental payments from AHCCCS to cover certain costs of health care services that exceed defined thresholds.

AHCCCS Contract — On March 22, 2013, the Company was notified that it was not awarded an acute care program contract with AHCCCS for the three-year period commencing on October 1, 2013. However, on April 1, 2013, the Company agreed with AHCCCS on the general terms of a capped contract to provide services to members in Maricopa County for the three-year period commencing on October 1, 2013. Enrollment is limited to existing members as of October 1, 2013, and the enrollment cap will not be lifted at any time during the contract period, unless AHCCCS deems additional plan capacity necessary based upon growth in covered lives or for other reasons, as outlined in a letter provided by AHCCCS that clarifies certain terms of the capped contract.

The Company has approximately 78,390 members as of June 30, 2014. AHCCCS held open enrollment for the Company in June 2014.

In determining the capitation rates for the contract period ended September 30, 2013, AHCCCS has utilized a national episodic and diagnostic risk adjustment model (“RAM”) that has been applied to all health plan-specific capitation rates for prospective risk groups. The Company’s management estimated that no RAM settlement was due for the contract year ended September 30, 2013.

The Company’s contract is terminable without cause on 90 days written notice from AHCCCS or for cause upon written notice from AHCCCS if the Company 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. AHCCCS may also terminate the contract with the Company in the event of unavailability of state or federal funding. The Company may not terminate the contract during the initial three-year term. The Company may choose not to renew the contract for the one-year renewal period effective October 1, 2016 by providing 180 days’ notice of such election. If the Company makes such election, the Company would be subject to various administrative guidelines that would require it to assist AHCCCS in transitioning enrollees to coverage under a new health plan. Should AHCCCS terminate its contract with the Company, the Company would cease operations.

Prior-Period Adjustment — The Company recorded an adjustment to the opening equity balance as of July 1, 2013 as a result of erroneous assumptions utilized in certain AHCCCS settlement accounts as of June 30, 2013. The adjustment would have decreased net income (unaudited) and member's equity by \$17,414,972 had the adjustment been reflected in the consolidated financial statements as of and for the year ending June 30, 2013.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Cash and Cash Equivalents — Cash equivalents include all highly liquid investments with initial maturities of three months or less when purchased. Cash and cash equivalents are maintained at high-quality financial institutions, and management believes exposure to credit risk is not significant.

Receivables — The Company had \$7,058,653 of receivables as of June 30, 2014, including reinsurance reimbursement receivables due from AHCCCS for amounts paid by the Company for enrollee health care services that exceeded maximum limits set forth in its contract with AHCCCS and other supplemental reimbursement receivables. The reinsurance reimbursement receivables are determined on an enrollee-specific basis and are stated at net realizable value. The Company writes off 100% of reinsurance reimbursement receivables related to completed AHCCCS contract years that exceed the AHCCCS reinsurance timely filing limits.

In November 2012, the Centers for Medicare and Medicaid Services issued a final rule that requires that physicians who practice in family medicine, general internal medicine, pediatric medicine and related subspecialties serving Medicaid members be reimbursed in parity with Medicare levels beginning January 1, 2013. AHCCCS has communicated its intentions to reimburse the plans for these excess parity costs, whether by direct reimbursement for approved encounters or by capitation rate increases to the plans. As of June 30, 2014, the Company had made excess parity payments above the normal Medicaid rates for services incurred beginning January 1, 2013 that are due from AHCCCS totaling \$16,753,534. This amount is reflected on the consolidated statement of operations in capitation revenue and medical compensation expense.

Property and Equipment — Property and equipment are recorded at cost and depreciated using the straight-line method over the estimated useful lives of the assets. The estimated useful lives of the Company's property and equipment range from three to eight years. Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase values, change capacities, or extend useful lives are capitalized. The Company had capital expenditures of \$97,168 during the year ended June 30, 2014.

Depreciation expense for property and equipment was \$709,513 for the year ended June 30, 2014, which is included in administrative expenses in the accompanying consolidated statement of operations.

Revenue — The Company receives monthly capitation payments under the AHCCCS contract based on the number of enrollees and type of enrollee coverage. Capitation payments are recognized as revenue in the month in which the Company is notified that a member is eligible for health care coverage provided by the Company. Included in these monthly payments are capitation amounts applicable to Social Security Act Title XIX waiver group ("TWG") members. The TWG medical expense deduction ("MED") population includes TWG members whose incomes exceed the limits of all other Title XIX categories and who have medical expenses that reduce income to at or below 40% of the federal poverty level. The TWG non-medical expense deduction ("Non-MED") population includes adults or childless couples at or below 100% of the federal poverty level who do not meet the requirements of another categorically linked Title XIX program. AHCCCS limits the profitability and loss that health plans may recognize for the TWG prospective Non-MED population for program years through September 30, 2013 and for the MED population for program years through September 30, 2011.

The MED reconciliation limited the Company's profits or losses related to this population to 3% of related capitation revenue (net of reinsurance, administrative expenses, and premium taxes), as defined in the applicable AHCCCS contract for specific contract years. During the year ended June 30, 2014, the Company settled its 2011 MED payable to AHCCCS and has no remaining settlement balance for this population.

The Non-MED reconciliation limited the Company's profits or losses related to this population to 2% of related capitation revenue (net of reinsurance, administrative expenses, and premium taxes), as defined in the applicable AHCCCS contract for specific contract years. As of June 30, 2014, the Company had an estimated net Non-MED settlement payable of approximately \$4,743,551, which was included in program settlements and other accrued expenses on the accompanying consolidated balance sheet, that relates to the contract years ended September 30, 2012 and 2013.

The Company is subject to a tiered prospective reconciliation for certain groups related to the program years ended September 30, 2012, 2013 and 2014, based upon prospective expenses and prospective net capitation. Populations subject to this tiered prospective reconciliation are limited to recipients of benefits through the Department of Health and Human Services' ("DHS") Temporary Assistance to Needy Families ("TANF") program, eligible pregnant women under Section 9401 of the Sixth Omnibus Budget and Reconciliation Act of 1986 ("SOBRA"), recipients of supplemental security income ("SSI") with Medicare, recipients of SSI without Medicare, and recipients of SOBRA family planning services. The former TWG Non-MED population was assimilated into this population beginning with the program year ended September 30, 2014. Expenses incurred and revenue received for covered services with dates of service during prior-period coverage ("PPC") are excluded from this tiered prospective reconciliation. As of June 30, 2014, the Company had an estimated acute tiered settlement payable of \$7,934,870 for program years ended September 30, 2012, 2013 and 2014, which was included in program settlements and other accrued expenses on the accompanying consolidated balance sheet.

The Company receives capitation payments for PPC separately from its prospective capitation payments. PPC capitation payments are applicable to all types of enrollee coverages at the Company and are intended to cover health care costs incurred by individuals while they await enrollment in the Company's health care plan and prior to the Company's ability to manage the health care of such enrollees. PPC revenue is recognized in the month in which the Company is notified that a member is eligible for coverage provided by the Company. AHCCCS limits the profitability and loss that health plans may recognize during the PPC eligibility period to 2% of related capitation revenue (net of administrative expenses and premium taxes) and reconciles the PPC member costs incurred by the Company. As of June 30, 2014, the Company had a net settlement receivable for PPC costs incurred in excess of PPC payments received of approximately \$2,192,516 for the contract years ended September 30, 2013 and 2014, which was included in program settlements and other accrued expenses on the accompanying consolidated balance sheet.

The Company also receives supplemental payments for delivery premiums to cover the cost of maternity care for qualified members under the federally funded SOBRA program. The Company recognizes supplemental revenue during the month in which AHCCCS notifies the Company of payment.

Due From Affiliates — Due from affiliates primarily represents the net excess of funds transferred to the centralized cash management account of Vanguard Health Management, Inc. ("VHM"), a wholly owned subsidiary of Tenet, over funds transferred to, or paid on behalf of, the Company by VHM. Due from affiliates balances are readily available to the Company for settlement of its current liabilities as they become due.

Generally, this balance is decreased by automatic cash transfers from VHM's centralized cash management account to reimburse the Company's bank accounts for operating expenses and capital expenditures and to pay the Company's fees for services provided by VHM, including information systems services and other operating expenses, such as payroll, interest, and insurance. Generally, the due from affiliates balance is increased through daily cash deposits by the Company to VHM's centralized cash management account. As of June 30, 2014, due from affiliates was reduced by approximately \$3,652,254 due to cash overdrafts for disbursements from a bank account in which the Company does not have the right of offset.

Interest income of \$472,512 was earned by the Company on outstanding due from affiliates balances during the year ended June 30, 2014, which was included in other revenue in the accompanying consolidated statement of operations. The Company earned interest income on amounts due from affiliates at an annual rate of less than 1.0% during the year ended June 30, 2014. The interest rate earned approximates the variable portion of the total interest rate paid by Tenet under London InterBank Offered Rate ("LIBOR") contracts for Tenet's outstanding term loan debt. The Company also earned \$451 in interest income on its outstanding cash balances during the year ended June 30, 2014, which was included in other revenue in the accompanying consolidated statement of operations.

Medical Expenses and Reinsurance Proceeds — Monthly capitation payments to primary care physicians and other health care providers are expensed in the month services are contracted to be performed. Claims expense for noncapitated arrangements are accrued as services are rendered by hospitals, physicians, and other health care providers during the year. The Company is at risk for hospitalization and medical service claims, including medical compensation and other medical expenses, that exceed its capitation payments from AHCCCS. Medical compensation includes primary care and specialty physician services. Other medical expenses include hospital outpatient services and other ancillary services, such as radiology and lab services.

The Company is reimbursed by AHCCCS for costs incurred for those enrollees with severe illnesses to the extent such costs exceed designated per enrollee limits as set forth in the AHCCCS contract for each program year. The Company estimates reinsurance recoveries monthly based on reported claims by member, subject to encounter verification as set forth in the provisions of the AHCCCS contract. Reinsurance recoveries are deducted from gross medical expenses on the accompanying consolidated statement of operations. The Company is at risk for excess medical costs under reinsurance claims that are disputed and not honored by AHCCCS. Medical claims payable include claims received, but not paid, as well as estimated claims incurred, but not reported ("IBNR"). During the year ended June 30, 2014, the Company increased medical claims payable related to health claims experience in the prior fiscal year by approximately \$1,540,000. Medical claims payable is estimated using a combination of historical claims payment data and current cost-per-member estimates and is supported by independent actuarial estimates including a risk margin considered appropriate by the Company. While management believes that its estimation methodology captures trends in medical claims costs in a timely manner, actual payments could differ significantly from its estimates in the event of changes in the health care cost structure or adverse experience.

The activity in medical claims payable for the fiscal year ended June 30, 2014, is as follows:

Medical claims payable at beginning of year	<u>\$ 66,810,700</u>
Medical costs and claims incurred:	
Current year insured events	287,146,585
Prior year insured events	<u>1,540,000</u>
Total incurred	<u>288,686,585</u>
Payments:	
Current year insured events	265,776,789
Prior year insured events	<u>67,117,386</u>
Total paid	<u>332,894,175</u>
Medical claims payable at end of year	<u>\$ 22,603,110</u>

Income Taxes — Tenet files consolidated federal and state income tax returns that include the operating results of the Company. Tenet allocates taxes to the Company as if the Company was a separate taxpayer, pursuant to the asset and liability method. Such allocations were deducted from due from affiliates in the accompanying consolidated balance sheet.

Fair Value of Financial Instruments — The carrying amounts of cash and cash equivalents, receivables, amounts due from affiliates, and payables approximate fair values because of the short maturities of these financial instruments.

Premium Deficiency Reserves — Premium deficiency reserves and the related expenses are recognized when it is probable that expected future health care expenses, claim adjustment expenses, direct administration costs, and an allocation of indirect administration costs under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries considered over the remaining lives of the contracts. The methods for making such estimates and for establishing the resulting reserves are periodically reviewed and updated. The Company did not record a premium deficiency reserve as of June 30, 2014.

Use of Estimates — The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Areas of the consolidated financial statement areas that involve significant estimation include reinsurance and parity receivables; PPC, acute tiered, and Non-MED settlements; and medical claims IBNR. Such estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates and are accounted for in the period identified.

Comprehensive Income — During the fiscal year ended June 30, 2014, there was no other comprehensive income. Accordingly, net income equals comprehensive income for the period presented.

3. IMPAIRMENT OF GOODWILL AND INTANGIBLE ASSETS

The significant change in the membership and pricing under the Company's new capped AHCCCS contract that went into effect on October 1, 2013, represented an indicator of impairment. As a result, the

Company performed an impairment assessment to determine the recoverability of the goodwill balance of \$79,402,908 and the net intangible assets balance of \$3,260,000 as of September 30, 2013. Based upon projections of future cash flows under the remaining capped contract period through September 30, 2016, the Company determined that the goodwill and intangible assets balances were fully impaired as of September 30, 2013. The Company recorded an impairment charge of \$82,662,908 (\$76,920,628 net of taxes) during the year ended June 30, 2014.

4. TRANSACTIONS WITH AFFILIATES

Advantage Health Care Management Company, Inc. (“AHCMC”), a wholly owned subsidiary of Tenet, manages the general and administrative functions of the Company, including payroll services, lease agreements and expenses, general and professional liability insurance coverages, advertising, and related expenses. The Company has recorded expenses of approximately \$20,360,300 for services provided by AHCMC for the year ended June 30, 2014. Expenses for services provided by AHCMC were included in administrative expenses on the accompanying consolidated statement of operations. At June 30, 2014, the Company had approximately \$962,000 payable to AHCMC for services provided, which was included in accounts payable on the accompanying consolidated balance sheet. Operations of the Company may not be indicative of those that would have occurred if it had operated as an independent company.

Affiliates of the Company include certain hospitals and outpatient centers, also affiliated with Tenet, that provide services to eligible members of the Company’s health plan. Medical services provided by these affiliates to eligible members of the Company’s health plan totaled approximately \$25,198,000 during the year ended June 30, 2014. At June 30, 2014, medical claims payable included approximately \$2,181,250 payable to these affiliates.

Effective January 1, 2014, the Company became subject to an annual fee under section 9010 of the Patient Protection and Affordable Care Act (“PPACA”). This annual fee is allocated to individual health insurers based on the ratio of the amount of each entity’s net premiums written during the preceding calendar year to the amount of health insurance for any United States health risk that is written during the preceding calendar year. The PPACA fee was paid in September 2014 by Tenet. The portion of Tenet’s payment related to the Company for calendar year 2014 was approximately \$6,504,000. During the year ended June 30, 2014, approximately \$3,252,000 of PPACA fees was included in premium taxes and health insurer fees in the Company’s consolidated statement of operations representing the fees related to the first six months of calendar 2014. The PPACA fees were included in program settlements and other accrued expenses with an offsetting amount included in reinsurance and other receivables on the Company’s consolidated balance sheet as of June 30, 2014 to reflect the expected reimbursement of these fees from AHCCCS. The PPACA fee is not deductible by Tenet for tax purposes, but the reimbursement from AHCCCS is taxable to Tenet.

5. COMMITMENTS AND CONTINGENCIES

Operating Leases — As a result of the Company’s management agreement with AHCMC, AHCMC assumed the remaining facility and equipment leases. The related rent expenses were included within the management fee charged by AHCMC, which was included in administrative expenses in the accompanying consolidated statement of operations.

Professional, General, and Other Liability Insurance — In the normal course of business, the Company is subject to claims and lawsuits relating to injuries arising from patient treatment and denials thereof. The Company’s contract with AHCCCS requires that it maintain professional liability insurance, comprehensive general insurance, and automobile liability insurance coverage of at least

\$1,000,000 for each occurrence. The Company is covered under Tenet's wholly owned captive insurance subsidiary or Tenet's self-insurance program for professional and general liability claims at levels that exceed the AHCCCS minimum requirements. There is no guarantee that existing coverage will be sufficient for professional and general liability claims either individually or in the aggregate. Professional and general liability insurance expenses are not allocated from Tenet but included in the management fee charged by AHCMC.

The Company is covered under Tenet's self-insurance program for workers' compensation claims. Tenet maintains coverage for workers' compensation claims exceeding its \$1,000,000 retention level at amounts the Company believes to be adequate. Workers' compensation insurance coverage is included in the management fee charged by AHCMC.

Tenet maintains reserves for general and professional liability and workers' compensation risks and makes any necessary claims payments on the Company's behalf. Accordingly, no reserve for liability risks was recorded on the accompanying consolidated balance sheet. The Company is currently not a party to any such proceedings that, in management's opinion, would have a material adverse effect on the Company's business, consolidated results of operations, or consolidated financial position.

Other Claims — The Company is subject to claims and suits arising in the ordinary course of business. Plaintiffs in these matters may request punitive or other damages that may not be covered by insurance. The Company is not aware of any such proceedings that, in management's opinion, if adversely decided, would have a material effect on the Company's consolidated results of operations or consolidated financial position.

Subcontracted Services — The Company subcontracts with physician specialists, affiliated hospitals, and unaffiliated hospitals to provide covered services to certain patients enrolled in, or assigned to, the Company on either a capitated or fee-for-service basis.

AHCCCS Plan Compliance — Under the Company's contract with AHCCCS, the Company is required to maintain a performance guaranty calculated based upon monthly capitation revenues received. As of June 30, 2014, the Company maintained performance bonds through Tenet totaling \$19.0 million to meet this performance guaranty.

The AHCCCS contract contains certain financial viability standards on which the Company must report on a quarterly and annual basis. These standards enable AHCCCS to monitor the financial health of its contracted health plans. The Company must meet the financial viability standards, which include a current ratio requirement of at least one; equity per member requirement of at least \$170; a medical expense ratio, as defined in the AHCCCS contract (at least 85%); and an administrative cost percentage ratio, as defined in the AHCCCS contract (no more than 10%). AHCCCS does not automatically penalize or sanction health plans that do not meet these standards, but utilizes these guidelines in combination with other measures to determine the overall operational health and compliance of its contracted health plans. As of June 30, 2014, the Company met these financial viability standards.

The Company is also subject to minimum performance standards for certain clinical quality performance measures under its contract with AHCCCS. The Company accrues for potential sanctions based upon its estimated rate of noncompliance, as reported by AHCCCS, until such time as the Company is able to document compliance within the timeline to remedy the noncompliance established by AHCCCS. Management believes that, as of June 30, 2014, possible additional sanctions beyond those already accrued related to contract years ended September 30, 2012, 2013, and 2014, were not material to the consolidated financial position, consolidated results of operations, or consolidated cash flows of the Company.

Compliance With Laws and Regulations — The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse regulations. Management believes that the Company is in compliance with fraud and abuse regulations, as well as other applicable government laws and regulations. While no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or not asserted at this time.

6. INCOME TAXES

Income tax expense allocated to the Company by Vanguard on a separate return basis for the year ended June 30, 2014, consisted of the following:

	Impairment Portion	Non-impairment Portion	Total
Current federal	\$ -	\$ 279,937	\$ 279,937
Deferred federal	<u>(5,742,280)</u>	<u>223,093</u>	<u>(5,519,187)</u>
	<u>\$ (5,742,280)</u>	<u>\$ 503,030</u>	<u>\$ (5,239,250)</u>

The tax effects of temporary differences that gave rise to deferred tax assets and liabilities at June 30, 2014, were as follows:

Depreciation, amortization, and fixed asset basis differences	\$ 597,929
Excess book basis over tax basis of prepaid expenses	769,824
Discounted unpaid losses	<u>203,975</u>
Net deferred tax asset	<u>\$ 1,571,728</u>

Income tax expense allocated to the Company by Tenet approximated the federal statutory rate for the year ended June 30, 2014. The tax effects of temporary differences that gave rise to deferred tax assets and liabilities were included in due from affiliates in the accompanying consolidated balance sheet.

7. SUBSEQUENT EVENTS

The Company has evaluated subsequent events for the year ended June 30, 2014, through November 7, 2014, the date these consolidated financial statements were available to be issued.

* * * * *