UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2019

OR

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
for the transition period from to .

Commission file number: 001-37392

Apollo Medical Holdings, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**95-4472349**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

1668 S. Garfield Avenue, 2nd Floor, Alhambra, California 91801
(Address of principal executive offices, including zip code)

Registrant's telephone number, including area code: **(626) 282-0288**

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Trading Symbol	Name of Each Exchange on Which Registered
Common Stock, $0.001 par value per share	AMEH	Nasdaq Capital Market

Securities registered pursuant to Section 12(g) of the Act:
None
(Title of class)

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☐ No ☒

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Exchange Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☐	Accelerated filer ☒
Non-accelerated filer ☐	Smaller reporting company ☐
	Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ Yes ☒ No

The aggregate market value of common stock held by non-affiliates of the registrant, as of June 30, 2019, the last day of the registrant's most recently completed second fiscal quarter, was approximately $480.1 million (based on the closing price for shares of the registrant's common stock as reported by the NASDAQ Capital Market on June 28, 2019).

As of March 2, 2020, there were 52,804,187 shares of common stock of the registrant, $0.001 par value per share, issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive Proxy Statement for the 2020 annual meeting of the stockholders of the registrant are incorporated herein by reference in Part III of this Annual Report on Form 10-K to the extent stated herein. Such Proxy Statement will be filed with the Securities and Exchange Commission (the "SEC") within 120 days of the registrant's fiscal year ended December 31, 2019.

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Glossary

The following abbreviations or acronyms that may be used in this document shall have the adjacent meanings set forth below:

AIPBP	All-Inclusive Population-Based Payments
AMG	AMG, a Professional Medical Corporation
AMH	ApolloMed Hospitalists
AMM	Apollo Medical Management, Inc
APC	Allied Pacific of California IPA
BAHA	Bay Area Hospitalist Associates
CDSC	Concourse Diagnostic Surgery Center, LLC
CQMC	Critical Quality Management Corp
CSI	College Street Investment LP, a California limited partnership
DMG	Diagnostic Medical Group
HSMSO	Health Source MSO Inc. a California corporation
ICC	AHMC International Cancer Center, a Medical Corporation
LMA	LaSalle Medical Associates
MMG	Maverick Medical Group Inc
MPP	Medical Property Partners
NGACO	Next Generation Accountable Care Organization
NMM	Network Medical Management Inc
PASC	Pacific Ambulatory Health Care, LLC
PMIOC	Pacific Medical Imaging and Oncology Center Inc
SCHC	Southern California Heart Centers
Tag-2	Tag-2 Medical Investment Group LLC
UCAP	Universal Care Acquisition Partners, LLC
UCI	Universal Care, Inc

INTRODUCTORY NOTE

Unless the context dictates otherwise, references in this Annual Report on Form 10-K to the "Company," "we," "us," "our," and similar words are references to Apollo Medical Holdings, Inc., a Delaware corporation ("ApolloMed"), and its consolidated subsidiaries and affiliated entities, as appropriate, including its consolidated variable interest entities ("VIEs").

The following discussion and analysis provides information that management believes is relevant to an assessment and understanding of our results of operations and financial performance. This discussion should be read in conjunction with the consolidated financial statements and notes thereto appearing elsewhere herein, and with our prior filings with the Securities and Exchange Commission (the "SEC").

The Centers for Medicare & Medicaid Services ("CMS") has not reviewed any statements contained in this Report, including statements describing the participation of APA ACO, Inc. ("APAACO") in the next generation accountable care organization ("NGACO") model.

Trade names and trademarks of ApolloMed and its subsidiaries referred to herein and their respective logos, are our property. This Annual Report on Form 10-K may contain additional trade names and/or trademarks of other companies, which are the property of their respective owners. We do not intend our use or display of other companies' trade names and/or trademarks, if any, to imply an endorsement or sponsorship of us by such companies, or any relationship with any of these companies.

NOTE ABOUT FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K contains "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995, Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). All statements other than statements of historical fact are "forward-looking statements" for purposes of federal and state securities laws, including, but not limited to, any statements about our business, financial condition, operating results, plans, objectives, expectations and intentions, any projections of earnings, revenue or other financial items, such as our projected capitation from CMS and our future liquidity; any statements of any plans, strategies and objectives of management for future operations such as the material opportunities that we believe exist for our

company; any statements concerning proposed services, developments, mergers or acquisitions; any statements regarding the outlook on our NGACO or strategic transactions; any statements regarding management's view of future expectations and prospects for us; any statements about prospective adoption of new accounting standards or effects of changes in accounting standards; any statements regarding future economic conditions or performance; any statements of belief; any statements of assumptions underlying any of the foregoing; and other statements that are not historical facts. Forward-looking statements may be identified by the use of forward-looking terms such as "anticipate," "could," "can," "may," "might," "potential," "predict," "should," "estimate," "expect," "project," "believe," "think," "plan," "envision," "intend," "continue," "target," "seek," "contemplate," "budgeted," "will," "would," and the negative of such terms, other variations on such terms or other similar or comparable words, phrases or terminology. These forward-looking statements present our estimates and assumptions only as of the date of this Annual Report on Form 10-K and are subject to change.

Forward-looking statements involve risks and uncertainties and are based on the current beliefs, expectations and certain assumptions of management. Some or all of such beliefs, expectations and assumptions may not materialize or may vary significantly from actual results. Such statements are qualified by important economic, competitive, governmental and technological factors that could cause our business, strategy, or actual results or events to differ materially from those in our forward-looking statements. Although we believe that the expectations reflected in our forward-looking statements are reasonable, actual results could differ materially from those projected or assumed in any of our forward-looking statements. Our future financial condition and results of operations, as well as any forward-looking statements, are subject to change and significant risks and uncertainties that could cause actual condition, outcomes and results to differ materially from those indicated by such statements.

PART I

Item 1. Business

Overview

We, together with our affiliated physician groups and consolidated entities, are a physician-centric integrated population health management company providing coordinated, outcomes-based medical care in a cost-effective manner and serving patients in California, the majority of whom are covered by private or public insurance provided through Medicare, Medicaid and health maintenance organizations ("HMOs"), with a small portion of our revenue coming from non-insured patients. We provide care coordination services to each major constituent of the healthcare delivery system, including patients, families, primary care physicians, specialists, acute care hospitals, alternative sites of inpatient care, physician groups and health plans. Our physician network consists of primary care physicians, specialist physicians and hospitalists. We operate primarily through Apollo Medical Holdings, Inc. ("ApolloMed") and the following subsidiaries: Network Medical Management ("NMM"), Apollo Medical Management, Inc. ("AMM"), APAACO and Apollo Care Connect, Inc. ("Apollo Care Connect"), and their consolidated entities, including consolidated VIEs.

Led by a management team with several decades of experience, we have built a company and culture that is focused on physicians providing high-quality medical care, population health management and care coordination for patients. We are well-positioned to take advantage of the growing trends in the U.S. healthcare industry towards value-based and results-oriented healthcare focusing on the triple aim of patient satisfaction, high-quality care and cost efficiency.

Through our NGACO model and a network of independent practice associations ("IPAs") with more than 7,000 contracted physicians, which physician groups have agreements with various health plans, hospitals and other HMOs, we are responsible for coordinating the care for over 980,000 patients in California, as of December 31, 2019. These covered patients are comprised of managed care members whose health coverage is provided through their employers or who have acquired health coverage directly from a health plan or as a result of their eligibility for Medicaid or Medicare benefits. Our managed patients benefit from an integrated approach that places physicians at the center of patient care and utilizes sophisticated risk management techniques and clinical protocols to provide high-quality, cost effective care. To implement a patient-centered, physician-centric experience, we also have other integrated and synergistic operations, including (i) management service organizations ("MSOs") that provide management and other services to our affiliated IPAs, (ii) outpatient clinics and (iii) hospitalists that coordinate the care of patients in hospitals.

In December 2017, we completed a business combination with NMM, a California corporation formed in 1994 (the "Merger"). As a result of the Merger, NMM became a wholly owned subsidiary of ApolloMed, following which former NMM shareholders owned more than 80% of the issued and outstanding shares of ApolloMed's common stock, after completing the Merger. The combined company operates under the Apollo Medical Holdings name. NMM is the larger entity in terms of assets, revenues and earnings. In addition, as of the closing of the Merger, the majority of the board of directors of the combined company was comprised of former NMM directors and directors nominated for election by NMM. Accordingly, ApolloMed is considered to be the legal acquirer (and accounting acquiree), whereas NMM is considered to be the accounting acquirer (and legal acquiree).

Our affiliated medical groups provide hospitalist services at multiple acute-care hospitals, long-term acute care facilities and outpatient clinics. ApolloMed and its subsidiaries, and consolidated VIEs, generate revenue by providing administrative, medical management and clinical services to affiliated IPAs and medical groups. The administrative services cover billing, collection, accounting, administrative, quality assurance, marketing, compliance and education. In addition, our NGACO, APA ACO, which served over 29,000 beneficiaries in 2019, is eligible to receive periodic advance payments from CMS for managing care for aligned beneficiaries.

We implement and operate different innovative health care models, primarily including the following integrated operations:

- IPAs, which contract with physicians and provide care to Medicare, Medicaid, commercial and dual-eligible patients on a risk- and value-based fee basis;
- MSOs, which provide management, administrative and other support services to our affiliated physician groups such as IPAs;
- APAACO, which participates in the Medicare Shared Savings Program (the "MSSP") sponsored by CMS and focuses on providing high-quality and cost-efficient care to Medicare fee-for-service ("FFS") patients;

- Outpatient clinics providing specialty care, including an ambulatory surgery center and a specialty clinic that focuses on cardiac care and diagnostic testing;
- Hospitalists, which include our employed and contracted physicians who focus on the delivery of comprehensive medical care to hospitalized patients; and
- A cloud-based population health management IT platform, which includes digital care plans, a case management module, connectivity with multiple healthcare tracking devices and integrated clinical data.

We operate under one reportable segment, the healthcare delivery segment. Our revenue streams are diversified among our various operations and contract types, and include:

- Capitation payments, including payments made by CMS from the NGACO Model;
- Risk pool settlements and incentives;
- Management fees, including stipends from hospitals and percentages of collections; and
- FFS reimbursements.

ApolloMed's common stock is listed on the NASDAQ Capital Market and traded under the symbol "AMEH."

Organization

Subsidiaries

We operate through our subsidiaries, including:

- NMM;
- AMM;
- APAACO; and
- Apollo Care Connect.

Each of NMM and AMM operates as an MSO and is in the business of providing management services to physician practice corporations under long-term management and/or administrative services agreements ("MSAs"), pursuant to which the MSO manages certain non-medical services for the physician groups and have exclusive authority over all non-medical decision making related to ongoing business operations. The MSAs generally provide for management fees that are recognized as earned based on a percentage of revenue or cash collections generated by the physician practices.

APAACO has participated in the NGACO Model of CMS since January 2017. The NGACO Model is a CMS program that allows provider groups to assume higher levels of financial risk and potentially achieve a higher reward from participating in this new attribution-based risk sharing model.

Apollo Care Connect provides a cloud and mobile-based population health management platform, with an emphasis on chronic care management and high-risk patient management in addition to a comprehensive platform for total patient engagement. Features include a personal health assistant that allows patients to view their health data and interact with their physician and care managers, and evidence-based digital care plans that leverage our expertise in clinical care, care coordination and medical risk management to deliver value-based care.

Variable Interest Entities

If an entity is determined to be a VIE, we evaluate whether we are the primary beneficiary. The primary beneficiary analysis is a qualitative analysis based on power and benefits. We consolidate a VIE if we have both power and benefits – that is, (i) we have the power to direct the activities of a VIE that most significantly influence the VIE's economic performance, and (ii) we have the obligation to absorb losses of, or the right to receive benefits from, the VIE that could potentially be significant to the VIE. See Note 18 – "Variable Interest Entities (VIEs)" to our consolidated financial statements for information on our entities

that qualify as consolidated VIEs. If we have a variable interest in a VIE but are not the primary beneficiary, we may account for our investment using the equity method of accounting (see Note 6 – "Investments in Other Entities").

Some states have laws that prohibit business entities with non-physician owners from practicing medicine, which are generally referred to as the corporate practice of medicine laws. States that have corporate practice of medicine laws require only physicians to practice medicine, exercise control over medical decisions or engage in certain arrangements with other physicians, such as fee-splitting. California is a corporate practice of medicine state.

Therefore, in addition to our subsidiaries, we mainly operate by maintaining long-term MSAs with our affiliated IPAs, which are owned and operated by a network of independent primary care physicians and specialists, and which employ or contract with additional physicians to provide medical services. Under such agreements, we provide and perform non-medical management and administrative services, including financial management, information systems, marketing, risk management and administrative support.

NMM has entered into MSAs with several affiliated IPAs, including Allied Physicians of California IPA d.b.a. Allied Pacific of California IPA ("APC"), Alpha Care Medical Group, Inc. ("Alpha Care"), and Accountable Health Care, IPA ("Accountable Health Care"). APC, Alpha Care, and Accountable Health Care contract with various HMOs or licensed health care service plans, each of which pays a fixed capitation payment. In return, APC, Alpha Care, and Accountable Health Care arrange for the delivery of health care services by contracting with physicians or professional medical corporations for primary care and specialty care services. APC, Alpha Care, and Accountable Health Care assume the financial risk of the cost of delivering health care services in excess of the fixed amounts received. The risk is subject to stop-loss provisions in contracts with HMOs. Some risk is transferred to the contracted physicians or professional corporations. The physicians in the IPA are exclusively in control of, and responsible for, all aspects of the practice of medicine for enrolled patients. In accordance with relevant accounting guidance, APC, Alpha Care, and Accountable Health Care, have been determined to be VIEs of NMM, as NMM is their primary beneficiary with the ability, through majority representation on the APC Joint Planning Board and otherwise, to direct the activities (excluding clinical decisions) that most significantly affect their economic performance.

Through AMM, we manage a number of our affiliates pursuant to their long-term MSAs, including: ApolloMed Hospitalists ("AMH"), a physician group that provides hospitalist, intensivist and physician advisor services and Southern California Heart Centers ("SCHC"), a specialty clinic that focuses on cardiac care and diagnostic testing. Each of AMH and SCHC are VIEs of AMM as it has been determined that AMM is the primary beneficiary of such entities. Concourse Diagnostic Surgery Center, LLC ("CDSC") is an ambulatory surgery center in City of Industry, California. The facility is Medicare Certified and accredited by the Accreditation Association for Ambulatory Healthcare. CDSC is consolidated as a VIE by APC as it was determined that APC has a controlling financial interest in CDSC and is the primary beneficiary of CDSC. AHMC International Cancer Center ("ICC") provides comprehensive, compassionate post-cancer-diagnosis care and a wide range of support services. ICC was determined to be a VIE of APC and is consolidated by APC as it was determined that APC is the primary beneficiary of ICC through its power and obligation to absorb losses and rights to receive benefits that could potentially be significant to ICC.

APC, Alpha Care, Accountable Health Care, AP-AMH, AMH, SCHC, CDSC and ICC are therefore consolidated in the accompanying financial statements.

Investments

We invested in several entities in the healthcare industry through APC, our VIE. Universal Care Acquisition Partners, LLC ("UCAP"), a wholly owned subsidiary of APC, holds a 48.9% ownership interest and 50% voting interest in Universal Care, Inc. ("UCI"), a private full-service health plan that contracts with CMS under Medicare Advantage. Pacific Ambulatory Surgery Center, LLC ("PASC"), in which APC had a 40% non-controlling ownership interest, was a multi-specialty outpatient surgery center that was certified to participate in the Medicare program and accredited by the Accreditation Association for Ambulatory Health Care. As of December 31, 2019, APC also holds a 32.50% ownership interest in ApolloMed.

Due to laws prohibiting a California professional corporation which has more than one shareholder (such as APC) from being a shareholder in another California professional corporation, APC cannot directly own shares in other professional corporations in which APC has invested. An exception to this prohibition, however, permits a professional corporation that has only one shareholder to own shares in another professional corporation. In reliance on this exception, APC-LSMA, a designated shareholder professional corporation solely owned by Dr. Thomas Lam and controlled by APC, holds controlling and non-controlling ownership interests in several medical corporations. APC-LSMA holds controlling interests in Alpha Care and Accountable Health Care and non-controlling interests in the IPA line of business of LaSalle Medical Associates ("LMA"), Pacific Medical Imaging and Oncology Center, Inc. ("PMIOC"), and Diagnostic Medical Group ("DMG"). The IPA line of business of LMA operates six neighborhood medical centers and serves patients across Fresno, Kings, Los Angeles, Madera, Riverside, San

Bernardino and Tulare Counties in California and is managed by NMM through an MSA. PMIOC offers comprehensive diagnostic imaging services at its facilities. DMG, operates complete outpatient imaging centers to improve the detection and treatment of heart disease.

Our Industry

Industry Overview

U.S. healthcare spending has increased steadily over the past 20 years. According to CMS, the estimated total U.S. healthcare expenditures are expected to grow by 5.5% from 2018 to 2027 and to reach $6.0 trillion by 2027. Health spending is projected to grow 0.8% faster than the U.S. gross domestic product over the 2018-2027 projection period, and as a result, the healthcare share of gross domestic product is expected to rise from 17.9% in 2017 to 19.4% by 2027. Medicare spending increased 6.4% to $750.2 billion and Medicaid spending increased by 3.0% to $597.4 billion in 2018, which accounted for 21% and 16% of total health expenditures, respectively. Private health insurance spending increased 5.8% to $1.2 trillion in 2018, accounting for 34% of total health expenditures. Growth in Medicare (7.4%) and Medicaid (5.5%) are both substantial contributors to the rate of national health expenditure growth for the projection period. Both trends reflect the impact of an aging population, but in different ways. For Medicare, projected enrollment growth is a primary driver; for Medicaid, it is an increasing projected share of aged and disabled enrollees.

Managed care health plans were developed in the U.S. primarily during the 1980s, in an attempt to mitigate the rising cost of providing health care to populations covered by health insurance. These managed care health plans enroll members through their employers in connection with federal Medicare benefits or state Medicaid programs. As a result of the prevalence of these health plans, many seniors now becoming eligible for Medicare have been interacting with managed care companies through their employers for the last 30 years. Individuals now turning 65 are likely more familiar with the managed care setting than previous Medicare populations. The healthcare industry, however, is highly regulated by various government agencies and heavily relies on reimbursement and payments from government sponsored programs such as Medicare and Medicaid. Companies in the healthcare industry therefore have to organize and operate around, and face challenges from, idiosyncratic laws and regulations.

Many health plans recognize both the opportunity for growth from adding members as well as the potential risks and costs associated with managing additional members. In California, many health plans subcontract a significant portion of the responsibility for managing patient care to integrated medical systems such as us and our affiliated physician groups. These integrated health care systems offer a comprehensive medical delivery system and sophisticated care management know-how and infrastructure to more efficiently provide for the health care needs of the population enrolled with that health plan. While reimbursement models for these arrangements vary around the U.S., health plans often prospectively pay the integrated health care system a fixed capitation payment, which is often based on a percentage of the amount received by the health plan. Capitation payments to integrated health care systems, in the aggregate, represent a prospective budget from which the system manages care-related expenses on behalf of the population enrolled with that system. To the extent that these systems manage such expenses under the capitated levels, the system realizes an operating profit. On the other hand, if the expenses exceed projected levels, the system will realize an operating deficit. Since premiums paid represent a substantial amount per person, there is a significant revenue opportunity for an integrated medical system that is able to effectively manage health care costs for the capitated arrangements entered into by its affiliated physician groups.

Industry Trends and Demand Drivers

We believe that the healthcare industry is undergoing a significant transformation and the demand for our offerings is driven by the confluence of a number of fundamental healthcare industry trends, including:

Shift to Value-Based and Results-Oriented Models. According to the 2018 National Health Expenditure Projections prepared by CMS, healthcare spending in the U.S. is projected to have increased 4.6% on a year-over-year basis to $3.6 trillion in 2018, representing 17.7% of U.S. Gross Domestic Product ("GDP"). CMS projects healthcare spending in the U.S. to increase at an average rate of 5.5% per year for 2018-27 and to reach approximately $6.0 trillion by 2027. To address this expected significant rise in healthcare costs, the U.S. healthcare market is seeking more efficient and effective methods of delivering care. It is argued that the fee-for-service reimbursement model has played a major role in increasing the level and growth rate of healthcare spending. In response, both the public and private sectors are shifting away from the fee-for-service reimbursement model toward value-based, capitated payment models that are designed to incentivize value and quality at an individual patient level. The number of Americans covered by capitated payment programs continues to increase, which drives more coordinated and outcomes-based patient care.

Increasingly Patient-Centered. More patients want to take a more active and informed role in how their own healthcare is delivered. This transformation results in the healthcare marketplace becoming increasingly patient-centered and requires providers to deliver team-based, coordinated and accessible care to stay competitive.

Added Complexity. In the healthcare space, more sophisticated technology has been employed, new diagnostics and treatments have been introduced, research and development has expanded, and regulations have multiplied. This expanding complexity drives a growing and continuous need for integrated care delivery systems.

Integration of Healthcare Information. Across the healthcare landscape, a significant amount of data is being created every day, driven by patient care, payment systems, regulatory compliance, and record keeping. As the amount of healthcare data continues to grow, it becomes increasingly important to connect disparate data and apply insights in a targeted manner in order to better achieve the goals of higher quality and more efficient care.

Integrated Medical Systems

Integrated medical systems that are able to pool a large number of patients, such as our Company and our affiliated physician groups, are positioned to take advantage of industry trends, meet patient and government demands, and benefit from cost advantages resulting from their scale of operation and integrated approach of care delivery. In addition, integrated medical systems with years of managed care experience can leverage their expertise and sizeable medical data to identify specific treatment strategies and interventions, improve the quality of medical care and lower cost. Many integrated medical systems have also established physician performance metrics that allow them to monitor quality and service outcomes achieved by participating physicians in order to reward efficient, high quality care delivered to members and initiate improvement efforts for physicians whose performance can be enhanced.

IPAs and MSOs

An IPA is an association of independent physicians, or other organization that contracts with independent physicians, and provides services to HMOs, which are medical insurance groups that provide health services generally for a fixed annual fee, on a negotiated per capita rate, flat retainer fee, or negotiated FFS basis. Because of the prohibition against corporate practice of medicine under certain state laws, MSOs are formed to provide management and administrative support services to affiliated physician groups such as IPAs. These services include payroll, benefits, human resource services, physician practice billing, revenue cycle services, physician practice management, administrative oversight, coding and other consulting services.

NGACOs and MSSP ACOs

CMS established the NGACO Model to test whether health outcomes will improve and Medicare Parts A and B expenditures for Medicare beneficiaries will decrease if ACOs (1) accept a higher level of financial risk compared to the existing MSSP model, and (2) are permitted to select certain innovative Medicare payment arrangements and offer certain additional benefit enhancements to their assigned Medicare beneficiaries. As a result, ACOs generally assume higher levels of financial risk and reward under the NGACO Model. CMS also established the MSSP to improve the care quality and reduce costs for beneficiaries in the Medicare FFS program. MSSP promotes accountability, facilitates coordination and cooperation among care providers, and encourages investment in infrastructure and redesign of care processes.

Outpatient Clinics

Ambulatory surgery centers and other outpatient clinics are healthcare facilities that specialize in performing outpatient surgeries, ambulatory treatments and diagnostic and other services in local communities. As medical care has increasingly been delivered in clinic settings, many integrated medical systems also operate healthcare facilities primarily focused on the diagnosis and/or care of outpatients, including those with chronic conditions such as heart disease and diabetes, to cover the primary healthcare needs of local communities.

Hospitalists

Hospitalists are doctors specialized in the care of patients in the hospital. Hospitalists assume the inpatient care responsibilities otherwise provided by primary care or other attending physicians and are reimbursed through the same billing procedures as other physicians. Hospitalists tend to focus exclusively on inpatient care. By practicing in the same facilities, hospitalists perform consistent functions, interact regularly with the same healthcare professionals and thus are familiar with specific and unique hospital processes, which can result in greater efficiency, less process variability and better outcomes. Through managing the treatment of a large number of patients with similar clinical needs, hospitalists generally develop practice expertise

in both the diagnosis and treatment of common conditions that require hospitalization. For these reasons, hospitalists have an increasingly important role in improving care quality. According to the Society of Hospital Medicine, in the U.S., the number of hospitalists grew in the past decade from a few hundred to more than 60,000 by 2018.

Population Health Management

Population health management ("PHM") is a central trend within healthcare delivery, which includes the aggregation of patient data across multiple health information technology resources, the analysis of that data into a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes. PHM seeks to improve the health outcomes, by monitoring and identifying individual patients, aggregating data, and providing a comprehensive clinical picture of each patient. Using that data, providers can track, and hopefully improve, clinical outcomes while lowering costs. A successful PHM platform requires a robust care and risk management infrastructure, a cohesive delivery system, and a well-managed partnership network.

Our Business Operations

IPAs

Each of our affiliated IPAs is comprised of a network of independent primary care physicians and specialists who collectively care for patients and contract with HMOs to provide physician services to their enrollees typically under capitated arrangements. Under the capitated model, a HMO pays the IPA a capitation payment and assigns it the responsibility for providing physician services required by patients. The IPA physicians are exclusively in control of, and responsible for, all aspects of the practice of medicine for enrolled patients. Most of the HMO agreements have an initial term of two years renewing automatically for successive one-year terms. The HMO agreements generally allow either party to terminate the HMO agreements without cause typically with a four to six months advance notice and provide for a termination for cause by the HMO at any time.

MSOs

Our MSOs generally provide services to our affiliated IPAs or ACOs under long-term MSAs, pursuant to which they manage certain non-medical services for the physician groups and have exclusive authority over all non-medical decision making related to ongoing business operations. These services include but are not limited to:

- Physician recruiting;
- Physician and health plan contracting;
- Medical management, including utilization management and quality assurance;
- Provider relations;
- Member services, including annual wellness evaluations; and
- Pre-negotiating contracts with specialists, labs, imaging centers, nursing homes and other vendors.

NGACO

On January 18, 2017, CMS announced that APAACO was approved to participate in the NGACO Model and APAACO began operations under this new model. We have devoted, and expect to continue to devote, significant effort and resources, financial and otherwise, to the NGACO Model. APAACO is now in its fourth year of participation under its Participation Agreement with CMS.

In advance of its participation in the NGACO Model, APAACO entered into agreements with over 750 medical care providers, including physicians, hospitals, nursing facilities and multiple labs, radiology centers, outpatient surgery centers, dialysis clinics and other service providers. APAACO negotiated discounted rates and such providers agreed to receive 100% of their claims for beneficiaries reimbursed by APAACO.

Among many requirements to be eligible to participate in the NGACO Model, ACOs must have at least 10,000 assigned Medicare beneficiaries and must maintain that number throughout each performance year. APAACO started its 2017 performance year with more than 29,000 aligned Medicare FFS beneficiaries. Its aligned beneficiaries total approximately 30,000 in 2018 and approximately 29,000 in 2019, respectively. This number may decrease if beneficiaries join a managed care plan, pass away or move out of the service area.

Under the Participation Agreement, APAACO must require its participants and preferred providers to make medically necessary covered services available to beneficiaries in accordance with applicable laws, regulations and guidance, and APAACO and its participants may not participate in any other Medicare shared savings initiatives.

There are different levels of financial risk and reward that an ACO may select under the NGACO Model, and the extent of risk and reward may be limited on a percentage basis. The NGACO Model offers two risk arrangement options. In Arrangement A, the ACO takes 80% of Medicare Part A and Part B risk. In Arrangement B, the ACO takes 100% of Medicare Part A and Part B risk. Under each risk arrangement, the ACO can cap aggregate savings and losses anywhere between 5% to 15%. The cap is elected annually by the ACO. APAACO has opted for Risk Arrangement A and a shared savings and losses cap of 5%.

The NGACO Model offers four payment mechanisms:

- Payment Mechanism #1: Normal FFS.
- Payment Mechanism #2: Normal FFS plus Infrastructure payments of $6 Per Beneficiary Per Month ("PBPM").
- Payment Mechanism #3: Population-Based Payments ("PBP"). PBP provide ACOs with a monthly payment to support ongoing ACO activities. ACO participants and preferred providers must agree to percentage payment fee reductions, which are then used to estimate a monthly PBP to be received by the ACO.
- Payment Mechanism #4: All-Inclusive Population-Based Payments ("AIPBP"). Under this mechanism, CMS will estimate the total annual expenditures of the ACO's aligned beneficiaries and pay that projected amount in PBPM payments. ACOs in AIPBP may have alternative compensation arrangements with their providers, including 100% FFS, discounted FFS, capitation or case rates.

APAACO opted for, and was approved by CMS effective on April 1, 2017 to participate in, the AIPBP track, which is the most advanced risk-taking payment model. When approved, APAACO was the only ACO participating in the AIPBP track, out of 44 ACOs approved for the NGACO Model in the U.S. Under the AIPBP track, CMS estimates the total annual expenditures for APAACO's beneficiaries and then pays that projected amount to APAACO on a PBPM basis. APAACO is responsible for paying all Part A and Part B costs for in-network participating providers and preferred providers with whom it has contracted. Between April and December 2017, this resulted in APAACO receiving approximately $9.3 million per month from CMS.

In October 2017, CMS notified the Company that it would not be renewed for participation in the AIPBP mechanism of the NGACO Model for performance year 2018 due to certain alleged deficiencies in performance. The Company submitted a reconsideration request and received an official decision from CMS in December 2017 that reversed the prior decision against the Company's continued participation in the AIPBP mechanism. As a result, the Company was eligible for receiving monthly AIPBP at a rate of approximately $7.3 million per month from CMS that started in February 2018. Effective October 1, 2018, CMS reduced our AIPBP to approximately $5.5 million per month based on the estimated total annual expenditures APAACO expected to incur. The monthly AIPBP received by the Company for performance year 2019 were approximately $8.3 million per month for the period beginning April 1, 2019 through August 30, 2019. Subsequently, CMS adjusted the monthly AIPBP to approximately $3.7 million for the period starting September 1, 2019 based on CMS' updated estimate of total claims to be incurred.

The Company was notified by CMS that under the NGACO alternative payment arrangement, the Company was paid excess amounts of approximately $34.5 million related to the first performance year (January 1, 2017 through December 31, 2017) and approximately $7.8 million related to the second performance year (February 1, 2018 through December 31, 2018) with 18 month run outs. The excess amount for the first performance year was paid by the Company on December 4, 2018, the excess for the second performance year was paid in February 2020.

Our Revenue Streams

Our revenue reflected in the accompanying consolidated financial statements includes revenue generated by our subsidiaries and consolidated entities. Revenue generated by consolidated entities, however, does not necessarily result in available or distributable cash for ApolloMed. Our revenue streams flow from various multi-year renewable contractual arrangements that vary by type of business operation as follows:

Capitation Revenue

Our capitation revenue consists primarily of capitated fees for medical services we provide under capitated arrangements made directly with various managed care providers including HMOs. Capitation revenues are typically prepaid monthly to us based on the number of enrollees selecting us as their healthcare provider. Capitation is a fixed payment amount per patient per unit of time paid in advance for the delivery of health care services, whereby the service providers are generally liable for excess medical costs. The actual amount paid is determined by the ranges of services provided, the number of patients enrolled, and the

period of time during which the services are provided. Capitation rates are generally based on local costs and average utilization of services. Because Medicare pays capitation using a "risk adjustment model," which compensates managed care providers based on the health status (acuity) of each individual enrollee, managed care providers with higher acuity enrollees receive more, and those with lower acuity enrollees receive less, capitation that can be allocated to service providers. Under the risk adjustment model, capitation is paid on an interim basis based on enrollee data submitted for the preceding year and is adjusted in subsequent periods after the final data is compiled.

Per member per month ("PMPM") managed care contracts generally have a term of one year or longer. All managed care contracts have a single performance obligation that constitutes a series for the provision of managed healthcare services for a population of enrolled members for the duration of the contract. The transaction price for PMPM contracts is variable as it primarily includes PMPM fees associated with unspecified membership that fluctuates throughout the term of the contract. In certain contracts, PMPM fees also include adjustments for items such as performance incentives, performance guarantees and risk shares.

Risk Pool Settlements and Incentives

Capitation arrangements are supplemented by risk sharing arrangements. We have two different types of capitation risk sharing arrangements: full risk and shared risk arrangements.

We enter into full risk capitation arrangements with certain health plans and local hospitals, which are administered by a related party, where the hospital is responsible for providing, arranging and paying for institutional risk. We are responsible for providing, arranging and paying for professional risk. Under a full risk pool sharing agreement, we generally receive a percentage of the net surplus from the affiliated hospital's risk pools with HMOs after deductions for the affiliated hospital's costs. Advance settlement payments are typically made quarterly in arrears if there is a surplus. Risk pool settlements under arrangements with health plans and hospitals are recognized using the most likely amount methodology and amounts are only included in revenue to the extent that it is probable that a significant reversal of cumulative revenue will not occur once any uncertainty is resolved. The assumptions for medical loss ratios ("MLR"), incurred but not reported ("IBNR") completion factor and constraint percentages were used by management in applying the most likely amount methodology.

Under capitation arrangements with certain HMOs, we participate in one or more shared risk arrangements relating to the provision of institutional services to enrollees (shared risk arrangements) and thus can earn additional revenue or incur losses based upon the enrollee utilization of institutional services. Shared risk capitation arrangements are entered into with certain health plans, which are administered by the health plan, where we are responsible for rendering professional services, but the health plan does not enter into a capitation arrangement with a hospital and therefore the health plan retains the institutional risk. Shared risk deficits, if any, are not payable until and unless (and only to the extent of any) risk sharing surpluses are generated. At the termination of the HMO contract, any accumulated deficit will be extinguished.

In addition to risk-sharing revenues, we also receive incentives under "pay-for-performance" programs for quality medical care, based on various criteria. As an incentive to control enrollee utilization and to promote quality care, certain HMOs have designed quality incentive programs and commercial generic pharmacy incentive programs to compensate us for our efforts to improve the quality of services and to promote the efficient and effective use of pharmacy supplemental benefits provided to HMO members. The incentive programs track specific performance measures and calculate payments to us based on the performance measures.

Generally, for the foregoing arrangements, the final settlement is dependent on each distinct day's performance within the annual measurement period, but cannot be allocated to specific days until the full measurement period has occurred and performance can be assessed.

Management Fee Income

Management fee income encompasses fees paid for management, physician advisory, healthcare staffing, administrative and other non-medical services provided by us to IPAs, hospitals and other healthcare providers. Such fees may be in the form of billings at agreed-upon hourly rates, percentages of revenue or fee collections, or amounts fixed on a monthly, quarterly or annual basis. The revenue may include variable arrangements measuring factors such as hours staffed, patient visits or collections per visit against benchmarks, and, in certain cases, may be subject to achieving quality metrics or fee collections.

NGACO Revenue

Through APAACO, we participate in the AIPBP track of the NGACO Model sponsored by CMS. Under the NGACO Model, CMS grants us a pool of patients to manage (direct care and pay providers) based on a budgetary benchmark established

with CMS. We are ultimately responsible for managing the medical costs for these beneficiaries. The beneficiaries will receive services from physicians and other medical service providers that are both in-network and out-of-network. Under the AIPBP track, CMS estimates an average of monthly expenditures for the previous calendar year for APAACO's aligned beneficiaries and pays that projected amount to us in monthly installments, and we are responsible for all Part A and Part B costs for in-network participating providers and preferred providers contracted by us to provide services to the aligned beneficiaries. Claims from out-of-network providers are processed and paid by CMS, our shared savings or losses in managing the services provided by out-of-network providers are generally determined on an annual basis after reconciliation with CMS. Pursuant to our risk share agreement with CMS, we will be eligible to receive the surplus or be liable for the deficit according to the budgetary benchmark established by CMS based on our efficiency or lack thereof, in managing how the beneficiaries aligned to us by CMS are served by in-network and out-of-network providers. Our shared savings or losses on providing such services are both capped by CMS. We recognize such savings or deficit upon substantial completion of reconciliation and determination of the amounts.

Under the AIPBP agreement we received $0.9 million and $5.9 million in risk pool savings related to the 2018 and 2017 performance years, respectively, and have recognized such amounts as revenue in the risk pool settlements and incentives in the accompanying consolidated statements of income for the years ended December 31, 2019 and 2018, respectively.

In October 2017, CMS notified the Company that it would not be renewed for participation in the AIPBP mechanism of the NGACO Model for performance year 2018 due to certain alleged deficiencies in performance. The Company submitted a reconsideration request and received an official decision from CMS in December 2017 that reversed the prior decision against the Company's continued participation in the AIPBP mechanism. As a result, the Company was eligible to receive monthly AIPBP at a rate of approximately $7.3 million per month from CMS beginning in February 2018. Effective October 1, 2018, CMS reduced our AIPBP to approximately $5.5 million per month based on the estimated total annual expenditures APAACO expected to incur. The monthly AIPBP received by the Company for performance year 2019 was approximately $8.3 million per month for the period from April 1, 2019 through August 30, 2019. Subsequently, CMS adjusted the AIPBP to approximately$3.7 million for the period starting September 1, 2019 based on CMS' updated estimate of total claims to be incurred.

Fee For Service Revenue

FFS revenue represents revenue earned under contracts in which we bill and collect the professional component of charges for medical services rendered by our contracted physicians and employed physicians. Under the FFS arrangements, we bill, and receive payments from, the hospitals and third-party payors for physician staffing and further bill patients or their third-party payors for patient care services provided.

Our Key Payors

We have a few key payors that represent a significant portion of our net revenue. For the years ended December 31, 2019, 2018 and 2017, four payors accounted for an aggregate of 51.6%, 61.5% and 54.6% of our total net revenue, respectively.

Our Strengths and Advantages

The following are some of the material opportunities that we believe exist for our company.

Combination of Clinical, Administrative and Technology Capabilities

We believe our key strength lies in our combined clinical, administrative and technology capabilities. While many companies separately provide clinical, MSO or technology support services, to our knowledge there are currently very few organizations like us that provide all three types of services to over 980,000 patients as of December 31, 2019.

Diversification

Through our subsidiaries, consolidated affiliates and invested entities, we have been able to reduce our business risk and increase revenue opportunities by diversifying our service offerings and expanding our ability to manage patient care across a horizontally integrated care network. Our revenue is spread across our operations. Additionally, with our ability to monitor and manage care within our wide network, we are an attractive business partner to health plans, hospitals, IPAs and other medical groups seeking to provide better care at lower costs.

Strong Management Team

Our management team has, collectively, several decades of experience managing physician practices, risk-based organizations, health plans, hospitals and health systems, a deep understanding of the healthcare marketplace and emerging trends, and a vision for the future of healthcare delivery led by physician-driven healthcare networks.

A Robust Physician Network

As of December 31, 2019, our physician network consisted of over7,000 contracted physicians, including primary care physicians, specialist physicians and hospitalists, through our affiliated physician groups and ACOs.

Cultural Affinities with Patients

In addition to delivering premium health care, we believe in the importance of providing services that are sensitive to the needs of local communities, including their cultural affinities. This value is shared by physicians within our affiliated IPAs and medical groups, and promotes patient comfort in communicating with care providers.

Long-Standing Relationships with Partners

We have developed long-standing relationships with and have earned trust from multiple health plans, hospitals, IPAs and other medical groups that have helped to generate recurring contractual revenue for us.

Comprehensive and Effective Healthcare Management Programs

We offer comprehensive and effective healthcare management programs to patients. We have developed expertise in population health management and care coordination, and in proper medical coding, which results in improved Risk Adjustment Factor ("RAF") scores and higher payments from health plans, and in improving quality metrics in both inpatient and outpatient settings and thus patient satisfaction and CMS scores. Using our own proprietary risk assessment scoring tool, we have also developed our own protocol for identifying high-risk patients.

Competition

The healthcare industry is highly competitive and fragmented. We compete for customers across all of our services with other health care management companies including MSOs and healthcare providers such as local, regional and national networks of physicians, medical groups and hospitals, many of which are substantially larger than us and have significantly greater financial and other resources, including personnel, than we have.

IPAs

Our affiliated IPAs compete with other IPAs, medical groups and hospitals, many of which have greater financial, personnel and other resources available to them. In the greater Los Angeles area, such competitors include Regal Medical Group and Lakeside Medical group, which are part of Heritage Provider Network ("Heritage"), as well as HealthCare Partners, which was recently acquired by UnitedHealth Group.

ACOs

Our NGACO, APAACO, competes with sophisticated provider groups in the creation, administration, and management of ACOs, including MSSP ACOs and NGACOs, many of which have greater financial, personnel and other resources available to them. In the greater Los Angeles area, major competitors of APAACO include Heritage California ACO and DaVita Medical ACO California.

Outpatient Clinics

Our outpatient clinics compete with large ambulatory surgery centers and/or diagnostic centers such as Foothill Cardiology (California Heart Medical Group), RadNet and Envision Healthcare, many of which have greater financial, personnel and other resources available to them, as well as smaller clinics that have ties to local communities. HealthCare Partners also has its own urgent care centers, clinics and diagnostic centers.

Hospitalists

Because individual physicians may provide hospitalist services if they have necessary credentials and privileges, the markets for hospitalist services are highly fragmented. Our affiliated hospitalist groups face competition primarily from numerous small inpatient practices in existing and expanding markets, but also compete with large physician groups, many of which have greater financial, personnel and other resources available to them. Some of such competitors operate on a national level, including EmCare, Team Health and Sound Physicians.

Regulatory Matters

As a healthcare company, our operations and relationships with healthcare providers such as hospitals, other healthcare facilities, and healthcare professionals are subject to extensive and increasing regulation by numerous federal, state, and local government agencies including the Office of Inspector General ("OIG"), the Department of Justice, CMS and various state authorities. These laws and regulations often are interpreted broadly and enforced aggressively. Imposition of liabilities associated with a violation of any of these healthcare laws and regulations could have a material adverse effect on our business, financial condition or results of operations. We cannot guarantee that our practices will not be subject to government scrutiny or be found to violate certain healthcare laws. Government investigations and prosecutions, even if we are ultimately found to be without fault, can be costly and disruptive to our business. Moreover, changes in healthcare legislation or government regulation may restrict our existing operations, limit our expansion or impose additional compliance requirements and costs, any of which could have a material adverse effect on our business, financial condition or results of operations. Below are brief descriptions of some, but not all, of such laws and regulations that affect our business operations.

Corporate Practice of Medicine

Our consolidated financial statements include our subsidiaries and VIEs. Some states have laws that prohibit business entities with non-physician owners, such as ApolloMed and its subsidiaries, from practicing medicine, employing physicians to practice medicine, exercising control over medical decisions by physicians; which are generally referred to as corporate practice of medicine laws. States that have corporate practice of medicine laws require only physicians to practice medicine, exercise control over medical decisions or engage in certain arrangements, such as fee-splitting, with physicians. In these states, a violation of the corporate practice of medicine prohibition constitutes the unlawful practice of medicine, which is a public offense punishable by fines and other criminal penalties. In addition, any physician who participates in a scheme that violates the state's corporate practice of medicine prohibition may be punished for aiding and abetting a lay entity in the unlawful practice of medicine.

California is a corporate practice of medicine state and we operate by maintaining long-term MSAs with our affiliated IPAs and medical groups, each of which is owned and operated by physicians only, and employs or contracts with additional physicians to provide medical services. Under such MSAs, our wholly owned MSOs are contracted to provide non-medical management and administrative services such as financial and risk management as well as information systems, marketing and administrative support to the IPAs and medical groups. The MSAs typically have an initial term of 3-30 years and are generally not terminable by our affiliated IPAs and medical groups except in the case of bankruptcy, gross negligence, fraud, or other illegal acts by the contracting MSO.

Through the MSAs and the relationship with the physician owners of our medical affiliates, we have exclusive authority over all non-medical decisions related to the ongoing business operations of those affiliates. Consequently, ApolloMed consolidates the revenue and expenses of such affiliates as their primary beneficiary from the date of execution of the applicable MSA. When necessary, our Co-Chief Executive Officers, Dr. Kenneth Sim and Dr. Thomas Lam, serve as nominee shareholders, of affiliated

medical practices on ApolloMed's behalf, in order to comply with corporate practice of medicine laws and certain accounting rules applicable to consolidated financial reporting by our affiliates as VIEs.

Under these arrangements our MSOs perform only non-medical functions, do not represent to offer medical services, and do not exercise influence or control over the practice of medicine by physicians. The California Medical Board, as well as other state's regulatory bodies, has taken the position that MSAs that confer too much control over a physician practice to MSOs may violate the prohibition against corporate practice of medicine. Some of the relevant laws, regulations, and agency interpretations in California and other states that have corporate practice prohibitions have been subject to limited judicial and regulatory interpretation. Moreover, state laws are subject to change and regulatory authorities. Other parties, including our affiliated physicians, may assert that, despite these arrangements, ApolloMed and its subsidiaries are engaged in the prohibited corporate practice of medicine or that such arrangements constitute unlawful fee-splitting between physicians and non-physicians. If this occurred, we could be subject to civil or criminal penalties, our MSAs could be found legally invalid and unenforceable in whole or in part, and we could be required to restructure arrangements with our affiliated IPAs and medical groups. If we were required to change our operating structures due to determination that a corporate practice of medicine violation existed, such a restructuring might require revising our MSOs' management fees.

False Claims Acts

The False Claims Act, 31 U.S.C. §§ 3729 - 3733, imposes civil liability on individuals or entities that submit false or fraudulent claims for payment to the federal government. The False Claims Act provides, in part, that the federal government may bring a lawsuit against any person whom it believes has knowingly or recklessly presented, or caused to be presented, a false or fraudulent request for payment from the federal government, or who has made a false statement or used a false record to get a claim for payment approved. Private parties may initiate qui tam whistleblower lawsuits against any person or entity under the False Claims Act in the name of the federal government and may share in the proceeds of a successful suit. The federal government has used the False Claims Act to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare and state healthcare programs. By way of illustration, these prosecutions may be based upon alleged coding errors, billing for services not rendered, billing services at a higher payment rate than appropriate, and billing for care that is not considered medically necessary. The federal government and a number of courts have taken the position that claims presented in violation of certain other statutes, including the federal Anti-Kickback Statute or the Stark Law, can also be considered a violation of the False Claims Act based on the theory that a provider impliedly certifies compliance with all applicable laws, regulations, and other rules when submitting claims for reimbursement.

Penalties for False Claims Act violations include fines ranging from $5,500 to $11,000 for each false claim, plus up to three times the amount of damages sustained by the government. A False Claims Act violation may provide the basis for the imposition of administrative penalties as well as exclusion from participation in governmental healthcare programs, including Medicare and Medicaid. In addition to the provisions of the False Claims Act, which provide for civil enforcement, the federal government also can use several criminal statutes to prosecute persons who are alleged to have submitted false or fraudulent claims to the government for payments.

A number of states including California have enacted laws that are similar to the federal False Claims Act. Under Section 6031 of the Deficit Reduction Act of 2005 ("DRA"), as amended, if a state enacts a false claims act that is at least as stringent as the federal statute and that also meets certain other requirements, the state will be eligible to receive a greater share of any monetary recovery obtained pursuant to certain actions brought under the state's false claims act. As a result, more states are expected to enact laws that are similar to the federal False Claims Act in the future along with a corresponding increase in state false claims enforcement efforts. In addition, section 6032 of the DRA requires entities that make or receive annual Medicaid payments of $5.0 million or more from any one state to provide their employees, contractors and agents with written policies and employee handbook materials on federal and state False Claims Acts and related statues.

Anti-Kickback Statutes

The federal Anti-Kickback Statute is a provision of the Social Security Act of 1972 that prohibits as a felony offense the knowing and willful offer, payment, solicitation or receipt of any form of remuneration in return for, or to induce, (1) the referral of a patient for items or services for which payment may be made in whole or part under Medicare, Medicaid or other federal healthcare programs, (2) the furnishing or arranging for the furnishing of items or services reimbursable under Medicare, Medicaid or other federal healthcare programs or (3) the purchase, lease, or order or arranging or recommending the purchasing, leasing or ordering of any item or service reimbursable under Medicare, Medicaid or other federal healthcare programs. The Patient Protection and Affordable Care Act ("ACA") amended section 1128B of the Social Security Act to make it clear that a person need not have actual knowledge of the statute, or specific intent to violate the statute, as a predicate for a violation. The OIG, which has the authority to impose administrative sanctions for violation of the statute, has adopted as its standard for review a judicial interpretation

which concludes that the statute prohibits any arrangement where even one purpose of the remuneration is to induce or reward referrals. A violation of the Anti-Kickback Statute is a felony punishable by imprisonment, criminal fines of up to $25,000, civil fines of up to $50,000 per violation and three times the amount of the unlawful remuneration. A violation also can result in exclusion from Medicare, Medicaid or other federal healthcare programs. In addition, pursuant to the changes of the ACA, a claim that includes items or services resulting from a violation of the Anti-Kickback Statute is a false claim for purposes of the False Claims Act.

Due to the breadth of the Anti-Kickback Statute's broad prohibitions, statutory exceptions exist that protect certain arrangements from prosecution. In addition, the OIG has published safe harbor regulations that specify arrangements that are deemed protected from prosecution under the Anti-Kickback Statute, provided all applicable criteria are met. The failure of an activity to meet all of the applicable safe harbor criteria does not necessarily mean that the particular arrangement violates the Anti-Kickback Statute, but these arrangements may be subject to scrutiny and prosecution by enforcement agencies. We may be less willing than some competitors to take actions or enter into arrangements that do not clearly satisfy the OIG safe harbors and suffer a competitive disadvantage.

Some states have enacted statutes and regulations similar to the Anti-Kickback Statute, but which may be applicable regardless of the payor source for the patient. These state laws may contain exceptions and safe harbors that are different from and/or more limited than those of the federal law and that may vary from state to state. For example, California has adopted the Physician Ownership and Referral Act of 1993 ("PORA"). PORA makes it unlawful for physicians, surgeons and other licensed professionals to refer a person for certain health care services if they have a financial interest with the person or entity that receives the referral. While PORA also provides certain exemptions from this prohibition, failure to fit within an exemption in violation of PORA can lead to a misdemeanor offense that may subject a physician to civil penalties and disciplinary action by the Medical Board of California.

We cannot assure that the applicable regulatory authorities will not determine that some of our arrangements with physicians violate the federal Anti-Kickback Statute or other applicable laws. An adverse determination could subject us to different liabilities, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other health care programs, any of which could have a material adverse effect on our business, financial condition or results of operations.

Stark Laws

The federal Stark Law, 42 U.S.C. 1395nn, also known as the physician self-referral law, generally prohibits a physician from referring Medicare and Medicaid patients to an entity (including hospitals) providing "designated health services," if the physician or a member of the physician's immediate family has a "financial relationship" with the entity, unless a specific exception applies. Designated health services include, among other services, inpatient hospital services, outpatient prescription drug services, clinical laboratory services, certain imaging services (e.g., MRI, CT, ultrasound), and other services that our affiliated physicians may order for their patients. The prohibition applies regardless of the reasons for the financial relationship and the referral; and therefore, unlike the federal Anti-Kickback Statute, intent to violate the law is not required. Like the Anti-Kickback Statute, the Stark Law contains statutory and regulatory exceptions intended to protect certain types of transactions and arrangements. Unlike safe harbors under the Anti-Kickback Statute with which compliance is voluntary, an arrangement must comply with every requirement of a Stark Law exception or the arrangement is in violation of the Stark Law.

Because the Stark Law and implementing regulations continue to evolve and are detailed and complex, while we attempt to structure its relationships to meet an exception to the Stark Law, there can be no assurance that the arrangements entered into by us with affiliated physicians and facilities will be found to be in compliance with the Stark Law, as it ultimately may be implemented or interpreted. The penalties for violating the Stark Law can include the denial of payment for services ordered in violation of the statute, mandatory refunds of any sums paid for such services and civil penalties of up to $15,000 for each violation, double damages, and possible exclusion from future participation in the governmental healthcare programs. A person who engages in a scheme to circumvent the Stark Law's prohibitions may be fined up to $100,000 for each applicable arrangement or scheme.

Some states have enacted statutes and regulations against self-referral arrangements similar to the federal Stark Law, but which may be applicable to the referral of patients regardless of their payor source and which may apply to different types of services. These state laws may contain statutory and regulatory exceptions that are different from those of the federal law and that may vary from state to state. An adverse determination under these state laws and/or the federal Stark Law could subject us to different liabilities, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other health care programs, any of which could have a material adverse effect on our business, financial condition or results of operations.

Health Information Privacy and Security Standards

The privacy regulations Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended, contain detailed requirements concerning the use and disclosure of individually identifiable patient health information ("PHI") by entities like our MSOs and affiliated IPAs and medical groups. HIPAA covered entities must implement certain administrative, physical, and technical security standards to protect the integrity, confidentiality and availability of certain electronic health information received, maintained, or transmitted. HIPAA also implemented standard transaction code sets and standard identifiers that covered entities must use when submitting or receiving certain electronic healthcare transactions, including billing and claim collection activities.

Violations of the HIPAA privacy and security rules may result in civil and criminal penalties, including a tiered system of civil money penalties that range from $100 to $50,000 per violation, with a cap of $1.5 million per year for identical violations. A HIPAA covered entity must also promptly notify affected individuals where a breach affects more than 500 individuals and report annually any breaches affecting fewer than 500 individuals.

State attorneys general may bring civil actions on behalf of state residents for violations of the HIPAA privacy and security rules, obtain damages on behalf of state residents and enjoin further violations. Many states also have laws that protect the privacy and security of confidential, personal information, which may be similar to or even more stringent than HIPAA. Some of these state laws may impose fines and penalties on violators and may afford private rights of action to individuals who believe their personal information has been misused.

We expect increased federal and state privacy and security enforcement efforts.

Knox-Keene Act and State Insurance Laws

The Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code Section 1340, et seq.), as amended (the "Knox-Keene Act"), is the California law that regulates managed care plans. Neither our MSOs nor their managed medical groups and IPAs hold a Knox-Keene license. Some of the medical groups and IPAs that have entered into MSAs with our MSOs have historically contracted with health plans and other payors to receive capitation payments and assumed the financial responsibility for professional services. In many of these cases, the health plans or other payors separately enter into contracts with hospitals that receive payments and assume some type of contractual financial responsibility for their institutional services. In some instances, our affiliated medical groups and IPAs have been paid by their contracting payor for the financial outcome of managing the care costs associated with both the professional and institutional services received by patients and have recognized a percentage of the surplus of institutional revenues less institutional expense as the medical groups' and IPAs' net revenues and has been responsible for a percentage of any short-fall in the event that institutional expenses exceed institutional revenues. While our MSOs and their managed medical groups and IPAs are not contractually obligated to pay claims to hospitals or other institutions under these arrangements, if it is determined that our MSOs or the medical groups and IPAs have been inappropriately taking financial risk for institutional and professional services without Knox-Keene licenses as a result of their hospital and physician arrangements, we may be required to obtain limited Knox-Keene licenses to resolve such violations and we could be subject to civil and criminal liability, any of which could have a material adverse effect on our business, financial condition or results of operations.

In addition, some states require ACOs to be registered or otherwise comply with state insurance laws. Our ACOs do not currently take financial risk, and are therefore not registered with any state insurance agency. If it is determined that we have been inappropriately operating an ACO without state registration or licensure, we may be required to obtain such registration or licensure to resolve such violations and we could be subject to liability, which could have a material adverse effect on our business, financial condition or results of operations.

Environmental and Occupational Safety and Health Administration Regulations

We are subject to federal, state and local regulations governing the storage, use and disposal of waste materials and products. Although we believe that our safety procedures for storing, handling and disposing of these materials and products comply with the standards prescribed by law and regulation, we cannot eliminate the risk of accidental contamination or injury from those hazardous materials. In the event of an accident, we could be held liable for any damages that result and any liability could exceed the limits or fall outside the coverage of our insurance policies, which we may not be able to maintain on acceptable terms, or at all. We could incur significant costs and the attention of our management could be diverted to comply with current or future environmental laws and regulations. Federal regulations promulgated by the Occupational Safety and Health Administration impose additional requirements on us including those protecting employees from exposure to elements such as blood-borne pathogens. We cannot predict the frequency of compliance, monitoring, or enforcement actions to which we may be subject as those regulations are being implemented, which could adversely affect our operations.

Other Federal and State Healthcare Laws

We are also subject to other federal and state healthcare laws that could have a material adverse effect on our business, financial condition or results of operations. The Health Care Fraud Statute prohibits any person from knowingly and willfully executing, or attempting to execute, a scheme to defraud any healthcare benefit program, which can be either a government or private payor plan. Violation of this statute, even in the absence of actual knowledge of or specific intent to violate the statute, may be charged as a felony offense and may result in fines, imprisonment or both. The Health Care False Statement Statute prohibits, in any matter involving a federal health care program, anyone from knowingly and willfully falsifying, concealing or covering up, by any trick, scheme or device, a material fact, or making any materially false, fictitious or fraudulent statement or representation, or making or using any materially false writing or document knowing that it contains a materially false or fraudulent statement. A violation of this statute may be charged as a felony offense and may result in fines, imprisonment or both. Under the Civil Monetary Penalties Law of the Social Security Act, a person (including an organization) is prohibited from knowingly presenting or causing to be presented to any United States officer, employee, agent, or department, or any state agency, a claim for payment for medical or other items or services where the person knows or should know (a) the items or services were not provided as described in the coding of the claim, (b) the claim is a false or fraudulent claim, (c) the claim is for a service furnished by an unlicensed physician, (d) the claim is for medical or other items or service furnished by a person or an entity that is in a period of exclusion from the program, or (e) the items or services are medically unnecessary items or services. Violations of the law may result in penalties of up to $10,000 per claim, treble damages, and exclusion from federal healthcare programs. In addition, the OIG may impose civil monetary penalties against any physician who knowingly accepts payment from a hospital (as well as against the hospital making the payment) as an inducement to reduce or limit medically necessary services provided to Medicare or Medicaid program beneficiaries. Further, except as permitted under the Civil Monetary Penalties Law, a person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary's selection of a particular provider of Medicare or Medicaid payable items or services may be liable for civil money penalties of up to $10,000 for each wrongful act.

In addition to the state laws previously described, we may also be subject to other state fraud and abuse statutes and regulations if we expand our operations beyond California. Many states have adopted a form of anti-kickback law, self-referral prohibition, and false claims and insurance fraud prohibition. The scope of these laws and the interpretations of them vary from state to state and are enforced by state courts and regulatory authorities, each with broad discretion. Generally, state laws reach to all healthcare services and not just those covered under a governmental healthcare program. A determination of liability under any of these laws could result in fines and penalties and restrictions on our ability to operate in these states. We cannot assure that our arrangements or business practices will not be subject to government scrutiny or be found to violate applicable fraud and abuse laws.

Licensure, Certification, Accreditation and Related Laws and Guidelines

Our clinical personnel are subject to numerous federal, state and local licensing laws and regulations, relating to, among other things, professional credentialing and professional ethics. Clinical professionals are also subject to state and federal regulation regarding prescribing medication and controlled substances. Our affiliated physicians and hospitalists must satisfy and maintain their individual professional licensing in each state where they practice medicine, including California, and many states require that nurse practitioners and physician assistants work in collaboration with or under the supervision of a physician. Each state defines the scope of practice of clinical professionals through legislation and through the respective Boards of Medicine and Nursing. Activities that qualify as professional misconduct under state law may subject our clinical personnel to sanctions, or to even lose their license and could, possibly, subject us to sanctions as well. Some state boards of medicine impose reciprocal discipline, that is, if a physician is disciplined for having committed professional misconduct in one state where he or she is licensed, another state where he or she is also licensed may impose the same discipline even though the conduct occurred in another state. Since we and our affiliated medical groups perform services at hospitals and other healthcare facilities, we may indirectly be subject to laws, ethical guidelines and operating standards of professional trade associations and private accreditation commissions (such as the American Medical Association and The Joint Commission) applicable to those entities. Penalties for non-compliance with these laws and standards include loss of professional license, civil or criminal fines and penalties, loss of hospital admitting privileges, and exclusion from participation in various governmental and other third-party healthcare programs. In addition, our affiliated facilities are subject to state and local licensing regulations ranging from the adequacy of medical care, to compliance with building codes and environmental protection laws. Our ability to operate profitably will depend, in part, upon our ability and the ability of our affiliated physicians and facilities to obtain and maintain all necessary licenses and other approvals and operate in compliance with applicable health care and other laws and regulations that evolve rapidly. We provide home health, hospice and palliative care, which require compliance with additional regulatory requirements. Reimbursement for palliative care and house call services is generally conditioned on clinical professionals providing the correct procedure and diagnosis codes and properly documenting both the service and the medical necessity for the service. Incorrect or incomplete documentation and billing information, or the incorrect selection of codes for the level and type of service provided, could result in non-payment for services rendered or lead to allegations of billing fraud. We must also comply with laws relating to hospice care eligibility, development and maintenance of care plans and coordination with nursing homes or assisted living facilities where patients live.

Professional Liability and Other Insurance Coverage

Our business has an inherent and significant risk of claims of medical malpractice against us and our affiliated physicians. We and our affiliated physician groups pay premiums for third-party professional liability insurance that provides indemnification on a claims-made basis for losses incurred related to medical malpractice litigation in order to carry out our operations. Our physicians are required to carry first dollar coverage with limits of liability equal to not less than $1.0 million for claims based on occurrence up to an aggregate of $3.0 million per year. Our IPAs purchase stop-loss insurance, which will reimburse them for claims from service providers on a per enrollee basis. The specific retention amount per enrollee per policy period is $60,000 to $75,000 for professional coverage. We also maintain worker's compensation, director and officer, and other third-party insurance coverage subject to deductibles and other restrictions that we believe are in accordance with industry standards. While we believe that our insurance coverage is adequate based upon claims experience and the nature and risks of our business, we cannot be certain that our insurance coverage will be adequate to cover liabilities arising out of pending or future claims asserted against us or our affiliated physician groups in the future where the outcomes of such claims are unfavorable. The ultimate resolution of pending and future claims in excess of our insurance coverage, may have a material adverse effect on our business, financial position, results of operations or cash flows.

Employees

As of December 31, 2019, ApolloMed and its subsidiaries had 555 employees, of whom 547 were full-time and 8 were part-time, and our consolidated VIEs employed 141 physicians and other staff. We had a broader physician network which, as of December 31, 2019, comprised of 36 additional physicians as independent contractors to provide medical services. None of our employees is a member of a labor union, and we have not experienced any work stoppage. We believe we enjoy a good working relationship with our staff.

Available Information

We maintain a website at www.apollomed.net and make available there, free of charge, our periodic reports filed with the Securities and Exchange Commission (SEC), as soon as is reasonably practicable after filing. The SEC maintains a website at http://www.sec.gov that contains reports, proxy and information statements, and other information regarding issuers such as us that file electronically with the SEC.

Item 1A. Risk Factors

Investing in our common stock involves a high degree of risk. You should carefully consider the risks and uncertainties described below, together with all of the other information in this Annual Report on Form 10-K, including the section titled "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7, and our consolidated financial statements and related notes, before making a decision to invest in our common stock. The risks and uncertainties described below may not be the only ones we face. If any of the risks actually occur, our business, financial condition, operating results and prospects could be materially and adversely affected. In that event, the market price of our common stock could decline, and you could lose part or all of your investment.

Risks Relating to Our General Business and Operations.

The Company, AP-AMH and APC, recently consummated a series of interrelated transactions that may expose the Company and its subsidiaries and VIEs to additional risks including the inability to repay a significant loan made in connection with such transactions.

On September 11, 2019, the Company, AP-AMH, and APC, concurrently consummated a series of interrelated transactions (collectively, the "APC Transactions"). As disclosed elsewhere in this Annual Report on Form 10-K and in the Company's other reports on file with the SEC, the APC Transactions included the following agreements and transactions: (i) the Company made a $545.0 million ten-year secured loan to AP-AMH; (ii) AP-AMH used all of the proceeds of that loan to purchase 1,000,000 shares of Series A Preferred Stock of APC; (iii) the Company obtained the funds to make the AP-AMH Loan (x) by entering into a $290.0 million senior secured credit facility (the "Credit Facility") with SunTrust Bank, in its capacity as administrative agent for various lenders, and then immediately drawing down $250.0 million in cash, and (y) by selling $300.0 million shares of the Company's common stock to APC, the purchase price of which was offset against $300.0 million of AP-AMH's purchase price for its APC Preferred Stock. NMM guaranteed the obligations of the Company under the Credit Facility, and both the Company and NMM have granted the lenders a security interest in all of their assets, including, without limitation, in all stock and other equity issued by their subsidiaries (including the shares of NMM) and all rights with respect to the AP-AMH Loan.

The APC Transactions may expose the Company, its subsidiaries and its VIEs to additional risks, including without limitation, the following: AP-AMH may never be able to repay the AP-AMH Loan; even if AP-AMH does not, or cannot repay the loan, the Company will be obligated to pay principal and interest on the $290.0 million Credit Facility; in connection with the Credit Facility, the lenders were granted a first priority perfected security interest over all of the assets of the Company and its subsidiaries, and such lenders have the right to foreclose on those assets if the Company defaults on its obligations under the Credit Facility; a disconnect could arise between APC achieving net income, declaring and paying dividends to AP-AMH, and AP-AMH making its required payments to the Company, which disconnect could materially impact the Company's financial results and its ability to make its required payments under the Credit Facility; APC may be prohibited from paying, or may be unable to pay the dividends on its Series A Preferred Stock, including under the California Corporations Code; regulators could determine that the current, post-APC Transactions consolidated structure amounts to the Company violating California's corporate practice of medicine doctrine; and the Company may be deemed an investment company, which could impose burdensome compliance requirements on the Company and restrict its future activities.

The "Risk Factors" section of the definitive proxy statement of the Company's board of directors that the Company filed with the SEC on July 31, 2019 (the "Proxy Statement") described these and certain other risks related to the APC Transactions that could arise if the APC Transactions are consummated. Since the APC Transactions have now closed, the APC Transactions-related risk factors described in the "Risk Factors" portion of the Proxy Statement, including the risks described in the Proxy Statement under the headings listed below, are hereby incorporated herein by reference:

- AP-AMH may never be able to repay the AP-AMH Loan.
- Whether or not AP-AMH pays us, we will be obligated to pay principal and interest on the secured senior credit facility we are entering into in order to make the AP-AMH Loan.
- The terms of the credit agreement we will need to secure could restrict our operations, particularly our ability to respond to changes in our business or to take specified actions, and an event of default under such credit agreement could harm our business.
- In connection with the credit facility, the creditor will have a first priority perfected security interest over all of our assets and those of our subsidiaries, and such creditor would be able to foreclose on our assets if we default on our obligations under the credit facility and security agreement.
- AP-AMH will be required to fund APC losses and deficits but may not have the funds to do so.
- There may be a timing disconnect between APC achieving net income subject to the Series A Dividend, declaring and paying dividends to AP-AMH and AP-AMH's payments to the Company, and any failure to pay or late payment of dividends could materially impact our financial results.
- The impact of the APC Transactions may prove to be negative in future periods.
- If there is a change in accounting principles or the interpretation thereof affecting our anticipated accounting treatment for the APC Transactions, it could impact our earnings per share.
- The Series A Dividends payable to AP-AMH must be declared by the APC board, and that board could fail to do so.
- APC may be prohibited from paying or unable to pay the Series A Dividends, including under the California Corporations Code, which could cause the APC Transactions structure to collapse.
- We may have no recourse against AP-AMH if it is unable to make its payments to the Company and NMM.
- The entitlement to receive the Series A Dividend will not necessarily mean that AP-AMH will be distributing all of the net income from APC's Healthcare Services business and assets.
- Regulators could determine that the post-APC Transactions consolidated structure amounts to the Company violating California's corporate practice of medicine doctrine.
- The Company could be subject to the California Finance Lenders Law as a result of the AP-AMH Loan.

- We may be deemed an investment company, which could impose on us burdensome compliance requirements and restrict our activities.

If our internal controls over financial reporting are not considered effective, our business and stock price could be adversely affected.

Section 404 of the Sarbanes-Oxley Act of 2002 requires us to evaluate the effectiveness of our internal controls over financial reporting as of the end of each fiscal year, and to include a management report assessing the effectiveness of our internal controls over financial reporting in our annual report on Form 10-K for that fiscal year. Section 404 also requires our independent registered public accounting firm to attest to, and report on, management's assessment of our internal controls over financial reporting. Our management, including our principal executive officer and principal financial officer, does not expect that our internal controls over financial reporting will prevent all errors and all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the control system's objectives will be met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud involving a company have been, or will be, detected. The design of any system of controls is based in part on certain assumptions about the likelihood of future events, and we cannot assure you that any design will succeed in achieving its stated goals under all potential future conditions. Over time, controls may become ineffective because of changes in conditions or deterioration in the degree of compliance with policies or procedures. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected. We cannot assure you that we or our independent registered public accounting firm will not identify a material weakness in our internal controls in the future. A material weakness in our internal controls over financial reporting would require management and our independent registered public accounting firm to consider our internal controls as ineffective. If our internal controls over financial reporting are not considered effective, we may experience a loss of public confidence, which could have an adverse effect on our business and on the market price of our common stock.

We may need to raise additional capital to grow, which might not be available.

We may in the future require additional capital to grow our business and may have to raise additional funds by selling equity, issuing debt, borrowing, refinancing our existing debt, or selling assets or subsidiaries. These alternatives may not be available on acceptable terms to us or in amounts sufficient to meet our needs. The failure to obtain any required future financing may require us to reduce or curtail certain existing operations.

Our net operating loss carryforwards and certain other tax attributes will be subject to limitations.

If a corporation undergoes an "ownership change" within the meaning of Section 382 of the Internal Revenue Code of 1986, as amended, its net operating loss carryforwards and certain other tax attributes arising from before the ownership change are subject to limitations on use after the ownership change. In general, an ownership change occurs if there is a cumulative change in the corporation's equity ownership by certain stockholders that exceeds 50 percentage points over a rolling three-year period. Similar rules may apply under state tax laws. The Merger likely resulted in an ownership change for us and, accordingly, our net operating loss carryforwards and certain other tax attributes will be subject to use limitations after the Merger. Additional ownership changes in the future could result in additional limitations on our net operating loss carryforwards. Consequently, we may not be able to utilize a material portion of our net operating loss carryforwards and other tax attributes, to offset our tax liabilities, which could have a material adverse effect on our cash flows and results of operations.

Uncertain or adverse economic conditions could adversely impact us.

A downturn in economic conditions could have a material adverse effect on our results of operations, financial condition, business prospects and stock price. Historically, government budget limitations have resulted in reduced spending. Given that Medicaid is a significant component of state budgets, an economic downturn would put continued cost containment pressures on Medicaid outlays for healthcare services in California. The existing federal deficit and continued deficit spending by the federal government can lead to reduced government expenditures including for government-funded programs in which we participate such as Medicare. An economic downturn and sustained unemployment may also impact the number of enrollees in managed care programs and the profitability of managed care companies, which could result in reduced reimbursement rates. Although we attempt to stay informed, any sustained failure to identify and respond to these trends could have a material adverse effect on our results of operations, financial condition, business and prospects.

Our operations and financial results could be adversely effected by a national or localized outbreak of a highly contagious disease or other public health crisis, and a pandemic outside of the United States could also adversely impact our business.

An epidemic outbreak or other public health crisis nationally or the markets where we operate could adversely affect our operations and financial results. For example, the recent outbreak of the 2019 Novel Coronavirus (COVID-19), which has been declared a global pandemic, has caused governments and the private sector to take a number of drastic measures to contain the spread of the coronavirus, including the suspension of classes at various colleges and universities, the cancellation of public events and other nonessential mass gatherings and the implementation of workplace telecommuting policies. Such measures may have a substantial impact on employee attendance or productivity, which in turn may adversely affect our operations, including our ability to effectively provide MSO services to our affiliated IPAs and contracted physician groups in compliance with regulatory requirements. An extended outbreak may also result in disruptions to critical infrastructures and our supply chains and the supply chains of our affiliated IPAs and contracted physician groups, including the supply of pharmaceuticals and medical supplies. The duration and extent of the impact from the coronavirus outbreak depends on future developments that cannot be accurately predicted at this time, such as the severity and transmission rate of the virus, the extent and effectiveness of containment actions. If we are not able to respond to and manage the impact of such events effectively, our business could be harmed.

We may be required to take write-downs or write-offs, restructuring and impairment or other charges that could have a significant negative effect on our financial condition, results of operations and stock price.

There can be no assurances that all material issues that may be present in our operations, including from prior to the Merger, have been uncovered, or that factors outside of our control will not later arise. As a result, we may be forced to write-down or write-off assets, restructure operations, or incur impairment or other charges that could result in losses. Unexpected risks may arise and previously known risks may materialize in a manner not consistent with each company's preliminary risk analysis. Even though these charges may not have an immediate impact on our liquidity, the fact that we report charges of this nature could contribute to negative market perceptions about us or our securities and may make our future financing difficult to obtain on favorable terms or at all.

From time to time, our intangible assets are subject to impairment testing. Under current accounting standards, our goodwill, including acquired goodwill, is tested for impairment on an annual basis and may be subject to impairment losses as circumstances change (e.g., after an acquisition). If we record an impairment loss, it could have a material adverse effect on our results of operations for the year in which the impairment is recorded.

A prolonged disruption of or any actual or perceived difficulties in the capital and credit markets may adversely affect our future access to capital, our cost of capital and our ability to continue operations.

Our operations and performance depend primarily on California and U.S. economic conditions and their impact on purchases of, or capitated rates for, our healthcare services, and our business is significantly exposed to risks associated with government spending and private payor reimbursement rates. As a result of the global financial crisis that began in 2008, general economic conditions deteriorated significantly. Although the markets have improved significantly, the overall economic recovery since that time has been uneven. Declines in consumer and business confidence as well as private and government spending, together with significant reductions in the availability and increases in the cost of credit and volatility in the capital and credit markets, have adversely affected the business and economic environment in which we operate and our profitability. Market disruption, increases in interest rates and/or sluggish economic growth in any future period could adversely affect our patients' spending habits, private payors' access to capital and governmental budgetary processes, which, in turn, could result in reduced revenue for us. The continuation or recurrence of any of these conditions may adversely affect our cash flows, results of operations and financial condition. As economic uncertainty may continue in future periods, our patients, private payors and government payors may alter their purchasing activities of healthcare services. Our patients may scale back healthcare spending, and private and government payors may reduce reimbursement rates, which may also cause delay or cancellation of consumer spending for discretionary and non-reimbursed healthcare. This uncertainty may also affect our ability to prepare accurate financial forecasts or meet specific forecasted results, and we may be unable to adequately respond to or forecast further changes in demand for healthcare services. Volatility and disruption of capital and credit markets may adversely affect our access to capital and increase our cost of capital. Should current economic and market conditions deteriorate, our ability to finance ongoing operations and our expansion may be adversely affected, we may be unable to raise necessary funds, our cost of debt or equity capital may increase significantly and future access to capital markets may be adversely affected.

If there is a change in accounting principles or the interpretation thereof affecting consolidation of VIEs, it could impact our consolidation of total revenues derived from our affiliated physician groups.

Our financial statements are consolidated and include the accounts of our majority-owned subsidiaries and various non-owned affiliated physician groups that are VIEs, which consolidation is effectuated in accordance with applicable accounting rules promulgated by the Financial Accounting Standards Board ("FASB"). Such accounting rules require that, under some circumstances, the VIE consolidation model be applied when a reporting enterprise holds a variable interest (e.g., equity interests, debt obligations, certain management and service contracts) in a legal entity. Under this model, an enterprise must assess the entity in which it holds a variable interest to determine whether it meets the criteria to be consolidated as a VIE. If the entity is a VIE, the consolidation framework next identifies the party, if one exists, that possesses a controlling financial interest in the VIE, and then requires that party to consolidate as the primary beneficiary. An enterprise's determination of whether it has a controlling financial interest in a VIE requires that a qualitative determination be made, and is not solely based on voting rights. If an enterprise determines the entity in which it holds a variable interest is not subject to the VIE consolidation model, the enterprise should apply the traditional voting control model which focuses on voting rights.

In our case, the VIE consolidation model applies to our controlled, but not owned, physician affiliated entities. Our determination regarding the consolidation of our affiliates, however, could be challenged, which could have a material adverse effect on our operations. In addition, in the event of a change in accounting rules or FASB's interpretations thereof, or if there were an adverse determination by a regulatory agency or a court or a change in state or federal law relating to the ability to maintain present agreements or arrangements with our affiliated physician groups, we may not be permitted to continue to consolidate the revenues of our VIEs.

Breaches or compromises of our information security systems or our information technology systems or infrastructure could result in exposure of private information, disruption of our business and damage to our reputation, which could harm our business, results of operation and financial condition.

As a routine part of our business, we utilize information security and information technology systems and websites that allow for the secure storage and transmission of proprietary or private information regarding our patients, employees, vendors and others, including individually identifiable health information. A security breach of our network, hosted service providers, or vendor systems, may expose us to a risk of loss or misuse of this information, litigation and potential liability. Hackers and data thieves are increasingly sophisticated and operate large-scale and complex automated attacks, including on companies within the healthcare industry. Although we believe that we take appropriate measures to safeguard sensitive information within our possession, we may not have the resources or technical sophistication to anticipate or prevent rapidly-evolving types of cyber-attacks targeted at us, our patients, or others who have entrusted us with information. Actual or anticipated attacks may cause us to incur costs, including costs to deploy additional personnel and protection technologies, train employees, and engage third-party experts and consultants. We invest in industry standard security technology to protect personal information. Advances in computer capabilities, new technological discoveries, or other developments may result in the technology used by us to protect personal information or other data being breached or compromised. In addition, data and security breaches can also occur as a result of non-technical failures. To our knowledge, we have not experienced any material breach of our cybersecurity systems. If we or our third-party service providers systems fail to operate effectively or are damaged, destroyed, or shut down, or there are problems with transitioning to upgraded or replacement systems, or there are security breaches in these systems, any of the aforementioned could occur as a result of natural disasters, software or equipment failures, telecommunications failures, loss or theft of equipment, acts of terrorism, circumvention of security systems, or other cyber-attacks, we could experience delays or decreases in service, and reduced efficiency of our operations. Additionally, any of these events could lead to violations of privacy laws, loss of customers, or loss, misappropriation or corruption of confidential information, trade secrets or data, which could expose us to potential litigation, regulatory actions, sanctions or other statutory penalties, any or all of which could adversely affect our business, and cause it to incur significant losses and remediation costs.

We rely on complex software systems and hosted applications to operate our business, and our business may be disrupted if we are unable to successfully or efficiently update these systems or convert to new systems.

We are increasingly dependent on technology systems to operate our business, reduce costs, and enhance customer service. These systems include complex software systems and hosted applications that are provided by third parties. Software systems need to be updated on a regular basis with patches, bug fixes and other modifications. Hosted applications are subject to service availability and reliability of hosting environments. We also migrate from legacy systems to new systems from time to time. Maintaining existing software systems, implementing upgrades and converting to new systems are costly and require personnel and other resources. The implementation of these systems upgrades and conversions is a complex and time-consuming project involving substantial expenditures for implementation activities, consultants, system hardware and software, often requires transforming our current business and processes to conform to new systems, and therefore, may take longer, be more disruptive, and cost more than forecast and may not be successful. If the implementation is delayed or otherwise is not successful, it may hinder our business operations and negatively affect our financial condition and results of operations. There are many factors that may materially and adversely affect the schedule, cost, and execution of the implementation process, including, without limitation,

problems in the design and testing of new systems; system delays and malfunctions; the deviation by suppliers and contractors from the required performance under their contracts with us; the diversion of management attention from our daily operations to the implementation project; reworks due to unanticipated changes in business processes; difficulty in training employees in the operation of new systems and maintaining internal control while converting from legacy systems to new systems; and integration with our existing systems. Some of such factors may not be reasonably anticipated or may be beyond our control.

Some of our agreements for services or products have limited terms, and we may be unable to renew such agreements and may lose access to such services or products.

We have various agreements with a number of third parties that provide products or services to us. These agreements often require reoccurring payments for continued access and have limited terms. We will be required to renegotiate the terms of these agreements from time to time, and may be unable to renew such agreements on favorable terms. If any such agreement cannot be renewed or can only be renewed on terms materially worse for us, we may lose access to the service or product, and our business and operating results may be adversely affected.

We may be unable to renew our leases on favorable terms or at all as our leases expire, which could adversely affect our business, financial condition and results of operations.

We operate several leased premises. There is no assurance that we will be able to continue to occupy such premises in the future. For example, we currently rent our corporate headquarters on a month-to-month basis. We could thus spend substantial resources to meet the current landlords' demands or look for other premises. We may be unable to timely renew such leases or renew them on favorable terms, if at all. If any current lease is terminated or not renewed, we may be required to relocate our operations at substantial costs or incur increased rental expenses, which could adversely affect our business, financial condition and results of operations.

We currently derive 100% of revenues in California and are vulnerable to changes in that state.

We only operate in California. Any material changes with respect to consumer preferences, taxation, reimbursements, financial requirements or other aspects of the healthcare delivery in California or the state's economic conditions could have an adverse effect on our business, results of operations and financial condition.

Our success depends, to a significant degree, upon our ability to adapt to the ever-changing healthcare industry and continued development of additional services.

Although we expect to provide a broad and competitive range of services, there can be no assurance of acceptance of current services by the marketplace. Our ability to procure new contracts may be dependent upon the continuing results achieved at the current facilities, upon pricing and operational considerations, and the potential need for continuing improvement to our existing services. Moreover, the markets for our new services may not develop as expected nor can there be any assurance that we will be successful in marketing any such services.

Risks Relating to Our Growth Strategy and Business Model.

Our growth strategy may not prove viable and we may not realize expected results.

Our business strategy is to grow rapidly by building a network of medical groups and integrated physician networks and is significantly dependent on locating and acquiring, partnering or contracting with medical practices to provide health care delivery services. We seek growth opportunities both organically and through acquisitions of or alliances with other medical service providers. As part of our growth strategy, we regularly review potential strategic opportunities. Identifying and establishing suitable strategic relationships are time-consuming and costly. There can be no assurance that we will be successful. We cannot guarantee that we will be successful in pursuing such strategic opportunities or assure the consequences of any strategic transactions. If we fail to evaluate and execute strategic transactions properly, we may not achieve anticipated benefits and may incur increased costs.

Our strategic transactions involve a number of risks and uncertainties, including that:

- We may not be able to successfully identify suitable strategic opportunities, complete desired strategic transactions, or realize their expected benefits. In addition, we compete for strategic transactions with other potential players, some of whom may have greater resources than we do. This competition may intensify due to the ongoing consolidation in the healthcare industry, which may increase our costs to pursue such opportunities.

- We may not be able to establish suitable strategic relationships and may fail to integrate them into our business. We cannot be certain of the extent of any unknown, undisclosed or contingent liabilities of any acquired business, including liabilities for failure to comply with applicable laws. We may incur material liabilities for past activities from strategic relationships. Also, depending on the location of the strategic transactions, we may be required to comply with laws and regulations that may differ from those of California, the state in which we currently operate.

- We may form strategic relationships with medical practices that operate with lower profit margins as compared with ours or which have a different payor mix than our other practice groups, which would reduce our overall profit margin. Depending upon the nature of the local market, we may not be able to implement our business model in every local market that we enter, which could negatively impact our revenues and financial condition.

- We may incur substantial costs to complete strategic transactions, integrate strategic relationships into our business, or expand our operations, including hiring more employees and engaging other personnel, to provide services to additional patients that we are responsible for managing pursuant to the new relationships. If such relationships terminate or diminish before we can realize their expected benefits, any costs that we have already incurred may not be recovered.

- If we finance strategic transactions by issuing our equity securities or securities convertible thereto, our existing stockholders could be diluted. If we finance strategic transactions with debt, it could result in higher leverage and interest costs for us.

If we are not successful in our efforts to identify and execute strategic transactions on beneficial terms, our ability to implement our business plan and achieve our targets could be adversely affected.

The process of integrating strategic relationships also involves significant risks including:

- difficulties in coping with demands on management related to the increased size of our business;
- difficulties in not diverting management's attention from our daily operations;
- difficulties in assimilating different corporate cultures and business practices;
- difficulties in converting other entities' books and records and conforming their practices to ours;
- difficulties in integrating operating, accounting and information technology systems of other entities with ours and in maintaining uniform procedures, policies and standards, such as internal accounting controls;
- difficulties in retaining employees who may be vital to the integration of the acquired entities; and
- difficulties in maintaining contracts and relationships with payors of other entities.

We may be required to make certain contingent payments in connection with strategic transactions from time to time. The fair value of such payments is re-evaluated periodically based on changes in our estimate of future operating results and changes in market discount rates. Any changes in our estimated fair value are recognized in our results of operations. The actual payments, however, may exceed our estimated fair value. Increases in actual contingent payments compared to the amounts recognized may have an adverse effect on our financial condition.

There can be no assurance that we will be able to effectively integrate strategic relationships into our business, which may negatively impact our business model, revenues, results of operations and financial condition. In addition, strategic transactions are time-intensive, requiring significant commitment of our management's focus. If our management spends too much time on assessing potential opportunities, completing strategic transactions and integrating strategic relationships, our management may not have sufficient time to focus on our existing operations. This diversion of attention could have material and adverse consequences on our operations and profitability.

Obligations in our credit or loan documents could restrict our operations, particularly our ability to respond to changes in our business or to take specified actions. An event of default could harm our business, and creditors having security interests over our assets would be able to foreclose on our assets.

The terms of our credit agreements and other indebtedness from time to time require us to comply with a number of financial and other obligations, which may include maintaining debt service coverage and leverage ratios and maintaining insurance coverage, that impose significant operating and financial restrictions on us, including restrictions on our ability to take actions that may be in our interests. These obligations may limit our flexibility in our operations, and breaches of these obligations could result in defaults under the agreements or instruments governing the indebtedness, even if we had satisfied our payment obligations. Moreover, if we defaulted on these obligations, creditors having security interests over our assets could exercise various remedies,

including foreclosing on and selling our assets. Unless waived by creditors, for which no assurance can be given, defaulting on these obligations could result in a material adverse effect on our financial condition and ability to continue our operations.

We may encounter difficulties in managing our growth, and the nature of our business and rapid changes in the healthcare industry makes it difficult to reliably predict future growth and operating results.

We may not be able to successfully grow and expand. Successful implementation of our business plan will require management of growth, including potentially rapid and substantial growth, which could result in an increase in the level of responsibility for management personnel and strain on our human and capital resources. To manage growth effectively, we will be required, among other things, to continue to implement and improve our operating and financial systems, procedures and controls and to expand, train and manage our employee base. If we are unable to implement and scale improvements to our existing systems and controls in an efficient and timely manner or if we encounter deficiencies, we will not be able to successfully execute our business plans. Failure to attract and retain sufficient numbers of qualified personnel could also impede our growth. If we are unable to manage our growth effectively, it will have a material adverse effect on its business, results of operations and financial condition.

The evolving nature of our business and rapid changes in the healthcare industry makes it difficult to anticipate the nature and amount of medical reimbursements, third party private payments and participation in certain government programs and thus to reliably predict our future growth and operating results.

We could experience significant losses under capitation contracts if our expenses exceed revenues.

Under a capitation contract, a health plan typically prospectively pays an IPA periodic capitation payments based on a percentage of the amount received by the health plan. Capitation payments, in the aggregate, represent a prospective budget from which an IPA manages care-related expenses on behalf of the population enrolled with that IPA. If our affiliated IPAs are able to manage care-related expenses under the capitated levels, we realize operating profits from capitation contracts. However, if care-related expenses exceed projected levels, our affiliated IPAs may realize substantial operating deficits, which are not capped and could lead to substantial losses. Additionally, factors beyond our control such as natural disasters, the potential effects of climate change, major epidemics, pandemics or newly emergent viruses (such as the 2019 novel coronavirus, COVID-19) could reduce our ability to effectively manage the costs of providing health care.

If our agreements with affiliated physician groups are deemed invalid or are terminated under applicable law, our results of operations and financial condition will be materially impaired.

There are various state laws, including laws in California, regulating the corporate practice of medicine which prohibit us from directly owning medical professional entities. These prohibitions are intended to prevent unlicensed persons from interfering with or inappropriately influencing a physician's professional judgment. These and other laws may also prevent fee-splitting, which is the sharing of professional service income with non-professional or business interests. The interpretation and enforcement of these laws vary significantly from state to state. We currently derive revenues from MSAs or similar arrangements with our affiliated IPAs, whereby we provide management and administrative services to them. If these agreements and arrangements were held to be invalid under laws prohibiting the corporate practice of medicine and other laws or if there are new laws that prohibit such agreements or arrangements, a significant portion of our revenues will be lost, resulting in a material adverse effect on our results of operations and financial condition.

The arrangements we have with our VIEs are not as secure as direct ownership of such entities.

Because of corporate practice of medicine laws, we entered into contractual arrangements to manage certain affiliated physician practice groups, which allow us to consolidate those groups for financial reporting purposes. We do not have direct ownership interests in any of our VIEs and are not able to exercise rights as an equity holder to directly change the members of the boards of directors of these entities so as to affect changes at the management and operational level. Under our arrangements with our VIEs, we must rely on their equity holders to exercise our control over the entities. If our affiliated entities or their equity holders fail to perform as expected, we may have to incur substantial costs and expend additional resources to enforce such arrangements.

Any failure by our affiliated entities or their owners to perform their obligations under their agreements with us would have a material adverse effect on our business, results of operations and financial condition.

Our affiliated physician practice groups are owned by individual physicians who could die, become incapacitated or become no longer affiliated with us. Although our MSAs with these affiliates provide that they will be binding on successors of

current owners, as the successors are not parties to the MSAs, it is uncertain in case of the death, bankruptcy or divorce of a current owner whether his or her successors would be subject to such MSAs.

Our revenues and operations are dependent on a limited number of key payors.

Our operations are dependent on a concentrated number of payors. Four payors accounted for an aggregate of51.6% and 61.5% of our total net revenue for the years ended December 31, 2019 and 2018, respectively. We believe that a majority of our revenues will continue to be derived from a limited number of key payors, which may terminate their contracts with us or our physicians credentialed by them upon the occurrence of certain events. They may also amend the material terms of the contracts under certain circumstances. Failure to maintain such contracts on favorable terms, or at all, would materially and adversely affect our results of operations and financial condition.

An exodus of our patients could have a material adverse effect on our results of operations. We may also be impacted by a shift in payor mix including eligibility changes to government and private insurance programs.

A material decline in the number of patients that we and our affiliated physician groups serve, whether a government or a private entity is paying for their healthcare, could have a material adverse effect on our results of operations and financial condition, which could result from increased competition, new developments in the healthcare industry or regulatory overhauls. In light of the repeal of the individual mandate requirement under the Patient Protection and Affordable Care Act of 2010 (also known as Affordable Care Act or Obamacare) via the Tax Cuts and Jobs Act of 2017, starting in 2019, some people are expected to lose their health insurance and thus may not continue to afford services by our managed medical groups. In addition, due to potential decreased availability of healthcare through private employers, the number of patients who are uninsured or participate in governmental programs may increase. A shift in payor mix from managed care and other private payors to government payors or the uninsured may result in a reduction in our rates of reimbursement or an increase in our uncollectible receivables or uncompensated care, with a corresponding decrease our net revenue. Changes in the eligibility requirements for governmental programs could also change the number of patients who participate in such programs or the number of uninsured patients. For those patients who remain with private insurance, changes in those programs could increase patient responsibility amounts, resulting in a greater risk for uncollectible receivables. Such events could have a material adverse effect on our business, results of operations and financial condition.

Our future growth could be harmed if we lose the services of our key management personnel.

Our success depends to a significant extent on the continued contributions of our key management personnel, particularly our Executive Chairman and Co-Chief Executive Officer, Dr. Sim, and our Co-Chief Executive Officer and President, Dr. Lam, for the management of our business and implementation of our business strategy. The loss of their services could have a material adverse effect on our business, financial condition and results of operations.

If having our key management personnel serving as nominee equity holders of our VIEs is invalid under applicable laws, or if we lost the services of key management personnel for any reason, it could have a material adverse impact on our results of operations and financial condition.

There are various state laws, including laws in California, regulating the corporate practice of medicine which prohibits us from owning various healthcare entities. These corporate practice of medicine prohibitions are intended to prevent unlicensed persons from interfering with or inappropriately influencing a physician's professional judgment. The interpretation and enforcement of these laws vary significantly from state to state. As a result, many of our affiliated physician practice groups are either wholly-owned or primarily owned by Dr. Lam as the nominee shareholder for our benefit. If these arrangements were held to be invalid under applicable laws, which may change from time to time, a significant portion of our consolidated revenues would be affected, which may result in a material adverse effect on our results of operations and financial condition. Similarly, if Dr. Lam died, was incapacitated or otherwise was no longer affiliated with us, our relationships and arrangements with those VIEs could be in jeopardy, and our business could be adversely affected.

We are dependent in part on referrals from third parties and preferred provider status with payors.

Our business relies in part on referrals from third parties for our services. We receive referrals from community medical providers, emergency departments, payors, and hospitals in the same manner as other medical professionals receive patient referrals. We do not provide compensation or other remuneration to referral sources for referring patients to us. A decrease in these referrals due to competition, concerns about our services and other factors could result in a significant decrease in our revenues and adversely impact our financial condition. Similarly, we cannot assure that we will be able to obtain or maintain preferred provider status

with significant third-party payors in the communities where we operate. If we are unable to maintain our referral base or our preferred provider status with significant third-party payors, it may negatively impact our revenues and financial performance.

Partner facilities may terminate agreements with our affiliated physician groups or reduce their fees.

Our hospitalist physician services net revenue is derived from contracts directly with hospitals and other inpatient and post-acute care facilities. Our current partner facilities may decide not to renew contracts with, impose unfavorable terms on, or reduce fees paid to our affiliated physician groups. Any of these events may impact the ability of our affiliated physician groups to operate at such facilities, which would negatively impact our revenues, results of operations and financial condition.

Many of our agreements with hospitals and medical groups have limited durations, may be terminated without cause by them, and prohibit us from acquiring physicians or patients from or competing with them.

Many of our agreements with hospitals and medical groups are limited in their terms or may be terminated without cause by providing advance notice. If such agreements are not renewed or terminated, we would lose the revenue generated by them. Any such events could have a material adverse effect on our results of operations, financial condition and future business plans. Because many of such agreements with hospitals and medical groups prohibit us from acquiring physicians or patients from or competing with them, our ability to hire physicians, attract patients or conduct business in certain areas may be limited in some cases.

Our business model depends on numerous complex management information systems, and any failure to successfully maintain these systems or implement new systems could undermine our ability to receive payments and otherwise materially harm our operations and may result in violations of healthcare laws and regulations.

We depend on a complex, specialized, integrated management information system and standardized procedures for operational and financial information, as well as for our billing operations. We may be unable to enhance existing management information systems or implement new management information systems when necessary. We may experience unanticipated delays, complications or expenses in implementing, integrating and operating our systems. Our management information systems may require modifications, improvements or replacements that may require both substantial expenditures as well as interruptions in operations. Our ability to create and implement these systems depends on the availability of technology and skilled personnel. Our failure to successfully implement and maintain all of our systems could undermine our ability to receive payments and otherwise have a material adverse effect on our business, results of operations and financial condition. Our failure to successfully operate our billing systems could also lead to potential violations of healthcare laws and regulations.

Risks Relating to the Healthcare Industry.

The healthcare industry is highly competitive.

We compete directly with national, regional and local providers of inpatient healthcare for patients and physicians. There are many other companies and individuals currently providing health care services, many of which have been in business longer and/or have substantially more resources. Since there are virtually no substantial capital expenditures required for providing health care services, there are few financial barriers to entry the healthcare industry. Other companies could enter the healthcare industry in the future and divert some or all of our business. On a national basis, our competitors include, but are not limited to, Team Health, EmCare, DaVita Medical Group and Heritage, each of which has greater financial and other resources available to them. We also compete with physician groups and privately-owned health care companies in local markets. In addition, our relationships with governmental and private third-party payors are not exclusive and our competitors have established or could seek to establish relationships with such payors to serve their covered patients. Competitors may also seek to compete with us for acquisitions, which could have the effect of increasing the price and reducing the number of suitable acquisitions, which would have an adverse impact on our growth strategy. Individual physicians, physician groups and companies in other healthcare industry segments, including those with which we have contracts, and some of which have greater financial, marketing and staffing resources, may become competitors in providing health care services, and this competition may have a material adverse effect on our business operations and financial position.

We therefore may be unable to compete successfully and even after we expend significant resources.

New physicians and other providers must be properly enrolled in governmental healthcare programs before we can receive reimbursement for their services, and there may be delays in the enrollment process.

Each time a new physician joins us or our affiliated groups, we must enroll the physician under our applicable group identification number for Medicare and Medicaid programs and for certain managed care and private insurance programs before we can receive reimbursement for services the physician renders to beneficiaries of those programs. The estimated time to receive approval for the enrollment is sometimes difficult to predict and, in recent years, the Medicare program carriers often have not issued these numbers to our affiliated physicians in a timely manner. These practices result in delayed reimbursement that may adversely affect our cash flows.

Hospitals where our affiliated physicians provide services may deny privileges to our physicians.

In general, our affiliated physicians may only provide services in a hospital where they have maintained certain credentials, also known as privileges, which are granted by the medical staff according to the bylaws of the hospital. The medical staff could decide that our affiliated physicians can no longer receive privileges to practice there. Such a decision would limit our ability to furnish services at the hospital, decrease the number of our affiliated physicians, or preclude us from entering new hospitals. In addition, hospitals may attempt to enter into exclusive contracts for certain physician services, which would reduce our access to patient populations within the hospital.

We may be impacted by eligibility changes to government and private insurance programs.

Due to potential decreased availability of healthcare through private employers, the number of patients who are uninsured or participate in governmental programs may increase. A shift in payor mix from managed care and other private payors to government payors or the uninsured may result in a reduction in our rates of reimbursement or an increase in our uncollectible receivables or uncompensated care, with a corresponding decrease in our net revenue. Changes in the eligibility requirements for governmental programs also could increase the number of patients who participate in such programs or the number of uninsured patients. Even for those patients who remain with private insurance, changes in those programs could increase patient responsibility amounts, resulting in a greater risk of uncollectible receivables for us. These factors and events could have a material adverse effect on our business, results of operations and financial condition.

Changes associated with reimbursements by third-party payors may adversely affect our operations.

The medical services industry is undergoing significant changes with government and other third-party payors that are taking measures to reduce reimbursement rates or, in some cases, denying reimbursement altogether. There is no assurance that government or other third-party payors will continue to pay for the services provided by our affiliated medical groups. Furthermore, there has been, and continues to be, a great deal of discussion and debate about the repeal and replacement of existing government reimbursement programs, such as the ACA. As a result, the future of healthcare reimbursement programs is uncertain, making long-term business planning difficult and imprecise. The failure of government or other third party payors to cover adequately the medical services provided by us could have a material adverse effect on our business, results of operations and financial condition.

Our business may be significantly and adversely affected by legislative initiatives aimed at or having the effect of reducing healthcare costs associated with Medicare and other government healthcare programs and changes in reimbursement policies. In order to participate in the Medicare program, we must comply with stringent and often complex enrollment and reimbursement requirements. These programs generally provide for reimbursement on a fee-schedule basis rather than on a charge-related basis. As a result, we cannot increase our revenue by increasing the amount that we and our affiliates charge for services. To the extent that our costs increase, we may not be able to recover the increased costs from these programs. In addition, cost containment measures in non-governmental insurance plans have generally restricted our ability to recover, or shift to non-governmental payors, these increased costs. In attempts to limit federal and state spending, there have been, and we expect that there will continue to be, a number of proposals to limit or reduce Medicare reimbursement for various services. For example, the Medicare Access and CHIP Reauthorization Act of 2015 made numerous changes to Medicare, Medicaid, and other healthcare related programs, including new systems for establishing annual updates to Medicare rates for physicians' services.

We may have difficulty collecting payments from third-party payors in a timely manner.

We derive significant revenue from third-party payors, and delays in payment or refunds to payors may adversely impact our net revenue. We assume the financial risks relating to uncollectible and delayed payments. In particular, we rely on some key governmental payors. Governmental payors typically pay on a more extended payment cycle, which could require us to incur substantial expenses prior to receiving corresponding payments. In the current healthcare environment, as payors continue to control expenditures for healthcare services, including through revising their coverage and reimbursement policies, we may continue to experience difficulties in collecting payments from payors that may seek to reduce or delay such payments. If we are not timely paid in full or if we need to refund some payments, our revenues, cash flows and financial condition could be adversely affected.

Decreases in payor rates could adversely affect us.

Decreases in payor rates, either prospectively or retroactively, could have a significant adverse effect on our revenues, cash flows and results of operations.

Federal and state laws may limit our ability to collect monies owed by patients.

We use third-party collection agencies whom we do not control to collect from patients any co-payments and other payments for services that our physicians provide. The federal Fair Debt Collection Practices Act of 1977 (the "FDCPA") restricts the methods that third-party collection companies may use to contact and seek payment from consumer debtors regarding past due accounts. State laws vary with respect to debt collection practices, although most state requirements are similar to those under the FDCPA. Therefore, such agencies may not be successful in collecting payments owed to us and our affiliated physician groups. If practices of collection agencies utilized by us are inconsistent with these standards, we may be subject to actual damages and penalties. These factors and events could have a material adverse effect on our business, results of operations and financial condition.

We have established reserves for our potential medical claim losses which are subject to inherent uncertainties and a deficiency in the established reserves may lead to a reduction in our assets or net incomes.

We establish reserves for estimated IBNR claims. IBNR estimates are developed using actuarial methods and are based on many variables, including the utilization of health care services, historical payment patterns, cost trends, product mix, seasonality, changes in membership, and other factors. The estimation methods and the resulting reserves are periodically reviewed and updated.

Many of our contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such interpretations may not come to light until a substantial period of time has passed. The inherent difficulty in interpreting contracts and estimating necessary reserves could result in significant fluctuations in our estimates from period to period. Our actual losses and related expenses therefore may differ, even substantially, from the reserve estimates reflected in our financial statements. If actual claims exceed our estimated reserves, we may be required to increase reserves, which would lead to a reduction in our assets or net income.

Competition for qualified physicians, employees and management personnel is intense in the healthcare industry, and we may not be able to hire and retain qualified physicians and other personnel.

We depend on our affiliated physicians to provide services and generate revenue. We compete with many types of healthcare providers, including teaching, research and government institutions, hospitals and other practice groups, for the services of clinicians and management personnel. The limited number of residents and other licensed providers on the job market with the expertise necessary to provide services within our business makes it challenging to meet our hiring needs and may require us to train new employees, contract temporary physicians, or offer more attractive wage and benefit packages to experienced professionals, which could decrease our profit margins. The limited number of available residents and other licensed providers also impacts our ability to renew contracts with existing physicians on acceptable terms. As a result, our ability to provide services could be adversely affected. Even though our physician turnover rate has remained stable over the last three years, if the turnover rate were to increase significantly, our growth could be adversely affected. Moreover, unlike some of our competitors who sometimes pay additional compensation to physicians who agree to provide services exclusively to that competitor, our affiliated IPAs have historically not entered into such exclusivity agreements and have allowed our affiliated physicians to affiliate with multiple IPAs. This practice may place us at a competitive disadvantage regarding the hiring and retention of physicians relative to those competitors who do enter into such exclusivity agreements.

Our risk-sharing arrangements with health plans and hospitals could result in costs exceeding the corresponding revenues, which could reduce or eliminate any shared risk profitability for us.

Under certain risk-sharing arrangements with health plans and hospitals, we are responsible for a portion of the cost of services that are not capitated. These risk-sharing arrangements generally allocate deficits to the respective parties when the cost of services exceeds the related revenue, and permit the parties to share surplus amounts when actual cost is less than the related revenue. The amount of non-capitated costs could be affected by factors beyond our control, such as changes in treatment protocols, new technologies, longer lengths of stay by the patient and inflation. To the extent that the cost is higher than anticipated, the related revenue may not be sufficient to cover the cost that we are partially responsible for, which could adversely affect our results of operations. Additionally, factors beyond our control such as natural disasters, the potential effects of climate change, major epidemics, pandemics or newly emergent viruses (such as the 2019 novel coronavirus, COVID-19) could reduce our ability to effectively manage the costs of providing health care.

The healthcare industry is increasingly reliant on technology, which could increase our risks.

The role of technology is greatly increasing in the delivery of healthcare, which makes it difficult for traditional physician-driven companies, such as us, to adopt and integrate electronic health records, databases, cloud-based billing systems and many other technology applications in the delivery of healthcare services. Additionally, consumers are using mobile applications and care and cost research in selecting and usage of healthcare services. We may need to incur significant costs to implement these technology applications and comply with applicable laws. For example, the nature of our business and the requirements of healthcare privacy laws impose significant obligations on us to maintain privacy and protection of patient medical information. We rely on employees and third parties with technology knowledge and expertise and could be at risk if technology applications are not properly established, maintained or secured. Any cybersecurity incident, even unintended, could expose us to significant fines and remediation costs and materially impair our business operations and financial position.

If we are unable to effectively adapt to changes in the healthcare industry, including changes to laws and regulations regarding or affecting the U.S. healthcare reform, our business may be harmed.

Due to the importance of the healthcare industry in the lives of all Americans, federal, state, and local legislative bodies frequently pass legislation and promulgate regulations relating to healthcare reform or that affect the healthcare industry. As has been the trend in recent years, it is reasonable to assume that there will continue to be increased government oversight and regulation of the healthcare industry in the future. We cannot assure our stockholders as to the ultimate content, timing or effect of any new healthcare legislation or regulations, nor is it possible at this time to estimate the impact of potential new legislation or regulations on our business. It is possible that future legislation enacted by Congress or state legislatures, or regulations promulgated by regulatory authorities at the federal or state level, could adversely affect our business or could change the operating environment of the hospitals and other facilities where our affiliated physicians provide services. It is possible that the changes to the Medicare, Medicaid or other governmental healthcare program reimbursements may serve as precedent to possible changes in other payors' reimbursement policies in a manner adverse to us. Similarly, changes in private payor reimbursements could lead to adverse changes in Medicare, Medicaid and other governmental healthcare programs which could have a material adverse effect on our business, financial condition and results of operations.

Although we do not anticipate that a single-payer national health insurance system will be enacted by the current Congress, several legislative initiatives have been proposed by members of Congress and presidential candidates that would establish some form of a single public or quasi-public agency that organizes healthcare financing, but under which healthcare delivery would remain private. If enacted, such a system could adversely affect our business.

Risks Relating to NGACO.

The success of our emphasis on the NGACO Model is uncertain.

In January 2017, CMS approved APAACO, our subsidiary, to participate in the NGACO Model. To position us to participate in the NGACO Model and meet its requirements, we have invested significant resources in reshaping our business and organizations and in establishing related infrastructure, and expect to continue to devote, significant financial and other resources to the NGACO Model. These efforts have required us to refocus away from certain other parts of our historic business and revenue streams, which will receive less emphasis and could result in reduced revenue from these activities for us. For example, we have converted physicians and patients from our MSSP ACOs to our NGACO. It is unknown whether this strategic decision will be eventually successful.

The NGACO Model has certain political risks and is undergoing changes.

If the Patient Protection and the ACA is amended, repealed, declared unconstitutional or replaced, or if Center for Medicare and Medicaid Innovation ("CMMI") is terminated, the NGACO Model program could be discontinued or significantly altered. In addition, CMS and CMMI leadership could be changed and influenced by Congress and/or the current Trump Administration, and may elect to combine any existing programs, including bundled payments, which could greatly alter the NGACO Model program. The rules regarding NGACOs have also been altered and may be further altered in the future. Any material change to the NGACO requirements and governing rules or the discontinuation of the program as a whole could create significant uncertainties for us and alter our strategic direction, thereby increasing financial risks for our stockholders.

There are uncertainties regarding the design and administration of the NGACO Model and CMS' initial financial reports to NGACO participants, which could negatively impact our results of operations.

Due to the newness of the NGACO Model, and due to being the only participant in the AIPBP track, we are subject to initial program challenges including, but not limited to, process design, data and other related aspects. We rely on CMS for design, oversight and governance of the NGACO Model. If CMS cannot provide accurate data, claims benchmarking and calculations, make timely payments and conduct periodic process reviews, our results of operations and financial condition could be materially and adversely affected. CMS relies on various third parties to effect the NGACO program, including other departments of the U.S. government, such as CMMI. CMS also relies on multiple third party contractors to manage the NGACO Model program, including claims and auditing. As a result, there is the potential for errors, delays and poor communication among the differing entities involved, which are beyond the control of us. As CMS is implementing extensive reporting protocols for the NGACO Model, CMS has indicated that because of inherent biases in reporting the results, its initial financial reports under the NGACO Model may not be indicative of final results of actual risk-sharing and revenues which we receive. Were that to be the case, we might not report accurately our revenues for relevant periods, which could result in adjustment in a later period when we receive final results from CMS. We and our contracted providers have experienced various apparent errors in the NGACO Model, resulting in some providers terminating their relationships with us, and the resolution of these issues and impact on us remains uncertain. If we continue to experience such issues or new issues emerge, this could have a material adverse effect on our results of operations on a consolidated basis.

We chose to participate in the AIPBP mechanism, which entails certain special risks.

Under the AIPBP mechanism, CMS estimates the total annual Part A and Part B Medicare expenditures of our assigned Medicare beneficiaries and pay us that projected amount in per beneficiary per month payments. We chose "Risk Arrangement A," comprising 80% risk for Part A and Part B Medicare expenditures and a shared savings and losses cap of 5% (or a 4% effective shared savings and losses cap when factoring in 80% risk impact). Our benchmark Medicare Part A and Part B expenditures for beneficiaries for the 2019 performance year are approximately $410.0 million, and under "Risk Arrangement A" of the AIPBP mechanism we could therefore have profits or be liable for losses of up to 4% of such benchmarked expenditures, or approximately $16.4 million. While performance can be monitored throughout the year, end results for the 2019 performance year will not be known until mid-2020.

AIPBP operations and benchmarking calculations are complex and could result in uncertainties for us.

AIPBP operations and benchmarking calculations are complex and can lead to errors in the application of the NGACO Model, which could create reimbursement delays to our contracted, in-network providers and adversely affect our performance and results of operations. For example, we discovered a feature in the AIPBP claim processing system that does not allow us to break down certain claims amounts by individual patient codes. This has created confusion for our in-network providers in reconciling payments, causing some providers to terminate their agreements with us. This feature and other complexities within the AIPBP mechanism could also create uncertainties for our operations including under agreements with our contracted, in-network providers

The NGACO Model requires significant capital reserves for program participation, which could negatively impact our working capital and substantially increase our capital requirements.

NGACOs must provide a financial guarantee to CMS. Our financial guarantee generally must be in an amount of 2% of our benchmark Medicare Part A and Part B expenditures. Because our benchmark Medicare Part A and Part B expenditures for beneficiaries assigned to us for the 2019 performance year was approximately $410.0 million, we established and submitted an irrevocable standby letter of credit on August 14, 2019 for $8.2 million with respect to that year. If we reach the maximum of our shared losses for a performance year, CMS may increase the risk reserve amount for future performance years, which will put restraints on our working capital and liquidity. If we reach the maximum of our shared losses of $16.4 million for the 2019 performance year, we will need to pay another $8.2 million to CMS and CMS may increase the future risk reserve amount. The $6.6 million standby letter of credit relating to the 2018 performance year remains open until twelve months after the settlement period of October 2019.

We may suffer losses and not generate savings through our participation in the NGACO Model.

Through the NGACO Model, CMS provides an opportunity to provider groups that are willing to assume higher levels of financial risk and reward, to participate in this new attribution-based risk sharing model. The NGACO Model uses a prospectively-set cost benchmark, which is established prior to the start of each performance year. The benchmark is based on various factors, including baseline expenditures with the baseline updated each year to reflect the NGACO's participant list for the given year. Our 2019 performance year baseline is based on calendar year 2018 expenditures that are risk adjusted and trended. A discount is then applied that incorporates regional and national efficiency. The benchmarked expenditures therefore could potentially underestimate our actual expenditures for assigned Medicare beneficiaries and there can be no assurance that we could successfully

adjust such benchmarked expenditures. Under the NGACO Model, we are responsible for savings and losses related to care received by assigned patients by covering claims from physicians, nurses and other medical professionals. If claim costs exceed the benchmarked expenditures, or the baseline years are statistical anomalies, we could experience losses, which could be significant. Among other things, this could result from factors beyond our control such as natural disasters, the potential effects of climate change, major epidemics, pandemics or newly emergent viruses (such as the 2019 novel coronavirus, COVID-19) As we are providing care coordination through APAACO, but do not provide direct patient care, our influence could be limited. Because of our limited influence, it is possible that we may not be able to control care providers' behavior, utilization, and costs. As a result, we may not be able to generate savings through our participation in the NGACO Model to cover our administrative and care coordination operating costs, and any savings generated, if at all, will be earned in arrears and uncertain in both timing and amount.

We do not control, but are responsible for savings and losses related to, care received by assigned patients at out-of-network providers, which could negatively impact our ability to control claim costs.

Medicare beneficiaries in the NGACO Model are not required to receive care from a specified network of contracted providers and facilities, which could make it difficult for us to control the financial risks of those beneficiaries. CMS notified us that its Medicare beneficiaries historically had received approximately 62% of care at non-contracted, out-of-network ("OON") providers. While we are not responsible for directly paying claims for OON providers, we may have difficulty managing patient care and costs in relation to such OON providers as compared to contracted, in-network providers, which, could adversely impact our financial results as we are responsible for savings and losses of assigned beneficiaries, irrespective of whether they are using in-network or OON providers. In addition, even if we are successful in encouraging more assigned patients to receive care from our contracted, in-network providers, there is the possibility that the monthly AIPBP from CMS will be insufficient to cover our expenditures, since the AIPBP is generally based on historical in-network/out-of-network ratios. If CMS fails to monitor the in-network/OON provider ratio for our assigned patients on a frequent basis or CMS' reconciliation payments to us are not timely made, this could result in negative cash flows for us, especially if increased payments will need to be made to our contracted, in-network providers.

Third parties used by us could hinder our performance.

We use third parties to perform certain administrative and care coordination tasks. We have contracted with participating Part A and Part B providers and sometimes with discounted rates. This could, however, create operational and performance risk; for example, if a third party does not perform its responsibilities properly. In addition, such providers could increase their current rates or discontinue their agreements with us.

We face competition from traditional MSSP ACOs and other NGACOs

Managed care providers experienced in coordinating care for populations of patients compete with each other to be selected by CMS to participate in the NGACO Model. Since MSSP and pioneer ACOs began in 2012, the number of Medicare ACOs continues to rise and have grown to several hundred nationwide but there are still a growing number of ACOs in different program types that compete with us for resources and patients.

Our continued participation in the NGACO Model cannot be guaranteed.

APAACO and CMS entered into a Next Generation ACO Model Participation Agreement (the "Participation Agreement") with a term of two performance years through December 31, 2018. Subsequently CMS and APAACO has renewed the Participation Agreement for an additional year with the option for a second renewal year through December 31, 2020. In addition, the Participation Agreement may be terminated sooner by CMS as specified therein and CMS has the flexibility to alter or change the program over time. Among many requirements to be eligible to participate in the NGACO Model, we must have at least 10,000 aligned Medicare beneficiaries and must maintain that number throughout each performance year. Although we started the 2019 performance year with more than 29,000 aligned Medicare beneficiaries, there can be no assurance that we will maintain the required number of assigned Medicare beneficiaries. If that number were not maintained, we would become ineligible for the NGACO Model. In addition, we are required to comply with all applicable laws and regulations regarding provider-based risk-bearing entities. If these laws or regulations change, for example, to require a Knox-Keene license in California, which we do not currently have, we could be required to cease our NGACO operations. We could be terminated from the NGACO Model at any time if we do not continue to comply with the NGACO participation requirements. In October 2017, CMS notified us that our participation in the AIPBP mechanism for performance year 2018 would not be renewed due to alleged deficiencies in performance by us. We submitted a request for reconsideration to CMS. In December 2017, we received the official decision on our reconsideration request that CMS reversed the prior decision against our continued participation in the AIPBP mechanism. As a result, we were again eligible to receive monthly AIPBP from CMS. We, however, will need to continue to comply with all terms and conditions in the Participation Agreement and various regulatory requirements to be eligible to participate in the AIPBP

mechanism and/or NGACO Model. If future compliance or performance issues arise, we may lose our current eligibility and may be subject to CMS' enforcement or contract actions, including our potential inability to participate in the AIPBP mechanism (where the payment mechanism would default to traditional fee for service) or dismissal from the NGACO Model, which would have a material adverse effect on our revenues and cash flows. In addition, the payments from CMS to us will decrease if the number of beneficiaries assigned to our NGACO declines, or the contracted providers terminate their relationships with us, which could have a material adverse effect on our results of operations on a consolidated basis.

Risks Relating to Regulatory Compliance.

Laws regulating the corporate practice of medicine could restrict the manner in which we are permitted to conduct our business and the failure to comply with such laws could subject us to penalties and restructuring.

Some states have laws that prohibit business entities from practicing medicine, employing physicians to practice medicine, exercising control over medical decisions by physicians (also known collectively as the corporate practice of medicine) or engaging in some arrangements, such as fee-splitting, with physicians. In some states these prohibitions are expressly stated in a statute or regulation, while in other states the prohibition is a matter of judicial or regulatory interpretation. California is one of the states that prohibit the corporate practice of medicine.

In California, we operate by maintaining contracts with our affiliated physician groups which are each owned and operated by physicians and which employ or contract with additional physicians to provide physician services. Under these arrangements, we or our subsidiaries provide management services, receive a management fee for providing management services, do not represent to offer medical services, and do not exercise influence or control over the practice of medicine by the physicians or the affiliated physician groups.

In addition to the above management arrangements, in certain instances, we have contractual rights relating to the transfer of equity interests in our affiliated physician groups under physician shareholder agreements that we entered into with the controlling equity holder of such affiliated physician groups. However, even in such instances, such equity interests cannot be transferred to or held by us or by any non-professional organization. Accordingly, we do not directly own any equity interests in any affiliated physician groups in California. In the event that any of these affiliated physician groups or their equity holders fail to comply with these management or ownership transfer arrangements, these arrangements are terminated, we are unable to enforce such arrangements, or these arrangements are invalidated under applicable laws, there could be a material adverse effect on our business, results of operations and financial condition and we may have to restructure our organization and change our arrangements with our affiliated physician groups, which may not be successful.

The healthcare industry is intensely regulated at the federal, state, and local levels and government authorities may determine that we fail to comply with applicable laws or regulations and take actions against us.

As a company involved in providing healthcare services, we are subject to numerous federal, state and local laws and regulations. There are significant costs involved in complying with these laws and regulations. If we are found to have violated any applicable laws or regulations, we could be subject to civil and/or criminal damages, fines, sanctions or penalties, including exclusion from participation in governmental healthcare programs, such as Medicare and Medicaid, and we may be required to change our method of operations and business strategy. These consequences could be the result of our current conduct or even conduct that occurred a number of years ago, including prior to the completion of the Merger. We could incur significant costs to defend ourselves if we become the subject of an investigation or legal proceeding alleging a violation of these laws and regulations. We cannot predict whether a federal, state or local government will determine that we are not operating in accordance with law, or whether, when or how the laws will change in the future and impact our business. The following is a non-exhaustive list of some of the more significant healthcare laws and regulations that could affect us:

- the False Claims Act, that provide for penalties against entities and individuals which knowingly or recklessly make claims to Medicare, Medicaid, and other governmental healthcare programs, as well as third-party payors, that contain or are based upon false or fraudulent information;
- a provision of the Social Security Act, commonly referred to as the "Anti-Kickback Statute," that prohibits the knowing and willful offering, payment, solicitation or receipt of any bribe, kickback, rebate or other remuneration, in cash or in kind, in return for the referral or recommendation of patients for items and services covered, in or in part, by federal healthcare programs such as Medicare and Medicaid;
- a provision of the Social Security Act, commonly referred to as the Stark Law or physician self-referral law, that (subject to limited exceptions) prohibits physicians from referring Medicare patients to an entity for the provision

of specific "designated health services" if the physician or a member of such physician's immediate family has a direct or indirect financial relationship with the entity, and prohibits the entity from billing for services arising out of such prohibited referrals;

- a provision of the Social Security Act that provides for criminal penalties on healthcare providers who fail to disclose known overpayments;

- a provision of the Social Security Act that provides for civil monetary penalties on healthcare providers who fail to repay known overpayments within 60 days of identification or the date any corresponding cost report was due, if applicable, and also allows improper retention of known overpayments to serve as a basis for False Claims Act violations;

- provisions of the Social Security Act (emanating from the DRA) that require entities that make or receive annual Medicaid payments of $5 million or more from a single Medicaid program to provide its employees, contractors and agents with written policies and employee handbook materials on federal and state false claims acts and related statutes, that establish a new Medicaid Integrity Program designed to enhance federal and state efforts to detect Medicaid fraud, waste, and abuse, and that increase financial incentives for both states and individuals to bring fraud and abuse claims against healthcare companies;

- state law provisions pertaining to anti-kickback, self-referral and false claims issues;

- provisions of, and regulations relating to, HIPAA that provide penalties for knowingly and willfully executing a scheme or artifice to defraud a health-care benefit program or falsifying, concealing or covering up a material fact or making any material false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services;

- provisions of HIPAA and the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH") limiting how covered entities, business associates and business associate sub-contractors may use and disclose PHI and the security measures that must be taken in connection with protecting that information and related systems, as well as similar or more stringent state laws;

- federal and state laws that provide penalties for providers for billing and receiving payments from a governmental healthcare program for services unless the services are medically necessary and reasonable, adequately and accurately documented, and billed using codes that accurately reflect the type and level of services rendered;

- state laws that provide for financial solvency requirements relating to risk-bearing organizations ("RBOs"), plan operations, plan-affiliate operations and transactions, plan-provider contractual relationships and provider-affiliate operations and transactions, such as California Business & Professions Code Section 1375.4 (§ 1375.4; Cal. Code Regs., tit. 28, § 1300.75.4 et seq.);

- federal laws that provide for administrative sanctions, including civil monetary penalties for, among other violations, inappropriate billing of services to federal healthcare programs, payments by hospitals to physicians for reducing or limiting services to Medicare or Medicaid patients, or employing or contracting with individuals or entities who/which are excluded from participation in federal healthcare programs;

- federal and state laws and policies that require healthcare providers to enroll in the Medicare and Medicaid programs before submitting any claims for services, to promptly report certain changes in its operations to the agencies that administer these programs, and to re-enroll in these programs when changes in direct or indirect ownership occur or in response to revalidation requests from Medicare and Medicaid;

- state laws that prohibit general business entities from practicing medicine, controlling physicians' medical decisions or engaging in certain practices, such as splitting fees with physicians;

- state laws that require timely payment of claims, including §1371.38, et al, of the California Health & Safety Code, which imposes time limits for the payment of uncontested covered claims and required health care service plans to pay interest on uncontested claims not paid promptly within the required time period;

- laws in some states that prohibit non-domiciled entities from owning and operating medical practices in such states; and

- federal and state laws and regulations restricting the techniques that may be used to collect past due accounts from consumers, such as our patients, for services provided to the consumer.

- state laws that require healthcare providers that assume professional and institutional risk (i.e., global risk) to either obtain a license under the Knox-Keene Health Care Service Plan Act of 1975 or receive an exemption from the Department of Managed Healthcare ("DMHC") for the contract(s) under which the entity assumes global risk.

Any violation or alleged violation of any of these laws or regulations by us or our affiliates could have a material adverse effect on our business, financial condition and results of operations.

Changes in healthcare laws could create an uncertain environment and materially impact us. We cannot predict the effect that the ACA (also known as Obamacare) and its implementation, amendment, or repeal and replacement, may have on our business, results of operations or financial condition.

Any changes in healthcare laws or regulations that reduce, curtail or eliminate payments, government-subsidized programs, government-sponsored programs, and/or the expansion of Medicare or Medicaid, among other actions, could have a material adverse effect on our business, results of operations and financial condition.

For example, the ACA dramatically changed how healthcare services are covered, delivered, and reimbursed. The ACA requires insurers to accept all applicants, regardless of pre-existing conditions, cover an extensive list of conditions and treatments, and charge the same rates, regardless of pre-existing condition or gender. The ACA and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Health Care Reform Acts") also mandated changes specific to home health and hospice benefits under Medicare. In 2012, the U.S. Supreme Court upheld the constitutionality of the ACA, including the "individual mandate" provisions of the ACA that generally require all individuals to obtain healthcare insurance or pay a penalty. However, the U.S. Supreme Court also held that the provision of the ACA that authorized the Secretary of the U.S. Department of Health and Human Services ("HHS") to penalize states that choose not to participate in the expansion of the Medicaid program by removing all of its existing Medicaid funding was unconstitutional. In response to the ruling, a number of state governors opposed its state's participation in the expanded Medicaid program, which resulted in the ACA not providing coverage to some low-income persons in those states. In addition, several bills have been, and are continuing to be, introduced in U.S. Congress to amend all or significant provisions of the ACA, or repeal and replace the ACA with another law. In December 2017, the individual mandate was repealed via the Tax Cuts and Jobs Act of 2017. Afterwards, legal and political challenges as to the constitutionality of the remaining provisions of the ACA resumed. Just as the fate of the ACA is uncertain, so is the future of care organizations established under the ACA such as ACOs and NGACOs. Under its NGACO Participation Agreement with CMS, our operations are always subject to the nation's healthcare laws, as amended, repealed or replaced from time to time.

The net effect of the ACA on our business is subject to numerous variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, gradual and potentially delayed implementation or possible amendment, as well as the uncertainty as to the extent to which states will choose to participate in the expanded Medicaid program. The continued implementation of provisions of the ACA, the adoption of new regulations thereunder and ongoing challenges thereto, also added uncertainty about the current state of U.S. healthcare laws and could negatively impact our business, results of operations and financial condition.

Healthcare providers could be subject to federal and state investigations and payor audits.

Due to our and our affiliates' participation in government and private healthcare programs, we are from time to time involved in inquiries, reviews, audits and investigations by governmental agencies and private payors of our business practices, including assessments of our compliance with coding, billing and documentation requirements. Federal and state government agencies have active civil and criminal enforcement efforts against healthcare companies, and their executives and managers. The DRA, which provides a financial incentive to states to enact their own false claims acts, and similar laws encourage investigations against healthcare companies by different agencies. These investigations could also be initiated by private whistleblowers. Responding to audit and investigative activities are costly and disruptive to our business operations, even when the allegations are without merit. If we are subject to an audit or investigation, a finding could be made that we or our affiliates erroneously billed or were incorrectly reimbursed, and we may be required to repay such agencies or payors, may be subjected to pre-payment reviews, which can be time-consuming and result in non-payment or delayed payments for the services we or our affiliates provide, and may be subject to financial sanctions or required to modify our operations.

Controls designed to reduce inpatient services and associated costs may reduce our revenues.

Controls imposed by Medicare, Medicaid and private payors designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our operations. Federal law contains numerous provisions designed to ensure that services rendered by hospitals and other care providers to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by quality improvement organizations, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, and the appropriateness of cases of extraordinary length of stay or cost on a post-discharge basis. Quality improvement organizations may deny payment for services or assess fines and also have the authority to recommend to the HHS that a provider is in substantial noncompliance with the standards of the quality improvement organization and should be excluded from participation in the Medicare program. The ACA potentially expands the use of prepayment review by Medicare contractors by eliminating statutory restrictions on its use, and, as a result, efforts to impose more stringent cost controls are expected to continue. Utilization review is also a requirement of most non-governmental managed care organizations and other third-party payors. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payor-required preadmission authorization and utilization review and by third party payor pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Although we are unable to predict the effect these controls and any changes thereto may have on our operations, significant limits on the scope of our services reimbursed and on reimbursement rates and fees could have a material, adverse effect on our business, financial position and results of operations.

We do not have any Knox-Keene license.

The Knox-Keene Health Care Service Plan Act of 1975 was passed by the California State Legislature to regulate California managed care plans and is currently administered by the DMHC. A Knox-Keene Act license is required to operate a health care service plan, e.g., an HMO, or an organization that accepts global risk, i.e., accepts full risk for a patient population, including risk related to institutional services, e.g., hospital, and professional services. Applying for and obtaining such a license is a time consuming and detail-oriented undertaking. We currently do not hold any Knox-Keene license. If the DMHC were to determine that we have been inappropriately taking risk for institutional and professional services as a result of our various hospital and physician arrangements without having any Knox-Keene license, we may be required to obtain a Knox-Keene license and could be subject to civil and criminal liability, any of which could have a material adverse effect on our business, results of operations and financial condition.

A Knox-Keene Act license *or exemption from licensure, where applicable,* is required to operate a health care service plan, e.g., an HMO, or an organization that accepts global risk, i.e., accepts full risk for a patient population, including risk related to institutional services, e.g., hospital, and professional services.

If our affiliated physician groups are not able to satisfy California financial solvency regulations, they could become subject to sanctions and their ability to do business in California could be limited or terminated.

The DMHC has instituted financial solvency regulations. The regulations are intended to provide a formal mechanism for monitoring the financial solvency of a RBO in California, including capitated physician groups. Under current DMHC regulations, our affiliated physician groups, as applicable, are required to, among other things:

- Maintain, at all times, a minimum "cash-to-claims ratio" (which means the organization's cash, marketable securities, and certain qualified receivables, divided by the organization's total unpaid claims liability) of 0.75; and

- Submit periodic reports to the DMHC containing various data and attestations regarding their performance and financial solvency, including IBNR calculations and documentation and attestations as to whether or not the organization (i) was in compliance with the "Knox-Keene Act" requirements related to claims payment timeliness, (ii) had maintained positive tangible net equity ("TNE"), and (iii) had maintained positive working capital.

In the event that a physician group is not in compliance with any of the above criteria, it would be required to describe in a report submitted to the DMHC the reasons for non-compliance and actions to be taken to bring it into compliance. Under such regulations, the DMHC can also make some of the information contained in the reports public, including, but not limited to, whether or not a particular physician organization met each of the criteria. In the event any of our affiliated physician groups are not able to meet certain of the financial solvency requirements, and fail to meet subsequent corrective action plans, it could be subject to sanctions, or limitations on, or removal of, its ability to do business in California. There can be no assurance that our affiliated physician groups, such as our IPAs, will remain in compliance with DMHC requirements or be able to timely and

adequately rectify non-compliance. To the extent that we need to provide additional capital to our affiliated physician groups in the future in order to comply with DMHC regulations, we would have less cash available for other parts of our operations.

Our revenue will be negatively impacted if our physicians fail to appropriately document their services.

We rely upon our affiliated physicians to appropriately and accurately complete necessary medical record documentation and assign appropriate reimbursement codes for their services. Reimbursement is conditioned upon, in part, our affiliated physicians providing the correct procedure and diagnosis codes and properly documenting the services themselves, including the level of service provided and the medical necessity for the services. If our affiliated physicians have provided incorrect or incomplete documentation or selected inaccurate reimbursement codes, this could result in nonpayment for services rendered or lead to allegations of billing fraud. This could subsequently lead to civil and criminal penalties, including exclusion from government healthcare programs, such as Medicare and Medicaid. In addition, third-party payors may disallow, in whole or in part, requests for reimbursement based on determinations that certain amounts are not covered, services provided were not medically necessary, or supporting documentation was not adequate. Retroactive adjustments may change amounts realized from third-party payors and result in recoupments or refund demands, affecting revenue already received.

Primary care physicians may seek to affiliate with our and our competitors' IPAs at the same time.

It is common in the medical services industry for primary care physicians to be affiliated with multiple IPAs. Our affiliated IPAs therefore may enter into agreements with physicians who are also affiliated with our competitors. However, some of our competitors at times have agreements with physicians that require the physician to provide exclusive services. Our affiliated IPAs often have no knowledge, and no way of knowing, whether a physician is subject to an exclusivity agreement without being informed by the physician. Competitors have initiated lawsuits against us alleging in part interference with such exclusivity arrangements, and may do so in the future. An adverse outcome from any such lawsuit could adversely affect our business, cash flows and financial condition.

If we inadvertently employ or contract with an excluded person, we may face government sanctions.

Individuals and entities can be excluded from participating in the Medicare and Medicaid programs for violating certain laws and regulations, or for other reasons such as the loss of a license in any state, even if the person retains other licensure. This means that the excluded person and others are prohibited from receiving payments for such person's services rendered to Medicare or Medicaid beneficiaries, and if the excluded person is a physician, all services ordered (not just provided) by such physician are also non-covered and non-payable. Entities which employ or contract with excluded individuals are prohibited from billing the Medicare or Medicaid programs for the excluded individual's services, and are subject to civil penalties if it does. The U.S. Department of Health and Human Services Office of the Inspector General maintains a list of excluded persons. Although we have instituted policies and procedures to minimize such risks, there can be no assurance that we will not inadvertently hire or contract with an excluded person, or that our employees or contracts will not become excluded in the future without our knowledge. If this occurs, we may be subject to substantial repayments and civil penalties, and the hospitals at which we furnish services may also be subject to repayments and sanctions, for which they may seek recovery from us, which could adversely affect our business, cash flows and financial condition.

Compliance with federal and state privacy and data security laws is expensive, and we may be subject to government or private actions due to privacy and security breaches.

We must comply with various federal and state laws and regulations governing the collection, dissemination, access, use, security and confidentiality of PHI, including HIPAA and HITECH. As part of our medical record keeping, third-party billing, and other services, we collect and maintain PHI in paper and electronic format. Privacy and data security laws and regulations thus could have a significant effect on the manner in which we handle healthcare-related data and communicates with payors. In addition, compliance with these standards could limit our ability to offer services, thereby negatively impacting the business opportunities available to us. Despite our efforts to prevent privacy and security breaches, it may still occur. If any non-compliance with such laws and regulations results in privacy or security breaches, we could be subject to monetary fines, suits, penalties or sanctions. As a result of the expanded scope of HIPAA through HITECH, we may incur significant costs in order to minimize the amount of "unsecured PHI" that we handle and retain and/or to implement improved administrative, technical or physical safeguards to protect PHI. We may have to demonstrate and document our compliance efforts, even if there is a low probability that PHI has been compromised, in order to overcome the presumption that an impermissible use or disclosure of PHI results in a reportable breach. We may incur significant costs to notify the relevant individuals, government entities and, in some cases, the media, in the event of a breach and to provide appropriate remediation and monitoring to mitigate any potential damage.

We may be subject to liability for failure to fully comply with applicable corporate and securities laws.

We are subject to various corporate and securities laws. Any failure to comply with such laws could cause government agencies to take action against us, which could restrict our ability to issue securities and result in fines or penalties. Any claim brought by such an agency could also cause us to expend resources to defend ourselves, divert the attention of our management from our business and could significantly harm our business, operating results and financial condition, even if the claim is resolved in our favor.

A plaintiffs' securities law firm announced that it was investigating ApolloMed and its pre-Merger board of directors for potential federal law violations and breaches of fiduciary duties in connection with the Merger. This investigation purportedly focused on whether ApolloMed and its board of directors violated federal securities laws or breached their fiduciary duties to ApolloMed's stockholders by failing to properly value the Merger and failing to disclose all material information in connection with the Merger. As of filing of this Annual Report on Form 10-K, no lawsuit has been filed against us by that firm.

We cannot preclude the possibility that claims or lawsuits brought relating to any alleged securities law violations or breaches of fiduciary duty in connection with the Merger could potentially require significant time and resources to defend and/or settle and distract our management and board of directors from focusing on our business.

We may face lawsuits not covered by insurance and related expenses may be material. Our failure to avoid, defend and accrue for claims and litigation could negatively impact our results of operations or cash flows.

We are exposed to and become involved in various litigation matters arising out of our business, including from time to time, actual or threatened lawsuits. Malpractice lawsuits are common in the healthcare industry. The medical malpractice legal environment varies greatly by state. The status of tort reform, availability of non-economic damages or the presence or absence of other statutes, such as elder abuse or vulnerable adult statutes, influence the incidence and severity of malpractice litigation. We may also be subject to other types of lawsuits, such as those initiated by our competitors, stockholders, employees, service providers, contractors or by government agencies, including when we terminate relationships with them, which may involve large claims and significant defense costs. Many states have joint and several liabilities for providers who deliver care to a patient and are at least partially liable. As a result, if one provider is found liable for medical malpractice for the provision of care to a particular patient, all other providers who furnished care to that same patient, including possibly us and our affiliated physicians, may also share in the liability, which could be substantial individually or in aggregate.

The defense of litigation, including fees of legal counsel, expert witnesses and related costs, is expensive and difficult to forecast accurately. Such costs may be unrecoverable even if we ultimately prevail in litigation and could consume a significant portion of our limited capital resources. To defend lawsuits, it may also be necessary for us to divert officers and other employees from our normal business functions to gather evidence, give testimony and otherwise support litigation efforts. If we lose any material litigation, we could face material judgments or awards against them. An unfavorable resolution of one or more of the proceedings in which we are involved now or in the future could have a material adverse effect on our business, cash flows and financial condition. We may also in the future find it necessary to file lawsuits to recover damages or protect our interests. The cost of such litigation could also be significant and unrecoverable, which may also deter us from aggressively pursuing even legitimate claims.

We currently maintain malpractice liability insurance coverage to cover professional liability and other claims for certain hospitalists and clinic physicians. All of our affiliated physicians are required to carry first dollar coverage with limits of coverage equal to $1,000,000 for all claims based on occurrence up to an aggregate of $3,000,000 per year. We cannot be certain that our insurance coverage will be adequate to cover liabilities arising out of claims asserted against us, our affiliated professional organizations or our affiliated physicians. Liabilities incurred by us or our affiliates in excess of our insurance coverage, including coverage for professional liability and other claims, could have a material adverse effect on our business, financial condition, and results of operations. Our professional liability insurance coverage generally must be renewed annually and may not continue to be available to us in future years at acceptable costs and on favorable terms, which could increase our exposure to litigation.

We may also be subject to laws and regulations not specifically targeting the healthcare industry.

Certain regulations not specifically targeting the healthcare industry also could have material effects on our operations. For example, the California Finance Lenders Law (the "CFLL"), Division 9, Sections 22000-22780 of the California Financial Code, could be applied to us as a result of our various affiliate and subsidiary loans and similar arrangements. If a regulator were to take the position that such loans were covered by the California Finance Lenders Law, we could be subject to regulatory action which could impair our ability to continue to operate and may have a material adverse effect on our profitability and business as we currently do not hold a CFLL licensure. Pursuant to an exemption under the CFLL, a person may make five or fewer commercial loans in a 12-month period without a CFLL licensure if the loans are "incidental" to the business of the person. This exemption, however, creates some uncertainty as to which loans could be deemed as incidental to our business. In addition, a person without

a CFLL licensure may also make a single commercial loan in a 12-month period without the loan being "incidental" to such person's business but this single-loan exemption is currently set to expire on January 1, 2022.

Risks Relating to the Ownership of ApolloMed's Common Stock.

We have to meet certain requirements in order to remain as a NASDAQ-listed public company.

As a public company, ApolloMed is required to comply with various regulatory and reporting requirements, including those required by the SEC. After ApolloMed uplisted to NASDAQ in December 2017, it is also subject to NASDAQ listing rules. Complying with these requirements is time-consuming and expensive. No assurance can be given that ApolloMed can continue to meet the SEC reporting and NASDAQ listing requirements.

ApolloMed's common stock may continue to be thinly traded and its market price may be subject to fluctuations and volatility. Stockholders may be unable to sell their shares at a profit and might incur losses.

The trading price of ApolloMed's common stock was volatile and may continue to be so from time to time. The price at which ApolloMed's common stock trades could be subject to significant fluctuation and may be affected by a variety of factors, including the trading volume, our results of operations, the announcement and consummation of certain transactions, our ability or inability to raise additional capital and the terms thereof, and therefore could fluctuate, and decline, significantly. Other factors that may cause the market price of ApolloMed's common stock to fluctuate include:

- variations in our operating results, such as actual or anticipated quarterly and annual increases or decreases in revenue, gross margin or earnings;
- changes in our business, operations or prospects, including announcements relating to strategic relationships, mergers, acquisitions, partnerships, collaborations, joint ventures, capital commitments, or other events by us or our competitors;
- announcements of acquisitions, dispositions and other corporate transactions as well as financings and other capital raising transactions;
- developments, conditions or trends in the healthcare industry;
- changes in the economic performance or market valuations of other healthcare-related companies;
- general market conditions or domestic or international macroeconomic and geopolitical factors unrelated to our performance or financial condition, including economic or political instability, wars, civil unrest, terrorism, epidemics (including the recent novel coronavirus (COVID-19)) outbreak and natural disasters.
- sales of stock by ApolloMed's stockholders generally and ApolloMed's larger stockholders, including insiders, in particular, including sale or distributions of large blocks of common stock by our executives and directors;
- volatility and limitations in trading volumes of ApolloMed's common stock and the stock market;
- approval, maintenance and withdrawal of our and our affiliates' certificates, permits, registration, licensure, certification and accreditation by the applicable regulatory or other oversight bodies;
- our financing activities, including our ability to obtain financings and prices that we sell our equity securities, including notes convertible to and warrants to purchase shares of ApolloMed's common stock;
- failures to meet external expectations or management guidance;
- changes in our capital structure and cash position;
- analyst research reports on ApolloMed's common stock, including analysts' recommendations and changes in recommendations, price targets, and withdrawals of coverage;
- departures and additions of our key personnel, including our officers or directors;

- disputes and litigations related to intellectual properties, proprietary rights, and contractual obligations;
- changes in applicable laws, rules, regulations, or accounting practices and other dynamics; and
- other events or factors, many of which may be out of our control.

There may continue to be a limited trading market for ApolloMed's common stock. A lack of an active market may contribute to stock price volatility or supply/demand imbalances, make an investment in ApolloMed's common stock less attractive to certain investors, impair the ability of ApolloMed's stockholders to sell shares at the time they desire or at a price that they consider favorable. The lack of an active market may also reduce the fair market value of ApolloMed's common stock, impair our ability to raise capital by selling shares of ApolloMed's common stock or use such stock as consideration to attract and retain talent or engage in business transactions.

If analysts do not report about us, or negatively evaluate us, ApolloMed's stock price could decline.

The trading market for ApolloMed's common stock will rely in part on the availability of research and reports that third-party analysts publish about us. There are many large companies active in the healthcare industry, which make it more difficult for us to receive widespread coverage. Furthermore, if one or more of the analysts who do cover us downgrade ApolloMed's common stock, its price would likely decline. If one or more of these analysts cease coverage of us, we could lose market visibility, which in turn could cause ApolloMed's stock price to decline.

Our current principal stockholders, executive officers and directors have significant influence over our operations and strategic direction and they could cause us to take actions with which other stockholders might not agree and could delay, deter or prevent a change of control or a business combination with respect to us.

As of December 31, 2019, our executive officers, directors, five percent or greater stockholders and their respective affiliated entities in the aggregate own approximately 43.4% of our outstanding common stock. As a result, these stockholders, who are entitled to vote their shares in their own interests, acting together, exert a significant degree of influence over our management and affairs and over matters requiring stockholder approval, including the election of directors and approval of significant corporate transactions. This concentration of ownership may have the effect of delaying or preventing a change of control, merger, consolidation, sale of all or substantially all of our assets or other corporate transactions that other stockholders may view as beneficial, or conversely this concentrated control could result in the consummation of a transaction that other stockholders may not support. This may harm the value of our shares and discourage investors from investing in us.

Provisions under Delaware law and ApolloMed's charter and bylaws could deter takeover attempts or attempts to remove its board members or management that might otherwise be beneficial to its stockholders.

ApolloMed is subject to Section 203 of the Delaware General Corporation Law, which makes the acquisition of ApolloMed and the removal of its incumbent officers and directors more difficult for potential acquirers by prohibiting stockholders holding 15% or more of its outstanding voting stock from acquiring it without the consent of its board of directors for at least three years from the date they first hold 15% or more of the voting stock. These provisions and others that could be adopted in the future could deter unsolicited takeovers or delay or prevent changes in ApolloMed's control or management, including transactions in which ApolloMed's stockholders might otherwise receive a premium for their shares over then current market prices. These provisions may also limit the ability of ApolloMed's stockholders to approve transactions that they may deem to be in their best interests.

Additionally, ApolloMed's charter and bylaws contain additional provisions, such as the authorization for its board of directors to issue one or more classes of preferred stock and determine the rights, preferences and privileges of the preferred stock, which could cause substantial dilution to a person or group that attempts to acquire ApolloMed on terms not approved by the board, and the ownership requirement for ApolloMed's stockholders to call special meetings, that could deter, discourage or make it more difficult for a change in control of ApolloMed or for a third party to acquire ApolloMed, even if such a change in control could be deemed in the interest of ApolloMed's stockholders or if such an acquisition would provide ApolloMed's stockholders with a substantial premium for their shares over the market price of ApolloMed's common stock.

As such, these provisions could discourage a potential acquirer from acquiring us or otherwise attempting to obtain our control and increase the likelihood that our incumbent directors and officers will retain their positions.

We may issue additional equity securities in the future, which may result in dilution to existing investors.

If ApolloMed issues additional equity securities, its existing stockholders may experience substantial dilution. ApolloMed may sell equity securities and may issue convertible notes and warrants in one or more transactions at prices and manners as we may determine from time to time, including at prices (or exercise prices) below the market price of ApolloMed's common stock, for capital raising purposes, including in any debt financing, registered offering or private placement, and new investors could have superior rights such as liquidation and other preferences. To attract and retain the right talent, ApolloMed may also issue equity awards under its equity compensation plans to its officers, other employees, directors and consultants from time to time. ApolloMed may also issue additional shares of its common stock or other securities that are convertible into or exercisable for common stock in connection with future acquisitions or for other business purposes. In addition, the exercise or conversion of outstanding options or warrants to purchase shares of ApolloMed's stock may result in dilution to its existing stockholders upon any such exercise or conversion.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our corporate headquarters is located in Alhambra, California, where we lease and occupy approximately 35,000 square feet of office spaces in two neighboring buildings from an entity that shares certain common ownership with ApolloMed. The current lease for our headquarters is on a month-to-month basis and requires monthly rental payment of approximately $84,000.

We lease approximately 47,500 square feet of space in Monterey Park, California. The lease has a term of 5 years and requires monthly rental payments of approximately $69,000 per month.

We lease approximately 8,800 square feet of space in San Gabriel, California, which is the primary office for SCHC. The base rent for the space is approximately $33,000 per month, subject to adjustments, and for a term expiring in 2024 (or subject to the terms of the lease, in 2021).

We also maintain other office and warehouse spaces located in Monterey Park, Alhambra, City of Industry, Arcadia and El Monte, California. These leases require monthly rent payments ranging from approximately $2,300 to $30,000 and have terms that expire between January 2020 and, subject to options to extend provided thereunder, February 2031.

We believe our existing facilities are in good condition and are suitable and adequate for our current requirements. Based on current information and subject to future events and circumstances, we anticipate that we may extend leases on our various facilities as necessary, as they expire, and lease additional facilities to accommodate possible future growth.

Item 3. Legal Proceedings

Certain of the pending or threatened legal proceedings or claims in which we are involved are discussed under "Note 13 - "Commitments and Contingencies," to our consolidated financial statements in this Annual Report on Form 10-K, which disclosure is incorporated by reference herein.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market Information

The information presented below is our historical data and not necessarily indicative of our future financial condition or results of operations.

ApolloMed's common stock is listed on the NASDAQ Capital Market, under the symbol, "AMEH."

Record Holders

As of March 2, 2020, there were approximately 545 holders of record of ApolloMed's common stock based on its transfer agent's report. Because many shares of ApolloMed's common stock are held by brokers and other nominees on behalf of stockholders, including in trust, we are unable to estimate the total number of stockholders represented by these record holders.

Dividends

To date we have not paid any cash dividends on ApolloMed's common stock and we do not contemplate the payment of cash dividends thereon in the foreseeable future. Our future dividend policy will depend on our earnings, capital requirements, financial condition, and other factors relevant to our ability to pay dividends.

Recent Sales of Unregistered Securities

Below sets forth the Company's equity securities sold by it during the fiscal year ended December 31, 2019 that were not registered under the Securities Act of 1933, as amended (the "Securities Act"):

During the three months ended December 31, 2019, the Company issued an aggregate of 27,851 shares of common stock and received approximately $255,843 from the exercise of certain warrants at an exercise price ranging from $9.00 - $10.00 per share.

The foregoing issuances were exempt from the registration provisions of the Securities Act, pursuant to Section 4(a)(2) thereof, and/or Regulation D promulgated thereunder.

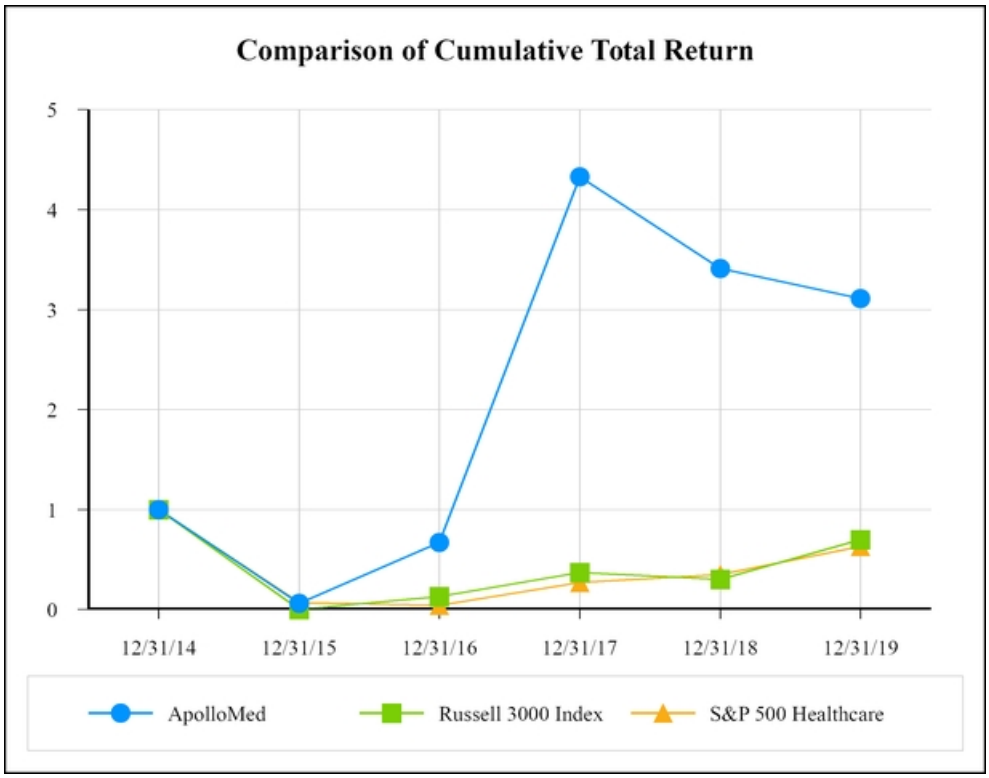
Purchases of Equity Securities by the Issuer and Affiliated Purchasers

Period	(a) Total number of shares (or units) purchased	(b) Average price paid per share (or unit)	(c) Total number of shares (or units) purchased as part of publicly announced plans or programs	(d) Maximum number (or approximate dollar value) of shares (or units) that may yet be purchased under the plans or programs
Common Stock				
November 2019	109,203	$ 17.59	N/A	N/A
December 2019	297,089	$ 18.17	N/A	N/A

Performance Measurement Comparison

The following chart compares the cumulative total return of our common stock with the cumulative total return of the Russell 3000 Index and the S&P 500 Healthcare Index, from December 31, 2014 to December 31, 2019.

We believe the Russell 3000 Index is an appropriate independent broad market index, since it measures the performance of similar sized companies in numerous sectors. In addition, we believe the S&P 500 Healthcare Index is an appropriate third party published industry index since it measures the performance of healthcare companies.



		Indexed Returns Years Ending				
Company/Index	**Base Period 12/31/2014**	**12/31/2015**	**12/31/2016**	**12/31/2017**	**12/31/2018**	**12/31/2019**
ApolloMed	1.00	0.06	0.67	4.33	3.41	3.11
Russell 3000 Index	1.00	—	0.13	0.37	0.30	0.70
S&P 500 Healthcare	1.00	0.07	0.04	0.27	0.35	0.63

Item 6. Selected Financial Data

The following selected consolidated financial data should be read in conjunction with "Management's Discussion and Analysis of Financial Condition and Results of Operations" and the consolidated financial statements and the related notes included elsewhere in this Annual Report on Form 10-K.

APOLLO MEDICAL HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF INCOME

	Years ended December 31,				
	2019	**2018**	**2017**	**2016**	**2015**
Revenue					
Capitation, net	$ 454,168,024	$ 344,307,058	$ 272,921,240	$ 247,639,181	$ 247,244,135
Risk pool settlements and incentives	51,097,661	100,927,841	44,598,373	22,641,884	37,656,242
Management fee income	34,668,358	49,742,755	26,983,695	24,774,941	20,834,222
Fee-for-service, net	15,475,264	19,703,999	7,449,249	9,163,970	6,437,354
Other income	5,208,790	5,226,099	4,403,373	1,714,939	952,752
Total revenue	560,618,097	519,907,752	356,355,930	305,934,915	313,124,705
Operating expenses					
Cost of services	467,804,899	361,132,111	273,453,287	255,048,120	238,088,985
General and administrative expenses	41,482,375	43,353,787	26,249,532	20,759,436	22,277,282
Depreciation and amortization	18,280,198	19,303,179	19,075,353	18,114,440	9,085,312
Provision for doubtful accounts	(1,363,363)	3,887,647	—	—	—
Impairment of goodwill and intangible assets	1,994,000	3,798,866	2,431,791	324,306	—
Total expenses	528,198,109	431,475,590	321,209,963	294,246,302	269,451,579
Income from operations	32,419,988	88,432,162	35,145,967	11,688,613	43,673,126
Other (expense) income					
Income (loss) from equity method investments	(6,900,859)	(8,125,285)	(1,112,541)	4,748,542	1,206,654
Interest expense	(4,733,256)	(560,515)	(79,689)	(61,589)	(209,929)
Interest income	2,023,873	1,258,638	1,015,204	504,696	208,917
Change in fair value of derivative instrument	—	—	(44,886)	1,722,221	(833,333)
Gain on settlement of preexisting note receivable from ApolloMed	—	—	921,938	—	—
Gain from investments – fair value adjustments	—	—	13,697,018	—	—
Other income	3,030,203	1,622,131	168,102	233,726	1,931,635
Total other (expense) income, net	(6,580,039)	(5,805,031)	14,565,146	7,147,596	2,303,944
Income before provision for income taxes	25,839,949	82,627,131	49,711,113	18,836,209	45,977,070
Provision for income taxes	8,166,632	22,359,640	3,886,785	8,816,412	19,297,447
Net income	17,673,317	60,267,491	45,824,328	10,019,797	26,679,623

Net income (loss) attributable to noncontrolling interests	3,556,772	49,432,489	20,022,486	(1,433,730)	13,862,522
Net income attributable to Apollo Medical Holdings, Inc.	$ 14,116,545	$ 10,835,002	$ 25,801,842	$ 11,453,527	$ 12,817,101
Earnings per share – basic	$ 0.41	$ 0.33	$ 1.01	$ 0.03	$ 0.05
Earnings per share – diluted	$ 0.39	$ 0.29	$ 0.90	$ 0.03	$ 0.05
Weighted average shares of common stock outstanding – basic	34,708,429	32,893,940	25,525,786	360,634,339	256,619,159
Weighted average shares of common stock outstanding – diluted	36,403,279	37,914,886	28,661,735	367,945,833	263,734,916

CONSOLIDATED BALANCE SHEET DATA

	December 31,				
	2019	**2018**	**2017**	**2016**	**2015**
Cash and cash equivalents	$ 103,189,328	$ 106,891,503	$ 99,749,199	$ 54,824,580	$ 59,014,715
Working capital	223,644,503	100,843,145	34,557,563	30,530,467	32,439,944
Total assets	728,713,347	512,999,049	490,635,793	349,998,962	362,486,567
Long-term debt, net of current portion and deferred financing costs	232,172,134	—	—	—	—
Total shareholders' equity	192,335,148	181,544,152	164,183,426	(391,694)	8,180,159

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following management's discussion and analysis should be read in conjunction with the audited consolidated financial statements and the notes thereto included in Part II, Item 8, "Financial Statements and Supplementary Data" of this Annual Report on Form 10-K.

In this section, "we," "our," "ours" and "us" refer to Apollo Medical Holdings, Inc.("ApolloMed") and its consolidated subsidiaries and affiliated entities, as appropriate, including its consolidated variable interest entities ("VIEs").

Overview

We together with our affiliated physician groups and consolidated entities are a physician-centric integrated population health management company working to provide coordinated, outcomes-based medical care in a cost-effective manner and serving patients in California, the majority of whom are covered by private or public insurance such as Medicare, Medicaid and health maintenance organizations ("HMOs"), with a small portion of our revenue coming from non-insured patients. We provide care coordination services to each major constituent of the healthcare delivery system, including patients, families, primary care physicians, specialists, acute care hospitals, alternative sites of inpatient care, physician groups and health plans. Our physician network consists of primary care physicians, specialist physicians and hospitalists. We operate primarily through the following subsidiaries of ApolloMed: Network Medical Management ("NMM"), Apollo Medical Management, Inc. ("AMM"), APA ACO, Inc. ("APAACO") and Apollo Care Connect, Inc. ("Apollo Care Connect"), and their consolidated entities.

Through our next generation accountable organization (“NGACO”) model and our network of independent practice associations (“IPAs”) with more than7,000 contracted physicians, which physical groups have agreements with various health plans, hospitals and other HMOs, we were responsible for coordinating the care for over 980,000 patients in California as of December 31, 2019. These covered patients are comprised of managed care members whose health coverage is provided through their employers or who have acquired health coverage directly from a health plan or as a result of their eligibility for Medicaid or Medicare benefits. Our managed patients benefit from an integrated approach that places physicians at the center of patient care and utilizes sophisticated risk management techniques and clinical protocols to provide high-quality, cost effective care. To implement a patient-centered, physician-centric experience, we also have other integrated and synergistic operations, including (i) MSOs that provide management and other services to our affiliated IPAs, (ii) outpatient clinics and (iii) hospitalists.

On December 8, 2017, ApolloMed completed its business combination with NMM (the “Merger”). The combination of ApolloMed and NMM brought together two complementary healthcare organizations to form one of the nation’s largest integrated population health management companies. As a result of the Merger, NMM became a wholly-owned subsidiary of ApolloMed and the former NMM shareholders received a majority of the issued and outstanding common stock of ApolloMed. For accounting purposes NMM was considered the accounting acquirer and accordingly, as of the closing of the Merger, NMM’s historical results of operations replaced ApolloMed’s historical results of operations for periods prior to the Merger, and the results of operations of both companies are included in the accompanying consolidated financial statements for periods following the Merger.

2019 Highlights

On May 31, 2019, Allied Physicians of California, a Professional Medical Corporation, a California professional medical corporation (“APC”), through its consolidated VIE, APC-LSMA, acquired Alpha Care Medical Group, an IPA that has been operating in California since 1993 as a risk bearing organization engaged in providing professional services under capitation arrangements with its contracted health plans through a provider network consisting of primary care and specialty care physicians. Alpha Care specializes in delivering high-quality healthcare to over 174,000 enrollees, as of December 31, 2019, and focuses on Medi-Cal, Medicaid, Commercial, Medicare and Dual Eligible members in the Riverside and San Bernardino counties of Southern California.

Accountable Health Care is a California based IPA that has served the local community in the greater Los Angeles County area through a network of physicians and health care providers for more than 20 years. Accountable Health Care currently has a network of over 400 primary care physicians and 700 specialty care physicians, and five community and regional hospital medical centers that provide quality health care services to more than 84,000 members of three federally qualified health plans and multiple product lines, including Medi-Cal, Commercial, Medicare and the California Healthy Families program. On August 30, 2019, APC and APC-LSMA, acquired the remaining 75% of outstanding shares of capital stock of Accountable Health Care that were not already owned by APC and APC-LSMA.

AP-AMH Medical Corporation ("AP-AMH") was formed on May 7, 2019 as a designated shareholder professional corporation. Dr. Thomas Lam, a shareholder, and the Chief Executive Officer and Chief Financial Officer of APC and Co-Chief Executive Officer and President of ApolloMed, is the sole shareholder of AP-AMH. ApolloMed makes all the decisions on behalf of AP-AMH and funds and receives all the distributions from its operations. ApolloMed has the right to receive benefits from the operations of AP-AMH and has the option, but not the obligation, to cover losses. AP-AMH's sole function and only activity is to act as the nominee shareholder for ApolloMed's investments in APC. Therefore, AP-AMH is controlled and consolidated by ApolloMed as the primary beneficiary of this VIE.

On September 11, 2019, ApolloMed completed the following series of transactions with its affiliates, AP-AMH and APC:

1. The Company loaned AP-AMH $545.0 million pursuant to a ten-year secured loan agreement. The loan bears interest at a rate of10% per annum simple interest, is not prepayable (except in certain limited circumstances), requires quarterly payments of interest only in arrears, and is secured by a first priority security interest in all of AP-AMH's assets, including the shares of APC Series A Preferred Stock to be purchased by AP-AMH. To the extent that AP-AMH is unable to make any interest payment when due because it has received dividends on the APC Series A Preferred Stock insufficient to pay in full such interest payment, then the outstanding principal amount of the loan will be increased by the amount of any such accrued but unpaid interest, and any such increased principal amounts will bear interest at the rate of 10.75% per annum simple interest.

2. AP-AMH purchased 1,000,000 shares of APC Series A Preferred Stock for an aggregate consideration of $545.0 million in a private placement. Under the terms of the APC Certificate of Determination of Preferences of Series A Preferred Stock (the "Certificate of Determination"), AP-AMH is entitled to receive preferential, cumulative dividends that accrue on a daily basis and that are equal to the sum of (i) APC's net income from Healthcare Services (as defined in the Certificate

of Determination), plus (ii) any dividends received by APC from certain of APC's affiliated entities, less (iii) any Retained Amounts (as defined in the Certificate of Determination). During the year ended December 31, 2019, APC distributed $8.9 million to ApolloMed as preferred returns.

3. APC purchased 15,015,015 shares of the Company's common stock for total consideration of$300.0 million in private placement. In connection therewith, the Company granted APC certain registration rights with respect to the Company's common stock that APC purchased, and APC agreed that APC votes in excess of 9.99% of the Company's then outstanding shares will be voted by proxy given to the Company's management, and that those proxy holders will cast the excess votes in the same proportion as all other votes cast on any specific proposal coming before the Company's stockholders.

4. The Company licensed to AP-AMH the right to use certain tradenames for certain specified purposes for a fee equal to a percentage of the aggregate gross revenues of AP-AMH. The license fee is payable out of any Series A Preferred Stock dividends received by AP-AMH from APC.

5. Through its subsidiary, NMM, the Company agreed to provide certain administrative services to AP-AMH for a fee equal to a percentage of the aggregate gross revenues of AP-AMH. The administrative fee also is payable out of any APC Series A Preferred Stock dividends received by AP-AMH from APC.

As of a result of the transaction, APC's ownership in ApolloMed increased to32.50% at December 31, 2019 from 4.82% at December 31, 2018.

531 W. College

On April 23, 2019, NMM and APC entered into an agreement whereby NMM assigned and APC assumed NMM’s 25% membership interest in 531 W. College LLC for approximately $8.3 million. Subsequently, APC has a 50% ownership in 531 W. College LLC with a total investment balance of approximately $16.1 million.

Acquisitions

AMG

On September 10, 2019, APC and APC-LSMA purchased all of the shares of all shareholders of AMG, a professional medical corporation ("AMG") for $1.6 million. AMG is a network of family practice clinics operating out of three main locations in Southern California. AMG provides professional and post-acute care services to Medicare, Medi-Cal/Medicaid, and Commercial patients through its networks of doctors and nurse practitioners.

Other

On October 2, 2019, the Company entered into a new MSA, effective January 1, 2020, to provide select management services, via a subcontract agreement, to an IPA. The IPA currently serves approximately 145,000 members in the following three main markets within Southern California: South Los Angeles, San Fernando Valley, and Antelope Valley. The majority of the members are enrolled in Medi-Cal, with members also enrolled in Medicare Advantage and Commercial health plans, and are supported by a network of hundreds of primary care physicians and nearly a thousand specialists.

On December 31, 2019, Universal Care Acquisition Partners, LLC (“UCAP”), a wholly-owned subsidiary of APC, and other sellers entered into a stock purchase agreement with Bright Health Company of California, Inc. (“Bright”) to sell to Bright all of the shares of capital stock of Universal Care, Inc., a California corporation doing business as Brand New Day (“UCI”). UCAP has a 48.9% ownership interest in UCI. The sale is subject to certain closing conditions and pending completion.

Recent Developments

Refer to 2019 highlights for significant developments that occurred during the year ended December 31, 2019.

Key Financial Measures and Indicators

Operating Revenues

Our revenue primarily consists of capitation revenue, risk pool settlements and incentives, NGACO AIPBP revenue, management fee income, MSSP surplus revenue and fee-for-services ("FFS") revenue. Revenue is recorded in the period in which services are rendered. The form of billing and related risk of collection for such services may vary by type of revenue and the customer.

Operating Expenses

Our largest expenses consist of the cost of patient care paid to contracted physicians, the cost of information technology equipment and software and the cost of hiring staff to provide management and administrative support services to our affiliated physician groups, as further described below. These services include payroll, benefits, human resource services, physician practice billing, revenue cycle services, physician practice management, administrative oversight, coding services, and other consulting services.

Results of Operations

As noted above, although ApolloMed was the legal acquirer in the Merger, for accounting purposes, NMM is considered the accounting acquirer and ApolloMed is the accounting acquiree. Accordingly, (i) the financial statements included in this Annual Report, and the description of our results of operations set forth below for the period in 2017 prior to the Merger reflect the operations of NMM and its consolidated entities and VIEs, and (ii) the financial statements and the description of our results of operations for 2019 and 2018 reflect the combined operations of ApolloMed and NMM and their consolidated VIEs. Because the financial results for 2017 exclude the results of ApolloMed, the results of operations in 2019 and 2018 are not directly comparable to our results of operations in 2017.

2019 Compared to 2018

Our consolidated operating results for the year ended December 31, 2019, as compared to the year ended December 31, 2018 were as follows:

Apollo Medical Holdings, Inc.
Consolidated Statements of Income

	Years Ended December 31,			
	2019	**2018**	**$ Change**	**% Change**
Revenue				
Capitation, net	$ 454,168,024	$ 344,307,058	$ 109,860,966	32 %
Risk pool settlements and incentives	51,097,661	100,927,841	(49,830,180)	(49)%
Management fee income	34,668,358	49,742,755	(15,074,397)	(30)%
Fee-for-services, net	15,475,264	19,703,999	(4,228,735)	(21)%
Other income	5,208,790	5,226,099	(17,309)	— %
Total revenue	560,618,097	519,907,752	40,710,345	8 %
Operating expenses				
Cost of services	467,804,899	361,132,111	106,672,788	30 %
General and administrative expenses	41,482,375	43,353,787	(1,871,412)	(4)%
Depreciation and amortization	18,280,198	19,303,179	(1,022,981)	(5)%
Provision for doubtful accounts	(1,363,363)	3,887,647	(5,251,010)	(135)%
Impairment of goodwill and intangibles assets	1,994,000	3,798,866	(1,804,866)	(48)%
Total expenses	528,198,109	431,475,590	96,722,519	22 %
Income from operations	32,419,988	88,432,162	(56,012,174)	(63)%
Other (expense) income				
Loss from equity method investments	(6,900,859)	(8,125,285)	1,224,426	(15)%
Interest expense	(4,733,256)	(560,515)	(4,172,741)	744 %
Interest income	2,023,873	1,258,638	765,235	61 %
Other income	3,030,203	1,622,131	1,408,072	87 %
Total other expense, net	(6,580,039)	(5,805,031)	(775,008)	13 %
Income before provision for income taxes	25,839,949	82,627,131	(56,787,182)	(69)%
Provision for income taxes	8,166,632	22,359,640	(14,193,008)	(63)%
Net income	$ 17,673,317	$ 60,267,491	$ (42,594,174)	(71)%
Net income attributable to noncontrolling interests	3,556,772	49,432,489	(45,875,717)	(93)%
Net income attributable to Apollo Medical Holdings, Inc.	$ 14,116,545	$ 10,835,002	$ 3,281,543	30 %

Net Income

Our net income in 2019 was $17.7 million, as compared to $60.3 million in 2018, a decrease of $42.6 million or 71%.

Physician Groups and Patients

As of December 31, 2019 and 2018, the total number of affiliated physician groups we managed was 13 groups and 11 groups, respectively, and the total number of patients for whom we managed the delivery of healthcare services was 914,000 and 992,100, respectively.

Revenue

Our revenue in 2019 was $560.6 million, as compared to $519.9 million in 2018, an increase of $40.7 million or 8%. The increase in revenue was primarily attributable to the following:

(i) an increase of $109.9 million in capitation revenue due to the acquisitions of Alpha Care and Accountable Health Care which were acquired as of May 31, 2019 and August 30, 2019, respectively, resulting in our recognition of approximately $79.2 million and $17.2 million in revenue, respectively, from these acquired IPAs, in addition to capitation revenue growth at APC of $22.4 million. These increase was offset by the delayed commencement by the Centers for Medicare & Medicaid Services ("CMS") of APAACO's 2019 Next Generation ACO performance year from January 1, 2019, to April 1, 2019 which resulted in decreased revenue of approximately $8.9 million.

(ii) a decrease of $49.9 million in risk pool revenue due to the refinement of the assumptions used to estimate the amount of net surplus expected to be received from the risk pool of our affiliated hospitals. Our estimated risk pool receivable is calculated based on reports received from our hospital partners and on management's estimate of the Company's portion of any estimated risk pool surpluses in which payments have not been received. The actual risk pool surpluses are settled approximately 18 months later.

(iii) a decrease in management fee income of $15.1 million, primarily due to the acquisition of Accountable Health Care and a decrease in the number of patients served by some of our affiliated physician groups, including Golden Shore Medical Group, which contributed approximately $3.8 million in management fee income for the year ended December 31, 2018, that ceased operations on January 31, 2019 as their primary health plan canceled their contract.

(iv) a decrease in FFS revenue of $4.2 million, primarily due to our wind down of affiliated medical groups, Bay Area Hospitalist Associates ("BAHA"), AKM Medical Group, Inc. ("AKM"), and Maverick Medical Group, Inc. ("MMG").

Cost of Services

Expenses related to cost of services in 2019 were $467.8 million, as compared to $361.1 million in 2018, an increase of $106.7 million or 30%. The increase was due to a $100.4 million increase in medical claims, capitation and other health services expenses driven by the Alpha Care and Accountable Health Care acquisitions, a $2.8 million increase in management fee expense paid to a third party MSO during Alpha Care's transition, and an increase of $3.5 million in personnel costs to support the continued growth in the depth and breadth of our operations.

General and Administrative Expenses

General and administrative expenses in 2019 were $41.5 million, as compared to $43.4 million in 2018, a decrease of $1.9 million or 4%. The decrease was primarily due to a reduction in professional services costs of $2.0 million.

Depreciation and Amortization

Depreciation and amortization expense was $18.3 million and $19.3 million for the years ended December 31, 2019 and 2018, respectively. These amounts included depreciation of property and equipment and the amortization of intangible assets.

Provision for Doubtful Accounts

During the year ended December 31, 2019, we released reserves related to certain management fees in the amount of $3.8 million as the collectability of the outstanding amount was no longer in doubt. These reserves related to Accountable Health Care and were no longer necessary as a result of our acquisition of the company. As such our provision for doubtful accounts was a negative $1.4 million.

Impairment of Goodwill and Intangible Assets

Impairment of goodwill and intangible assets was $2.0 million for the year ended December 31, 2019, as compared to $3.8 million for the year ended December 31, 2018. During 2019, we impaired intangible assets related to Medicare licenses obtained as part of the Merger. In 2018, we impaired the goodwill related to MMG. We will no longer utilize the Medicare licenses and MMG has been wound down. Accordingly, we do not expect to receive future economic benefits from such assets and goodwill.

Loss from Equity Method Investments

Loss from equity method investments in 2019 was $6.9 million, as compared to $8.1 million in 2018, a decrease of $1.2 million, or 15%. The decrease was primarily due to equity losses related to our investments in LMA's IPA line of business, Accountable Health Care, UCI, MWN Community Hospital, LLC, and 531 W. College LLC of $2.8 million, $2.5 million, $1.2 million, $0.2 million and $0.2 million, respectively, which was offset by equity earnings of $0.3 million from our investment in Diagnostic Medical Group ("DMG") for the year ended December 31, 2019. In addition, during the year ended December 31, 2019 we recognized an impairment loss of $0.3 million related to our investment in Pacific Ambulatory Surgery Center, LLC ("PASC") as we do not expect to recover our investment. This is compared to equity losses of $6.0 million, $2.4 million, $0.4 million and $0.3 million allocated from our investments in UCI, LSMA, 531 W. College, LLC and PASC, respectively, which were offset by income of $1.0 million allocated from our investment in DMG for the year ended 2018.

Interest Expense

Interest expense in 2019 was $4.7 million as compared to interest expense of $0.6 million in 2018. The increase was primarily due to interest incurred from a new credit facility we secured in September 2019 to fund growth, primarily through acquisitions.

Interest Income

Interest income in 2019 was $2.0 million as compared to $1.3 million in 2018, an increase of $0.7 million or 61%. The increase in interest income was a result of additional cash held in money market, certificates of deposit accounts and increased loan receivables issued in 2019.

Other Income

Other income was $3.0 million for 2019 as compared to $1.6 million in 2018, an increase of $1.4 million or 87%. The increase was primarily attributable to the assumption of a loan receivable as a result of the Accountable Health Care acquisition.

Provision for Income Taxes

Provision for income taxes was $8.2 million in 2019, as compared to $22.4 million in 2018, a decrease of $14.2 million or 63%. This decrease was primarily attributable to a decrease in the amount of pre-tax income in 2019 as compared to 2018.

Net Income Attributable to Noncontrolling Interests

Net income attributable to noncontrolling interests was $3.6 million for the year ended December 31, 2019, as compared to $49.4 million for the year ended December 31, 2018, a decrease of $45.8 million or 93%. This decrease was primarily due to reduced net income generated from APC mainly attributable to a decrease in risk pool revenue as a result of the refinement of the assumptions used to estimate the amount of net surplus expected to be received from the risk pools of our affiliated hospitals and our completion of a series of transactions with APC as further described in "2019 Highlights" above, which resulted in preferred, cumulative dividends from APC being allocated to AP-AMH.

2018 Compared to 2017

Our consolidated operating results for the year ended December 31, 2018, as compared to the year ended December 31, 2017 were as follows:

Apollo Medical Holdings, Inc.
Consolidated Statements of Income

	Years Ended December 31,			
	2018	**2017**	**$ Change**	**% Change**
Revenue				
Capitation, net	$ 344,307,058	$ 272,921,240	$ 71,385,818	26 %
Risk pool settlements and incentives	100,927,841	44,598,373	56,329,468	126 %
Management fee income	49,742,755	26,983,695	22,759,060	84 %
Fee-for-services, net	19,703,999	7,449,249	12,254,750	165 %
Other income	5,226,099	4,403,373	822,726	19 %
Total revenue	519,907,752	356,355,930	163,551,822	46 %
Operating expenses				
Cost of services	361,132,111	273,453,287	87,678,824	32 %
General and administrative expenses	43,353,787	26,249,532	17,104,255	65 %
Depreciation and amortization	19,303,179	19,075,353	227,826	1 %
Provision for doubtful accounts	3,887,647	—	3,887,647	100 %
Impairment of goodwill and intangibles assets	3,798,866	2,431,791	1,367,075	56 %
Total expenses	431,475,590	321,209,963	110,265,627	34 %
Income from operations	88,432,162	35,145,967	53,286,195	152 %
Other (expense) income				
Loss from equity method investments	(8,125,285)	(1,112,541)	(7,012,744)	630 %
Interest expense	(560,515)	(79,689)	(480,826)	603 %
Interest income	1,258,638	1,015,204	243,434	24 %
Change in fair value of derivative instrument	—	(44,886)	44,886	(100)%
Gain on settlement of preexisting note receivable from ApolloMed	—	921,938	(921,938)	(100)%
Gain from investments - fair value adjustments	—	13,697,018	(13,697,018)	(100)%
Other income	1,622,131	168,102	1,454,029	865 %
Total other (expense) income, net	(5,805,031)	14,565,146	(20,370,177)	(140)%
Income before provision for income taxes	82,627,131	49,711,113	32,916,018	66 %
Provision for income taxes	22,359,640	3,886,785	18,472,855	475 %
Net income	$ 60,267,491	$ 45,824,328	$ 14,443,163	32 %
Net income attributable to noncontrolling interests	49,432,489	20,022,486	29,410,003	147 %
Net income attributable to Apollo Medical Holdings, Inc.	$ 10,835,002	$ 25,801,842	$ (14,966,840)	(58)%

Net Income

Our net income in 2018 was $60.3 million, as compared to $45.8 million in 2017, an increase of $14.5 million or 32%.

Physician Groups and Patients

As of December 31, 2018 and 2017, the total number of affiliated physician groups we managed was 11 groups, respectively, and the total number of patients for whom we managed the delivery of healthcare services was 992,100 and 795,960, respectively.

Revenue

Our revenue in 2018 was $519.9 million, as compared to $356.4 million in 2017, an increase of $163.5 million or 46%. The increase in revenue was attributable to the following:

(i) an increase of $71.4 million in capitation revenue due to increases in membership and capitation rates, as well as, revenue received from CMS associated with APAACO,

(ii) an increase of $56.3 million in risk pool revenue due to favorable healthcare utilization trends and the recognition of full risk pool, as well as shared risk revenue arrangements with certain health plans,

(iii) an increase in management fee income of $22.8 million, which was mainly driven by an increase in the number of patients served by our affiliated physician groups that were primarily driven by Accountable Health Care (effective December 2017) and Golden Shore Medical Group (effective January 1, 2018), and

(iv) an increase in FFS revenue of $12.2 million, which was mainly due to increased surgery center income from the increase in patients and fees received, as well as revenue generated from our hospitalist and heart center services and increases in other income of $0.8 million. ApolloMed's operations acquired in the Merger accounted for $91.7 million of such increase.

Cost of Services

Expenses related to cost of services in 2018 were $361.1 million, as compared to $273.5 million in 2017, an increase of $87.6 million, or 32%. Of this increase, $97.1 million was attributable to the net increase in medical claims, primarily driven by APAACO and MMG, capitation and other health services expense, $22.2 million was attributable to increased personnel costs and related benefits and $5.3 million related to increased outsourced and temporary labor. This was offset by decreases in provider bonuses of $35.7 million, which were discretionary and provider share based compensation expense of $1.3 million.

General and Administrative Expenses

General and administrative expenses in 2018 were $43.4 million, as compared to $26.2 million in 2017, an increase of $17.2 million, or 65%. The increase was attributable to a $1.0 million increase in legal fees, $0.8 million increase in legal settlement costs, $0.8 million increase in technology expenses, $0.8 million increase in accounting expenses, a $2.9 million increase in other operating expenses, $2.0 million increase related to ICC operations and $8.9 million increase related to ApolloMed's operations acquired in the Merger.

Depreciation and Amortization

Depreciation and amortization expense in 2018 was $19.3 million, as compared to $19.1 million in 2017, an increase of $0.2 million, or 1%. The increase was attributable to additional property and equipment purchased during 2018 and the addition of intangible assets from the Merger.

Provision for Doubtful Accounts

Provision for doubtful accounts was $3.9 million for the year ended December 31, 2018. During 2018, the Company recorded an allowance against certain management fees receivable based on management's assessment of collectability. There was no provision for doubtful accounts for the year ended December 31, 2017.

Impairment of Goodwill and Intangible Assets

Impairment of goodwill and intangible assets was $3.8 million for the year ended December 31, 2018, as compared to $2.4 million in 2017. During 2018, we impaired the goodwill related to MMG as this IPA was no longer utilized and therefore were no longer expected to provide any future economic benefit. During 2017, we impaired the remaining intangible assets balance of APCN-ACO and AP-ACO that were acquired in 2016, as these member relationships were no longer utilized by ApolloMed and therefore were no longer expected to provide any future economic benefit.

Loss from Equity Method Investments

Loss from equity method investments in 2018 was $8.1 million, as compared to $1.1 million in 2017. This was mainly due to the losses of $6.0 million, $2.4 million, $0.4 million and $0.3 million allocated from our investments in UCI, LSMA, 531 W. College and PASC, respectively, offset by income of $1.0 million allocated from our investment in DMG.

Interest Expense

Interest expense in 2018 was $0.6 million as compared to interest expense of $0.1 million in 2017. The increase was mainly driven by increased drawdown on our line of credit.

Interest Income

Interest income in 2018 was $1.3 million for 2018, as compared to $1.0 million in 2017, an increase of $0.3 million or 24%, mainly due to more cash held in money market accounts which resulted in more interest earned and the interest from notes receivable.

Change in Fair Value of Derivative Instrument

Change in fair value of derivative instrument in 2017 was $45,000 due to fluctuations of ApolloMed's stock price. ApolloMed did not have any derivative instruments in 2018.

Gain on Settlement of Preexisting Note Receivable from ApolloMed

Gain on settlement of preexisting note receivable between NMM and ApolloMed prior to the Merger was $0.9 million in 2017, there was no comparable amount in 2018.

Gain from investments – fair value adjustments

Gain from investments – fair value adjustment was $13.7 million in 2017. ApolloMed's preferred stock (previously accounted for under the cost method) was $8.6 million and gain from NMM's noncontrolling interest in APAACO (previously accounted for under the equity method) was $5.1 million as a result of the fair value adjustment related to the Merger. There was no comparable amount in 2018.

Other Income

Other income was $1.6 million for 2018 as compared to $0.2 million in 2017, an increase of $1.4 million or 865%. The increase was primarily attributable to dividends received from our investment in DMG and rental income from our sublet properties.

Provision for Income Taxes

Provision for income taxes was $22.4 million for 2018, as compared to $3.9 million in 2017, an increase of $18.5 million or 475%. This increase was primarily attributable to the increase in the amount of pre-tax income in 2018 as compared to 2017.

Net Income Attributable to Noncontrolling Interests

Net income attributable to noncontrolling interests was $49.4 million for the year ended December 31, 2018, as compared to $20.0 million for the year ended December 31, 2017, an increase of $29.4 million or 147%. This increase was primarily due to net income generated from APC mainly attributable to its increased revenue due to favorable healthcare utilization trends and the recognition of full risk pool surplus.

Liquidity and Capital Resources

Cash, cash equivalents and investment in marketable securities at December 31, 2019 totaled $219.7 million. Working capital totaled $223.7 million at December 31, 2019, compared to $100.8 million at December 31, 2018, an increase of $122.9 million, or 122%.

We have historically financed our operations primarily through internally generated funds. We generate cash primarily from capitations, risk pool settlements and incentives, fees for medical management services provided to our affiliated physician

groups, as well as FFS reimbursements. We generally invest cash in money market accounts, which are classified as cash and cash equivalents. We believe we have sufficient liquidity to fund our operations at least through March 2021.

Our cash and cash equivalents and restricted cash decreased by $3.6 million from $107.6 million at December 31, 2018 to $104.0 million at December 31, 2019. Cash provided by operating activities during the year ended December 31, 2019 was $13.7 million, as compared to $25.5 million during the year ended December 31, 2018. The cash generated from operations during the year ended December 31, 2019 is a function of net income of $17.7 million, adjusted for the following non-cash operating activities: depreciation and amortization of $18.8 million, impairment of intangible assets of $2.0 million, share-based compensation of $1.5 million and loss from equity method investments of $6.9 million, which were offset by a reduction in our provision for doubtful accounts of $1.4 million, gain related to assumption of loan receivables of $2.2 million and a reduction in deferred tax liability of $6.8 million. Our cash provided by operating activities includes a net decrease in operating assets and liabilities of $22.8 million.

Cash used in investing activities during the year ended December 31, 2019 was $180.6 million, as compared to cash used by investing activities of $25.2 million during the year ended December 31, 2018. This increase was primarily attributable to purchases of marketable securities of $115.4 million, payments for business acquisitions, net of cash acquired of $49.4 million, advances on loans receivable of $11.4 million, investments made in our equity method investments and investments in privately held entities of $3.6 million and purchases of property and equipment of $1.0 million, which were offset with dividends received of $0.2 million during the year ended December 31, 2019.

Cash provided in financing activities during the year ended December 31, 2019 was $163.3 million, as compared to $11.2 million used during the year ended December 31, 2018. The increase was primarily attributable to proceeds from borrowings on the line of credit and long term debt of $289.6 million and proceeds from exercise of stock options and warrants of $3.1 million, common stock offering of $0.8 million, which were offset by dividend payments of $61.7 million, repayments of bank loans totaling $55.0 million, repurchase of common shares totaling $7.6 million, cost related to debt and equity issuances of $5.8 million, and repayment of capital lease obligations totaling $0.1 million.

Credit Facilities

Credit Facility

The Company's credit facility consisted of the following:

	December 31, 2019
Term Loan A	$ 187,625,000
Revolver Loan	60,000,000
Total Debt	247,625,000
Less: current portion of debt	(9,500,000)
Less: unamortized financing cost	(5,952,866)
Long-term debt	$ 232,172,134

The following table presents scheduled maturities of the Company's credit facility as of December 31, 2019:

	Amount
2020	$ 9,500,000
2021	10,687,500
2022	14,250,000
2023	15,437,500
2024	197,750,000
Total	$ 247,625,000

Credit Agreement

On September 11, 2019, the Company entered into a secured credit agreement (the "Credit Agreement") with SunTrust Bank, in its capacity as administrative agent for the lenders (in such capacity, the "Agent"), as a lender, an issuer of letters of credit and as a swingline lender, and Preferred Bank, which is affiliated with one of the Company's board members, JPMorgan Chase Bank, N.A., MUFG Union Bank, N.A., Royal Bank of Canada, Fifth Third Bank and City National Bank, as lenders (the "Lenders"). In connection with the closing of the Credit Agreement, the Company, its subsidiary, NMM, and the Agent entered into a Guaranty and Security Agreement (the "Guaranty and Security Agreement"), pursuant to which, among other things, NMM guaranteed the obligations of the Company under the Credit Agreement.

The Credit Agreement provides for a five-year revolving credit facility to the Company of $100.0 million ("Revolver Loan"), which includes a letter of credit subfacility of up to $25.0 million. As of December 31, 2019 the Company has outstanding letters of credit totaling $14.8 million and the Company has $25.2 million available under the revolving credit facility. The Credit Agreement also provides for a term loan of $190.0 million, ("Term Loan A"). The unpaid principal amount of the term loan is payable in quarterly installments on the last day of each fiscal quarter commencing on December 31, 2019. The principal payment for each of the first eight fiscal quarters is $2.4 million, for the following eight fiscal quarters thereafter is $3.6 million and for the following three fiscal quarters thereafter is $4.8 million. The remaining principal payment on the term loan is due on September 11, 2024.

The proceeds of the term loan and up to $60.0 million of the revolving credit facility may be used to (i) finance a portion of the $545.0 million loan made by the Company to AP-AMH, concurrently with the closing of the Credit Agreement (the "AP-AMH Loan") as described in the May 13, 2019, Current Report and the August 29, 2019, Current Report, (ii) refinance certain indebtedness of the Company and its subsidiaries and, indirectly, APC, (iii) pay transaction costs and expenses arising in connection with the Credit Agreement, the AP-AMH Loan and certain other related transactions and (iv) provide for working capital, capital expenditures and other general corporate purposes. The remainder of the revolving credit facility will be used to finance future acquisitions and investments and to provide for working capital needs, capital expenditures and other general corporate purposes.

The Company is required to pay an annual facility fee of 0.20% to 0.35% on the available commitments under the Credit Agreement, regardless of usage, with the applicable fee determined on a quarterly basis based on the Company's leverage ratio. The Company is also required to pay customary fees as specified in a separate fee agreement between the Company and SunTrust Robinson Humphrey, Inc., the lead arranger of the Credit Agreement.

Amounts borrowed under the Credit Agreement will bear interest at an annual rate equal to either, at the Company's option, (a) the rate for Eurocurrency deposits for the corresponding deposits of U.S. dollars appearing on Reuters Screen LIBOR01 Page ("LIBOR"), adjusted for any reserve requirement in effect, plus a spread of from 2.00% to 3.00%, as determined on a quarterly basis based on the Company's leverage ratio, or (b) a base rate, plus a spread of 1.00% to 2.00%, as determined on a quarterly basis based on the Company's leverage ratio. The base rate is defined in a manner such that it will not be less than LIBOR. As of December 31, 2019 the interest rate on the Credit Agreement was 4.54%. The Company will pay fees for standby letters of credit at an annual rate equal to 2.00% to 3.00%, as determined on a quarterly basis based on the Company's leverage ratio, plus facing fees and standard fees payable to the issuing bank on the respective letter of credit. Loans outstanding under the Credit Agreement may be prepaid at any time without penalty, except for LIBOR breakage costs and expenses. If LIBOR ceases to be reported, the Credit Agreement requires the Company and the Agent to endeavor to establish a commercially reasonable alternative rate of interest and until they are able to do so, all borrowings must be at the base rate.

The Credit Agreement requires the Company and its subsidiaries to comply with various affirmative covenants, including, without limitation, furnishing updated financial and other information, preserving existence and entitlements, maintaining properties and insurance, complying with laws, maintaining books and records, requiring any new domestic subsidiary meeting

a materiality threshold specified in the Credit Agreement to become a guarantor thereunder and paying obligations. The Credit Agreement requires the Company and its subsidiaries to comply with, and to use commercially reasonable efforts to the extent permitted by law to cause certain material associated practices of the Company, including APC, to comply with, restrictions on liens, indebtedness and investments (including restrictions on acquisitions by the Company), subject to specified exceptions. The Credit Agreement also contains various other negative covenants binding the Company and its subsidiaries, including, without limitation, restrictions on fundamental changes, dividends and distributions, sales and leasebacks, transactions with affiliates, burdensome agreements, use of proceeds, maintenance of business, amendments of organizational documents, accounting changes and prepayments and modifications of subordinated debt.

The Credit Agreement requires the Company to comply with two key financial ratios, each calculated on a consolidated basis. The Company must maintain a maximum consolidated leverage ratio of not greater than 3.75 to 1.00 as of the last day of each fiscal quarter. The maximum consolidated leverage ratio decreases by 0.25 each year, until it is reduced to 3.00 to 1.00 for each fiscal quarter ending after September 30, 2022. The Company must maintain a minimum consolidated interest coverage ratio of not less than 3.25 to 1.00 as of the last day of each fiscal quarter. As of December 31, 2019, the Company was in compliance with the covenants relating to its credit facility.

Pursuant to the Guaranty and Security Agreement, the Company and NMM have granted the Lenders a security interest in all of their assets, including, without limitation, all stock and other equity issued by their subsidiaries (including NMM) and all rights with respect to the AP-AMH Loan. The Guaranty and Security Agreement requires the Company and NMM to comply with various affirmative and negative covenants, including, without limitation, covenants relating to maintaining perfected security interests, providing information and documentation to the Agent, complying with contractual obligations relating to the collateral, restricting the sale and issuance of securities by their respective subsidiaries and providing the Agent access to the collateral.

The Credit Agreement contains events of default, including, without limitation, failure to make a payment when due, default on various covenants in the Credit Agreement, breach of representations or warranties, cross-default on other material indebtedness, bankruptcy or insolvency, occurrence of certain judgments and certain events under the Employee Retirement Income Security Act of 1974 aggregating more than $10.0 million, invalidity of the loan documents, any lien under the Guaranty and Security Agreement ceasing to be valid and perfected, any change in control, as defined in the Credit Agreement, an event of default under the AP-AMH Loan, failure by APC to pay dividends in cash for any period of two consecutive fiscal quarters, failure by AP-AMH to pay cash interest to the Company, or if any modification is made to the Certificate of Determination or the Special Purpose Shareholder Agreement that directly or indirectly restricts, conditions, impairs, reduces or otherwise limits the payment of the Series A Preferred dividend by APC to AP-AMH. In addition, it will constitute an event of default under the Credit Agreement if APC uses all or any portion of the consideration received by APC from AP-AMH on account of AP-AMH's purchase of Series A Preferred Stock for any purpose other than certain specific approved uses described in the following sentence, unless not less than 50.01% of all holders of common stock of APC at such time approve such use; provided that APC may use up to $50.0 million in the aggregate of such consideration for any purpose without any requirement to obtain such approval of the holders of common stock of APC. The approved uses include (i) any permitted investment, (ii) any dividend or distribution to the holders of the common stock of APC, (iii) any repurchase of common stock of APC, (iv) paying taxes relating to or arising from certain assets and transactions, or (v) funding losses, deficits or working capital support on account of certain non-healthcare assets in an amount not to exceed $125.0 million. If any event of default occurs and is continuing under the Credit Agreement, the Lenders may terminate their commitments, and may require the Company and its guarantors to repay outstanding debt and/or to provide a cash deposit as additional security for outstanding letters of credit. In addition, the Agent, on behalf of the Lenders, may pursue remedies under the Guaranty and Security Agreement, including, without limitation, transferring pledged securities of the Company's subsidiaries in the name of the Agent and exercising all rights with respect thereto (including the right to vote and to receive dividends), collect on pledged accounts, instruments and other receivables (including the AP-AMH Loan), and all other rights provided by law or under the loan documents and the AP-AMH Loan.

In the ordinary course of business, certain of the Lenders under the Credit Agreement and their affiliates have provided to the Company and its subsidiaries and the associated practices, and may in the future provide, (i) investment banking, commercial banking (including pursuant to certain existing business loan and credit agreements being terminated in connection with entering into the Credit Agreement), cash management, foreign exchange or other financial services, and (ii) services as a bond trustee and other trust and fiduciary services, for which they have received compensation and may receive compensation in the future.

Deferred Financing Costs

The Company recorded deferred financing costs of $6.4 million related to the issuance of the Credit Facility. This amount was recorded as a direct reduction of the carrying amount of the related debt liability. The deferred financing costs related to the term loan will be amortized over the life of the Credit Facility using the effective interest rate method. The deferred financing costs related to the revolver will be amortized using the straight line method over the term of the revolver. During the year ended

December 31, 2019, $0.5 million of amortization relating to deferred financing costs is included under "Depreciation and Amortization" of the cash flow statement.

Effective Interest Rate

The Company's average effective interest rate on its total debt during the years ended December 31, 2019, 2018 and 2017 was 3.39%, 4.72% and 2.27%, respectively.

Bank Loans

In December 2010, ICC obtained a loan of $4.6 million from a financial institution. The loan bears interest based on the Wall Street Journal "prime rate" or 5.50% per annum, as of December 31, 2018. The loan is collateralized by the medical equipment ICC owns and guaranteed by one of ICC's shareholders. The loan matured on December 31, 2018 and final payment was made in January 2019.

Lines of Credit – Related Party

NMM Business Loan

On June 14, 2018, NMM amended its promissory note agreement with Preferred Bank, which is affiliated with one of the Company's board members, ("NMM Business Loan Agreement"), which provides for loan availability of up to $20.0 million with a maturity date of June 22, 2020. One of the Company's board members is the chairman and CEO of Preferred Bank. The NMM Business Loan Agreement was amended on September 1, 2018 to temporarily increase the loan availability from $20.0 million to $27.0 million for the period from September 1, 2018 through January 31, 2019, further extended to October 31, 2019 to facilitate the issuance of an additional standby letter of credit for the benefit of CMS. The interest rate is based on the Wall Street Journal "prime rate" plus 0.125%, or 5.625%, as of December 31, 2018. The loan was guaranteed by Apollo Medical Holdings, Inc. and is collateralized by substantially all of the assets of NMM. The amounts outstanding as of June 30, 2019 of $5.0 million was fully repaid on September 11, 2019.

On September 5, 2018, NMM entered into a non-revolving line of credit agreement with Preferred Bank, which is affiliated with one of the Company's board members, ("NMM Line of Credit Agreement") which provides for loan availability of up to $20.0 million with a maturity date of September 5, 2019. This credit facility was subsequently amended on April 17, 2019 and July 29, 2019 to reduce the loan availability from $20.0 million to $16.0 million and from $16.0 million to $2.2 million, respectively. The interest rate is based on the Wall Street Journal "prime rate" plus 0.125%, or 4.875%, as of December 31, 2019. The line of credit is guaranteed by Apollo Medical Holdings, Inc. and is collateralized by substantially all assets of NMM. NMM obtained this line of credit to finance potential acquisitions. Each drawdown from the line of credit is converted into a five-year term loan with monthly principal payments plus interest based on afive-year amortization schedule.

On September 11, 2019, the NMM Business Loan Agreement, dated as of June 14, 2018, between NMM and Preferred Bank, as amended, and the Line of Credit Agreement, dated as of September 5, 2018, between NMM and Preferred Bank, as amended, was terminated in connection with the closing of the Credit Facility. Certain letters of credit issued by Preferred Bank under the Line of Credit Agreement were terminated and reissued under the Credit Agreement. These outstanding letters of credit totaled $14.8 million as of December 31, 2019 and the Company has $10.2 million available under the letter of credit subfacility.

APC Business Loan

On June 14, 2018, APC amended its promissory note agreement with Preferred Bank, which is affiliated with one of the Company's board members, ("APC Business Loan Agreement") which provides for loan availability of up to $10.0 million with a maturity date of June 22, 2020. This credit facility was subsequently amended on April 17, 2019 and June 11, 2019 to increase the loan availability from $10.0 million to $40.0 million and extend the maturity date through December 31, 2020. On August 1, 2019 and September 10, 2019, this credit facility was further amended to increase loan availability from $40.0 million to $43.8 million, and decrease loan availability from $43.8 million to $4.1 million, respectively. This decrease further limited the purpose of the indebtedness under APC Business Loan Agreement to the issuance of standby letters of credit, and added as a permitted lien the security interest in all of its assets granted by APC in favor of NMM under a Security Agreement dated on or about September 11, 2019 securing APC's obligations to NMM under, and as required pursuant to, that certain Management Services Agreement dated as of July 1, 1999, as amended. The interest rate is based on the Wall Street Journal "prime rate" plus 0.125%, or 4.875% and 5.625%, as of December 31, 2019 and December 31, 2018, respectively. As of December 31, 2019 there is no additional availability under this line of credit.

Standby Letters of Credit

On March 3, 2017, APAACO established an irrevocable standby letter of credit with Preferred Bank, which is affiliated with one of the Company's board members, (through the NMM Business Loan Agreement) for $6.7 million for the benefit of CMS. The letter of credit expired on December 31, 2018 and was automatically extended without amendment for additional one - year periods from the present or any future expiration date, unless notified by the institution to terminate prior to 90 days from any expiration date. APAACO may continue to draw from the letter of credit for one year following the bank's notification of non-renewal. As of December 31, 2019, CMS has released the Company from this obligation.

On October 2, 2018, APAACO established a second irrevocable standby letter of credit with Preferred Bank, which is affiliated with one of the Company's board members, (through the NMM Business Loan Agreement) for $6.6 million for the benefit of CMS. The letter of credit expires on December 31, 2019 and is automatically extended without amendment for additional one - year periods from the present or any future expiration date, unless notified by the institution to terminate prior to 90 days from any expiration date. APAACO may continue to draw from the letter of credit for one year following the bank's notification of non-renewal. This standby letter of credit was subsequently amended on August 14, 2019 to increase the amount from $6.6 million to $14.8 million and extended the expiration date to December 31, 2020 while all other terms and conditions remained unchanged. In connection with the closing of the Credit Facility, this letter of credit was terminated and reissued under the Credit Agreement.

APC established irrevocable standby letters of credit with a financial institution for a total of $0.3 million for the benefit of certain health plans. The standby letters of credit are automatically extended without amendment for additional one-year periods from the present or any future expiration date, unless notified by the institution in advance of the expiration date that the letter will be terminated.

Alpha Care established irrevocable standby letters of credit with Preferred Bank, which is affiliated with one of the Company's board members, under the APC Business Loan Agreement for a total of $3.8 million for the benefit of certain health plans. The standby letters of credit are automatically extended without amendment for additional one-year periods from the present or any future expiration date, unless notified by the institution in advance of the expiration date that the letter will be terminated.

Intercompany Loans

Each of AMH, MMG, BAHA, ACC, AKM and SCHC has entered into an Intercompany Loan Agreement with AMM under which AMM has agreed to provide a revolving loan commitment to each of the affiliated entities in an amount set forth in each Intercompany Loan Agreement. Each Intercompany Loan Agreement provides that AMM's obligation to make any advances automatically terminates concurrently with the termination of the management agreement with the applicable affiliated entity. In addition, each Intercompany Loan Agreement provides that (i) any material breach by the shareholder of record of the applicable Physician Shareholder Agreement or (ii) the termination of the management agreement with the applicable affiliated entity constitutes an event of default under the Intercompany Loan Agreement. All the intercompany loans have been eliminated in consolidation.

			Year Ended December 31, 2019			
Entity	Facility	Interest rate per Annum	Maximum Balance During Period	Ending Balance	Principal Paid During Period	Interest Paid During Period
AMH	$ 10,000,000	10%	$ 5,798,674	$ 5,798,674	$ 770,000	$ —
ACC	1,000,000	10%	1,288,643	1,283,078	5,565	—
MMG	3,000,000	10%	3,395,588	3,395,588	—	—
AKM	5,000,000	10%	—	—	—	—
SCHC	5,000,000	10%	4,710,385	4,710,385	—	—
BAHA	250,000	10%	4,065,992	4,065,992	—	—
	$ 24,250,000		$ 19,259,282	$ 19,253,717	$ 775,565	$ —

Contractual Obligations

The following summarizes our contractual obligations as of December 31, 2019:

	Total	Less than One Year	One to Three Years	Three to Five Years	More than Five Years
Operating leases	$ 17,570,789	$ 3,781,174	$ 5,087,961	$ 3,918,273	$ 4,783,381
Finance leases	554,935	118,920	237,840	198,175	—
Debt	247,625,000	9,500,000	24,937,500	213,187,500	—
Interest on debt	60,000,000	12,000,000	24,000,000	24,000,000	—
Total contractual obligations	$ 325,750,724	$ 25,400,094	$ 54,263,301	$ 241,303,948	$ 4,783,381

Critical Accounting Policies and Estimates

The consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("U.S. GAAP"), which require management to make a number of estimates and assumptions relating to the reported amount of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the consolidated financial statements and to the reported amounts of revenues and expenses during the period. The Company bases its estimates on historical experience and on various other assumptions that the Company believes are reasonable under the circumstances. Changes in estimates are recorded if and when better information becomes available. Actual results could significantly differ from those estimates under different assumptions and conditions. The Company believes that the accounting policies discussed below are those that are most important to the presentation of its financial condition and results of operations and that require its management's most difficult, subjective and complex judgments.

Principles of Consolidation

The consolidated balance sheets as of December 31, 2019 and 2018 and consolidated statements of income for the years endedDecember 31, 2019, 2018 and 2017 include the accounts of ApolloMed, its consolidated subsidiaries NMM, AMM, APAACO and Apollo Care Connect, including ApolloMed's consolidated VIE, AP-AMH, NMM's subsidiaries, APCN-ACO and AP-ACO, NMM's consolidated VIE, APC, APC's subsidiary, UCAP, and APC's consolidated VIEs, CDSC, APC-LSMA and ICC, and APC-LSMA's consolidated subsidiaries Alpha Care and Accountable Health Care.

Use of Estimates

The preparation of consolidated financial statements and related disclosures in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. The more significant items subject to such estimates and assumptions include collectability of receivables, recoverability of long-lived and intangible assets, business combination and goodwill valuation and impairment, accrual of medical liabilities (including historical medical loss ratios ("MLR"), and incurred, but not reported ("IBNR") claims), determination of full-risk revenue and receivables (including constraints and completion factors), income taxes and valuation of share-based compensation. Management evaluates its estimates and assumptions on an ongoing basis using historical experience and other factors, including the current economic environment, and makes adjustments when facts and circumstances dictate. As future events and their effects cannot be determined with precision, actual results could differ materially from those estimates and assumptions.

Receivables and Receivables – Related Parties

The Company's receivables are comprised of accounts receivable, capitation and claims receivable, risk pool settlements and incentive receivables, management fee income and other receivables. Accounts receivable are recorded and stated at the amount expected to be collected.

The Company's receivables – related parties are comprised of risk pool settlements and incentive receivables, management fee income and other receivables. Receivables – related parties are recorded and stated at the amount expected to be collected.

Capitation and claims receivable relate to each health plan's capitation, which is received by the Company in the month following the month of service. Risk pool settlements and incentive receivables mainly consist of the Company's full risk pool

receivable that is recorded quarterly based on reports received from our hospital partners and management's estimate of the Company's portion of the estimated risk pool surplus for open performance years. Settlement of risk pool surplus or deficits occurs approximately 18 months after the risk pool performance year is completed. Other receivables include fee-for-services ("FFS") reimbursement for patient care, certain expense reimbursements, and stop loss insurance premium reimbursements from IPAs.

The Company maintains reserves for potential credit losses on accounts receivable. Management reviews the composition of accounts receivable and analyzes historical bad debts, customer concentrations, customer credit worthiness, current economic trends and changes in customer payment patterns to evaluate the adequacy of these reserves. The Company also regularly analyzes the ultimate collectability of accounts receivable after certain stages of the collection cycle using a look-back analysis to determine the amount of receivables subsequently collected and adjustments are recorded when necessary. Reserves are recorded primarily on a specific identification basis.

Amounts are recorded as a receivable when the Company is able to determine amounts receivable under applicable contracts and/or agreements based on information provided and collection is reasonably likely to occur. The Company continuously monitors its collections of receivables and its policy is to write off receivables when they are determined to be uncollectible. As of December 31, 2019 and 2018, the Company's allowance for doubtful accounts were approximately$2.9 million and approximately $4.3 million, respectively.

Fair Value Measurements

The Company's financial instruments consist of cash and cash equivalents, restricted cash, investment in marketable securities, receivables, loans receivable – related parties, accounts payable, certain accrued expenses, capital lease obligations, bank loan, line of credit – related party, and long-term debt. The carrying values of the financial instruments classified as current in the accompanying consolidated balance sheets are considered to be at their fair values, due to the short maturity of these instruments. The carrying amount of the loan receivables – related parties, net of current portion, bank loan, capital lease obligations line of credit - related party, and long-term debt approximate fair value as they bear interest at rates that approximate current market rates for debt with similar maturities and credit quality. The FASB ASC 820, Fair Value Measurement ("ASC 820"), applies to all financial assets and financial liabilities that are measured and reported on a fair value basis and requires disclosure that establishes a framework for measuring fair value and expands disclosure about fair value measurements. ASC 820 establishes a fair value hierarchy for disclosures of the inputs to valuations used to measure fair value.

This hierarchy prioritizes the inputs into three broad levels as follows:

Level 1—Inputs are unadjusted quoted prices in active markets for identical assets or liabilities that can be accessed at the measurement date.

Level 2—Inputs include quoted prices for similar assets and liabilities in active markets, quoted prices for identical or similar assets or liabilities in markets that are not active, inputs other than quoted prices that are observable for the asset or liability (i.e., interest rates and yield curves), and inputs that are derived principally from or corroborated by observable market data by correlation or other means (market corroborated inputs).

Level 3—Unobservable inputs that reflect assumptions about what market participants would use in pricing the asset or liability. These inputs would be based on the best information available, including the Company's own data.

Business Combinations

We use the acquisition method of accounting for all business combinations, which requires assets and liabilities of the acquiree to be recorded at fair value, to measure the fair value of the consideration transferred, including contingent consideration, to be determined on the acquisition date, and to account for acquisition related costs separately from the business combination.

Investments in Other Entities

Variable interest model

We perform a primary beneficiary analysis on all our identified variable interest entities, which comprises a qualitative analysis based on power and economics. We consolidate a VIE if both power and benefits belong to us – that is, we (i) have the power to direct the activities of a VIE that most significantly influence the VIE's economic performance (power), and (ii) have the obligation to absorb losses of, or the right to receive benefits from, the VIE that could potentially be significant to the VIE (benefits). We consolidate VIEs whenever it is determined that we are the primary beneficiary.

Equity Method

We account for certain investments using the equity method of accounting when it is determined that the investment provides us the ability to exercise significant influence, but not control, over the investee. Significant influence is generally deemed to exist if the Company has an ownership interest in the voting stock of the investee of between 20% and 50%, although other factors, such as representation on the investee's board of directors, are considered in determining whether the equity method of accounting is appropriate. Under the equity method of accounting, the investment, originally recorded at cost, is adjusted to recognize our share of net earnings or losses of the investee and is recognized in the consolidated statements of income under "Income from equity method investments" and also is adjusted by contributions to and distributions from the investee. Equity method investments are subject to impairment evaluation. During the period ended December 31, 2019, the Company recognized an impairment loss of approximately $0.3 million related to its investment in PASC as the Company does not believe it will recover its investment balance. Such impairment loss is included in loss from equity method investment in the accompanying consolidated statements of income. No impairment loss was recognized on equity method investments for the years ended December 31, 2018 and 2017.

Noncontrolling Interests

The Company consolidates entities in which the Company has a controlling financial interest. The Company consolidates subsidiaries in which the Company holds, directly or indirectly, more than 50% of the voting rights, and variable interest entities (VIEs) in which the Company is the primary beneficiary. Noncontrolling interests represent third-party equity ownership interests (including certain VIEs) in the Company's consolidated entities. The amount of net income attributable to noncontrolling interests is disclosed in the consolidated statements of income.

Mezzanine Equity

Based on the shareholder agreements for APC, in the event of a disqualifying event, as defined in the agreements, APC could be required to repurchase the shares from their respective shareholders based on certain triggers outlined in the shareholder agreements. As the redemption feature of the shares is not solely within the control of APC, the equity of APC does not qualify as permanent equity and has been classified as mezzanine or temporary equity. Accordingly, the Company recognizes noncontrolling interests in APC as mezzanine equity in the consolidated financial statements. APC's shares were not redeemable and it was not probable that the shares would become redeemable as of December 31, 2019 and 2018.

Revenue Recognition

The Company adopted Accounting Standards Update ("ASU") 2014-09, "Revenue from Contracts with Customers (Topic 606)", using the modified retrospective method on January 1, 2108. Modified retrospective adoption required entities to apply the standard retrospectively to the most current period presented in the financial statements, requiring the cumulative effect of the retrospective application as an adjustment to the opening balance of retained earnings and noncontrolling interests at the date of initial application. Revenue from substantially all of the Company's contracts with customers continues to be recognized over time as services are rendered. The 2017 comparative information has not been restated and continues to be reported under the accounting standards in effect for that period ("ASC 605") (See Note 16).

Income Taxes

Federal and state income taxes are computed at currently enacted tax rates less tax credits using the asset and liability method. Deferred taxes are adjusted both for items that do not have tax consequences and for the cumulative effect of any changes in tax rates from those previously used to determine deferred tax assets or liabilities. Tax provisions include amounts that are currently payable, changes in deferred tax assets and liabilities that arise because of temporary differences between the timing of when items of income and expense are recognized for financial reporting and income tax purposes, changes in the recognition of tax positions and any changes in the valuation allowance caused by a change in judgment about the realizability of the related deferred tax assets. A valuation allowance is established when necessary to reduce deferred tax assets to amounts expected to be realized.

The Company uses a recognition threshold of more-likely-than-not and a measurement attribute on all tax positions taken or expected to be taken in a tax return in order to be recognized in the financial statements. Once the recognition threshold is met, the tax position is then measured to determine the actual amount of benefit to recognize in the financial statements.

On December 22, 2017, the U.S. government enacted comprehensive tax legislation known as the Tax Cuts and Jobs Act (the "TCJA"). The TCJA established new tax laws that took effect in 2018, including, but not limited to (1) reduction of the U.S.

federal corporate tax rate from a maximum of 35% to 21%; (2) elimination of the corporate alternative minimum tax; (3) a new limitation on deductible interest expense; (4) the transition tax; (5) limitations on the deductibility of certain executive compensation; (6) changes to the bonus depreciation rules for fixed asset additions; and (7) limitations on net operating losses generated after December 31, 2018, to 80% of taxable income.

ASC Topic 740, Income Taxes ("ASC 740"), requires the effects of changes in tax laws to be recognized in the period in which the legislation is enacted. However, due to the complexity and significance of the TCJA's provisions, the SEC staff issued Staff Accounting Bulletin ("SAB 118"), which provides guidance on accounting for the tax effects of the TCJA. SAB 118 provides a measurement period that should not extend beyond one year from the TCJA enactment date for companies to complete the accounting under ASC 740.

Goodwill and Intangible Assets

Under FASB ASC 350, *Intangibles – Goodwill and Other* ("ASC 350"), goodwill and indefinite-lived intangible assets are reviewed at least annually for impairment.

At least annually, at the Company's fiscal year end, or sooner, if events or changes in circumstances indicate that an impairment has occurred, the Company performs a qualitative assessment to determine whether it is more likely than not that the fair value of each reporting unit is less than its carrying amount as a basis for determining whether it is necessary to complete quantitative impairment assessments for each of the Company's three main reporting units, (1) management services, (2) IPA, and (3) ACO. The Company is required to perform a quantitative goodwill impairment test only if the conclusion from the qualitative assessment is that it is more likely than not that a reporting unit's fair value is less than the carrying value of its assets. Should this be the case, a quantitative analysis is performed to identify whether a potential impairment exists by comparing the estimated fair values of the reporting units with their respective carrying values, including goodwill.

An impairment loss is recognized if the implied fair value of the asset being tested is less than its carrying value. In this event, the asset is written down accordingly. The fair values of goodwill are determined using valuation techniques based on estimates, judgments and assumptions management believes are appropriate in the circumstances.

At least annually, indefinite-lived intangible assets are tested for impairment. Impairment for intangible assets with indefinite lives exists if the carrying value of the intangible asset exceeds its fair value. The fair values of indefinite-lived intangible assets are determined using valuation techniques based on estimates, judgments and assumptions management believes are appropriate in the circumstances.

Effect of New Accounting Standards

In February 2016, the FASB issued ASU No. 2016-02, Leases (Topic 842) ("ASC 842"), which amends the existing accounting standards for leases to increase transparency and comparability among organizations by requiring the recognition of right-of-use assets and lease liabilities on the balance sheet. Most prominent among the changes in the standard is the recognition of right-of-use assets and lease liabilities by lessees for those leases classified as operating leases. Under the standard, disclosures are required to meet the objective of enabling users of financial statements to assess the amount, timing, and uncertainty of cash flows arising from leases.

The Company adopted ASC 842 effective January 1, 2019 on a modified retrospective using the following practical expedients as permitted under the transition guidance within the new standard; (i) not reassess whether any expired or existing contracts are or contain leases; not reassess the lease classification for any expired or existing leases; not reassess initial direct costs for existing leases; and (ii) use hindsight in determining the lease term and in assessing impairment of the entity's right-of-use assets. The Company has also implemented additional internal controls to enable future preparation of financial information in accordance with ASC 842.

The standard had a material impact on our consolidated balance sheets, but did not materially impact our consolidated results of operations and had no impact on cash flows. The most significant impact was the recognition of right-of-use assets of $9.0 million and lease liabilities of $8.9 million for operating leases, while our accounting for finance leases remained substantially unchanged. The 2018 comparative information has not been restated and continues to be reported under the accounting standards in effect for that period (ASC 840). See Note 19 for further details.

The Company elected to adopt the standard using the "package of practical expedients", which permits it not to reassess under the new standard its prior conclusions about lease identification, lease classification, and initial direct costs, and the use-of-hindsight in determining the lease term and in assessing impairment of right-of-use assets. In addition, the new standard provides

practical expedients for an entity's ongoing accounting that the Company anticipates making, comprised of the following: (1) the election for classes of underlying asset to not separate non-lease components from lease components, and (2) the election for short-term lease recognition exemption for all leases that qualify.

See *"Recent Accounting Pronouncements" under "Note 2 — Basis of Presentation and Summary of Significant Accounting Policies."*

Off-Balance Sheet Arrangements

We have no off-balance sheet arrangements that have or are reasonably likely to have a current or future effect on our financial condition, changes in financial condition, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources that are material to investors.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Interest Rate Risk

Borrowings under our Credit Agreement exposed us to interest rate risk. As of December 31, 2019, we had $247.6 million in outstanding borrowings under our Credit Agreement. Amount borrowed under the Credit Agreement bears interest at an annual rate equal to either, at the Company's option, (a) the rate for Eurocurrency deposits for the corresponding deposits of U.S. dollars appearing on Reuters Screen LIBOR01 Page ("LIBOR"), adjusted for any reserve requirement in effect, plus a spread of 2.00% to 3.00%, as determined on a quarterly basis based on the Company's leverage ratio, or (b) a base rate, plus a spread of 1.00% to 2.00%, as determined on a quarterly basis based on the Company's leverage ratio. The base rate is defined in a manner such that it will not be less than LIBOR. The Company will pay fees for standby letters of credit at an annual rate equal to 2.00% to 3.00%, as determined on a quarterly basis based on the Company's leverage ratio, plus facing fees and standard fees payable to the issuing bank on the respective letter of credit. A hypothetical 1% change in our interest rates would have increased or decreased our interest expense for the years ended December 31, 2019 by $2.5 million.

Item 8. Financial Statements and Supplementary Data

Index to the Consolidated Financial Statements **Page**

Report of Independent Registered Public Accounting Firm

Shareholders and Board of Directors
Apollo Medical Holdings, Inc.
Alhambra, California

Opinion on the Consolidated Financial Statements

We have audited the accompanying consolidated balance sheets of Apollo Medical Holdings, Inc. (the "Company") as of December 31, 2019 and 2018, the related consolidated statements of income, mezzanine and shareholders' equity, and cash flows for each of the three years in the period ended December 31, 2019, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2019 and 2018, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2019**,** in conformity with accounting principles generally accepted in the United States of America.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) ("PCAOB"), the Company's internal control over financial reporting as of December 31, 2019, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") and our report dated March 16, 2020 expressed an unqualified opinion thereon.

Change in Accounting Method Related to Leases and Revenue

As discussed in Notes 2 and 19 to the consolidated financial statements, the Company changed its method for accounting for leases effective January 1, 2019 as a result of the adopting Accounting Standards Codification ("ASC") 842 - Leases.

As discussed in Notes 2 and 16 to the consolidated financial statements, the Company changed its method for recognizing revenue from contracts with customers effective January 1, 2018 as a result of adopting ASC 606 - Revenue from Contracts with Customers.

Basis for Opinion

These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's consolidated financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud.

Our audits included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ BDO USA, LLP

We have served as the Company's auditor since 2014.

Los Angeles, California

March 16, 2020

APOLLO MEDICAL HOLDINGS, INC.
CONSOLIDATED BALANCE SHEETS

	December 31, 2019	December 31, 2018
Assets		
Current assets		
Cash and cash equivalents	$ 103,189,328	$ 106,891,503
Restricted cash	75,000	—
Investment in marketable securities	116,538,673	1,127,102
Receivables, net	11,003,563	7,734,631
Receivables, net – related parties	48,136,313	48,721,325
Other receivables	16,885,448	1,003,133
Prepaid expenses and other current assets	10,315,093	7,385,098
Loans receivable	6,425,000	—
Loans receivable - related parties	16,500,000	—
Total current assets	329,068,418	172,862,792
Noncurrent assets		
Land, property and equipment, net	12,129,901	12,721,082
Intangible assets, net	103,011,849	86,875,883
Goodwill	238,505,204	185,805,880
Loans receivable – related parties	—	17,500,000
Investments in other entities – equity method	28,427,455	34,876,980
Investments in privately held entities	896,000	405,000
Restricted cash	746,104	745,470
Operating lease right-of-use assets	14,247,727	—
Other assets	1,680,689	1,205,962
Total noncurrent assets	399,644,929	340,136,257
Total assets	$ 728,713,347	$ 512,999,049

APOLLO MEDICAL HOLDINGS, INC.
CONSOLIDATED BALANCE SHEETS (Continued)

	December 31, 2019	December 31, 2018
Liabilities, Mezzanine Equity and Shareholders' Equity		
Current liabilities		
Accounts payable and accrued expenses	$ 27,279,579	$ 25,075,489
Fiduciary accounts payable	2,027,081	1,538,598
Medical liabilities	58,724,682	33,641,701
Income taxes payable	4,528,867	11,621,861
Bank loan	—	40,257
Dividend payable	271,279	—
Finance lease liabilities	101,741	101,741
Operating lease liabilities	2,990,686	—
Current portion of long term debt	9,500,000	—
Total current liabilities	105,423,915	72,019,647
Noncurrent liabilities		
Lines of credit - related party	—	13,000,000
Deferred tax liability	18,269,448	19,615,935
Liability for unissued equity shares	—	1,185,025
Finance lease liabilities, net of current portion	415,519	517,261
Operating lease liabilities, net of current portion	11,372,597	—
Long-term debt, net of current portion and deferred financing costs	232,172,134	—
Total noncurrent liabilities	262,229,698	34,318,221
Total liabilities	367,653,613	106,337,868
Commitments and Contingencies (Note 13)		
Mezzanine equity		
Noncontrolling interest in Allied Physicians of California, a Professional Medical Corporation ("APC")	168,724,586	225,117,029
Shareholders' equity		
Series A Preferred stock, par value $0.001; 5,000,000 shares authorized (inclusive of Series B Preferred stock); 1,111,111 issued and zero outstanding	—	—
Series B Preferred stock, par value $0.001; 5,000,000 shares authorized (inclusive of Series A Preferred stock); 555,555 issued and zero outstanding	—	—
Common stock, par value $0.001; 100,000,000 shares authorized, 35,908,057 and 34,578,040 shares outstanding, excluding 17,458,810 and 1,850,603 Treasury shares, at December 31, 2019 and 2018, respectively	35,908	34,578
Additional paid-in capital	159,608,293	162,723,051
Retained earnings	31,904,748	17,788,203
	191,548,949	180,545,832
Noncontrolling interest	786,199	998,320
Total shareholders' equity	192,335,148	181,544,152

Total liabilities, mezzanine equity and shareholders' equity	$ 728,713,347	$ 512,999,049

See accompanying notes to consolidated financial statements.

APOLLO MEDICAL HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF INCOME

	Years ended December 31,		
	2019	**2018**	**2017**
Revenue			
Capitation, net	$ 454,168,024	$ 344,307,058	$ 272,921,240
Risk pool settlements and incentives	51,097,661	100,927,841	44,598,373
Management fee income	34,668,358	49,742,755	26,983,695
Fee-for-service, net	15,475,264	19,703,999	7,449,249
Other income	5,208,790	5,226,099	4,403,373
Total revenue	560,618,097	519,907,752	356,355,930
Operating expenses			
Cost of services	467,804,899	361,132,111	273,453,287
General and administrative expenses	41,482,375	43,353,787	26,249,532
Depreciation and amortization	18,280,198	19,303,179	19,075,353
Provision for doubtful accounts	(1,363,363)	3,887,647	—
Impairment of goodwill and intangible assets	1,994,000	3,798,866	2,431,791
Total expenses	528,198,109	431,475,590	321,209,963
Income from operations	32,419,988	88,432,162	35,145,967
Other (expense) income			
Loss from equity method investments	(6,900,859)	(8,125,285)	(1,112,541)
Interest expense	(4,733,256)	(560,515)	(79,689)
Interest income	2,023,873	1,258,638	1,015,204
Change in fair value of derivative instrument	—	—	(44,886)
Gain on settlement of preexisting note receivable from ApolloMed	—	—	921,938
Gain from investments – fair value adjustments	—	—	13,697,018
Other income	3,030,203	1,622,131	168,102
Total other (expense) income, net	(6,580,039)	(5,805,031)	14,565,146
Income before provision for income taxes	25,839,949	82,627,131	49,711,113
Provision for income taxes	8,166,632	22,359,640	3,886,785
Net income	17,673,317	60,267,491	45,824,328
Net income attributable to noncontrolling interests	3,556,772	49,432,489	20,022,486
Net income attributable to Apollo Medical Holdings, Inc.	$ 14,116,545	$ 10,835,002	$ 25,801,842
Earnings per share – basic	$ 0.41	$ 0.33	$ 1.01
Earnings per share – diluted	$ 0.39	$ 0.29	$ 0.90
Weighted average shares of common stock outstanding – basic	34,708,429	32,893,940	25,525,786
Weighted average shares of common stock outstanding – diluted	36,403,279	37,914,886	28,661,735

See accompanying notes to consolidated financial statements.

APOLLO MEDICAL HOLDINGS, INC.

CONSOLIDATED STATEMENTS OF MEZZANINE AND SHAREHOLDERS' EQUITY

	Mezzanine Equity – Noncontrolling Interest in APC	Common Stock Outstanding		Additional Paid-in Capital	Retained Earnings (Accumulated Deficit)	Noncontrolling Interest	Shareholders' Equity
		Shares	Amount				
Balance at December 31, 2016	$ 162,855,554	25,067,953	$ 25,068	$ 87,954,346	$ (773,311)	$ 381,617	$ 87,587,720
Net income	18,472,212	—	—	—	25,801,842	1,550,274	27,352,116
Shares repurchased	(1,523,550)	(132,752)	(133)	(1,652,153)	—	—	(1,652,286)
Shares issued for cash and exercise of options	266,000	232,254	233	2,059,300	—	—	2,059,533
Share-based compensation	809,528	—	—	1,933,588	—	—	1,933,588
Distribution of derivative assets - warrants	—	—	—	—	(5,294,000)	—	(5,294,000)
Noncontrolling interest capital change	—	—	—	—	—	859,430	859,430
Dividends	(8,750,000)	—	—	—	(18,000,000)	(1,697,923)	(19,697,923)
Reclassification of liability for unissued shares to equity	—	508,135	508	1,237,142	—	—	1,237,650
Effect of share exchange in Merger	—	6,109,205	6,109	61,273,274	—	3,142,000	64,421,383
Shares issued upon conversion of Alliance Note	—	520,081	520	5,375,695	—	—	5,376,215
Balance at December 31, 2017	172,129,744	32,304,876	32,305	158,181,192	1,734,531	4,235,398	164,183,426
ASC 606 Adoption	7,351,434	—	—	—	1,002,468	—	1,002,468
Net income	47,889,877	—	—	—	10,835,002	1,542,612	12,377,614
Purchase price adjustment from Merger	—	—	—	868,000	—	—	868,000
Repurchase of treasury shares	(1,263,554)	(168,493)	(168)	(3,783,921)	4,216,202	—	432,113
Shares issued for exercise of options and warrants	200,000	884,259	884	3,995,796	—	—	3,996,680
Share-based compensation	809,528	37,593	37	631,524	—	—	631,561
Noncontrolling interest capital change	—	—	—	—	—	27,500	27,500
Dividends	(2,000,000)	—	—	—	—	(1,975,010)	(1,975,010)
Acquisition of additional shares in consolidated entity	—	—	—	2,831,980	—	(2,832,180)	(200)
Release of 50% holdback shares	—	1,519,805	1,520	(1,520)	—	—	—
Balance at December 31, 2018	225,117,029	34,578,040	34,578	162,723,051	17,788,203	998,320	181,544,152
Net income	1,807,747	—	—	—	14,116,545	1,749,025	15,865,570
Repurchase of treasury shares	(283,300)	(601,581)	(601)	(7,285,784)	—	—	(7,286,385)
Shares issued for exercise of options and warrants	—	418,619	418	3,232,824	—	—	3,233,242
Share-based compensation	607,146	1,599	2	939,713	—	—	939,715
Stock subscription	754,998	—	—	—	—	—	—
Shares issued in connection with business acquisition	414,250	—	—	—	—	—	—
Cost of equity issuance of preferred shares	(878,309)	—	—	—	—	—	—
Noncontrolling interest capital change	—	—	—	—	—	27,500	27,500
Dividends	(60,000,000)	—	—	—	—	(1,988,646)	(1,988,646)
Reclassification of options liability to equity	1,185,025	—	—	—	—	—	—
Issuance of 50% holdback shares	—	1,511,380	1,511	(1,511)	—	—	—
Balance at December 31, 2019	$ 168,724,586	35,908,057	$ 35,908	$ 159,608,293	$ 31,904,748	$ 786,199	$ 192,335,148

APOLLO MEDICAL HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Years ended December 31,		
	2019	**2018**	**2017**
Cash flows from operating activities			
Net income	$ 17,673,317	$ 60,267,491	$ 45,824,328
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	18,753,270	19,303,179	19,075,353
Loss on disposal of property and equipment	—	41,784	—
Impairment of goodwill and intangible assets	1,994,000	3,798,866	2,431,791
Provision for doubtful accounts	(1,363,363)	3,887,647	—
Share-based compensation	1,546,861	1,441,089	2,743,116
Gain on loan assumption	(2,250,000)	—	—
Unrealized (gain) loss from investment in equity securities	(9,119)	25,005	(86,005)
Gain on settlement of preexisting note receivable from ApolloMed	—	—	(921,938)
Gain from investments – fair value adjustments	—	—	(13,697,018)
Change in fair value of derivative instrument	—	—	44,886
Loss from equity method investments	6,900,859	8,125,285	1,112,541
Deferred tax	(6,800,919)	(8,345,235)	(20,675,807)
Changes in operating assets and liabilities, net of acquisition amounts:			
Receivable, net	10,713,803	(263,191)	4,108,970
Receivable, net – related parties	(1,435,306)	(28,363,108)	6,593,783
Other receivable	(15,079,346)	—	—
Prepaid expenses and other current assets	(2,755,599)	(2,813,564)	1,260,064
Right-of-use assets	2,479,862	—	—
Other assets	(572,213)	2,446	(220,925)
Accounts payable and accrued expenses	(4,883,243)	(22,669,230)	(3,687,022)
Fiduciary accounts payable	488,483	—	—
Capitation incentives payable	—	(21,500,000)	1,878,355
Medical liabilities	(2,391,459)	4,134,209	5,661,313
Income taxes payable	(7,092,994)	8,423,366	388,138
Operating lease liabilities	(2,243,511)	—	—
Net cash provided by operating activities	13,673,383	25,496,039	51,833,923
Cash flows from investing activities			
Cash acquired from Merger	—	—	37,112,775
Cash received from consolidation of VIE	—	—	228,287
Purchases of marketable securities	(115,402,452)	(9,013)	(5,283)
Proceeds from loan receivable	—	—	200,000
Advances on loans receivable	(11,425,000)	(7,500,000)	(10,000,000)
Dividends received from equity method investments	240,000	607,411	1,240,000
Proceeds on sale of investments in a privately held entity	—	—	25,000
Payments for business acquisitions, net of cash acquired	(49,402,514)	—	—
Purchases of investments in privately held entities	(491,000)	(405,000)	—
Purchases of investments – equity method	(3,108,000)	(16,706,152)	—

Purchases of property and equipment	(1,041,670)	(1,170,064)	(2,084,770)
Net cash (used in) provided by investing activities	(180,630,636)	(25,182,818)	26,716,009
Cash flows from financing activities			
Dividends paid	(61,717,367)	(17,758,808)	(10,447,923)
Change in noncontrolling interest capital	27,500	27,300	—
Borrowings on long-term debt	250,000,000	8,000,000	5,000,000
Borrowings on line of credit	39,600,000	—	—
Advances by NMM to ApolloMed prior to the Merger	—	—	(9,000,000)
Repayments on long-term debt	(2,375,000)	—	—
Repayments on bank loan, and lines of credit	(52,640,258)	(495,134)	—
Payment of capital lease obligations	(101,741)	(98,735)	(102,348)
Proceeds from exercise of stock options included in liabilities	—	—	425,025
Proceeds from exercise of stock options and warrants	3,123,709	3,996,677	164,797
Proceeds from common stock offering	754,998	200,000	2,160,736
Repurchase of common shares	(7,569,685)	(5,047,643)	(3,175,836)
Cost of debt and equity issuances	(5,771,444)	—	—
Net cash provided by (used in) financing activities	163,330,712	(11,176,343)	(14,975,549)
Net (decrease) increase in cash, cash equivalents and restricted cash	(3,626,541)	(10,863,122)	63,574,383
Cash, cash equivalents and restricted cash, beginning of year	107,636,973	118,500,095	54,925,712
Cash, cash equivalents and restricted cash, end of year	$ 104,010,432	$ 107,636,973	$ 118,500,095
Supplemental disclosures of cash flow information			
Cash paid for income taxes	$ 20,200,000	$ 23,642,662	$ 24,362,223
Cash paid for interest	4,257,536	462,336	51,043
Supplemental disclosures of non-cash investing and financing activities			
Cashless exercise of stock options	$ —	$ 109	$ —
Dividend declared included in dividend payable	271,279	—	—
APC stock issued in exchange for AMG	414,250	—	—
Deferred tax liability adjusted to goodwill	6,334,368	1,110,456	—
Reclassification of liability for equity shares	1,185,025	—	—
Purchase price adjustment for acceleration of vested stock options	—	868,000	—
Conversion of loan receivable to investment in Accountable Health Care, IPA	—	5,000,000	—
Reclassification of dividends related to share repurchase	—	4,216,202	—
Reclassification of APS noncontrolling interest to equity related to purchase of additional shares	—	2,832,180	—
Distribution of warrants to former NMM shareholders	—	—	5,294,000
Issuance of common stock upon conversion of debt and accrued interest	—	—	5,376,215
Reclassification of liability for unissued common shares payable to equity	—	—	1,237,650
Non-cash purchase consideration for acquisition – fair value of equity consideration to pre-Merger ApolloMed shareholders	—	—	61,092,050

Non-cash purchase consideration for acquisition – fair value of preferred stock held by former NMM shareholders	—	—	19,118,000
Non-cash purchase consideration for acquisition – fair value of NMM's 50% share of APAACO	—	—	5,129,000
Non-cash purchase consideration for acquisition – acceleration of unvested stock compensation	—	—	187,333

The following table provides a reconciliation of cash and cash equivalents and restricted cash reported within the consolidated balance sheets that sum to the total amounts of cash, cash equivalents, and restricted cash shown in the consolidated statements of cash flows.

	Years Ended December 31,		
	2019	**2018**	**2017**
Cash and cash equivalents	$ 103,189,328	$ 106,891,503	$ 99,749,199
Restricted cash – long-term - letters of credit	746,104	745,470	745,235
Restricted cash – short-term	75,000	—	18,005,661
Total cash, cash equivalents, and restricted cash shown in the statement of cash flows	$ 104,010,432	$ 107,636,973	$ 118,500,095

See accompanying notes to consolidated financial statements.

1. Description of Business

Apollo Medical Holdings, Inc. ("ApolloMed") entered into an Agreement and Plan of Merger dated as of December 21, 2016 (as amended on March 30, 2017 and October 17, 2017) (the "Merger Agreement") with Apollo Acquisition Corp., a California corporation and wholly-owned subsidiary of ApolloMed, ("Merger Subsidiary"), Network Medical Management, Inc. ("NMM"), and Kenneth Sim, M.D., in his capacity as the representative of the shareholders of NMM, pursuant to which Merger Subsidiary merged with and into NMM, with NMM as the surviving corporation (the "Merger"). The Merger closed and became effective on December 8, 2017 (the "Closing") (see Note 3). As a result of the Merger, NMM is now a wholly-owned subsidiary of ApolloMed and the former NMM shareholders own a majority of the issued and outstanding common stock of ApolloMed and control of the board of directors of ApolloMed. Effective as of the Closing, ApolloMed's board of directors approved a change in ApolloMed's fiscal year end from March 31 to December 31 to correspond with NMM's fiscal year end prior to the Merger.

The combined company, following the Merger, together with its affiliated physician groups and consolidated entities (collectively, the "Company") is a physician-centric integrated population health management company working to provide coordinated, outcomes-based medical care in a cost-effective manner and to patients in California, the majority of whom are covered by private or public insurance such as Medicare, Medicaid and health maintenance organization ("HMO") plans, with a portion of the Company's revenue coming from non-insured patients. The Company provides care coordination services to each major constituent of the healthcare delivery system, including patients, families, primary care physicians, specialists, acute care hospitals, alternative sites of inpatient care, physician groups and health plans. The Company's physician network consists of primary care physicians, specialist physicians and hospitalists. The Company operates primarily through the following subsidiaries of ApolloMed: NMM, Apollo Medical Management, Inc. ("AMM"), APA ACO, Inc. ("APAACO") and Apollo Care Connect, Inc. ("Apollo Care Connect"), and their consolidated entities.

NMM was formed in 1994 as a management service organization ("MSO") for the purposes of providing management services to medical companies and independent practice associations ("IPAs"). The management services cover primarily billing, collection, accounting, administrative, quality assurance, marketing, compliance and education.

Allied Physicians of California IPA, a Professional Medical Corporation d.b.a. Allied Pacific of California ("APC") was incorporated on August 17, 1992 for the purpose of arranging health care services as an IPA. APC has contracts with various HMOs or licensed health care service plans as defined in the California Knox-Keene Health Care Service Plan Act of 1975. Each HMO negotiates a fixed amount per member per month ("PMPM") that is to be paid to APC. In return, APC arranges for the delivery of health care services by contracting with physicians or professional medical corporations for primary care and specialty care services. APC assumes the financial risk of the cost of delivering health care services in excess of the fixed amounts received. Some of the risk is transferred to the contracted physicians or professional corporations. The risk is also minimized by stop-loss provisions in contracts with HMOs.

On July 1, 1999, APC entered into an amended and restated management and administrative services agreement with NMM (initial management services agreement was entered into in 1997) for an initial fixed term of 30 years. In accordance with relevant accounting guidance, APC is determined to be a VIE as NMM is the primary beneficiary with the ability to direct the activities that most significantly affect APC's economic performance through its majority representation of the APC Joint Planning Board. Accordingly, APC is consolidated by NMM.

AP-AMH Medical Corporation ("AP-AMH") was formed on May 7, 2019 as a designated shareholder professional corporation. Dr. Thomas Lam, a shareholder, and the Chief Executive Officer and Chief Financial Officer of APC and Co-Chief Executive Officer of ApolloMed, is the sole shareholder of AP-AMH. ApolloMed makes all the decisions on behalf of AP-AMH and funds and receives all the distributions from its operations. ApolloMed has the right to receive benefits from the operations of AP-AMH and has the option, but not the obligation, to cover its losses. AP-AMH's sole function and only activity is to act as the nominee shareholder for ApolloMed's investments in APC. Therefore, AP-AMH is controlled and consolidated by ApolloMed as the primary beneficiary of this variable interest entity ("VIE").

On September 11, 2019, ApolloMed completed the following series of transactions with its affiliates, AP-AMH and APC:

1. The Company loaned AP-AMH $545.0 million pursuant to a ten-year secured loan agreement. The loan bears interest at a rate of 10% per annum simple interest, is not prepayable (except in certain limited circumstances), requires quarterly payments of interest only in arrears, and is secured by a first priority security interest in all of AP-AMH's assets, including the shares of APC Series A Preferred Stock to be purchased by AP-AMH. To the extent that AP-AMH is unable to make any interest payment when due because it has received dividends on the APC Series A Preferred Stock insufficient to pay in full such interest payment, then the outstanding principal amount of the loan will be increased by the amount of any such accrued but unpaid interest, and any such increased principal amounts will bear interest at the rate of 10.75% per annum simple interest.

2. AP-AMH purchased 1,000,000 shares of APC Series A Preferred Stock for aggregate consideration of $545.0 million in a private placement. Under the terms of the APC Certificate of Determination of Preferences of Series A Preferred Stock (the "Certificate of Determination"), AP-AMH is entitled to receive preferential, cumulative dividends that accrue on a daily basis and that are equal to the sum of (i) APC's net income from Healthcare Services (as defined in the Certificate of Determination), plus (ii) any dividends received by APC from certain of APC's affiliated entities, less (iii) any Retained Amounts (as defined in the Certificate of Determination). During the year ended December 31, 2019, APC distributed $8.9 million to ApolloMed as preferred returns.

3. APC purchased 15,015,015 shares of the Company's common stock for total consideration of $300.0 million in private placement. In connection therewith, the Company granted APC certain registration rights with respect to the Company's common stock that APC purchased, and APC agreed that APC votes in excess of 9.99% of the Company's then outstanding shares will be voted by proxy given to the Company's management, and that those proxy holders will cast the excess votes in the same proportion as all other votes cast on any specific proposal coming before the Company's stockholders.

4. The Company licensed to AP-AMH the right to use certain tradenames for certain specified purposes for a fee equal to a percentage of the aggregate gross revenues of AP-AMH. The license fee is payable out of any Series A Preferred Stock dividends received by AP-AMH from APC.

5. Through its subsidiary, NMM, the Company agreed to provide certain administrative services to AP-AMH for a fee equal to a percentage of the aggregate gross revenues of AP-AMH. The administrative fee also is payable out of any APC Series A Preferred Stock dividends received by AP-AMH from APC.

As of a result of the transaction, APC's ownership in ApolloMed increased to 32.50% at December 31, 2019 from 4.82% at December 31, 2018.

Concourse Diagnostic Surgery Center, LLC (“CDSC”) was formed on March 25, 2010 in the state of California. CDSC is an ambulatory surgery center in City of Industry, California, is organized by a group of highly qualified physicians, and the surgical center utilizes some of the most advanced equipment in Eastern Los Angeles County and San Gabriel Valley. The facility is Medicare Certified and accredited by the Accreditation Association for Ambulatory Healthcare, Inc. As of December 31, 2019 APC's ownership percentage in CDSC’s capital stock was 45.01%. CDSC is consolidated as a VIE by APC as it was determined that APC has a controlling financial interest in CDSC and is the primary beneficiary of CDSC.

APC-LSMA Designated Shareholder Medical Corporation ("APC-LSMA") was formed on October 15, 2012 as a designated shareholder professional corporation. Dr. Thomas Lam, a shareholder and the Chief Executive Officer and Chief Financial Officer of APC and Co-Chief Executive Officer of ApolloMed, is a nominee shareholder of APC-LSMA. APC makes all investment decisions on behalf of APC-LSMA, funds all investments and receives all distributions from the investments. APC has the obligation to absorb losses and right to receive benefits from all investments made by APC-LSMA. APC-LSMA’s sole function is to act as the nominee shareholder for APC in other California medical professional corporations. Therefore, APC-LSMA is controlled and consolidated by APC as the primary beneficiary of this VIE. The only activity of APC-LSMA is to hold the investments in medical corporations, including the IPA lines of business of LaSalle Medical Associates (“LMA”), Pacific Medical Imaging and Oncology Center, Inc. (“PMIOC”), Diagnostic Medical Group (“DMG”) and AHMC International Cancer Center, a Medical Corporation (“ICC”). APC-LSMA also holds a 100% ownership interest in Maverick Medical Group, Inc. (“MMG”), Alpha Care Medical Group, Inc. (“Alpha Care”), Accountable Health Care IPA, a Professional Medical Corporation ("Accountable Health Care"), and AMG, a Professional Medical Corporation ("AMG").

Alpha Care, an IPA, was acquired 100% by APC-LSMA on May 31, 2019 for an aggregate purchase price of $45.1 million in cash, has been operating in California since 1993 and is a risk bearing organization engaged in providing professional services under capitation arrangements with its contracted health plans through a provider network consisting of primary care and specialty care physicians. Alpha Care specializes in delivering high-quality healthcare to over 174,000 enrollees, as of December 31, 2019, and focuses on Medi-Cal/Medicaid, Commercial, Medicare and Dual Eligible members in the Riverside and San Bernardino counties of Southern California (see Note 3).

Accountable Health Care is a California based IPA that has served the local community in the greater Los Angeles County area through a network of physicians and health care providers for more than 20 years. Accountable Health Care currently has a network of over 400 primary care physicians and 700 specialty care physicians, and five community and regional hospital medical centers that provide quality health care services to more than 84,000 members of three federally qualified health plans and multiple product lines, including Medi-Cal, Commercial, Medicare and the California Healthy Families program. On August 30, 2019, APC and APC-LSMA acquired the remaining outstanding shares of capital stock they did not already own (comprising 75%) for $7.3 million in cash (see Note 3 and Note 6).

AMG is a network of family practice clinics operating in three main locations in Southern California. AMG provides professional and post-acute care services to Medicare, Medi-Cal/Medicaid, and Commercial patients through its networks of doctors and nurse practitioners. On September 10, 2019, APC-LSMA acquired 100% of the aggregate issued and outstanding shares of capital stock of AMG for $1.2 million in cash and $0.4 million of APC common stock (see Note 3).

Universal Care Acquisition Partners, LLC (“UCAP”), a 100% owned subsidiary of APC, was formed on June 4, 2014, for the purpose of holding the investment in Universal Care, Inc. (“UCI”).

APAACO, a wholly-owned subsidiary of ApolloMed, has participated in the next generation accountable care organization (“NGACO") model of the Centers for Medicare & Medicaid Services (“CMS”) since January 2017. The NGACO Model is a new CMS program that allows provider groups to assume higher levels of financial risk and potentially achieve a higher reward from participating in this new attribution-based risk sharing model. In addition to APAACO, NMM and AMM previously operated three accountable care organizations (“ACOs”) that participated in the Medicare Shared Savings Program (“MSSP”), the goal of which was to improve the quality of patient care and outcomes through more efficient and coordinated approach among providers. MSSP revenues are uncertain, and, if such amounts are payable by CMS, they will be paid on an annual basis significantly after the time earned, and are contingent on various factors, including achievement of the minimum savings rate for the relevant period. Such payments are earned and made on an “all or nothing” basis.

AMM, a wholly-owned subsidiary of ApolloMed, manages affiliated medical groups, consisting of ApolloMed Hospitalists (“AMH”), a hospitalist company and Southern California Heart Centers (“SCHC”). AMH provides hospitalist, intensivist and physician advisor services. SCHC is a specialty clinic that focuses on cardiac care and diagnostic testing.

Apollo Care Connect, a wholly-owned subsidiary of ApolloMed, provides a cloud and mobile-based population health management platform that includes digital care plans, a case management module, connectivity with multiple healthcare tracking devices and the ability to integrate with multiple electronic health records to capture clinical data.

2. Basis of Presentation and Summary of Significant Accounting Policies

Basis of Presentation

The accompanying consolidated financial statements have been prepared by management in accordance with accounting principles generally accepted in the United States of America (“U.S. GAAP”).

Principles of Consolidation

The consolidated balance sheets as of December 31, 2019 and 2018 and consolidated statements of income for the years ended December 31, 2019, 2018 and 2017 include the accounts of ApolloMed, its consolidated subsidiaries NMM, AMM, APAACO, and Apollo Care Connect, including ApolloMed's consolidated VIE, AP-AMH, NMM’s subsidiaries, APCN-ACO and AP-ACO, NMM’s consolidated VIE, APC, APC’s subsidiary, UCAP, and APC’s consolidated VIEs, CDSC, APC-LSMA, ICC, and APC-LSMA's consolidated subsidiaries Alpha Care and Accountable Health Care.

All material intercompany balances and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of the consolidated financial statements and related disclosures in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. The more significant items subject to such estimates and assumptions include collectability of receivables, recoverability of long-lived and intangible assets, business combination and goodwill valuation and impairment, accrual of medical liabilities (including historical medical loss ratios ("MLR"), and incurred, but not reported ("IBNR") claims), determination of full-risk revenue and receivables (including constraints and completion factors), income taxes and valuation of share-based compensation. Management evaluates its estimates and assumptions on an ongoing basis using historical experience and other factors, including the current economic environment, and makes adjustments when facts and circumstances dictate. As future events and their effects cannot be determined with precision, actual results could differ materially from those estimates and assumptions.

Variable Interest Entities

On an ongoing basis, as circumstances indicate the need for reconsideration, the Company evaluates each legal entity that is not wholly owned by it in accordance with the consolidation guidance. The evaluation considers all of the Company's variable interests, including equity ownership, as well as management services agreements ("MSA"). To fall within the scope of the consolidation guidance, an entity must meet both of the following criteria:

- The entity has a legal structure that has been established to conduct business activities and to hold assets; such entity can be in the form of a partnership, limited liability company, or corporation, among others; and

- The Company has a variable interest in the legal entity – i.e., variable interests that are contractual, such as equity ownership, or other financial interests that change with changes in the fair value of the entity's net assets.

If an entity does not meet both criteria above, the Company applies other accounting guidance, such as the cost or equity method of accounting. If an entity does meet both criteria above, the Company evaluates such entity for consolidation under either the variable interest model if the legal entity meets any of the following characteristics to qualify as a VIE, or under the voting model for all other legal entities that are not VIEs.

A legal entity is determined to be a VIE if it has any of the following three characteristics:

- The entity does not have sufficient equity to finance its activities without additional subordinated financial support;

- The entity is established with non-substantive voting rights (i.e., where the entity deprives the majority economic interest holder(s) of voting rights); or

- The equity holders, as a group, lack the characteristics of a controlling financial interest. Equity holders meet this criterion if they lack any of the following:

    - The power, through voting rights or similar rights, to direct the activities of the entity that most significantly influence the entity's economic performance, as evidenced by:

        - Substantive participating rights in day-to-day management of the entity's activities; or

        - Substantive kick-out rights over the party responsible for significant decisions;

    - The obligation to absorb the entity's expected losses; or

    - The right to receive the entity's expected residual returns.

If the Company concludes that any of the three characteristics of a VIE are met, the Company will conclude that the entity is a VIE and evaluate it for consolidation under the variable interest model.

Variable interest model

If an entity is determined to be a VIE, the Company evaluates whether the Company is the primary beneficiary. The primary beneficiary analysis is a qualitative analysis based on power and economics. The Company consolidates a VIE if both power and benefits belongs to the Company – that is, the Company (i) has the power to direct the activities of a VIE that most significantly influence the VIE's economic performance (power), and (ii) has the obligation to absorb losses of, or the right to receive benefits from, the VIE that could potentially be significant to the VIE (benefits). The Company consolidates VIEs whenever it is determined that the Company is the primary beneficiary. Refer Note 18 – "Variable Interest Entities (VIEs)" to the consolidated financial statements for information on the Company's consolidated VIE. If there are variable interests in a VIE but the Company is not the primary beneficiary, the Company may account for the investment using the equity method of accounting, refer to Note 6 – "Investments in Other Entities" for entities that qualify as VIEs but the Company is not the primary beneficiary.

Business Combinations

The Company uses the acquisition method of accounting for all business combinations, which requires assets and liabilities of the acquiree to be recorded at fair value, to measure the fair value of the consideration transferred, including contingent consideration, to be determined on the acquisition date, and to account for acquisition related costs separately from the business combination.

Reportable Segments

The Company operates under one reportable segment, the healthcare delivery segment, and implements and operates innovative health care models to create a patient-centered, physician-centric experience. The Company reports its consolidated financial statements in the aggregate, including all activities in one reportable segment.

Reclassifications

Certain amounts disclosed in prior period financial statements have been reclassified to conform to the current period presentation. These reclassifications had no material effect on net income, cash flows or total assets.

Cash and Cash Equivalents

Cash and cash equivalents primarily consist of money market funds and certificates of deposit. The Company considers all highly liquid investments that are both readily convertible into known amounts of cash and mature within ninety days from their date of purchase to be cash equivalents.

The Company maintains its cash in deposit accounts with several banks, which at times may exceed Federal Deposit Insurance Corporation ("FDIC") insured limits. The Company believes it is not exposed to any significant credit risk on its cash and cash equivalents. As of December 31, 2019 and 2018, the Company's deposit accounts with banks exceeded the FDIC's insured limit by approximately $226.5 million, which included approximately $116.5 million in certificates of deposit that was treated as marketable securities (see section below) and $118.6 million, respectively. The Company has not experienced any losses to date and performs ongoing evaluations of these financial institutions to limit the Company's concentration of risk exposure.

Restricted Cash

Restricted cash consists of cash held as collateral to secure standby letters of credits as required by certain contracts. As of December 31, 2019 and December 31, 2018, there was $0.1 million and $0, respectively, included in restricted cash short-term in the accompanying consolidated balance sheets.

Investments in Marketable Securities

The appropriate classification of investments is determined at the time of purchase and such designation is reevaluated at each balance sheet date. As of December 31, 2019 and 2018, marketable securities in the amount of approximately $116.5 million and $1.1 million, consist of certificates of deposit with various financial institutions with maturity dates from four months to twenty-four months (see fair value measurements of financial instruments below). Investments in certificates of deposits are classified as Level 1 investments in the fair value hierarchy.

Receivables and Receivables – Related Parties

The Company's receivables are comprised of accounts receivable, capitation and claims receivable, risk pool settlements and incentive receivables, management fee income and other receivables. Accounts receivable are recorded and stated at the amount expected to be collected.

The Company's receivables – related parties are comprised of risk pool settlements and incentive receivables, management fee income and other receivables. Receivables – related parties are recorded and stated at the amount expected to be collected.

Capitation and claims receivable relate to each health plan's capitation, which is received by the Company in the month following the month of service. Risk pool settlements and incentive receivables mainly consist of the Company's full risk pool receivable that is recorded quarterly based on reports received from our hospital partners and management's estimate of the Company's portion of the estimated risk pool surplus for open performance years. Settlement of risk pool surplus or deficits occurs approximately 18 months after the risk pool performance year is completed. Other receivables include fee-for-services ("FFS") reimbursement for patient care, claims recovery, certain expense reimbursements, and stop loss insurance premium reimbursements.

The Company maintains reserves for potential credit losses on accounts receivable. Management reviews the composition of accounts receivable and analyzes historical bad debts, customer concentrations, customer credit worthiness, current economic trends and changes in customer payment patterns to evaluate the adequacy of these reserves. The Company also regularly analyzes the ultimate collectability of accounts receivable after certain stages of the collection cycle using a look-back analysis to determine the amount of receivables subsequently collected and adjustments are recorded when necessary. Reserves are recorded primarily on a specific identification basis.

Amounts are recorded as a receivable when the Company is able to determine amounts receivable under these contracts and/or agreements based on information provided and collection is reasonably likely to occur. The Company continuously monitors its collections of receivables and its policy is to write off receivables when they are determined to be uncollectible. As of December 31, 2019 and 2018, the Company's allowance for doubtful accounts were approximately $2.9 million and approximately $4.3 million, respectively.

Concentrations of Risks

The Company disaggregates revenue from contracts by service type and payor type. This level of detail provides useful information pertaining to how the Company generates revenue by significant revenue stream and by type of direct contracts. The consolidated statements of income present disaggregated revenue by service type. All of the revenues are generated from healthcare delivery in the state of California. The following table presents disaggregated revenue generated by each payor type:

	Years Ended December 31,		
	2019	**2018**	**2017**
Commercial	$107,339,950	$113,000,115	$116,947,692
Medicare	226,001,659	226,353,120	120,448,509
Medicaid	192,595,964	134,904,142	92,590,894
Other third parties	34,680,524	45,650,375	26,368,835
Revenue	$ 560,618,097	$ 519,907,752	$ 356,355,930

The Company had major payors that contributed the following percentages of net revenue:

	Years Ended December 31,		
	2019	**2018**	**2017**
Payor A	13.6%	14.6%	14.1%
Payor B	13.4%	18.7%	18.1%
Payor C	*%	*%	11.1%
Payor D	*%	14.1%	11.3%
Payor E	11.7%	14.1%	*%
Payor F	12.9%	*%	*%

* Less than 10% of total net revenues

The Company had major payors that contributed to the following percentages of gross receivables:

	As of December 31,	
	2019	**2018**
Payor G	30.4%	34.1%
Payor H	36.0%	42.2%

Land, Property and Equipment, Net

Land is carried at cost and is not depreciated as it is considered to have an infinite useful life.

Property and equipment, including leasehold improvements, are carried at cost less accumulated depreciation and amortization. Depreciation is provided principally on the straight-line method over the estimated useful lives of the assets ranging from three to ten years. Leasehold improvements are amortized on a straight-line basis over the shorter of the terms of the respective leases or the expected useful lives of those improvements.

Maintenance and repairs are charged to expense as incurred. Upon sale or retirement, the asset cost and related accumulated depreciation and amortization is removed from the accounts, and any related gain or loss is included in the determination of consolidated net income.

Fair Value Measurements of Financial Instruments

The Company's financial instruments consist of cash and cash equivalents, restricted cash, investment in marketable securities, receivables, loans receivable – related parties, accounts payable, certain accrued expenses, capital lease obligations, bank loan, and current portion of long-term debt. The carrying values of the financial instruments classified as current in the accompanying consolidated balance sheets are considered to be at their fair values, due to the short maturity of these instruments. The carrying amounts of the loans receivable – related parties, finance lease liabilities, net of current portion, operating lease liabilities, net of current portion, line of credit – related party, and long-term debt approximate fair value as they bear interest at rates that approximate current market rates for debt with similar maturities and credit quality.

Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") 820, *Fair Value Measurement* ("ASC 820"), applies to all financial assets and financial liabilities that are measured and reported on a fair value basis and requires disclosure that establishes a framework for measuring fair value and expands disclosure about fair value measurements. ASC 820 establishes a fair value hierarchy for disclosures of the inputs to valuations used to measure fair value.

This hierarchy prioritizes the inputs into three broad levels as follows:

Level 1 —Inputs are unadjusted quoted prices in active markets for identical assets or liabilities that can be accessed at the measurement date.

Level 2 —Inputs include quoted prices for similar assets and liabilities in active markets, quoted prices for identical or similar *assets* or liabilities in markets that are not active, inputs other than quoted prices that are observable for the asset or liability (i.e., interest rates and yield curves), and inputs that are derived principally from or corroborated by observable market data by correlation or other means (market corroborated inputs).

Level 3 —Unobservable inputs that reflect assumptions about what market participants would use in pricing the asset or liability. These inputs would be based on the best information available, including the Company's own data.

The carrying amounts and fair values of the Company's financial instruments as of December 31, 2019 are presented below:

	Fair Value Measurements			
	Level 1	Level 2	Level 3	Total
Assets				
Money market accounts*	$ 50,731,008	$ —	$ —	$ 50,731,008
Marketable securities – certificates of deposit	116,468,555	—	—	116,468,555
Marketable securities – equity securities	70,118	—	—	70,118
Total	$ 167,269,681	$ —	$ —	$ 167,269,681

The carrying amounts and fair values of the Company's financial instruments as of December 31, 2018 are presented below:

	Fair Value Measurements			
	Level 1	Level 2	Level 3	Total
Assets				
Money market accounts*	$ 85,500,745	$ —	$ —	$ 85,500,745
Marketable securities – certificates of deposit	1,066,103	—	—	1,066,103
Marketable securities – equity securities	60,999	—	—	60,999
Total	$ 86,627,847	$ —	$ —	$ 86,627,847

* *Included in cash and cash equivalents*

There were no Level 2 or Level 3 inputs measured on a recurring or non-recurring basis for the years ended December 31, 2019 and 2018.

There have been no changes in Level 1, Level 2, or Level 3 classifications and no changes in valuation techniques for these assets for the year ended December 31, 2019.

Intangible Assets and Long-Lived Assets

Intangible assets with finite lives include network/payor relationships, management contracts and member relationships and are stated at cost, less accumulated amortization and impairment losses. These intangible assets are amortized on the accelerated method using the discounted cash flow rate.

Intangible assets with finite lives also include a patient management platform and tradename/trademarks whose valuations were determined using the cost to recreate method and the relief from royalty method, respectively. These assets are stated at cost, less accumulated amortization and impairment losses and is amortized using the straight-line method.

Finite-lived intangibles and long-lived assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. If the expected future cash flows from the use of such assets (undiscounted and without interest charges) are less than the carrying value, a write-down would be recorded to reduce the carrying value of the asset to its estimated fair value. Fair value is determined based on appropriate valuation techniques. The Company determined that there was no impairment of its finite-lived intangible or long-lived assets during the year ended December 31, 2019 and 2018. For the year ended December 31, 2017 the Company wrote off the remaining carrying value of the intangible assets of APCN-ACO and AP-ACO of $2.4 million (included in impairment of goodwill and intangible assets in the accompanying consolidated statement of income), as these member relationships are no longer utilized by an entity controlled by NMM and therefore do not provide any future economic benefit.

Goodwill and Indefinite-Lived Intangible Assets

Under FASB ASC 350, *Intangibles – Goodwill and Other* ("ASC 350"), goodwill and indefinite-lived intangible assets are reviewed at least annually for impairment.

At least annually, at the Company's fiscal year end, or sooner if events or changes in circumstances indicate that an impairment has occurred, the Company performs a qualitative assessment to determine whether it is more likely than not that the fair value of each reporting unit is less than its carrying amount as a basis for determining whether it is necessary to complete quantitative impairment assessments for each of the Company's three main reporting units (1) management services, (2) IPA, and (3) ACO. The Company is required to perform a quantitative goodwill impairment test only if the conclusion from the qualitative assessment is that it is more likely than not that a reporting unit's fair value is less than the carrying value of its assets. Should this be the case, a quantitative analysis is performed to identify whether a potential impairment exists by comparing the estimated fair values of the reporting units with their respective carrying values, including goodwill.

The impairment test involves comparing the fair values of the applicable reporting units with their aggregate carrying values, including goodwill. If the carrying value of a reporting unit exceeds the reporting unit's fair value, an impairment loss is recognized for the difference. The fair values of goodwill are determined using valuation techniques based on estimates, judgments and assumptions management believes are appropriate in the circumstances.

At least annually, indefinite-lived intangible assets are tested for impairment. Impairment for intangible assets with indefinite lives exists if the carrying value of the intangible asset exceeds its fair value. The fair values of indefinite-lived intangible assets are determined using valuation techniques based on estimates, judgments and assumptions management believes are appropriate in the circumstances.

The Company wrote off indefinite-lived intangible assets of approximately $2.0 million related to Medicare licenses, acquired as part of the Merger, and approximately $3.8 million of goodwill related to MMG during the years endedDecember 31, 2019 and December 31, 2018, respectively, as the Company will no longer utilized these assets and therefore these assets will not provide any future economic benefits. The write-offs are included in impairment of goodwill and intangible assets in the accompanying consolidated statements of income (refer to Note 3 and 5). There was no impairment of indefinite-lived intangible assets for the year ended December 31, 2017.

Investments in Other Entities – Equity Method

Equity Method

The Company accounts for certain investments using the equity method of accounting when it is determined that the investment provides the Company with the ability to exercise significant influence, but not control, over the investee. Significant influence is generally deemed to exist if the Company has an ownership interest in the voting stock of the investee of between 20% and 50%, although other factors, such as representation on the investee's board of directors, are considered in determining whether the equity method of accounting is appropriate. Under the equity method of accounting, the investment, originally recorded at cost, is adjusted to recognize the Company's share of net earnings or losses of the investee and is recognized in the accompanying consolidated statements of income under "Loss from equity method investments" and also is adjusted by contributions to and distributions from the investee. Equity method investments are subject to impairment evaluation. During the years ended December 31, 2019, the Company recognized an impairment loss of approximately $0.3 million related to its investment in PASC as the Company does not believe it will recover its investment balance. Such impairment loss is included in loss from equity method investments in the accompanying consolidated statements of income. There was no impairment loss recorded related to equity method investments for the years ended December 31, 2018 and 2017.

Medical Liabilities

APC, Alpha Care, Accountable Health Care, APAACO and MMG are responsible for integrated care that the associated physicians and contracted hospitals provide to its enrollees. APC, Alpha Care, Accountable Health Care, APAACO and MMG provide integrated care to HMOs, Medicare and Medi-Cal enrollees through a network of contracted providers under sub-capitation and direct patient service arrangements. Medical costs for professional and institutional services rendered by contracted providers are recorded as cost of services expenses in the accompanying consolidated statements of income.

An estimate of amounts due to contracted physicians, hospitals, and other professional providers is included in medical liabilities in the accompanying consolidated balance sheets. Medical liabilities include claims reported as of the balance sheet date and estimated IBNR claims. Such estimates are developed using actuarial methods and are based on numerous variables, including the utilization of health care services, historical payment patterns, cost trends, product mix, seasonality, changes in membership, and other factors. The estimation methods and the resulting reserves are periodically reviewed and updated. Many of the medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various

services. Such differing interpretations may not come to light until a substantial period of time has passed following the contract implementation.

During the year ended December 31, 2017, as APAACO's NGACO program was new and there was insufficient claims history, the medical liabilities for the NGACO program were estimated and recorded at 100% of the revenue less actual claims processed for or paid to in-network providers. The Company was notified by CMS that under the NGACO alternative payment arrangement the Company was paid an excess amount of approximately $34.5 million and $7.8 million related to the first performance year (January 1, 2017 through December 31, 2017) and second performance year (February 1, 2018 through December 31, 2018) with 18 month claims run outs, respectively. The excess amount for the first performance year was paid by the Company on December 4, 2018, the excess for the second performance year will be paid in February 2020 and have been accrued in accounts payable and accrued expense account in the accompanying consolidated balance sheet as of December 31, 2019 and 2018. The excess amount related to the first performance year was previously accrued as part of the medical liabilities accrual on December 31, 2017. In 2018 and 2019, the Company had sufficient claims history and was able to estimate such IBNR amount using the aforementioned method.

Revenue Recognition

The Company receives payments from the following sources for services rendered: (i) commercial insurers; (ii) the federal government under the Medicare program administered by CMS; (iii) state governments under the Medicaid and other programs; (iv) other third party payors (e.g., hospitals and IPAs); and (v) individual patients and clients.

On January 1, 2018, the Company adopted the new revenue recognition standard Accounting Standards Update ("ASU") 2014-09, "Revenue from Contracts with Customers (Topic 606)", using the modified retrospective method. Modified retrospective adoption requires entities to apply the standard retrospectively to the most current period presented in the financial statements, requiring the cumulative effect of the retrospective application as an adjustment to the opening balance of retained earnings and noncontrolling interests at the date of initial application. Revenue from substantially all of the Company's contracts with customers continues to be recognized over time as services are rendered. The Company has elected to apply the modified retrospective method only to contracts not completed as of January 1, 2018. The 2017 comparative information has not been restated and continues to be reported under the accounting standards in effect for that period ("ASC 605") (See Note 16).

Under the new revenue standard, the Company has elected to apply the following practical expedients and optional exemptions:

- Recognize incremental costs of obtaining a contract with amortization periods of one year or less as expense when incurred. These costs are recorded within general and administrative expenses.

- Recognize revenue in the amount of consideration to which the Company has a right to invoice the customer if that amount corresponds directly with the value to the customer of the Company's services completed to date.

- Exemptions from disclosing the value of unsatisfied performance obligations for (i) contracts with an original expected length of one year or less, (ii) contracts for which revenue is recognized in the amount of consideration to which the Company has a right to invoice for services performed, and (iii) contracts for which variable consideration is allocated entirely to a wholly unsatisfied performance obligation or to a wholly unsatisfied promise to transfer a distinct service that forms part of a single performance obligation.

- Use a portfolio approach for the fee-for-service (FFS) revenue stream to group contracts with similar characteristics and analyze historical cash collections trends.

- No adjustment is made for the effects of a significant financing component as the period between the time of service and time of payment is typically one year or less.

Nature of Services and Revenue Streams

Revenue primarily consists of capitation revenue, risk pool settlements and incentives, NGACO All-Inclusive Population-Based Payments ("AIPBP") revenue, management fee income, and FFS revenue. Revenue is recorded in the period in which services are rendered or the period in which the Company is obligated to provide services. The form of billing and related risk of collection for such services may vary by type of revenue and the customer. The following is a summary of the principal forms of the Company's billing arrangements and how revenue is recognized for each.

Capitation, net

Managed care revenues of the Company consist primarily of capitated fees for medical services provided by the Company under a capitated arrangement directly made with various managed care providers including HMOs. Capitation revenue is typically prepaid monthly to the Company based on the number of enrollees selecting the Company as their healthcare provider. Under both ASC 605 and ASC 606, capitation revenue is recognized in the month in which the Company is obligated to provide services to plan enrollees under contracts with various health plans. Minor ongoing adjustments to prior months' capitation, primarily arising from contracted HMOs finalizing their monthly patient eligibility data for additions or subtractions of enrollees, are recognized in the month they are communicated to the Company. Additionally, Medicare pays capitation using a "Risk Adjustment" model, which compensates managed care organizations and providers based on the health status (acuity) of each individual enrollee. Health plans and providers with higher acuity enrollees will receive more and those with lower acuity enrollees will receive less. Under Risk Adjustment, capitation is determined based on health severity, measured using patient encounter data. Capitation is paid on a monthly basis based on data submitted for the enrollee for the preceding year and is adjusted in subsequent periods after the final data is compiled. Positive or negative capitation adjustments are made for Medicare enrollees with conditions requiring more or less healthcare services than assumed in the interim payments. Since the Company cannot reliably predict these adjustments, periodic changes in capitation amounts earned as a result of Risk Adjustment are recognized when those changes are communicated by the health plans to the Company.

PMPM managed care contracts generally have a term of one year or longer. All managed care contracts have a single performance obligation that constitutes a series for the provision of managed healthcare services for a population of enrolled members for the duration of the contract. The transaction price for PMPM contracts is variable as it primarily includes PMPM fees associated with unspecified membership that fluctuates throughout the contract. In certain contracts, PMPM fees also include adjustments for items such as performance incentives, performance guarantees and risk shares. The Company generally estimates the transaction price using the most likely methodology and amounts are only included in the net transaction price to the extent that it is probable that a significant reversal of cumulative revenue will not occur once any uncertainty is resolved. The majority of the Company's net PMPM transaction price relates specifically to the Company's efforts to transfer the service for a distinct increment of the series (e.g. day or month) and is recognized as revenue in the month in which members are entitled to service.

Risk Pool Settlements and Incentives

APC enters into full risk capitation arrangements with certain health plans and local hospitals, which are administered by a third party, where the hospital is responsible for providing, arranging and paying for institutional risk and APC is responsible for providing, arranging and paying for professional risk. Under a full risk pool sharing agreement, APC generally receives a percentage of the net surplus from the affiliated hospital's risk pools with HMOs after deductions for the affiliated hospitals costs. Advance settlement payments are typically made quarterly in arrears if there is a surplus. Under ASC 605, the Company has historically recognized revenue from risk pool settlements under arrangements with health plans and hospitals when such amounts are known as the related revenue amounts were not deemed to be fixed and determinable until that time. Under ASC 606, risk pool settlements under arrangements with health plans and hospitals are recognized using the most likely amount methodology and amounts are only included in revenue to the extent that it is probable that a significant reversal of cumulative revenue will not occur once any uncertainty is resolved. The assumptions for historical MLR, IBNR completion factor and constraint percentages were used by management in applying the most likely amount methodology.

Under capitated arrangements with certain HMOs APC participates in one or more shared risk arrangements relating to the provision of institutional services to enrollees (shared risk arrangements) and thus can earn additional revenue or incur losses based upon the enrollee utilization of institutional services. Shared risk capitation arrangements are entered into with certain health plans, which are administered by the health plan, where APC is responsible for rendering professional services, but the health plan does not enter into a capitation arrangement with a hospital and therefore the health plan retains the institutional risk. Shared risk deficits, if any, are not payable until and unless (and only to the extent of any) risk sharing surpluses are generated. At the termination of the HMO contract, any accumulated deficit will be extinguished.

Under ASC 605, the Company has historically recognized revenue from risk pool settlements under arrangements with HMOs when such amounts are known. Under ASC 606, risk pool settlements under arrangements with HMOs are recognized, using the most likely methodology, and only included in revenue to the extent that it is probable that a significant reversal of cumulative revenue will not occur. Given the lack of access to the health plans' data and control over the members assigned to APC, the adjustments and/or the withheld amounts are unpredictable and as such APC's risk share revenue is deemed to be fully constrained until APC is notified of the amount by the health plan. Risk pools for the prior contract years are generally final settled in the third or fourth quarter of the following year.

In addition to risk-sharing revenues, the Company also receives incentives under "pay-for-performance" programs for quality medical care, based on various criteria. As an incentive to control enrollee utilization and to promote quality care, certain HMOs have designed quality incentive programs and commercial generic pharmacy incentive programs to compensate the Company for our efforts to improve the quality of services and efficient and effective use of pharmacy supplemental benefits provided to HMO members. The incentive programs track specific performance measures and calculate payments to the Company based on the performance measures. Under ASC 605, the Company has historically recognized incentives under "pay-for-performance" programs when such amounts are known as the related revenue amounts were not deemed to be fixed and determinable until that time. Under ASC 606, incentives under "pay-for-performance" programs are recognized using the most likely methodology. However, as the Company does not have sufficient insight from the health plans on the amount and timing of the shared risk pool and incentive payments these amounts are considered to be fully constrained and only recorded when such payments are known and/or received.

Generally, for the foregoing arrangements, the final settlement is dependent on each distinct day's performance within the annual measurement period but cannot be allocated to specific days until the full measurement period has occurred and performance can be assessed. As such, this is a form of variable consideration estimated at contract inception and updated through the measurement period (i.e. the contract year), to the extent the risk of reversal does not exist and the consideration is not constrained.

NGACO AIPBP Revenue

APAACO and CMS entered into a Next Generation ACO Model Participation Agreement (the "Participation Agreement") with an initial term oftwo performance years through December 31, 2018, which has been extended for anothertwo renewal years.

For each performance year, the Company shall submit to CMS its selections for risk arrangement; the amount of the profit/loss cap; alternative payment mechanism; benefits enhancements, if any; and its decision regarding voluntary alignment under the NGACO Model. The Company must obtain CMS consent before voluntarily discontinuing any benefit enhancement during a performance year.

Under the NGACO Model, CMS aligns beneficiaries to the Company to manage (direct care and pay providers) based on a budgetary benchmark established with CMS. The Company is responsible for managing medical costs for these beneficiaries. The beneficiaries will receive services from physicians and other medical service providers that are both in-network and out-of-network. The Company receives capitation from CMS on a monthly basis to pay claims from in-network providers. The Company records such capitation received from CMS as revenue as the Company is primarily responsible and liable for managing the patient care and for satisfying provider obligations, is assuming the credit risk for the services provided by in-network providers through its arrangement with CMS, and has control of the funds, the services provided and the process by which the providers are ultimately paid. Claims from out-of-network providers are processed and paid by CMS and the Company's shared savings or losses in managing the services provided by out-of-network providers are generally determined on an annual basis after reconciliation with CMS. Pursuant to the Company's risk share agreement with CMS, the Company will be eligible to receive the savings or be liable for the deficit according to the budget established by CMS based on the Company's efficiency or lack thereof, respectively, in managing how the beneficiaries aligned to the Company by CMS are served by in-network and out-of-network providers. The Company's savings or losses on providing such services are both capped by CMS, and are subject to significant estimation risk, whereby payments can vary significantly depending upon certain patient characteristics and other variable factors. Accordingly, the Company recognizes such surplus or deficit upon substantial completion of reconciliation and determination of the amounts. Under both ASC 605 and ASC 606, the Company records NGACO capitation revenues monthly, as that is when the Company is obligated to provide services to its members. Excess, over claims paid plus an estimate for the related IBNR (see Note 9), monthly capitation received are deferred and recorded as a liability until actual claims are paid or incurred. CMS will determine if there were any excess capitation paid for the performance year and the excess is refunded to CMS.

For each performance year, CMS shall pay the Company in accordance with the alternative payment mechanism, if any, for which CMS has approved the Company; the risk arrangement for which the Company has been approved by CMS; and as otherwise provided in the Participation Agreement. Following the end of each performance year and at such other times as may be required under the Participation Agreement, CMS will issue a settlement report to the Company setting forth the amount of any shared savings or shared losses and the amount of other monies. If CMS owes the Company shared savings or other monies, CMS shall pay the Company in full within 30 days after the date on which the relevant settlement report is deemed final, except as provided in the Participation Agreement. If the Company owes CMS shared losses or other monies owed as a result of a final settlement, the Company shall pay CMS in full within 30 days after the relevant settlement report is deemed final. If the Company fails to pay the amounts due to CMS in full within 30 days after the date of a demand letter or settlement report, CMS shall assess simple interest on the unpaid balance at the rate applicable to other Medicare debts under current provisions of law and applicable

regulations. In addition, CMS and the U.S. Department of the Treasury may use any applicable debt collection tools available to collect any amounts owed by the Company.

The Company participates in the AIPBP track of the NGACO Model. Under the AIPBP track, CMS estimates the total annual expenditures for APAACO's assigned patients and pays that projected amount to the Company in monthly installments, and the Company is responsible for all Part A and Part B costs for in-network participating providers and preferred providers contracted by the Company to provide services to the assigned patients.

As APAACO does not have sufficient insight into the financial performance of the shared risk pool with CMS because of unknown factors related to IBNR, risk adjustment factors, stop loss provisions, among other factors, an estimate cannot be developed. Due to these limitations, APAACO cannot determine the amount of surplus or deficit that will probably not be reversed in the future and therefore this shared risk pool revenue is considered fully constrained. The Company received $0.9 million and $5.9 million in risk pool savings, related to the 2018 and 2017 performance year, respectively, and have recognized it as revenue in risk pool settlements and incentives in the accompanying consolidated statements of income for the year ended December 31, 2019 and 2018, respectively.

In October 2017, CMS notified the Company that it would not be renewed for participation in the AIPBP mechanism of the NGACO Model for performance year 2018 due to certain alleged deficiencies in performance. The Company submitted a reconsideration request. In December 2017, the Company received the official decision on its reconsideration request that CMS reversed the prior decision against the Company's continued participation in the AIPBP mechanism. As a result, beginning in February 2018, the Company was eligible to receive monthly AIPBP at a rate of approximately $7.3 million per month from CMS, which was reduced to $5.5 million per month beginning October 1, 2018. The Company will need to continue to comply with all terms and conditions in the Participation Agreement and various regulatory requirements to be eligible to participate in the AIPBP mechanism and/or NGACO Model. The Company continues to be eligible in receiving AIPBP under the NGACO Model for performance year 2019, with the effective date of the performance year beginning April 1, 2019. The monthly AIPBP received by the Company for performance year 2019 was approximately $8.3 million per month for the period from April 1, 2019 through August 30, 2019. Subsequently, CMS adjusted the AIPBP to approximately $3.7 million for the period starting September 1, 2019 based on CMS' updated estimate of total claims to be incurred. The Company has received approximately $56.1 million in total AIPBP for the year ended December 31, 2019 of which $56.1 million has been recognized as revenue. The Company also recorded assets of approximately $6.5 million related to recoverable claims paid during the year ended December 31, 2019 which will be administered following instructions from CMS, a receivable of $8.5 million related to IBNR incurred, $3.0 million related to final settlement of the 2017 performance year, and $0.9 million related to the Company's shared risk earnings for the 2018 performance year. These balances are included in "Other receivables" in the accompanying consolidated balance sheet.

Management Fee Income

Management fee income encompasses fees paid for management, physician advisory, healthcare staffing, administrative and other non-medical services provided by the Company to IPAs, hospitals and other healthcare providers. Such fees may be in the form of billings at agreed-upon hourly rates, percentages of revenue or fee collections, or amounts fixed on a monthly, quarterly or annual basis. The revenue may include variable arrangements measuring factors such as hours staffed, patient visits or collections per visit against benchmarks, and, in certain cases, may be subject to achieving quality metrics or fee collections. Under both ASC 605 and ASC 606, such variable supplemental revenues are recognized as revenue in the period when such amounts are determined to be fixed and therefore contractually obligated as payable by the customer under the terms of the respective agreement. The Company's MSA revenue also includes revenue sharing payments from the Company's partners based on their non-medical services.

The Company provides a significant service of integrating the services selected by the Company's clients into one overall output for which the client has contracted. Therefore, such management contracts generally contain a single performance obligation. The nature of the Company's performance obligation is to stand ready to provide services over the contractual period. Also, the Company's performance obligation forms a series of distinct periods of time over which the Company stands ready to perform. The Company's performance obligation is satisfied as the Company completes each period's obligations.

Consideration from management contracts is variable in nature because the majority of the fees are generally based on revenue or collections, which can vary from period to period. The Company has control over pricing. Contractual fees are invoiced to the Company's clients generally monthly and payment terms are typically due within 30 days. The variable consideration in the Company's management contracts meets the criteria to be allocated to the distinct period of time to which it relates because (i) it

is due to the activities performed to satisfy the performance obligation during that period and (ii) it represents the consideration to which the Company expects to be entitled.

The Company's management contracts generally have long terms (e.g., ten years), although they may be terminated earlier under the terms of the respective contracts. Since the remaining variable consideration will be allocated to a wholly unsatisfied promise that forms part of a single performance obligation recognized under the series guidance, the Company has applied the optional exemption to exclude disclosure of the allocation of the transaction price to remaining performance obligations.

Fee-for-Service Revenue

FFS revenue represents revenue earned under contracts in which the Company bills and collects the professional component of charges for medical services rendered by the Company's contracted physicians and employed physicians. Under the FFS arrangements, the Company bills, and receive payments from, the hospitals and third-party payors for physician staffing and further bills patients or their third-party payors for patient care services provided. Under both ASC 605 and ASC 606, FFS revenue related to the patient care services is reported net of contractual allowances and policy discounts and are recognized in the period in which the services are rendered to specific patients. All services provided are expected to result in cash flows and are therefore reflected as net revenue in the financial statements. The recognition of net revenue (gross charges less contractual allowances) from such services is dependent on such factors as proper completion of medical charts following a patient visit, the forwarding of such charts to the Company's billing center for medical coding and entering into the Company's billing system and the verification of each patient's submission or representation at the time services are rendered as to the payor(s) responsible for payment of such services. Revenue is recorded based on the information known at the time of entering of such information into the Company's billing systems as well as an estimate of the revenue associated with medical services.

The Company is responsible for confirming member eligibility, performing program utilization review, potentially directing payment to the provider and accepting the financial risk of loss associated with services rendered, as specified within the Company's client contracts. The Company has the ability to adjust contractual fees with clients and possess the financial risk of loss in certain contractual obligations. These factors indicate the Company is the principal and, as such, the Company records gross fees contracted with clients in revenues.

Consideration from FFS arrangements is variable in nature because fees are based on patient encounters, credits due to clients and reimbursement of provider costs, all of which can vary from period to period. Patient encounters and related episodes of care and procedures qualify as distinct goods and services, provided simultaneously together with other readily available resources, in a single instance of service, and thereby constitute a single performance obligation for each patient encounter and, in most instances, occur at readily determinable transaction prices. As a practical expedient, the Company adopted a portfolio approach for the FFS revenue stream to group contracts with similar characteristics and analyze historical cash collections trends. The contracts within the portfolio share the characteristics conducive to ensuring that the results do not materially differ under the new standard if it were to be applied to individual patient contracts related to each patient encounter. Accordingly, there was not a change in the Company's method to recognize revenue under ASC 606 from the previous accounting guidance.

Estimating net FFS revenue is a complex process, largely due to the volume of transactions, the number and complexity of contracts with payors, the limited availability at times of certain patient and payor information at the time services are provided, and the length of time it takes for collections to fully mature. These expected collections are based on fees and negotiated payment rates in the case of third-party payors, the specific benefits provided for under each patient's healthcare plans, mandated payment rates in the case of Medicare and Medicaid programs, and historical cash collections (net of recoveries) in combination with expected collections from third party payors.

The relationship between gross charges and the transaction price recognized is significantly influenced by payor mix, as collections on gross charges may vary significantly, depending on whether and with whom the patients the Company provides services to in the period are insured and the Company's contractual relationships with those payors. Payor mix is subject to change as additional patient and payor information is obtained after the period services are provided. The Company periodically assesses the estimates of unbilled revenue, contractual adjustments and discounts, and payor mix by analyzing actual results, including cash collections, against estimates. Changes in these estimates are charged or credited to the consolidated statement of income in the period that the assessment is made. Significant changes in payor mix, contractual arrangements with payors, specialty mix, acuity, general economic conditions and health care coverage provided by federal or state governments or private insurers may have a significant impact on estimates and significantly affect the results of operations and cash flows.

Contract Assets

Typically, revenues and receivables are recognized once the Company has satisfied its performance obligation. Accordingly, the Company's contract assets are comprised of receivables and receivables – related parties. Generally, the Company does not have material amounts of other contract assets.

The Company's billing and accounting systems provide historical trends of cash collections and contractual write-offs, accounts receivable aging and established fee adjustments from third-party payors. These estimates are recorded and monitored monthly as revenues are recognized. The principal exposure for uncollectible fee for service visits is from self-pay patients and, to a lesser extent, for co-payments and deductibles from patients with insurance.

Contract Liabilities (Deferred Revenue)

Contract liabilities are recorded when cash payments are received in advance of the Company's performance, or in the case of the Company's NGACO, the excess of AIPBP capitation received and the actual claims paid or incurred. The Company's contract liability balance was $8.9 million and $9.1 million as of December 31, 2019 and December 31, 2018, respectively, and is presented within the "Accounts Payable and Accrued Expenses" line item of the accompanying consolidated balance sheets. Approximately $0.5 million of the Company's contracted liability accrued in2018 has been recognized as revenue during the year endedDecember 31, 2019.

Income Taxes

Federal and state income taxes are computed at currently enacted tax rates less tax credits using the asset and liability method. Deferred taxes are adjusted both for items that do not have tax consequences and for the cumulative effect of any changes in tax rates from those previously used to determine deferred tax assets or liabilities. Tax provisions include amounts that are currently payable, changes in deferred tax assets and liabilities that arise because of temporary differences between the timing of when items of income and expense are recognized for financial reporting and income tax purposes, changes in the recognition of tax positions and any changes in the valuation allowance caused by a change in judgment about the realizability of the related deferred tax assets. A valuation allowance is established when necessary to reduce deferred tax assets to amounts expected to be realized.

The Company uses a recognition threshold of more-likely-than-not and a measurement attribute on all tax positions taken or expected to be taken in a tax return in order to be recognized in the financial statements. Once the recognition threshold is met, the tax position is then measured to determine the actual amount of benefit to recognize in the financial statements.

Basic and Diluted Earnings Per Share

Basic earnings per share ("EPS") is computed by dividing net income attributable to common shareholders by the weighted average number of common shares outstanding during the periods presented. Diluted earnings per share is computed using the weighted average number of common shares outstanding plus the effect of dilutive securities outstanding during the periods presented, using treasury stock method. See Note 17 for a discussion of shares treated as treasury shares for accounting purposes.

The weighted-average number of common shares outstanding (the denominator of the EPS calculation) during the period in which the reverse acquisition occurred (2017) was computed as follows:

a) The number of common shares outstanding from the beginning of that period to the acquisition date was computed on the basis of the weighted-average number of common shares of the legal acquiree (accounting acquirer - NMM) outstanding during the period multiplied by the exchange ratio established in the Merger.

b) The number of common shares outstanding from the acquisition date to the end of that period was the actual number of common shares of the legal acquirer (the accounting acquire -ApolloMed) outstanding during that period.

Noncontrolling Interests

The Company consolidates entities in which the Company has a controlling financial interest. The Company consolidates subsidiaries in which the Company holds, directly or indirectly, more than 50% of the voting rights, and variable interest entities (VIEs) in which the Company is the primary beneficiary. Noncontrolling interests represent third-party equity ownership interests (including certain VIEs) in the Company's consolidated entities. The amount of net income attributable to noncontrolling interests is disclosed in the consolidated statements of income.

Mezzanine Equity

Based on the shareholder agreements for APC, in the event of a disqualifying event, as defined in the agreements, APC could be required to repurchase the shares from their respective shareholders based on certain triggers outlined in the shareholder agreements. As the redemption feature of the shares is not solely within the control of APC, the equity of APC does not qualify as permanent equity and has been classified as mezzanine or temporary equity. Accordingly, the Company recognizes noncontrolling interests in APC as mezzanine equity in the consolidated financial statements. APC's shares are not redeemable and it is not probable that the shares will become redeemable as of December 31, 2019 and 2018.

Recent Accounting Pronouncements

In February 2016, the FASB issued ASU No. 2016-02, Leases (Topic 842) ("ASC 842"), which amends the existing accounting standards for leases to increase transparency and comparability among organizations by requiring the recognition of right-of-use assets and lease liabilities on the balance sheet. Most prominent among the changes in the standard is the recognition of right-of-use assets and lease liabilities by lessees for those leases classified as operating leases. Under the standard, disclosures are required to meet the objective of enabling users of financial statements to assess the amount, timing, and uncertainty of cash flows arising from leases.

The Company adopted ASC 842 effective January 1, 2019 on a modified retrospective basis using the following practical expedients as permitted under the transition guidance within the new standard; (i) not reassess whether any expired or existing contracts are or contain leases; not reassess the lease classification for any expired or existing leases; not reassess initial direct costs for existing leases; and (ii) use hindsight in determining the lease term and in assessing impairment of the entity's right-of-use assets. The Company has also implemented additional internal controls to enable future preparation of financial information in accordance with ASC 842.

The standard had a material impact on our consolidated balance sheets, but did not materially impact our consolidated results of operations and had no impact on cash flows. The most significant impact was the recognition of right-of-use assets of $9.0 million and lease liabilities of $8.9 million for operating leases on the date of adoption, while our accounting for finance leases remained substantially unchanged. The 2018 comparative information has not been restated and continues to be reported under the accounting standards in effect for that period (ASC 840). See Note 19 for further details.

In addition, the Company elected practical expedients for ongoing accounting that is provided by the new standard comprised of the following: (1) the election for classes of underlying asset to not separate non-lease components from lease components, and (2) the election for short-term lease recognition exemption for all leases under 12 months term.

In June 2016, the FASB issued ASU No. 2016-13, "Financial Instruments-Credit Losses (Topic 326)-Measurement of Credit Losses on Financial Instruments" ("ASU 2016-13"). The new standard requires entities to measure all expected credit losses for financial assets held at the reporting date based on historical experience, current conditions and reasonable and supportable forecasts. ASU 2016-13 became effective on January 1, 2020. Based on the composition of the Company's investment portfolio and historical credit loss activity of receivables, the adoption of ASU 2016-13 is not expected to have a material impact on its consolidated financial statements.

In July 2017, the FASB issued ASU No. 2017-11, "Earnings Per Share (Topic 260): Distinguishing Liabilities from Equity (Topic 480); Derivatives and Hedging (Topic 815): (Part 1) Accounting for Certain Financial Instruments with Down Round Features, (Part II) Replacement of the Indefinite Deferral for Mandatorily Redeemable Financial Instruments of Certain Nonpublic Entities and Certain Mandatorily Redeemable Non-controlling Interests with a Scope Exception" ("ASU 2017-11"). The amendments in Part I of this Update change the classification analysis of certain equity-linked financial instruments (or embedded features) with down round features. When determining whether certain financial instruments should be classified as liabilities or equity instruments, a down round feature no longer precludes equity classification when assessing whether the instrument is indexed to an entity's own stock. The amendments also clarify existing disclosure requirements for equity-classified instruments. The amendments in Part 1 of this update are effective for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2018. Early adoption is permitted, including adoption in any interim period. If an entity early adopts the amendments in an interim period, any adjustments should be reflected as of the beginning of the fiscal year that includes that interim period. The Company adopted ASU 2017-11 on January 1, 2019. The adoption of ASU 2017-11 did not have a material impact on the Company's consolidated financial statements.

In October 2018, the FASB issued ASU No. 2018-17, “Consolidation (Topic 810): Targeted Improvements to Related Party Guidance for Variable Interest Entities” (“ASU 2018-17”). This ASU reduces the cost and complexity of financial reporting associated with consolidation of variable interest entities (VIEs). A VIE is an organization in which consolidation is not based on a majority of voting rights. The new guidance supersedes the private company alternative for common control leasing arrangements issued in 2014 and expands it to all qualifying common control arrangements. The amendments in this ASU are effective for fiscal years beginning after December 15, 2019, and interim periods within those fiscal years. The adoption of ASU 2018-17 is not expected to have a material impact on its consolidated financial statements.

In December 2019, the FASB issued ASU No. 2019-12, "Income Taxes (Topic 740): Simplifying the Accounting for Income Taxes" ("ASU 2019-12"). This ASU simplifies the accounting for income taxes by eliminating certain exceptions to the guidance in ASC 740 related to the approach for intraperiod tax allocation, the methodology for calculating income taxes in an interim period and the recognition of deferred tax liabilities for outside basis differences. The amendments in this ASU are effective for fiscal years beginning after December 15, 2020, and interim periods within those fiscal years. The Company is currently assessing the impact of the adoption of ASU 2019-12 will have on the Company's consolidated financial statements.

In January 2020, the FASB issued ASU No. 2020-01, "Investments - Equity Securities (Topic 321), Investments - Equity Method and Joint Ventures (Topic 323), and Derivatives and Hedging (Topic 815)" ("ASU 2020-01"). This ASU clarifies the interaction between accounting for equity securities, equity method investments and certain derivative instruments. This amendment in this ASU are effective for fiscal years beginning after December 15, 2020, and interim periods within those fiscal years. The Company is currently assessing the impact of the adoption of ASU 2020-01 will have on the Company's consolidation financial statements.

With the exception of the new standards discussed above, there have been no other new accounting pronouncements that have significance, or potential significance, to the Company’s financial position, results of operations and cash flows.

3. Business Combination and Goodwill

On December 8, 2017, (the “Effective Time”) the merger (the “Merger”) of ApolloMed’s wholly-owned subsidiary, Apollo Acquisition Corp., with Network Medical Management, Inc. was completed, in accordance with the terms and conditions of the Agreement and Plan of Merger, dated as of December 21, 2016 (as amended on March 30, 2017 and October 17, 2017), by and among the Company, Merger Sub, NMM and Kenneth Sim, M.D., as the NMM shareholders’ representative. As a result of the Merger, NMM now is a wholly-owned subsidiary of ApolloMed and former NMM shareholders own a majority of the issued and outstanding common stock of the Company and control the Board of ApolloMed. As of the Effective Time, the Company’s board of directors approved a change in the Company’s fiscal year end from March 31 to December 31.

Pursuant to the Merger Agreement, at the Effective Time, each issued and outstanding share of NMM common stock converted into the right to receive (i) such number of fully paid and nonassessable shares of ApolloMed’s common stock that resulted in the NMM shareholders having a right to receive an aggregate number of shares of ApolloMed’s common stock that represented 82% of the total issued and outstanding shares of ApolloMed common stock immediately following the Effective Time, withno NMM dissenting shareholder interests as of the Effective Time (the “exchange ratio”), plus (ii) an aggregate of 2,566,666 ApolloMed’s common stock, with no NMM dissenting shareholder interests as of the Effective Time, and (iii) common stock warrants to purchase a pro-rata portion of an aggregate of 850,000 shares of common stock of ApolloMed, exercisable at $11.00 per share and warrants to purchase an aggregate of900,000 shares of common stock of ApolloMed at$10.00 per share. At the Effective Time, pre-Merger ApolloMed stockholders held their existing shares of ApolloMed’s common stock. At the Effective Time, ApolloMed held back 10% of the total number of shares of ApolloMed’s common stock issuable to pre-Merger NMM shareholders in the Merger to secure indemnification of ApolloMed and its affiliates under the Merger Agreement. Separately, indemnification of pre-Merger NMM shareholders under the Merger Agreement was made by the issuance by ApolloMed to pre-Merger NMM shareholders of new additional shares of common stock (capped at the same number of shares of ApolloMed’s common stock as are subject to the holdback for the indemnification of ApolloMed). These holdback shares will be held for a period of up to 24 months after the closing of the Merger (to be distributed on a pro-rata basis to former NMM shareholders), during which ApolloMed may seek indemnification for any breach of, or noncompliance with, any provision of the Merger agreement, by NMM. Half of these shares will be issued on the first and second anniversary of the Effective Time respectively. As of December 31, 2019 all holdback shares had been released.

For purposes of calculating the exchange ratio, (A) the aggregate number of shares of ApolloMed common stock held by the NMM shareholders immediately following the Effective Time excluded (i) any shares of ApolloMed common stock owned by NMM shareholders immediately prior to the Effective Time, (ii) the Series A warrant and Series B warrant issued by ApolloMed to NMM to purchase ApolloMed common stock (the “ApolloMed Warrants”) and (iii) any shares of ApolloMed common stock issued or

issuable to NMM shareholders pursuant to the exercise of the ApolloMed Warrants, and (B) the total number of issued and outstanding shares of ApolloMed common stock immediately following the Effective Time excluded 520,081 shares of ApolloMed common stock issued or issuable under a Convertible Promissory Note to Alliance Apex, LLC ("Alliance"), whose 50% member and manager is a member of ApolloMed's board of directors, for $5.0 million and accrued interest pursuant to the Securities Purchase Agreement between ApolloMed and Alliance dated as of March 30, 2017.

The consideration for the transaction was 18% of the total issued and outstanding shares of ApolloMed common stock, or 6,109,205 (immediately following the Merger).

In addition, the fair value of NMM's 50% interest in APAACO, an entity that was owned 50% by ApolloMed and 50% by NMM, was remeasured at fair value as of the Effective Time and added to the consideration transferred to ApolloMed as a result of NMM relinquishing its equity investment in APAACO in order to obtain control of ApolloMed. The fair value of NMM's noncontrolling interest in APAACO was $5.1 million.

Total purchase consideration consisted of the following:

Equity consideration (1)	$	61,092,050
Fair value of ApolloMed preferred stock held by NMM (2)		19,118,000
Fair value of NMM's noncontrolling interest in APAACO (3)		5,129,000
Fair value of the outstanding ApolloMed stock options (4)		1,055,333
Total purchase consideration	**$**	**86,394,383**

(1) Equity consideration

Immediately following the Effective Time, pre-merger ApolloMed stockholders continued to hold an aggregate of 6,109,205 shares of ApolloMed common stock.

The equity consideration, which represents a portion of the consideration deemed transferred to the pre-Merger ApolloMed stockholders in the Merger, is calculated based on the number of shares of the combined company that the pre-Merger ApolloMed stockholders would own as of the closing of the Merger.

Number of shares of the combined company that would be owned by pre-Merger ApolloMed stockholders(*)		6,109,205
Multiplied by the price per share of ApolloMed's common stock(**)	$	10.00
Equity Consideration	$	61,092,050

(*) Represents the number of shares of the combined company that pre-Merger ApolloMed stockholders would own at closing of the Merger.

(**) Represents the closing price of ApolloMed's common stock on December 8, 2017.

(2) Fair value of ApolloMed's preferred shares held by NMM

NMM currently owns all the shares of ApolloMed Series A preferred stock and Series B preferred stock, which were acquired prior to the Merger. As part of the Merger, the ApolloMed Series A preferred stock and Series B preferred stock are remeasured at fair value and included as part of the consideration transferred to ApolloMed. The fair value of the Series A preferred stock and Series B preferred stock is reflective of the liquidation preferences, claims of priority and conversion option values thereof. In aggregate, the Series A preferred stock and Series B preferred stock were valued to be $19.1 million. The valuation methodology was based on an Option Pricing Method ("OPM") which utilized the observable publicly traded common stock price in valuing the Series A preferred stock and the Series B preferred stock within the context of the capital structure of the Company. OPM assumptions included an expected term of 2 years, volatility rate of 37.9%, and a risk-free rate of 1.8%. The fair value of the liquidation preference for the Series A preferred stock and the Series B preferred stock was determined to be $12.7 million and the fair value of the conversion option was determined to be $6.4 million or an aggregate total fair value of $19.1 million.

(3) Fair value of NMM's 50% share of APA ACO Inc.

Prior to the Merger, APAACO was owned 50% by ApolloMed and 50% NMM. NMM's noncontrolling interest in APAACO has been remeasured at fair value as of the closing date and is added to the consideration transferred to ApolloMed as a result of NMM relinquishing its equity investment in APAACO in order to obtain control of ApolloMed. The fair value of NMM's noncontrolling interest in APAACO has been estimated to be $5.1 million using the discounted cash flow method and NMM recorded a gain on investment for the same amount to reflect the fair value of this investment prior the Merger.

(4) Fair value of the ApolloMed outstanding stock options

The fair value of the outstanding ApolloMed stock options is included in consideration transferred in accordance with ASC 805. The outstanding ApolloMed stock options are expected to vest in conjunction with the Merger due to a pre-existing change-of-control provision associated with the awards. There is no future service requirement.

The following table sets forth the final allocation of the purchase consideration to the identifiable tangible and intangible assets acquired and liabilities assumed of ApolloMed and MMG (see "MMG Transaction" below), with the excess recorded as goodwill:

		Balance Sheet
Assets acquired		
Cash and cash equivalents	$	36,367,555
Accounts receivable, net		7,261,588
Other receivables		3,211,028
Prepaid expenses		249,193
Property, plant and equipment, net		1,114,332
Restricted cash		745,220
Fair value of intangible assets acquired		14,984,000
Deferred tax assets		2,498,417
Other assets		217,241
Goodwill		86,197,395
Accounts payable and accrued liabilities		(8,632,893)
Medical liabilities		(39,353,540)
Line of credit		(25,000)
Convertible note payable, net		(5,376,215)
Convertible note payable - related party		(9,921,938)
Noncontrolling interest		(3,142,000)
Net assets acquired	$	86,394,383
Total purchase consideration	$	86,394,383

During the year ended December 31, 2018, goodwill related to the Merger increased by $0.7 million due to the $0.9 million increase in the fair value of the outstanding ApolloMed stock options, which was partially offset by the $0.2 million decrease in the related deferred tax asset with a commensurate adjustment recorded to additional paid in capital. In addition, during the year ended December 31, 2018, goodwill and deferred tax assets decreased by $0.9 million resulting from an adjustment associated with the allocation of the Merger transaction costs. As a result, in aggregate, during the year ended December 31, 2018, goodwill decreased by $0.2 million.

Convertible Note Payable – Related Party

On March 30, 2017, ApolloMed issued a Convertible Promissory Note to Alliance Apex, LLC ("Alliance Note") for $5.0 million. Alliance's 50% member and manager is a member of ApolloMed's board of directors. The Alliance Note was due and payable to Alliance Apex, LLC on (i) March 31, 2018, or (ii) the date on which the Change of Control Transaction is terminated, whichever occurs first. As a result of the Merger, the Alliance Note together with the accrued and unpaid interest, automatically converted

into shares of the Company's common stock, at a conversion price of$10.00 per share (see Note 12). The Alliance Note was guaranteed by NMM prior to its conversion.

Pro Forma Combined Historical Results

The pro forma combined historical results, as if ApolloMed had been acquired as of January 1, 2017, are estimated as follows (unaudited):

		Year Ended December 31, 2017
Net revenues	$	478,873,780
Net income attributable to Apollo Medical Holdings, Inc.	$	9,982,706
Weighted average common shares outstanding:		
Basic		25,525,786
Earnings per share:		
Basic	$	0.39
Weighted average common shares outstanding:		
Diluted		28,661,735
Earnings per share:		
Diluted	$	0.35

The pro forma information has been prepared for comparative purposes only and does not purport to be indicative of what would have occurred had the acquisition actually been made at such date, nor is it necessarily indicative of future operating results.

Alpha Care Medical Group, Inc.

On May 31, 2019, APC and APC-LSMA completed their acquisition of 100% of the capital stock of Alpha Care from Dr. Kevin Tyson for an aggregate purchase price of approximately $45.1 million in cash, subject to post-closing adjustments. As part of the transaction the Company deposited$2.0 million into an escrow account for potential post-closing adjustments. As of December 31, 2019 no post-closing adjustment is expected to be paid to Dr. Tyson and the full amount of the escrow account is expected to be returned to the Company. As such, the escrow amount is presented within Prepaid expenses and other current assets in the accompanying consolidated balance sheet.

The following table summarizes the preliminary estimated fair values of the assets acquired and liabilities assumed, as of the acquisition date:

		Preliminary Balance Sheet
Assets acquired		
Cash and cash equivalents	$	3,568,554
Accounts receivable, net		10,335,664
Other current assets		4,360,850
Network relationship intangible assets		22,636,000
Goodwill		28,585,209
Accounts payable		(2,776,631)
Deferred tax liabilities		(6,334,368)
Medical liabilities		(15,319,714)
Net assets acquired	$	45,055,564
Cash paid	$	45,055,564

Accountable Health Care, IPA

On August 30, 2019, APC and APC-LSMA, acquired the remaining outstanding shares of capital stock they did not already own (comprising 75%) in Accountable Health Care in exchange for $7.3 million in cash. In addition to the payment of $7.3 million APC assumed all assets and liabilities of Accountable Health Care, including loans payable to NMM and APC of $15.4 million, which has been eliminated upon consolidation. Including the 25% investment valued at $2.4 million already owned by APC the total purchase price was $25.1 million (see Note 6).

The following table summarizes the preliminary estimated fair values of the assets acquired and liabilities assumed, as of the acquisition date:

		Preliminary Balance Sheet
Assets acquired		
Cash and cash equivalents	$	581,965
Accounts receivable, net		5,150,060
Other current assets		198,056
Network relationship intangible assets		11,411,000
Goodwill		23,018,675
Accounts payable		(3,211,349)
Medical liabilities		(12,154,726)
Subordinated loan		(15,327,013)
Net assets acquired	$	9,666,668
Equity investment contributed	$	2,416,668
Cash paid	$	7,250,000

The Company also completed one additional acquisition (AMG) on September 10, 2019 for total consideration of $1.6 million, of which $0.4 million was in the form of APC common stock. The business combination did not meet the quantitative thresholds to require separate disclosures based on the Company's consolidated net assets, investments and net income.

Pro Forma Financial Information for All 2019 Acquisitions

The following unaudited pro forma supplemental information is based on estimates and assumptions that ApolloMed believes are reasonable. However, this information is not necessarily indicative of the Company's consolidated results of income in future periods or the results that actually would have been realized if ApolloMed and the acquired businesses had been combined companies during the periods presented. These pro forma results exclude any savings or synergies that would have resulted from these business acquisitions had they occurred on January 1, 2018. This unaudited pro forma supplemental information includes incremental intangible asset amortization and other charges as a result of the acquisitions, net of the related tax effects.

The supplemental information on an unaudited pro forma financial basis presents the combined results of ApolloMed and its 2019 acquisitions as if each acquisition had occurred on January 1, 2018:

	Year Ended December 31, 2019 (unaudited)	Year Ended December 31, 2018 (unaudited)
Revenue	$ 658,010,954	$ 726,074,752
Net income	$ 10,867,496	$ 58,879,491
Net income attributable to Apollo Medical Holdings, Inc.	$ 7,310,724	$ 9,447,002
EPS - Basic	$ 0.21	$ 0.29
EPS - Diluted	$ 0.20	$ 0.25

The acquisitions were accounted for under the acquisition method of accounting. The fair value of the consideration for the acquired company was allocated to acquired tangible and intangible assets and liabilities based upon their fair values. The excess of the purchase consideration over the fair value of the net tangible and identifiable intangible assets acquired were recorded as goodwill. The determination of the fair value of assets and liabilities acquired requires the Company to make estimates and use valuation techniques when market value is not readily available. The results of operations of the company acquired have been included in the Company's financial statements from the respective dates of acquisition. Transaction costs associated with business acquisitions are expensed as they are incurred.

At the time of acquisition, the Company estimates the amount of the identifiable intangible assets based on a valuation and the facts and circumstances available at the time. The Company determines the final value of the identifiable intangible assets as soon as information is available, but not more than 12 months from the date of acquisition.

Goodwill is not deductible for tax purposes.

The following is a summary of goodwill activity for the years endedDecember 31, 2019 and 2018:

	Amount
Balance at January 1, 2018	$ 189,847,202
Adjustments	(242,456)
Impairment - (MMG)	(3,798,866)
Balance at December 31, 2018	$ 185,805,880
Acquisitions	52,699,324
Balance at December 31, 2019	$ 238,505,204

During December 31, 2018, the Company wrote off the remaining goodwill balance of MMG of$3.8 million (included in impairment of goodwill and intangible assets in the accompanying consolidated statements of income), as MMG was no longer utilized and therefore did not provide any future economic benefit.

4. Land, Property and Equipment, Net

Land, property and equipment, net consisted of:

	December 31, 2019	December 31, 2018
Land	$ 3,300,000	$ 3,300,000
Buildings	2,357,709	2,326,189
Computer software	3,088,508	2,929,317
Furniture and equipment	12,584,619	11,786,345
Construction in progress	167,248	144,008
Leasehold improvements	6,654,993	6,236,189
	28,153,077	26,722,048
Less accumulated depreciation and amortization	(16,023,176)	(14,000,966)
Land, property and equipment, net	$ 12,129,901	$ 12,721,082

As of December 31, 2019 and 2018, the Company had finance leases totaling$0.5 million and $0.6 million, respectively, included in Land, property and equipment, net in the accompanying consolidated balance sheets.

Depreciation expense was $2.0 million, $2.2 million and $1.6 million for the years ended December 31, 2019, 2018, and 2017, respectively, which is included in depreciation and amortization in the accompanying consolidated statements of income.

5. Intangible Assets, Net

At December 31, 2019, intangible assets, net consisted of the following:

	Useful Life (Years)	Gross January 1, 2019	Additions	Impairment/ Disposal	Gross December 31, 2019	Accumulated Amortization	Net December 31, 2019
Indefinite Lived Assets:							
Medicare license	N/A	$ 1,994,000	$ —	$ (1,994,000)	$ —	$ —	$ —
Amortized Intangible Assets:							
Network relationships	11-15	109,883,000	34,047,000	—	143,930,000	(60,524,996)	83,405,004
Management contracts	15	22,832,000	—	—	22,832,000	(9,676,381)	13,155,619
Member relationships	12	6,696,000	—	—	6,696,000	(2,352,133)	4,343,867
Patient management platform	5	2,060,000	—	—	2,060,000	(858,329)	1,201,671
Tradename/trademarks	20	1,011,000	—	—	1,011,000	(105,312)	905,688
		$ 144,476,000	$ 34,047,000	$ (1,994,000)	$ 176,529,000	$ (73,517,151)	$ 103,011,849

At December 31, 2018, intangible assets, net consisted of the following:

	Useful Life (Years)	Gross January 1, 2018	Additions	Impairment/ Disposal	Gross December 31, 2018	Accumulated Amortization	Net December 31, 2018
Indefinite Lived Assets:							
Medicare license	N/A	$ 1,994,000	$ —	$ —	$ 1,994,000	$ —	$ 1,994,000
Amortized Intangible Assets:							
Network relationships	11-15	109,883,000	—	—	109,883,000	(48,361,773)	61,521,227
Management contracts	15	22,832,000	—	—	22,832,000	(7,447,581)	15,384,419
Member relationships	12	6,696,000	—	—	6,696,000	(1,289,667)	5,406,333
Patient management platform	5	2,060,000	—	—	2,060,000	(446,333)	1,613,667
Tradename/trademarks	20	1,011,000	—	—	1,011,000	(54,763)	956,237
		$ 144,476,000	$ —	$ —	$ 144,476,000	$ (57,600,117)	$ 86,875,883

Amortization expense was $16.3 million, $17.1 million and $17.5 million (including $0.3 million, $0.4 million and $0.4 million of amortization expense for exclusivity incentives) for the years ended December 31, 2019, 2018, and 2017, respectively, which is included in depreciation and amortization in the accompanying consolidated statements of income.

During the year ended December 31, 2019, the Company wrote off indefinite-lived intangible assets of $2.0 million related to Medicare licenses it acquired as part of the Merger. The Company will no longer utilize these licenses and as such the Company will not receive future economic benefits.

Future amortization expense is estimated to be as follows for the years ending December 31:

	Amount
2020	$ 16,026,000
2021	14,542,000
2022	12,673,000
2023	10,842,000
2024	9,830,000
Thereafter	39,099,000
	$ 103,012,000

6. Investments in Other Entities

Equity Method

Investments in other entities – equity method consisted of the following:

	December 31, 2019	December 31, 2018
Universal Care, Inc.	$ 1,438,199	$ 2,635,945
LaSalle Medical Associates – IPA Line of Business	6,396,706	7,054,888
Diagnostic Medical Group	2,334,083	2,257,346
Pacific Medical Imaging & Oncology Center, Inc.	1,395,878	1,359,494
Pacific Ambulatory Surgery Center, LLC	—	285,198
Accountable Health Care IPA	—	4,977,957
531 W. College, LLC	16,697,898	16,273,152
MWN, LLC	164,691	33,000
	$ 28,427,455	$ 34,876,980

LaSalle Medical Associates - IPA Line of Business

LMA was founded by Dr. Albert Arteaga in 1996 and currently operates six neighborhood medical centers through its network of more than2,300 PCP and Specialists providers, treating children, adults and seniors in San Bernardino County. LMA's patients are primarily served by Medi-Cal and they also accept Blue Cross, Blue Shield, Molina, Care 1st, Health Net and Inland Empire Health Plan. LMA is also an IPA of independently contracted doctors, hospitals and clinics, delivering high quality care to more than 310,000 patients in Fresno, Kings, Los Angeles, Madera, Riverside, San Bernardino and Tulare Counties. During 2012, APC-LSMA and LMA entered into a share purchase agreement whereby APC-LSMA invested $5.0 million for a 25% interest in LMA's IPA line of business. NMM has a management services agreement with LMA. APC accounts for its investment in LMA under the equity method as APC has the ability to exercise significant influence, but not control over LMA's operations. For the year ended December 31, 2019, APC recorded a net loss of $2.8 million from its investment in LMA as compared to net loss of $2.4 million for the year ended December 31, 2018, in the accompanying consolidated statements of income. During the year ended December 31, 2019, the Company contributed $2.1 million to LMA as part of its 25% interest. The investment balance was $6.4 million and $7.1 million at December 31, 2019 and 2018, respectively.

LMA's IPA line of business unaudited summarized balance sheets at December 31, 2019 and 2018 and unaudited summarized statements of operations for the years ended December 31, 2019 and 2018 are as follows:

Balance Sheets

	December 31, 2019 (unaudited)	December 31, 2018 (unaudited)
Assets		
Cash and cash equivalents	$ 6,345,195	$ 18,444,702
Receivables, net	5,123,228	2,897,337
Other current assets	3,526,319	5,459,442
Loan receivable	2,250,000	1,250,000
Restricted cash	683,358	667,414
Total assets	17,928,100	28,718,895
Liabilities and Stockholders' (Deficit) Equity		
Current liabilities	$ 23,529,745	$ 26,837,814
Stockholders' (deficit) equity	(5,601,645)	1,881,081
Total liabilities and stockholders' (deficit) equity	$ 17,928,100	$ 28,718,895

Statements of Operations

	Year Ended December 31, 2019 (unaudited)	Year Ended December 31, 2018 (unaudited)
Revenues	$ 194,020,435	$ 239,031,485
Expenses	205,153,162	251,738,193
Loss from operations	(11,132,727)	(12,706,708)
Other Income	—	173,356
Loss before income tax benefit	(11,132,727)	(12,533,352)
Income tax benefit	—	(3,334,332)
Net loss	$ (11,132,727)	$ (9,199,020)

Pacific Medical Imaging and Oncology Center, Inc.

PMIOC was incorporated in 2004 in the state of California. PMIOC provides comprehensive diagnostic imaging services using state-of-the-art technology. PMIOC offers high quality diagnostic services such as MRI/MRA, PET/CT, CT, nuclear medicine, ultrasound, digital x-rays, bone densitometry and digital mammography at their facilities.

In July 2015, APC-LSMA and PMIOC entered into a share purchase agreement whereby APC-LSMA invested$1.2 million for a 40% ownership in PMIOC.

APC and PMIOC have an Ancillary Service Contract together whereby PMIOC provides covered services on behalf of APC to enrollees of the plans of APC. Under the Ancillary Service Contract APC paid PMIOC fees of $2.7 million and $2.5 million for the years ended December 31, 2019 and 2018, respectively. APC accounts for its investment in PMIOC under the equity method of accounting as APC has the ability to exercise significant influence, but not control over PMIOC's operations. During the year ended December 31, 2019, APC recorded net income of$36,384 from its investment as compared to net loss of$41,199 for the

year ended December 31, 2018 in the accompanying consolidated statements of income and has an investment balance of $1.4 million at December 31, 2019 and 2018, respectively.

Universal Care, Inc.

UCI is a privately held health plan that has been in operation since 1985 in order to help its members through the complexities of the healthcare system. UCI holds a license under the California Knox-Keene Health Care Services Plan Act (Knox-Keene Act) to operate as a full-service health plan. UCI contracts with the CMS under the Medicare Advantage Prescription Drug Program.

On August 10, 2015, UCAP, an entity solely owned 100% by APC with APC's executives, Dr. Thomas Lam, Dr. Pen Lee and Dr. Kenneth Sim, as designated managers, purchased from UCI 100,000 shares of UCI class A-2 voting common stock (comprising 48.9% of the total outstanding UCI shares, but 50% of UCI's voting common stock) for $10 million. APC accounts for its investment in UCI under the equity method of accounting as APC has the ability to exercise significant influence, but not control over UCI's operations.

During the years ended December 31, 2019 and 2018, APC recorded losses from this investment of $1.2 million and $6.0 million, respectively, in the accompanying consolidated statements of income and has an investment balance of $1.4 million and $2.6 million at December 31, 2019 and 2018, respectively.

UCI's unaudited balance sheets at December 31, 2019 and 2018 and unaudited statements of operations for the years ended December 31, 2019 and 2018 are as follows:

Balance Sheets

	December 31, 2019 (unaudited)	December 31, 2018 (unaudited)
Assets		
Cash	$ 33,889,962	$ 27,812,520
Receivables, net	63,843,009	46,978,703
Other current assets	38,280,156	18,670,350
Other assets	882,243	661,621
Property and equipment, net	4,021,341	2,786,996
Total assets	$ 140,916,711	$ 96,910,190
Liabilities and stockholders' deficit		
Current liabilities	$ 128,330,389	$ 89,731,133
Other liabilities	33,132,948	25,024,043
Stockholders' deficit	(20,546,626)	(17,844,986)
Total liabilities and stockholders' deficit	$ 140,916,711	$ 96,910,190

Statements of Operations

	Year Ended December 31, 2019 (unaudited)	Year Ended December 31, 2018 (unaudited)
Revenues	$ 500,374,910	$ 326,719,634
Expenses	502,566,659	335,242,582
Loss before income tax provision	(2,191,749)	(8,522,948)
Income tax provision	257,628	3,692,818
Net loss	$ (2,449,377)	$ (12,215,766)

Diagnostic Medical Group

APC accounts for its 40% investment in DMG, under the equity method of accounting as APC-LSMA, a designated shareholder professional corporation, has the ability to exercise significant influence, but not control over DMG's operations. APC recorded income from this investment of $0.3 million and $1.0 million in 2019 and 2018, respectively, in the accompanying consolidated statements of income. During the years ended December 31, 2019 and 2018, APC received dividends of $0.2 million and $0.6 million, respectively, from DMG. The investment balance was $2.3 million December 31, 2019 and 2018, respectively.

Pacific Ambulatory Surgery Center, LLC

Pacific Ambulatory Surgery Center, LLC ("PASC"), a California limited liability company, is a multi-specialty outpatient surgery center that is certified to participate in the Medicare program and is accredited by the Accreditation Association for Ambulatory Health Care. PASC has entered into agreements with organizations such as healthcare service plans, independent practice associations, medical groups and other purchasers of healthcare services for the arrangement of the provision of outpatient surgery center services to subscribers or enrollees of such health plans. APC accounts for its 40% investment in PASC under the equity method of accounting as APC has the ability to exercise significant influence, but not control over PASC's operations.

During the year ended December 31, 2019, the Company recognized an impairment loss of $0.3 million related to its investment in PASC as the Company does not believe it will recover its investment balance. Such impairment loss is included in loss from equity method investment in the accompanying consolidated statement of income.

During the year ended December 31, 2018, APC recorded a loss from this investment of $0.3 million, in the accompanying consolidated statements of income and has an investment balance of $0.3 million at December 31, 2018.

Accountable Health Care, IPA

Accountable Health Care is a California professional medical corporation that has served the local community in the greater Los Angeles County area through a network of physicians and health care providers for more than 20 years. Accountable currently has a network of over 400 primary and 700 specialty care physicians, and five community and regional hospital medical centers that provide quality health care services to more than 84,000 members of three federally qualified health plans and multiple product lines, including Medi-Cal, Commercial, Medicare and Healthy Families.

On September 21, 2018, APC and NMM each exercised their option to convert their respective $5.0 million loans into shares of Accountable capital stock (see Note 7). As a result, APC's $5.0 million loan was converted into a 25% equity interest with the remaining $5.0 million loan held by NMM to be converted into an equity interest that will be determined based on a third party valuation of Accountable's current enterprise value. On August 30, 2019, APC and APC-LSMA entered into separate agreements with Dr. Jayatilaka to acquire the remaining outstanding shares of capital stock (comprising 75%) of Accountable Health Care in exchange for $7.3 million in cash. In addition to the payment of $7.3 million, APC assumed all liabilities and assets of Accountable Health Care (See Note 3 and Note 7).

The Company recognized a gain of approximately $1.8 million as a result of the transaction, which represented the difference between the fair value of the 25% ownership held and the Company's basis at the time of acquisition. Such gain is included in loss from equity method investment in the accompanying consolidated statements of income for the year ended December 31, 2019.

Effective September 1, 2019, Accountable Health Care's financial result is included in the consolidated balance sheets and the consolidated statements of income for the year ended December 31, 2019.

531 W. College LLC

In June 2018, College Street Investment LP, a California limited partnership ("CSI"), a related party, APC and NMM, entered into an operating agreement to govern the limited liability company, 531 W. College, LLC and the conduct of its business, and to specify their relative rights and obligations. CSI, APC and NMM, each owns 50%, 25% and 25%, respectively, of member units based on initial capital contributions of $16.7 million, $8.3 million, and $8.3 million, respectively.

On June 29, 2018, 531 W. College, LLC closed its purchase of a non-operational hospital located in Los Angeles from Societe Francaise De Bienfaisance Mutuelle De Los Angeles, a California nonprofit corporation, for a total purchase price of $33.3 million. In June 2018, APC, NMM and AMHC Healthcare, Inc. on behalf of CSI, wired $8.3 million, $8.3 million and $16.7 million, respectively into an escrow account for the benefit of 531 W. College, LLC to purchase the hospital pursuant to the Purchase Agreement. The transaction closed on June 28, 2018. On April 23, 2019, NMM and APC entered into an agreement whereby NMM assigned and APC assumed NMM's 25% membership interest in 531 W. College, LLC for approximately $8.3 million. Subsequently, APC has a 50% ownership in 531 W. College LLC with a total investment balance of approximately $16.1 million.

APC accounts for its investment in 531 W. College, LLC under the equity method of accounting as APC has the ability to exercise significant influence, but not control over the operations of this joint venture. APC's investment is presented as an investment of equity method in the accompanying consolidated balance sheets as of December 31, 2019 and 2018.

During the years ended December 31, 2019 and 2018, NMM and APC recorded losses from its investment in 531 W. College LLC of $0.2 million and $0.4 million, respectively, in the accompanying consolidated statements of income. During the year ended December 31, 2019, APC contributed $0.7 million to 531 W. College, LLC as part of its 50% interest. The accompanying consolidated balance sheet includes the related investment balance of $16.7 million and $16.3 million, respectively, related to APC's investment at December 31, 2019 and APC's and NMM's investment at December 31, 2018.

531 W. College LLC's unaudited balance sheet at and unaudited statement of operations for the years ended December 31, 2019 and 2018 are as follows:

Balance Sheet

	December 31, 2019 (unaudited)	December 31, 2018 (unaudited)
Assets		
Cash	$ 139,436	$ 158,088
Other current assets	16,500	16,137
Other assets	70,000	70,000
Property and equipment, net	33,581,438	33,394,792
Total assets	$ 33,807,374	$ 33,639,017
Liabilities and Stockholders' Equity		
Current liabilities	$ 1,061,577	$ 1,007,413
Stockholders' equity	32,745,797	32,631,604
Total liabilities and stockholders' equity	$ 33,807,374	$ 33,639,017

Statement of Operations

	Year Ended December 31, 2019 (unaudited)	Year Ended December 31, 2018 (unaudited)
Revenues	$ —	$ —
Expenses	1,010,423	875,771
Loss from operations	(1,010,423)	(875,771)
Other income	474,617	162,451
Net loss	$ (535,806)	$ (713,320)

MWN LLC

On December 18, 2018, NMM along with 6 Founders LLC, a California limited liability company doing business as Pacific6 Enterprises ("Pacific6"), and Health Source MSO Inc., a California corporation ("HSMSO") entered into an operating agreement to govern MWN Community Hospital, LLC and the conduct of its business and to specify their relative rights and obligations. NMM, Pacific6, and HSMSO each owns 33.3% of membership shares based on each member's initial capital contributions of $3,000 and working capital contributions of $30,000. NMM invested an additional $0.3 million, as part of its 33.3% interest, for working capital purpose. As of December 31, 2019 and 2018, NMM's investment balance of $0.2 million and $33,000 are included in investments in other entities - equity method in the accompanying consolidated balance sheet.

Investment in privately held entities

MediPortal, LLC

In May 2018, APC purchased 270,000 membership interests of MediPortal LLC, a New York limited liability company, for $0.4 million or $1.50 per membership interest, which represented approximately 2.8% ownership. APC also received a 5-year warrant to purchase 270,000 membership interests. A 5-year option to purchase an additional 380,000 membership interests and a 5-year warrant to purchase 480,000 membership interests are contingent upon the portal completion date, which has not been completed as of December 31, 2019. As APC does not have the ability to exercise significant influence, and lacks control, over the investee, this investment is accounted for using a measurement alternative which allows the investment to be measured at cost, adjusted for observable price changes and impairments, with changes recognized in net income. During the year ended December 31, 2019 there were no observable price changes to our investment.

AchievaMed

On July 1, 2019, NMM and AchievaMed, Inc. a California corporation ("AchievaMed") entered into an agreement in which NMM would purchase up to 50% of the aggregate shares of capital stock of AchievaMed over a period of time not to exceed five years. As a result of this transaction, NMM invested $0.5 million for a 10% interest. The related investment balance of $0.5 million is included in "Investment in a privately held entities" in the accompanying consolidated balance sheet as of December 31, 2019. As NMM does not have the ability to exercise significant influence, and lacks control, over the investee, this investment is accounted for using a measurement alternative which allows the investment to be measured at cost, adjusted for observable price changes and impairments, with changes recognized in net income. During the year ended December 31, 2019 there were no observable price changes to our investment.

7. Loans Receivable and Loans Receivable – Related Parties

Loan Receivable

Dr. Albert Arteaga

On June 28, 2019, APC entered into a convertible secured promissory note with Dr. Albert H. Arteaga, M.D. ("Dr. Arteaga"), Chief Executive Officer of LMA, to loan $6.4 million to Dr. Arteaga. Interest on the loan accrues at a rate that is equal to the prime rate plus 1% (5.75% as of December 31, 2019) and payable in monthly installments of interest only on the first day of each month until the maturity date of June 28, 2020, at which time, all outstanding principal and accrued interest thereon shall be due and payable in full. The note is secured by certain shares of LMA common stock held by Dr. Arteaga.

At any time on or before June 28, 2020, and upon written notice by APC to Dr. Arteaga, APC has the right, but not the obligation, to convert the entire outstanding principal amount of this note into shares of LMA common stock which equal 21.25% of the aggregate then-issued and outstanding shares of LMA common stock to be held by APC's designee, which may include APC-LSMA. If converted, APC-LSMA and APC's designee will collectively own 46.25% of the equity of LMA with the remaining 53.75% to be owned by Dr. Arteaga. The entire note receivable has been classified under loans receivable - related parties in the consolidated balance sheet in the amount of $6.4 million as of December 31, 2019.

Loans Receivable - Related Parties

Accountable Health Care IPA

On August 30, 2019, APC and APC-LSMA acquired the remaining outstanding shares of capital stock they did not already own (comprising 75%) in Accountable Health Care in exchange for $7.3 million in cash. In addition to the payment of $7.3 million APC assumed all assets and liabilities of Accountable Health Care, these liabilities include the loan payable due to NMM of $5.0 million and the remaining loan receivable of $7.3 million originally to be paid to George M. Jayatilaka, M.D. As a result of the net loans assumed, APC recognized a gain of $2.3 million recorded in other income in the accompanying consolidated statement of income for the year ended December 31, 2019. All loan payables and receivables has been eliminated upon consolidation (see Note 3 and Note 6).

Universal Care, Inc.

In 2015, APC advanced $5.0 million on behalf of UCAP to UCI for working capital purposes. On June 29, 2018, November 28, 2018 and December 13, 2019 APC advanced an additional $2.5 million, $5.0 million and $4.0 million, respectively. The loans accrue interest at the prime rate plus 1%, or 5.75% and 6.50%, as of December 31, 2019 and 2018, respectively, with interest to be paid monthly. The entire note receivable has been classified under loans receivable - related parties in the consolidated balance sheets in the amount of $16.5 million and $12.5 million as of December 31, 2019 and 2018, respectively. As part of the stock purchase agreement to sell UCI, between UCAP, Bright Health Company of California, Inc., a California corporation, Bright Health, Inc., a Delaware corporation, and UCI, the outstanding loans receivable will be repaid prior to close of the transaction, which is subject to certain closing conditions, including but not limited to, certain regulatory or governmental filings and approvals having been made or obtained, and receipt of various third party consents.

8. Accounts Payable and Accrued Expenses

Accounts payable and accrued expenses consisted of the following:

	December 31, 2019	December 31, 2018
Accounts payable	$ 6,914,680	$ 4,481,544
Capitation payable	2,812,652	300,000
Subcontractor IPA payable	3,360,282	2,532,750
Professional fees	1,837,434	2,251,741
Due to related parties	225,000	1,488,313
Contract liabilities	8,891,966	9,024,235
Accrued compensation	3,237,565	4,996,906
	$ 27,279,579	$ 25,075,489

9. Medical Liabilities

Medical liabilities consisted of the following:

	December 31, 2019	December 31, 2018
Balance, beginning of year	$ 33,641,701	$ 63,972,318
Acquired (see Note 3)	27,474,440	—
Claims paid for previous year	(33,396,932)	(36,549,348)
Claims paid on acquired liabilities	(25,236,286)	—
Incurred health care costs	274,670,676	209,002,961
Claims paid for current year	(218,564,072)	(167,537,480)
Payment to CMS	—	(34,464,826)
Adjustments	135,155	(781,924)
Balance, end of year	$ 58,724,682	$ 33,641,701

10. Credit Facility, Bank Loan and Lines of Credit - Related Party

Credit Facility

The Company's credit facility consisted of the following:

	December 31, 2019
Term Loan A	$ 187,625,000
Revolver Loan	60,000,000
Total Debt	247,625,000
Less: current portion of debt	(9,500,000)
Less: unamortized financing cost	(5,952,866)
Long-term debt	$ 232,172,134

The following table presents scheduled maturities of the Company's credit facility as of December 31, 2019:

	Amount
2020	$ 9,500,000
2021	10,687,500
2022	14,250,000
2023	15,437,500
2024	197,750,000
Total	$ 247,625,000

Credit Agreement

On September 11, 2019, the Company entered into a secured credit agreement (the “Credit Agreement”) with SunTrust Bank, in its capacity as administrative agent for the lenders (in such capacity, the “Agent”), as a lender, an issuer of letters of credit and as swingline lender, and Preferred Bank, which is affiliated with one of the Company's board members, JPMorgan Chase Bank, N.A.,

MUFG Union Bank, N.A., Royal Bank of Canada, Fifth Third Bank and City National Bank, as lenders (the “Lenders”). In connection with the closing of the Credit Agreement, the Company, its subsidiary, NMM, and the Agent entered into a Guaranty and Security Agreement (the “Guaranty and Security Agreement”), pursuant to which, among other things, NMM guaranteed the obligations of the Company under the Credit Agreement.

The Credit Agreement provides for a five-year revolving credit facility to the Company of $100.0 million ("Revolver Loan"), which includes a letter of credit subfacility of up to $25.0 million. As of December 31, 2019 the Company has outstanding letters of credit totaling $14.8 million and the Company has $25.2 million available under the revolving credit facility. The Credit Agreement also provides for a term loan of $190.0 million, ("Term Loan A"). The unpaid principal amount of the term loan is payable in quarterly installments on the last day of each fiscal quarter commencing on December 31, 2019. The principal payment for each of the first eight fiscal quarters is $2.4 million, for the following eight fiscal quarters thereafter is $3.6 million and for the following three fiscal quarters thereafter is $4.8 million. The remaining principal payment on the term loan is due on September 11, 2024.

The proceeds of the term loan and up to $60.0 million of the revolving credit facility may be used to (i) finance a portion of the $545.0 million loan made by the Company to AP-AMH Medical Corporation, a California professional medical corporation (“AP-AMH”), concurrently with the closing of the Credit Agreement (the “AP-AMH Loan”) as described in the May 13, 2019, Current Report and the August 29, 2019, Current Report, (ii) refinance certain indebtedness of the Company and its subsidiaries and, indirectly, APC, (iii) pay transaction costs and expenses arising in connection with the Credit Agreement, the AP-AMH Loan and certain other related transactions and (iv) provide for working capital, capital expenditures and other general corporate purposes. The remainder of the revolving credit facility will be used to finance future acquisitions and investments and to provide for working capital needs, capital expenditures and other general corporate purposes.

The Company is required to pay an annual facility fee of 0.20% to 0.35% on the available commitments under the Credit Agreement, regardless of usage, with the applicable fee determined on a quarterly basis based on the Company’s leverage ratio. The Company is also required to pay customary fees as specified in a separate fee agreement between the Company and SunTrust Robinson Humphrey, Inc., the lead arranger of the Credit Agreement.

Amounts borrowed under the Credit Agreement will bear interest at an annual rate equal to either, at the Company’s option, (a) the rate for Eurocurrency deposits for the corresponding deposits of U.S. dollars appearing on Reuters Screen LIBOR01 Page (“LIBOR”), adjusted for any reserve requirement in effect, plus a spread of from 2.00% to 3.00%, as determined on a quarterly basis based on the Company’s leverage ratio, or (b) a base rate, plus a spread of 1.00% to 2.00%, as determined on a quarterly basis based on the Company’s leverage ratio. As of December 31, 2019 the interest rate on the Credit Agreement was 4.54%. The base rate is defined in a manner such that it will not be less than LIBOR. The Company will pay fees for standby letters of credit at an annual rate equal to 2.00% to 3.00%, as determined on a quarterly basis based on the Company’s leverage ratio, plus facing fees and standard fees payable to the issuing bank on the respective letter of credit. Loans outstanding under the Credit Agreement may be prepaid at any time without penalty, except for LIBOR breakage costs and expenses. If LIBOR ceases to be reported, the Credit Agreement requires the Company and the Agent to endeavor to establish a commercially reasonable alternative rate of interest and until they are able to do so, all borrowings must be at the base rate.

The Credit Agreement requires the Company and its subsidiaries to comply with various affirmative covenants, including, without limitation, furnishing updated financial and other information, preserving existence and entitlements, maintaining properties and insurance, complying with laws, maintaining books and records, requiring any new domestic subsidiary meeting a materiality threshold specified in the Credit Agreement to become a guarantor thereunder and paying obligations. The Credit Agreement requires the Company and its subsidiaries to comply with, and to use commercially reasonable efforts to the extent permitted by law to cause certain material associated practices of the Company, including APC, to comply with, restrictions on liens, indebtedness and investments (including restrictions on acquisitions by the Company), subject to specified exceptions. The Credit Agreement also contains various other negative covenants binding the Company and its subsidiaries, including, without limitation, restrictions on fundamental changes, dividends and distributions, sales and leasebacks, transactions with affiliates, burdensome agreements, use of proceeds, maintenance of business, amendments of organizational documents, accounting changes and prepayments and modifications of subordinated debt.

The Credit Agreement requires the Company to comply with two key financial ratios, each calculated on a consolidated basis. The Company must maintain a maximum consolidated leverage ratio of not greater than 3.75 to 1.00 as of the last day of each fiscal quarter. The maximum consolidated leverage ratio decreases by 0.25 each year, until it is reduced to 3.00 to 1.00 for each fiscal quarter ending after September 30, 2022. The Company must maintain a minimum consolidated interest coverage ratio of not less than 3.25 to 1.00 as of the last day of each fiscal quarter. As of December 31, 2019, the Company was in compliance with the covenants relating to its credit facility.

Pursuant to the Guaranty and Security Agreement, the Company and NMM have granted the Lenders a security interest in all of their assets, including, without limitation, all stock and other equity issued by their subsidiaries (including NMM) and all rights with respect to the AP-AMH Loan. The Guaranty and Security Agreement requires the Company and NMM to comply with various affirmative and negative covenants, including, without limitation, covenants relating to maintaining perfected security interests, providing information and documentation to the Agent, complying with contractual obligations relating to the collateral, restricting the sale and issuance of securities by their respective subsidiaries and providing the Agent access to the collateral.

The Credit Agreement contains events of default, including, without limitation, failure to make a payment when due, default on various covenants in the Credit Agreement, breach of representations or warranties, cross-default on other material indebtedness, bankruptcy or insolvency, occurrence of certain judgments and certain events under the Employee Retirement Income Security Act of 1974 aggregating more than $10.0 million, invalidity of the loan documents, any lien under the Guaranty and Security Agreement ceasing to be valid and perfected, any change in control, as defined in the Credit Agreement, an event of default under the AP-AMH Loan, failure by APC to pay dividends in cash for any period of two consecutive fiscal quarters, failure by AP-AMH to pay cash interest to the Company, or if any modification is made to the Certificate of Determination or the Special Purpose Shareholder Agreement that directly or indirectly restricts, conditions, impairs, reduces or otherwise limits the payment of the Series A Preferred dividend by APC to AP-AMH. In addition, it will constitute an event of default under the Credit Agreement if APC uses all or any portion of the consideration received by APC from AP-AMH on account of AP-AMH's purchase of Series A Preferred Stock for any purpose other than certain specific approved uses described in the following sentence, unless not less than 50.01% of all holders of common stock of APC at such time approve such use; provided that APC may use up to $50.0 million in the aggregate of such consideration for any purpose without any requirement to obtain such approval of the holders of common stock of APC. The approved uses include (i) any permitted investment, (ii) any dividend or distribution to the holders of the common stock of APC, (iii) any repurchase of common stock of APC, (iv) paying taxes relating to or arising from certain assets and transactions, or (v) funding losses, deficits or working capital support on account of certain non-healthcare assets in an amount not to exceed $125.0 million. If any event of default occurs and is continuing under the Credit Agreement, the Lenders may terminate their commitments, and may require the Company and its guarantors to repay outstanding debt and/or to provide a cash deposit as additional security for outstanding letters of credit. In addition, the Agent, on behalf of the Lenders, may pursue remedies under the Guaranty and Security Agreement, including, without limitation, transferring pledged securities of the Company's subsidiaries in the name of the Agent and exercising all rights with respect thereto (including the right to vote and to receive dividends), collect on pledged accounts, instruments and other receivables (including the AP-AMH Loan), and all other rights provided by law or under the loan documents and the AP-AMH Loan.

In the ordinary course of business, certain of the Lenders under the Credit Agreement and their affiliates have provided to the Company and its subsidiaries and the associated practices, and may in the future provide, (i) investment banking, commercial banking (including pursuant to certain existing business loan and credit agreements being terminated in connection with entering into the Credit Agreement), cash management, foreign exchange or other financial services, and (ii) services as a bond trustee and other trust and fiduciary services, for which they have received compensation and may receive compensation in the future.

Deferred Financing Costs

The Company recorded deferred financing costs of $6.4 million related to the issuance of the Credit Facility. This amount was recorded as a direct reduction of the carrying amount of the related debt liability. The deferred financing costs related to the term loan will be amortized over the life of the Credit Facility using the effective interest rate method. The deferred financing costs related to the revolver will be amortized using the straight line method over the term of the revolver. During the year ended December 31, 2019, $0.5 million of amortization relating to deferred financing costs is included under "Depreciation and Amortization" of the cash flow statement.

Effective Interest Rate

The Company's average effective interest rate on its total debt during the years ended December 31, 2019, 2018 and 2017 was 3.39%, 4.72%, and 2.27%, respectively.

Bank Loan

In December 2010, ICC obtained a loan of $4.6 million from a financial institution. The loan bears interest based on the Wall Street Journal "prime rate" of 5.50% per annum, as of December 31, 2018. The loan was collateralized by the medical equipment ICC owns and guaranteed by one of ICC's shareholders. The loan matured on December 31, 2018 and final payment was made in January 2019.

Lines of Credit – Related Party

NMM Business Loan

On June 14, 2018, NMM amended its promissory note agreement with Preferred Bank, which is affiliated with one of the Company's board members, ("NMM Business Loan Agreement"), which provides for loan availability of up to $20.0 million with a maturity date of June 22, 2020. One of the Company's board members is the chairman and CEO of Preferred Bank. The NMM Business Loan Agreement was amended on September 1, 2018 to temporarily increase the loan availability from $20.0 million to $27.0 million for the period from September 1, 2018 through January 31, 2019, further extended to October 31, 2019 to facilitate the issuance of an additional standby letter of credit for the benefit of CMS. The interest rate is based on the Wall Street Journal "prime rate" plus 0.125%, or 5.625%, as of December 31, 2018. The loan was guaranteed by Apollo Medical Holdings, Inc. and is collateralized by substantially all of the assets of NMM. The amounts outstanding as of June 30, 2019 of $5.0 million was fully repaid on September 11, 2019.

On September 5, 2018, NMM entered into a non-revolving line of credit agreement with Preferred Bank, which is affiliated with one of the Company's board members, ("NMM Line of Credit Agreement") which provides for loan availability of up to $20.0 million with a maturity date of September 5, 2019. This credit facility was subsequently amended on April 17, 2019 and July 29, 2019 to reduce the loan availability from $20.0 million to $16.0 million and from $16.0 million to $2.2 million, respectively. The interest rate is based on the Wall Street Journal "prime rate" plus 0.125%, or 4.875%, as of December 31, 2019. The line of credit is guaranteed by Apollo Medical Holdings, Inc. and is collateralized by substantially all assets of NMM. NMM obtained this line of credit to finance potential acquisitions. Each drawdown from the line of credit is converted into a five-year term loan with monthly principal payments plus interest based on afive-year amortization schedule.

On September 11, 2019, the NMM Business Loan Agreement, dated as of June 14, 2018, between NMM and Preferred Bank, as amended, and the Line of Credit Agreement, dated as of September 5, 2018, between NMM and Preferred Bank, as amended, was terminated in connection with the closing of the Credit Facility. Certain letters of credit issued by Preferred Bank under the Line of Credit Agreement was terminated and reissued under the Credit Agreement. These outstanding letters of credit totaled $14.8 million as of December 31, 2019 and the Company has $10.2 million available under the letter of credit subfacility.

APC Business Loan

On June 14, 2018, APC amended its promissory note agreement with Preferred Bank, which is affiliated with one of the Company's board members, ("APC Business Loan Agreement") which provides for loan availability of up to $10.0 million with a maturity date of June 22, 2020. This credit facility was subsequently amended on April 17, 2019 and June 11, 2019 to increase the loan availability from $10.0 million to $40.0 million and extend the maturity date through December 31, 2020. On August 1, 2019 and September 10, 2019, this credit facility was further amended to increase loan availability from $40.0 million to $43.8 million, and decrease loan availability from $43.8 million to $4.1 million, respectively. This decrease further limited the purpose of the indebtedness under APC Business Loan Agreement to the issuance of standby letters of credit, and added as a permitted lien the security interest in all of its assets granted by APC in favor of NMM under a Security Agreement dated on or about September 11, 2019 securing APC's obligations to NMM under, and as required pursuant to, that certain Management Services Agreement dated as of July 1, 1999, as amended. The interest rate is based on the Wall Street Journal "prime rate" plus 0.125%, or 4.875% and 5.625%, as of December 31, 2019 and December 31, 2018, respectively. As of December 31, 2019 there is no additional availability under this line of credit.

Standby Letters of Credit

On March 3, 2017, APAACO established an irrevocable standby letter of credit with Preferred Bank, which is affiliated with one of the Company's board members, (through the NMM Business Loan Agreement) for $6.7 million for the benefit of CMS. The letter of credit expired on December 31, 2018 and was automatically extended without amendment for additional one - year periods from the present or any future expiration date, unless notified by the institution to terminate prior to 90 days from any expiration date. APAACO may continue to draw from the letter of credit for one year following the bank's notification of non-renewal. As of December 31, 2019, CMS has released the Company from this obligation.

On October 2, 2018, APAACO established a second irrevocable standby letter of credit with Preferred Bank, which is affiliated with one of the Company's board members, (through the NMM Business Loan Agreement) for $6.6 million for the benefit of CMS. The letter of credit expires on December 31, 2019 and is automatically extended without amendment for additional one - year periods from the present or any future expiration date, unless notified by the institution to terminate prior to 90 days from any expiration date. APAACO may continue to draw from the letter of credit for one year following the bank's notification of non-renewal. This standby letter of credit was subsequently amended on August 14, 2019 to increase amount from $6.6 million to $14.8 million and extended the expiration date to December 31, 2020 with all other terms and conditions to remain unchanged. In connection with the closing of the Credit Facility, this letter of credit was terminated and reissued under the Credit Agreement.

APC established irrevocable standby letters of credit with a financial institution for a total of $0.3 million for the benefit of certain health plans. The standby letters of credit are automatically extended without amendment for additional one-year periods from the present or any future expiration date, unless notified by the institution in advance of the expiration date that the letter will be terminated.

Alpha Care established irrevocable standby letters of credit with Preferred Bank under the APC Business Loan Agreement for a total of $3.8 million for the benefit of certain health plans. The standby letters of credit are automatically extended without amendment for additional one-year periods from the present or any future expiration date, unless notified by the institution in advance of the expiration date that the letter will be terminated.

11. Income Taxes

Provision for income taxes consisted of the following:

	Years ended December 31,		
	2019	2018	2017
Current			
Federal	$ 9,034,736	$ 21,058,703	$ 19,219,251
State	5,924,933	9,646,172	5,336,885
	14,959,669	30,704,875	24,556,136
Deferred			
Federal	(3,508,348)	(5,954,666)	(18,718,113)
State	(3,284,689)	(2,390,569)	(1,951,238)
	(6,793,037)	(8,345,235)	(20,669,351)
Total provision for income taxes	$ 8,166,632	$ 22,359,640	$ 3,886,785

The Company uses the liability method of accounting for income taxes as set forth in ASC 740. Under the liability method, deferred taxes are determined based on differences between the financial statement and tax bases of assets and liabilities using enacted tax rates. As of December 31, 2019, the Company had Federal and California net operating loss carryforwards of approximately $45.6 million and $61.3 million, respectively. The Federal and California net operating loss carryforwards will expire at various dates from 2026 through 2039; however, $23.1 million of the Federal operating loss does not expire and will be carried forward indefinitely. Pursuant to Internal Revenue Code Sections 382 and 383, use of the Company's net operating loss and credit carryforwards may be limited if a cumulative change in ownership of more than 50% occurs within any three years' period since the last ownership change. The Company had a change in control under these Sections with the completion of the Merger. The Company has performed an analysis of the limitation on the NOLs acquired with the Merger and has determined it will be able to utilize all of the net operating losses (“NOLs”) before they expire.

Significant components of the Company's deferred tax assets (liabilities) as of December 31, 2019 and December 31, 2018 are shown below. During the year ended December 31, 2019, the Company recorded a non-cash reclassification $0.9 million of deferred tax liabilities to income tax payable related to utilization of NOLs. A valuation allowance of $8.2 million and $3.4 million as of December 31, 2019 and December 31, 2018, respectively, has been established against the Company's deferred tax assets related to loss entities the Company cannot consolidate under the Federal consolidation rules, as realization of these assets is uncertain.

	2019	2018
Deferred tax assets (liabilities)		
State taxes	$ 1,110,659	$ 1,886,010
Stock options	1,293,164	1,660,664
Accrued payroll and related cost	277,682	238,633
Accrued hospital pool deficit	188,075	168,413
Allowance for bad debts	544,028	1,124,917
Investment in other entities	2,977,431	884,922
Net operating loss carryforward	13,849,685	6,414,256
Lease liability	3,567,302	—
Property and equipment	(927,011)	(1,286,087)
Acquired intangible assets	(29,195,045)	(24,084,892)
Right-of-use assets	(3,544,315)	—
Risk Pool Receivable	(1,623,049)	(2,434,573)
Other	1,403,446	(792,781)
Net deferred tax liabilities before valuation allowance	(10,077,948)	(16,220,518)
Valuation allowance	(8,191,500)	(3,395,417)
Net deferred tax liabilities	$ (18,269,448)	$ (19,615,935)

	2019	2018
Tax valuation allowance		
Beginning balance	$ 3,395,417	$ 3,224,517
Charged (credited) to tax expense	1,085,842	170,900
Charged to goodwill	3,710,241	—
Ending balance	8,191,500	3,395,417

On December 22, 2017, the U.S. government enacted comprehensive tax legislation known as the Tax Cuts and Jobs Act (the "TCJA"). The TCJA establishes new tax laws that will take effect in 2018, including, but not limited to (1) reduction of the U.S. federal corporate tax rate from a maximum of 35% to 21%; (2) elimination of the corporate alternative minimum tax; (3) a new limitation on deductible interest expense; (4) the Transition Tax; (5) limitations on the deductibility of certain executive compensation; (6) changes to the bonus depreciation rules for fixed asset additions: and (7) limitations on NOLs generated after December 31, 2018, to 80% of taxable income.

ASC 740, Income Taxes, requires the effects of changes in tax laws to be recognized in the period in which the legislation is enacted. However, due to the complexity and significance of the TCJA's provisions, the SEC staff issued Staff Accounting Bulletin ("SAB 118"), which provides guidance on accounting for the tax effects of the TCJA. SAB 118 provides a measurement period that should not extend beyond one year from the TCJA enactment date for companies to complete the accounting under ASC 740.

During the first nine months of 2018, the Company recorded provisional amounts for certain enactment-date effects of the TCJA, for which the accounting had not been finalized, by applying the guidance in SAB 118. The Company recorded a decrease in its deferred tax assets and deferred tax liabilities of $6.6 million and $16.3 million, respectively, with a corresponding net adjustment to deferred income tax benefit of $9.7 million for the year ended December 31, 2017. Accordingly, the Company completed its accounting for the tax effects of the TCJA in 2018 and did not recognize any material adjustments to the 2018 provisional income tax expense.

The provision for income taxes differs from the amount computed by applying the federal income tax rate as follows for the years ended December 31:

	Years ended December 31,		
	2019	2018	2017
Tax provision at U.S. Federal statutory rates	21.0 %	21.0 %	35.0 %
State income taxes net of federal benefit	8.1	6.7	4.4
Non-deductible permanent items	3.3	1.3	(9.7)
Non-taxable entities	(2.7)	(0.7)	(1.9)
Stock-based compensation	(1.5)	(1.8)	0.9
Change in valuation allowance	13.7	—	(2.9)
Entity Conversion	(10.5)	0.5	—
Change in rate	—	—	(19.4)
Other	0.2	0.1	1.4
Effective income tax rate	31.6 %	27.1 %	7.8 %

The Company's effective tax rate is different from the federal statutory rate of21% due primarily to state taxes, share-based compensation and permanent adjustments. As of December 31, 2019 and 2018, the Company does not have any unrecognized tax benefits related to various federal and state income tax matters. The Company will recognize accrued interest and penalties related to unrecognized tax benefits in income tax expense.

The Company is subject to U.S. federal income tax as well as income tax in California. The Company and its subsidiaries' state and Federal income tax returns are open to audit under the statute of limitations for the years ended December 31, 2015 through December 31, 2018 and for the years ended December 31, 2016 through December 31, 2018, respectively. The Company does not anticipate material unrecognized tax benefits within the next 12 months.

12. Mezzanine and Shareholders' Equity

APC

As the redemption feature (see Note 2) of the shares is not solely within the control of APC, the equity of APC does not qualify as permanent equity and has been classified as noncontrolling interests in mezzanine or temporary equity. APC's shares were not redeemable and it was not probable that the shares would become redeemable as of December 31, 2019, 2018 and 2017.

On September 10, 2019, APC-LSMA, a holding company of APC, acquired 100% of the aggregate issued and outstanding shares of capital stock of AMG for$1.2 million in cash and $0.4 million of APC common stock.

On September 11, 2019, AP-AMH purchased 1,000,000 shares of APC Series A Preferred Stock for aggregate consideration of $545.0 million in a private placement. This investment was eliminated in consolidation. In relation to the issuance of APC Series A Preferred Stock, APC incurred $0.9 million in cost (see Note 1).

Shareholders' Equity

Preferred Stock – Series A

On October 14, 2015, ApolloMed entered into an agreement with NMM pursuant to which ApolloMed sold to NMM, and NMM purchased from ApolloMed, in a private offering of securities, 1,111,111 units, each unit consisting of one share of ApolloMed's Preferred Stock (the "Series A") and a common stock warrant (a "Series A Warrant") to purchase one share of ApolloMed's common stock at an exercise price of $9.00 per share. NMM paid ApolloMed an aggregate of $10.0 million for the units, the proceeds of which were used by ApolloMed primarily to repay certain outstanding indebtedness owed by ApolloMed to NNA of Nevada and the balance for working capital.

As required by ASC 805-10-25-10, NMM, who was the accounting acquirer, remeasured its previously held interest in ApolloMed's (the accounting acquiree) Series A at its acquisition-date fair value of $12.7 million and was added to the consideration transferred

in the exchange. As part of the Merger between NMM and ApolloMed (see Note 3), the fair value of $12.7 million of such shares of Series A were included in purchase price consideration. The valuation methodology was based on an Option Pricing Method ("OPM") which utilized the observable publicly traded common stock price in valuing the Series A preferred stock within the context of the capital structure of the Company. OPM assumptions included an expected term of 2 years, volatility rate of 37.9%, and a risk-free rate of 1.8%.

At December 31, 2019 and 2018, this investment was eliminated in consolidation due to the merger between ApolloMed and NMM (see Note 3).

Preferred Stock – Series B

On March 30, 2016, ApolloMed entered into an agreement with NMM pursuant to which ApolloMed sold to NMM, and NMM purchased from ApolloMed, in a private offering of securities, 555,555 units, each unit consisting of one share of ApolloMed's Series B Preferred Stock ("Series B") and a common stock warrant (a "Series B Warrant") to purchase one share of ApolloMed's common stock at an exercise price of $10.00 per share. NMM paid ApolloMed an aggregate $5.0 million for the units.

As required by ASC 805-10-25-10, NMM, who was the accounting acquirer, remeasured its previously held interest in ApolloMed's (the acquiree) Series B at its acquisition-date fair value of $6.4 million, and was added to the consideration transferred in the exchange. As part of the Merger between NMM and ApolloMed (see Note 3), the fair value of $6.4 million of such shares of Series B were included in purchase price consideration. The valuation methodology was based on an OPM which utilized the observable publicly traded common stock price in valuing the Series B preferred stock within the context of the capital structure of the Company. OPM assumptions included an expected term of 2 years, volatility rate of 37.9%, and a risk-free rate of 1.8%.

NMM recorded a gain of approximately $8.6 million to reflect the fair values of the Series A and Series B prior to the Merger date, which is included in gain from investments in the accompanying consolidated statement of income for the year ended December 31, 2017.

At December 31, 2019 and 2018, this investment was eliminated in consolidation due to the merger between ApolloMed and NMM (see Note 3).

2017 Share Issuances and Repurchases

Prior to the Merger date, NMM received cash in the aggregate amount of approximately $0.3 million from the exercise of stock options to purchase 102,199 shares of NMM common stock at $2.44 per share. In accordance with relevant accounting guidance, the amounts collected through December 7, 2017 were reflected as a long-term liability for unissued equity shares as of December 7, 2017 based on the terms of the forfeiture feature of the option, as noted above. In connection with the merger, the amount included in long-term liability of approximately $1.2 million for unissued equity shares were reclassified to equity to reflect the issuance of 508,133 shares of NMM common stock, which also resulted in the acceleration of the unvested portion of stock options in the amount of approximately $0.8 million which was recorded as share-based compensation expense in the consolidated statements of income.

Prior to the Merger date, an option (non-exclusivity) was exercised for the purchase of 102,641 shares of NMM common stock at $1.46 per share for gross proceeds of approximately $0.2 million.

Prior to the Merger date, NMM sold an aggregate of 129,651 shares of common stock at $14.61 per share for aggregate proceeds of approximately $1.9 million.

Prior to the Merger date, an aggregate of 109,123 shares of NMM common stock were repurchased for approximately $1.6 million at a price of $14.61 per share. An aggregate of 23,628 shares of NMM common stock were repurchased for $0.1 million at a price of $2.44 per share. Such share repurchases reduced the number of shares issued and outstanding as they were subsequently retired.

On December 8, 2017, ApolloMed completed its business combination with NMM following the satisfaction or waiver of the conditions set forth in the Merger Agreement, pursuant to which Merger Subsidiary merged with and into NMM, with NMM surviving as a wholly owned subsidiary of ApolloMed (see Note 3).

In connection with the Merger and as of the effective time of the Merger (the "Effective Time"):

- each issued and outstanding share of NMM common stock was converted into the right to receive such number of shares of common stock of ApolloMed that results in the former NMM shareholders who did not dissent from the Merger ("former NMM Shareholders") having a right to receive an aggregate of 30,397,489 shares of common stock of ApolloMed, subject to the 10% holdback pursuant to the Merger Agreement;

- ApolloMed issued to former NMM Shareholders each former NMM Shareholder's pro rata portion of (i) warrants to purchase an aggregate of 850,000 shares of common stock of ApolloMed, exercisable at $11.00 per share, and (ii) warrants to purchase an aggregate of 900,000 shares of common stock of ApolloMed, exercisable at $10.00 per share; and

- ApolloMed held back an aggregate of 3,039,749 shares of common stock issuable to former NMM Shareholders, representing 10% of the total number of shares of ApolloMed common stock issuable to former NMM Shareholders, to secure indemnification rights of AMEH and its affiliates under the Merger Agreement (the "Holdback Shares"). The Holdback Shares were issued and outstanding as of December 31, 2019. The first tranche of 1,519,805 shares were issued in December 2018 and the remaining 1,511,380 were issued in December 2019, net of shares repurchase (see Note 13).

The shares of common stock issuable to former NMM shareholders in the exchange were 25,675,630 (net of 10% holdback and Treasury Shares) (see Note 3). The 10% holdback shares will be released to all the former NMM shareholders based on their respective pro rata ownership interest in NMM at the Effective Time without regard to whether the former NMM shareholders are providing any services to the Company at the time of this distribution. This holdback accommodation was made as indemnification protection to the accounting acquiree (ApolloMed), and as such, is not considered compensatory. At the time when these holdback shares were issued to the former NMM shareholders, the Company recorded the stock issuance with a reduction to additional paid-in capital to properly reflect the shares outstanding.

Upon consummation of the Merger, the Company issued 520,081 shares its common stock with a fair value of approximately $5.4 million from the conversion of the Alliance Note and accrued interest.

Common Stock

As of the date of this Report, 535,392 holdback shares have not been issued to certain former NMM shareholders who were NMM shareholders at the time of closing of the Merger, as they have yet to submit properly completed letters of transmittal to ApolloMed in order to receive their pro rata portion of ApolloMed common stock and warrants as contemplated under the Merger Agreement. Pending such receipt, such former NMM shareholders have the right to receive, without interest, their pro rata share of dividends or distributions with a record date after the effectiveness of the Merger. The consolidated financial statements have treated such shares of common stock as outstanding, given the receipt of the letter of transmittal is considered perfunctory and the Company is legally obligated to issue these shares in connection with the Merger.

On March 21, 2018, the Company issued 37,593 shares of the Company's common stock to the Company's Chief Operating Officer for prior services rendered. The stock price on the date of issuance was $16.80 per share, which resulted in the Company recording $0.6 million of share-based compensation expense. See options and warrants section below for common stock issued upon exercise of stock options and stock purchase warrants.

Equity Incentive Plans

In connection with the Merger (see Note 3), the Company assumed ApolloMed's 2010 Equity Incentive Plan (the "2010 Plan") pursuant to which 500,000 shares of the Company's common stock were reserved for issuance thereunder. The 2010 Plan provides for awards including incentive stock options, non-qualified options, restricted common stock, and stock appreciation rights. As of December 31, 2019, there were no shares available for grant.

In connection with the Merger (see Note 3), the Company assumed ApolloMed's 2013 Equity Incentive Plan (the "2013 Plan"), pursuant to which 500,000 shares of the Company's common stock were reserved for issuance thereunder. The Company received approval of the 2013 Plan from the Company's stockholders on May 19, 2013. The Company issues new shares to satisfy stock option and warrant exercises under the 2013 Plan. As of December 31, 2019, there were no shares available for future grants under the 2013 Plan.

In connection with the Merger (see Note 3), the Company assumed ApolloMed's 2015 Equity Incentive Plan (the "2015 Plan"), pursuant to which1,500,000 shares of the Company's common stock were reserved for issuance thereunder. In addition, shares that are subject to outstanding grants under the Company's 2010 Plan and 2013 Plan but that ordinarily would have been restored to such plans reserve due to award forfeitures and terminations will roll into and become available for awards under the 2015 Plan. The 2015 Plan provides for awards, including incentive stock options, non-qualified options, restricted common stock, and stock appreciation rights. The 2015 Plan was approved by ApolloMed's stockholders at ApolloMed's 2016 annual meeting of stockholders that was held on September 14, 2016. As of December 31, 2019, 2018 and 2017, there were approximately 0.5 million, 0.9 million and 1.0 million shares available for future grants under the 2015 Plan, respectively.

Options

The Company's outstanding stock options consisted of the following:

	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value (in millions)
Options outstanding at January 1, 2017	—	$ —	—	$ —
Options assumed in the Merger (see Note 3)	1,141,040	3.95	5.85	22.6
Options granted	—	—	—	—
Options exercised	—	—	—	—
Options forfeited	—	—	—	—
Options outstanding at December 31, 2017	1,141,040	$ 3.95	5.79	$ 22.6
Options granted	155,000	9.85	—	—
Options exercised	(639,800)	4.11	—	9.8
Options forfeited	(9,000)	3.41	—	—
Options outstanding at December 31, 2018	647,240	$ 5.62	4.13	$ 9.2
Options granted	279,698	17.24	—	—
Options exercised	(241,214)	6.09	—	2.7
Options forfeited	(78,378)	17.62	—	—
Options outstanding at December 31, 2019	607,346	$ 9.22	3.42	$ 5.6
Options exercisable at December 31, 2019	439,776	$ 4.58	2.09	$ 5.6

During the year ended December 31, 2019 and 2018, stock options were exercised for241,214 and 488,464 shares, respectively, of the Company's common stock, which resulted in proceeds of approximately $1.5 million and $1.8 million, respectively. The exercise prices ranged from $1.50 to $10.00 per share for the exercises during the year ended December 31, 2019 and ranged from $0.01 to $10.00 per share for the exercises during the year endedDecember 31, 2018.

During the year ended December 31, 2018, stock options were exercised pursuant to the cashless exercise provision of the option agreement, with respect to151,346 shares of the Company's common stock, which resulted in the Company issuing 109,438 net shares. During the year ended December 31, 2019,no stock options were exercised pursuant the cashless exercise provision.

During the year ended December 31, 2019, the Company granted 145,228 and 56,092 five year stock options to certain ApolloMed board members and executives, respectively, with exercise price ranging from $15.35 - $18.11 and $18.91, respectively, which were recognized at fair value, as determining using the Black-Scholes option pricing model and following:

December 31, 2019	Board Members	Executives
Expected Term	3.0 years	3.0 years
Expected volatility	90.50% - 100.27%	84.42%
Risk-free interest rate	1.60% - 2.51%	1.65%
Market value of common stock	$15.35 - $18.11	$ 18.91
Annual dividend yield	—%	—%
Forfeiture rate	0%	0%

During the year ended December 31, 2019, the Company recorded approximately $0.9 million of share-based compensation expense associated with the issuance of restricted shares of common stock and vesting of stock options which is included in General and administrative expenses in the accompanying consolidated statement of income.

Stock Options Issued Under Primary Care Physician Agreements

On October 1, 2014, NMM and APC entered into an Exclusivity Amendment Agreement as part of the Primary Care Physician Agreement to issue stock options to purchase shares of NMM and APC common stock.

The medical providers agreed to exclusivity to APC for health enrollees in consideration per provider of an exclusivity incentive in the amount of $25,000 (or $15,000 if already a preferred provider). The stock options were granted from the date of agreement through May 1, 2015 and are treated as issuances to non-employees. The exercise price of the stock options was $2.44 (for NMM pre-merger) and $0.17 (for APC) per share and providers were able to exercise anytime between August 1, 2015 and October 1, 2019, as long as the providers continue to provide services pursuant to the terms of the agreement through October 1, 2019. If the agreement is terminated by the provider with or without cause, the exclusivity incentive and any capitation payment above standard rates made in accordance with the terms of the agreement shall be fully repaid to APC by the terminating medical provider. In addition, any unexercised share options held by the terminating medical provider will be forfeited on effective date of termination, and any share options that have been exercised will be bought back by NMM and APC at the original purchase price.

As of December 31, 2018 and 2017, a total of 7,110,150 APC stock options were exercised for the purchase of shares of common stock that resulted in aggregate proceeds received by APC of $1.2 million. In accordance with relevant accounting guidance the options are reflected as long-term liability for unissued equity shares as of December 31, 2018 and 2017 of $1.2 million based on the features noted above. As of December 31, 2019, the liability totaling $1.2 million was reclassified to the appropriate equity account as the contingency to repurchase these options expired on October 1, 2019.

The stock options under the Exclusivity Amendment Agreement were accounted for at fair value, as determined using the Black-Scholes option pricing model and the following assumptions:

	Years ended December 31,	
	2018	2017
Expected term	0.75 years	0.93 - 1.75 years
Expected volatility	38.10% - 41.60%	38.10% - 41.60%
Risk-free interest rate	1.64% - 1.86%	1.64% - 1.86%
Market value of common stock	$0.52 - $0.76	$0.52 - $0.76
Annual dividend yield	2.23% - 3.53%	2.23% - 3.53%
Forfeiture rate	0% - 6.8%	0% - 6.8%

Outstanding stock options granted to primary care physicians to purchase shares of APC's common stock consisted of the following:

	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value
Options outstanding at January 1, 2017	1,910,400	$ 0.167	2.75	$ 1.1
Options granted	—	—	—	—
Options exercised	(1,056,600)	0.167	—	(0.6)
Options forfeited	—	—	—	—
Options outstanding at December 31, 2017	853,800	$ 0.167	1.75	$ 0.5
Options granted	—	—	—	—
Options exercised	—	—	—	—
Options forfeited	—	—	—	—
Options outstanding at December 31, 2018	853,800	$ 0.167	0.75	$ 0.5
Options granted	—	—	—	—
Options exercised	—	—	—	—
Options forfeited	(853,800)	0.167	—	(0.5)
Options outstanding and exercisable at December 31, 2019	—	$ —	—	$ —

The aggregate intrinsic value is calculated as the difference between the exercise price and the estimated fair value of common stock as ofDecember 31, 2018 and 2017.

Share-based compensation expense related to option awards granted to primary care physicians with Exclusivity Agreements to purchase shares of APC's common stock, are recognized over their respective vesting periods, and consisted of the following:

	Years ended December 31,		
	2019	**2018**	**2017**
Share-based compensation expense:			
General and administrative	$ 607,146	$ 809,528	$ 2,113,116
	$ 607,146	$ 809,528	$ 2,113,116

The Company has no unrecognized share based compensation stock option awards granted in connection with the Exclusivity Amendment Agreements as of December 31, 2019.

Warrants

Common stock warrants, to purchase 1,111,111 shares of ApolloMed common stock, issued to NMM in connection with the Series A Preferred Stock investment in ApolloMed may be exercised at any time after issuance and through October 14, 2020, for $9.00 per share, subject to adjustment in the event of stock dividends and stock splits. As part of the Merger between NMM and ApolloMed (see Note 3), such warrants were distributed to former NMM shareholders on a pro-rata basis utilizing the percentage of shares of NMM held by each shareholder prior to the merger date.

Common stock warrants, to purchase 555,555 shares of ApolloMed common stock, issued to NMM in connection with the Series B Preferred Stock investment in ApolloMed may be exercised at any time after issuance and through March 30, 2021, for $10.00 per share, subject to adjustment in the event of stock dividends and stock splits. As part of the Merger between NMM and ApolloMed

(see Note 3), such warrants were distributed to former NMM shareholders on a pro-rata basis utilizing the percentage of shares of NMM held by each shareholder prior to the Merger date.

The Company's outstanding warrants consisted of the following:

	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value (In Millions)
Warrants outstanding at January 1, 2017	—	$ —	—	$ —
Warrants assumed in the Merger	1,898,541	9.06	2.69	1.8
Warrants granted (see Note 3)	1,750,000	10.49	5.00	—
Warrants outstanding at December 31, 2017	3,648,541	$ 9.75	3.74	$ 52.0
Warrants granted	—	—	—	—
Warrants exercised	(286,357)	7.84	—	3.0
Warrants forfeited	(30,189)	4.50	—	—
Warrants outstanding at December 31, 2018	3,331,995	$ 9.93	2.97	$ 33.1
Warrants granted	—	—	—	—
Warrants exercised	(177,405)	9.32	—	1.60
Warrants forfeited	—	—	—	—
Warrants outstanding at December 31, 2019	3,154,590	$ 9.96	2.01	$ 26.7

Exercise Price Per Share	Warrants Outstanding	Weighted Average Remaining Contractual Life	Warrants Exercisable	Weighted Average Exercise Price Per Share
$ 9.00	948,498	0.79	948,498	$ 9.00
10.00	1,386,083	2.30	1,386,083	10.00
11.00	820,009	2.94	820,009	11.00
$ 9.00 –11.00	3,154,590	2.01	3,154,590	$ 9.96

During the years ended December 31, 2019 and 2018, common stock warrants were exercised for 177,405 and 286,357 shares of the Company's common stock, respectively which resulted in proceeds of approximately $1.7 million and $2.2 million, respectively. The exercise price ranged from $9.00 to $11.00 per share during year ended December 31, 2019 and $4.00 to $11.00 per share during year ended December 31, 2018.

Dividends

During the years ended December 31, 2019, 2018 and 2017, NMM paid dividends of $0, $13.8 million and $0, respectively. The dividends paid in the year ended December 31, 2018 was declared in December 31, 2017 as part of the merger between ApolloMed and NMM and was classified as restricted cash (see Note 3).

During the years ended December 31, 2019, 2018 and 2017, APC paid dividends of $60 million, $2.0 million and $8.75 million, respectively.

During the years ended December 31, 2019, 2018 and 2017, CDSC paid distributions of $2.6 million, $2.0 million and $1.7 million, respectively.

Treasury Stock

APC owns 17,290,317 shares of ApolloMed's common stock as of December 31, 2019 and 1,682,110 shares of ApolloMed's common stock as of December 31, 2018 and 2017, respectively, which are legally issued and outstanding but excluded from shares of common stock outstanding in the consolidated financial statements, as such shares are treated as treasury shares for accounting purposes (see Note 1).

During the year ended December 31, 2019, APC established a brokerage account to invest excess capital in the equity market. The brokerage account is managed directly by an independent investment committee of the APC board, for which Dr. Kenneth Sim and Dr. Thomas Lam has been excluded. As of December 31, 2019 the brokerage account only held shares of ApolloMed, as such the brokerage account totaling $7.3 million has been recorded as treasury shares.

On December 18, 2018 the Company entered into a settlement agreement and mutual release with former APCN shareholders to repurchase all the equity interests in ApolloMed and APC previously held by these shareholders pursuant to the stipulation. Total common shares repurchased was 168,493 and 1,662,571 from ApolloMed and APC, respectively (See Note 13).

13. Commitments and Contingencies

Regulatory Matters

Laws and regulations governing the Medicare program and healthcare generally are complex and subject to interpretation. The Company believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. 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 significant regulatory action including fines, penalties, and exclusion from the Medicare and Medi-Cal programs.

As a risk-bearing organization, the Company is required to follow regulations of the DMHC. The Company must comply with a minimum working capital requirement, tangible net equity ("TNE") requirement, cash-to-claims ratio and claims payment requirements prescribed by the DMHC. TNE is defined as net assets less intangibles, less non-allowable assets (which include amounts due from affiliates), plus subordinated obligations. At December 31, 2019 and 2018, APC, Alpha Care and Accountable Health Care were in compliance with these regulations.

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

Standby Letters of Credit

As part of the APAACO participation with CMS, the Company must provide a financial guarantee to CMS, the guarantee generally must be in an amount of 2% of our benchmark Medicare Part A and Part B expenditures. The Company has established irrevocable standby letters of credit with Preferred Bank, which is affiliated with one of the Company's board members, of $8.2 million and $6.6 million for the 2019 and 2018 performance years, respectively (see Note 10).

APC established irrevocable standby letters of credit with a financial institution for a total of $0.3 million for the benefit of certain health plans. The standby letters of credit are automatically extended without amendment for additional one-year periods from the present or any future expiration date, unless notified by the institution in advance of the expiration date that the letter will be terminated (see Note 10).

Alpha Care established irrevocable standby letters of credit with Preferred Bank under the APC Business Loan Agreement for a total of $3.8 million for the benefit of certain health plans. The standby letters of credit are automatically extended without amendment for additional one-year periods from the present or any future expiration date, unless notified by the institution in advance of the expiration date that the letter will be terminated.

Litigation

From time to time, the Company is involved in various legal proceedings and other matters arising in the normal course of its business. The resolution of any claim or litigation is subject to inherent uncertainty and could have a material adverse effect on the Company's financial condition, cash flows or results of operations.

Prospect Medical Systems

On or about March 23, 2018 and April 3, 2018, a Demand for Arbitration and an Amended Demand for Arbitration were filed by Prospect Medical Group, Inc. and Prospect Medical Systems, Inc. (collectively, "Prospect") against MMG, ApolloMed and AMM with Judicial Arbitration Mediation Services in California, arising out of MMG's purported business plans, seeking damages in excess of $5.0 million, and alleging breach of contract, violation of unfair competition laws, and tortious interference with Prospect's current and future economic relationships with its health plans and their members. MMG, ApolloMed and AMM dispute the allegations and intend to vigorously defend against this matter. The resolution of this matter and any potential range of loss in excess of any current accrual cannot be reasonably determined or estimated at this time primarily because the matter has not been fully arbitrated and presents unique regulatory and contractual interpretation issues.

APCN Shareholders

On December 18, 2018 the Company entered into a settlement agreement and mutual release with former APCN shareholders to repurchase all the equity interests in ApolloMed and APC previously held by these shareholders pursuant to the stipulation. ApolloMed and APC paid approximately $4.2 million and $1.7 million, respectively, to repurchase 168,493 and 1,662,571 shares of common stock of each company, respectively. The Company recognized approximately $0.8 million of legal settlement liability based on the settlement amount which exceeded the fair value of the repurchased ApolloMed and APC shares of common stock and warrants.

Liability Insurance

The Company believes that its insurance coverage is appropriate based upon the Company's claims experience and the nature and risks of the Company's business. In addition to the known incidents that have resulted in the assertion of claims, the Company cannot be certain that its insurance coverage will be adequate to cover liabilities arising out of claims asserted against the Company, the Company's affiliated professional organizations or the Company's affiliated hospitalists in the future where the outcomes of such claims are unfavorable. The Company believes that the ultimate resolution of all pending claims, including liabilities in excess of the Company's insurance coverage, will not have a material adverse effect on the Company's financial position, results of operations or cash flows; however, there can be no assurance that future claims will not have such a material adverse effect on the Company's business. Contracted physicians are required to obtain their own insurance coverage.

Although the Company currently maintains liability insurance policies on a claims-made basis, which are intended to cover malpractice liability and certain other claims, the coverage must be renewed annually, and may not continue to be available to the Company in future years at acceptable costs, and on favorable terms.

14. Related Party Transactions

On November 16, 2015, UCAP entered into a subordinated note receivable agreement with UCI, a 48.9% owned equity method investee (See Note 6), in the amount of $5.0 million. On June 28, 2018 and November 28, 2018, UCAP entered into two new subordinated note receivable agreements with UCI in the amount of $2.5 million and $5.0 million, respectively (see Note 7).

During the years ended December 31, 2019 and 2018, NMM earned approximately $17.3 million and $21.6 million, respectively, in management fees, of which $2.0 million and $0.8 million, remained outstanding, respectively, from LMA, which is accounted for under the equity method based on 25% equity ownership interest held by APC (see Note 6).

During the years ended December 31, 2019 and 2018, APC paid approximately $2.7 million and $2.5 million, respectively, to PMIOC for provider services, which is accounted for under the equity method based on 40% equity ownership interest held by APC (see Note 6).

During the years ended December 31, 2019 and 2018, APC paid approximately $7.8 million and $7.0 million, respectively, to DMG for provider services, which is accounted for under the equity method based on 40% equity ownership interest held by APC (see Note 6).

During the year ended December 31, 2019 and 2018, APC paid approximately $0.4 million and $0.3 million, respectively, to Advance Diagnostic Surgery Center for services as a provider. Advance Diagnostic Surgery Center shares common ownership with certain board members of APC.

During the years ended December 31, 2019 and 2018, NMM paid approximately $1.1 million and $1.0 million to Medical Property Partners ("MPP") for an office lease. MPP shares common ownership with certain board members of NMM (see Note 19).

During the years ended December 31, 2018, APC paid approximately $0.2 million to Tag-2Medical Investment Group, LLC ("Tag-2") for an office lease. Tag-2 shares common ownership with a board member of APC.

During the years ended December 31, 2019 and 2018, the Company paid approximately $0.5 million and $0.4 million, respectively, to Critical Quality Management Corp ("CQMC") for an office lease. CQMC shares common ownership with certain board members of APC (see Note 19).

During the years ended December 31, 2019 and 2018, SCHC paid approximately $0.4 million and $0.5 million, respectively, to Numen, LLC ("Numen") for an office lease. Numen is owned by a shareholder of APC (see Note 19).

The Company has agreements with HSMSO, Aurion Corporation ("Aurion"), and AHMC Healthcare ("AHMC") for services provided to the Company. One of the Company's board members is an officer of AHMC, HSMSO and Aurion. Aurion is also partially owned by one of the Company's board members. The following table sets forth fees incurred and income received related to AHMC, HSMSO and Aurion Corporation:

	Years ended December 31,	
	2019	**2018**
AHMC – Risk pool revenue	$ 49,300,000	$ 68,200,000
HSMSO – Management fees, net	(1,700,000)	(2,600,000)
Aurion – Management fees	(300,000)	(317,000)
Receipts, Net	$ 47,300,000	$ 65,283,000

The Company and AHMC has a risk sharing agreement with certain AHMC hospitals to share the surplus and deficits of each of the hospital pools. During the years ended December 31, 2019 and 2018 the Company has recognized risk pool revenue under this agreement of $49.3 million and $68.2 million respectively, of which $40.4 million and $44.2 million, respectively, remain outstanding as of December 31, 2019 and 2018, respectively.

During the years ended December 31, 2019 and 2018, APC paid an aggregate of approximately $22.0 million and $35.2 million, respectively, to shareholders of APC for provider services, which included approximately $8.8 million and $13.5 million, respectively, to shareholders who are also officers of APC.

During the year ended December 31, 2019, NMM paid approximately $0.2 million to an Apollo board member for consulting services.

In addition, affiliates wholly-owned by the Company's officers, including our Co-CEO, Dr. Lam, are reported in the accompanying consolidated statements of income on a consolidated basis, together with the Company's subsidiaries, and therefore, the Company does not separately disclose transactions between such affiliates and the Company's subsidiaries as related party transactions.

For equity method investments, loans receivable and line of credits from related parties, see Notes 6, 7 and 10, respectively.

15. Employee Benefit Plan

NMM has a qualified 401(k) plan that covers substantially all employees who have completed at least six months of service and meet minimum age requirements. Participants may contribute a portion of their compensation to the plan, up to the maximum amount permitted under Section 401(k) of the Internal Revenue Code. Participants become fully vested after six years of service. NMM matches a portion of the participants' contributions. NMM's matching contributions for the years ended December 31, 2019 and 2018 were approximately $0.2 million.

16. Revenue Recognition

At the adoption of Topic 606, the cumulative effect of initially applying the new revenue standard is required to be presented as an adjustment to the opening balance of retained earnings. This cumulative effect amount was determined to be related to the full risk pool arrangements of APC, a variable interest entity (see Note 18). Due to uncertainty surrounding the settlement of the related IBNR reserve, under ASC Topic 605, the Company has historically recognized revenue from full risk pool settlements under arrangements with hospitals when such amounts are known as the related revenue amounts were not deemed to be fixed and determinable until that time. Under ASC Topic 606, the transaction price includes an assessment of variable consideration; therefore, full risk pool settlements under these arrangements are recognized using the most likely method and amounts are only included in revenue to the extent that it is probable that a significant reversal of cumulative revenue will not occur once any uncertainty is resolved. The assumptions for historical medical loss ratios, IBNR completion factors and constraint percentages were used by management in applying the most likely method. Accordingly, the Company has estimated an additional amount of revenue to recognize the expected amount that is most likely to be paid upon settlement of each of the open full risk pool fiscal year, which amount was included in the adoption date adjustment to retained earnings. Therefore, the cumulative net effect of initially applying Topic 606 in the amount of $10.2 million, which is comprised of $11.6 million of additional revenue, offset by $1.4 million in related management fee expense, has been presented as an adjustment to the opening balance of the mezzanine equity, "Noncontrolling interest in Allied Pacific of California IPA." Consequently, as a result of APC recording additional receivables, NMM recorded a corresponding entry of $1.4 million to retained earnings related to management fee income. These adjustments were offset by an aggregate adjustment to deferred tax liability of $3.2 million.

17. Earnings Per Share

Basic net income per share is calculated using the weighted average number of shares of the Company's common stock issued and outstanding during a certain period, and is calculated by dividing net income by the weighted average number of shares of the Company's common stock issued and outstanding during such period. Diluted net income per share is calculated using the weighted average number of common and potentially dilutive common shares outstanding during the period, using the as-if converted method for preferred stock and the treasury stock method for options and common stock warrants.

Pursuant to the Merger Agreement, ApolloMed held back 10% of the shares of its common stock that were issuable to NMM shareholders ("Holdback Shares") to secure indemnification of ApolloMed and its affiliates under the Merger Agreement. The Holdback Shares will be held for a period of up to 24 months, with 50% issued on the first anniversary of the merger and the remaining 50% issued on the second anniversary, after the closing of the Merger (to be distributed on a pro-rata basis to former NMM shareholders), during which ApolloMed may seek indemnification for any breach of, or noncompliance with, any provision of the Merger Agreement, by NMM. The Holdback Shares are excluded from the computation of basic earnings per share, but included in diluted earnings per share. As of December 31, 2019, APC held 17,290,317 shares of ApolloMed's common stock and as of December 31, 2018 and 2017, APC held 1,682,110 shares of ApolloMed's common stock, which are treated as treasury shares for accounting purposes and not included in the number of shares of common stock outstanding used to calculate earnings per share (see Note 12). The noncontrolling interests in APC are allocated their share of ApolloMed's income from APC's ownership of ApolloMed common stock and this is included in the net income attributable to noncontrolling interests on the consolidated statements of income. Therefore, none of the shares of ApolloMed held by APC are considered outstanding for the purposes of basic or diluted earnings per share computation.

Below is a summary of the earnings per share computations:

	Years ended December 31,		
	2019	2018	2017
Earnings per share – basic	$ 0.41	$ 0.33	$ 1.01
Earnings per share – diluted	$ 0.39	$ 0.29	$ 0.90
Weighted average shares of common stock outstanding – basic	34,708,429	32,893,940	25,525,786
Weighted average shares of common stock outstanding – diluted	36,403,279	37,914,886	28,661,735

Below is a summary of the shares included in the diluted earnings per share computations:

	Years ended December 31,		
	2019	2018	2017
Weighted average shares of common stock outstanding – basic	34,708,429	32,893,940	25,525,786
10% shares held back pursuant to indemnification clause	—	2,935,512	3,039,749
Stock options	295,672	459,440	44,716
Warrants	1,384,078	1,625,994	51,484
Restricted stock units	15,100	—	—
Weighted average shares of common stock outstanding – diluted	36,403,279	37,914,886	28,661,735

18. Variable Interest Entities (VIEs)

A VIE is defined as a legal entity whose equity owners do not have sufficient equity at risk, or, as a group, the holders of the equity investment at risk lack any of the following three characteristics: decision-making rights, the obligation to absorb losses, or the right to receive the expected residual returns of the entity. The primary beneficiary is identified as the variable interest holder that has both the power to direct the activities of the VIE that most significantly affect the entity's economic performance and the obligation to absorb expected losses or the right to receive benefits from the entity that could potentially be significant to the VIE.

The Company follows guidance on the consolidation of VIEs that requires companies to utilize a qualitative approach to determine whether it is the primary beneficiary of a VIE. See Note 2 to the accompanying consolidated financial statements for information on how the Company determines VIEs and its treatment.

The following table includes assets that can only be used to settle the liabilities of APC and the creditors of APC have no recourse to the Company. These assets and liabilities, with the exception of the investment in a privately held entity and amounts due to affiliate, which are eliminated upon consolidation with NMM, are included in the accompanying consolidated balance sheets.

	December 31,	
	2019	2018
Assets		
Current assets		
Cash and cash equivalents	$ 87,110,226	$ 71,726,342
Restricted cash – short-term	75,000	—
Investment in marketable securities	123,948,391	1,066,103
Receivables, net	9,300,076	4,512,000
Receivables, net – related party	42,976,262	44,651,502
Other receivables	743,757	—
Prepaid expenses and other current assets	7,403,057	3,647,654
Loans receivable	6,425,000	—

Loans receivable - related parties	16,500,000	—
Total current assets	294,481,769	125,603,601
Noncurrent assets		
Land, property and equipment, net	9,546,924	9,602,228
Intangible assets, net	81,439,224	58,984,420
Goodwill	108,912,763	56,213,450
Loans receivable – related parties	—	12,500,000
Investments in other entities – equity method	28,486,593	26,707,404
Investment in privately held entities	4,725,000	4,725,000
Restricted cash – long-term	746,104	745,470
Operating lease right-of-use assets	4,750,944	—
Other assets	1,056,828	839,085
Total noncurrent assets	239,664,380	170,317,057
Total assets	$ 534,146,149	$ 295,920,658
Current liabilities		
Accounts payable and accrued expenses	$ 11,186,808	$ 6,378,751
Fiduciary accounts payable	2,027,081	1,538,598
Medical liabilities	49,019,200	24,983,110
Income taxes payable	4,529,667	11,621,861
Dividend payable	271,279	—
Amount due to affiliate	28,057,793	11,505,680
Bank loan, short-term	—	40,257
Finance lease liabilities	101,741	101,741
Operating lease liabilities	1,088,260	—
Total current liabilities	96,281,829	56,169,998
Noncurrent liabilities		
Deferred tax liability	14,058,528	15,693,159
Liability for unissued equity shares	—	1,185,025
Finance lease liabilities, net of current portion	415,519	517,261
Operating lease liabilities, net of current portion	3,741,811	—
Total noncurrent liabilities	18,215,858	17,395,445
Total liabilities	$ 114,497,687	$ 73,565,443

19. Leases

The Company has operating and finance leases for corporate offices, doctors' offices, and certain equipment. These leases have remaining lease terms of1 month to 5 years, some of which may include options to extend the leases for up to 10 years, and some of which may include options to terminate the leases within one year. As of December 31, 2019 and December 31, 2018, assets recorded under finance leases were$0.5 million and $0.6 million, respectively, and accumulated depreciation associated with finance leases was $0.3 million and $0.2 million, respectively.

Also, the Company rents or subleases certain real estate to third parties, which are accounted for as operating leases.

Leases with an initial term of 12 months or less are not recorded on the balance sheet.

The components of lease expense were as follows:

	Year Ended December 31, 2019
Operating lease cost	$ 5,437,078
Finance lease cost	
Amortization of lease expense	101,741
Interest on lease liabilities	17,179
Sublease income	$ (414,704)
Total lease cost, net	$ 5,141,294

Other information related to leases was as follows:

	Year Ended December 31, 2019
Supplemental Cash Flows Information	
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows from operating leases	$ 5,254,079
Operating cash flows from finance leases	17,179
Financing cash flows from finance leases	101,741
Right-of-use assets obtained in exchange for lease liabilities:	
Operating leases	16,727,589
Finance leases	—

	Year Ended December 31, 2019
Weighted Average Remaining Lease Term	
Operating leases	6.48 years
Finance leases	4.67 years
Weighted Average Discount Rate	
Operating leases	6.11%
Finance leases	3.00%

Future minimum lease payments under non-cancellable leases as of December 31, 2019 were as follows:

Years ending December 31,	Operating Leases	Finance Leases
2020	$ 3,781,174	$ 118,920
2021	2,711,802	118,920
2022	2,376,159	118,920
2023	2,130,226	118,920
2024	1,788,047	79,255
Thereafter	4,783,381	—
Total future minimum lease payments	17,570,789	554,935
Less: imputed interest	3,207,506	37,675
Total lease obligations	14,363,283	517,260
Less: current portion	2,990,686	101,741
Long-term lease obligations	$ 11,372,597	$ 415,519

As of December 31, 2019, the Company does not have additional operating and finance leases that have not yet commenced.

Supplemental Information for Comparative Periods

As of December 31, 2018, prior to the adoption of ASC 842, future minimum payments under operating leases having initial or remaining non-cancellable lease terms in excess of one year were as follows:

Years ending December 31,	Operating Leases	Finance Leases
2019	$ 2,848,000	$ 119,000
2020	2,267,000	119,000
2021	783,000	119,000
2022	487,000	119,000
2023	489,000	119,000
Thereafter	243,000	79,000
Total future minimum lease payments	7,117,000	674,000

Rent expense for leases for the years ended December 31, 2018 and 2017 was approximately$4.3 million and $2.4 million, respectively.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

As of December 31, 2019, we carried out an evaluation, under the supervision and with the participation of our management, including our Co-Chief Executive Officers and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures. Based on that evaluation, our management, including Co-Chief Executive Officers and Chief Financial Officer, concluded that our disclosure controls and procedures were effective as of December 31, 2019.

Management's Annual Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting. Internal control over financial reporting is defined in Rule 13a-15(f) or 15d-15(f) promulgated under the Securities Exchange Act of 1934, as amended, as a process designed by, or under the supervision of, the Company's principal executive and principal financial officers and effected by the Company's board of directors, management and other personnel, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. Internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that in reasonable detail accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Projections of any evaluation of the effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Our management, with the participation of our Co-Chief Executive Officers and Chief Financial Officer, assessed the effectiveness of our internal control over financial reporting as of December 31, 2019, the end of our fiscal year. Our management based its assessment on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission. Our management's assessment included evaluation and testing of the design and operating effectiveness of key financial reporting controls, process documentation, accounting policies, and our overall control environment.

Based on our management's assessment, our management has concluded that our internal control over financial reporting was effective as of December 31, 2019. Our management communicated the results of its assessment to the Audit Committee of our Board of Directors.

Our independent registered public accounting firm, BDO USA, LLP, audited our consolidated financial statements for the fiscal year ended December 31, 2019 included in this Annual Report on Form 10-K, and has issued an audit report with respect to the effectiveness of the Company's internal control over financial reporting, a copy of which is included below in this Annual Report on Form 10-K.

Remediation of Material Weakness in Internal Control over Financial Reporting

As of December 31, 2018, management determined that our internal control over financial reporting was not effective due to a material weakness in the Company's internal control over the review of completeness and accuracy of data included in the full risk pool reports provided by an external party based on which material amounts of revenue were recognized. During the year ended December 31, 2019, we have implemented controls that have effectively addressed the material weakness identified in prior year's audit. The Company has designed new procedures to obtain reliance on the completeness and accuracy of the information included in full risk pool reports prepared for the Company by an external party. The Company has successfully tested the new control environment.

Changes in Internal Control Over Financial Reporting

Other than the controls implemented to remediate the material weakness from prior years audit, there have been no changes in our internal control over financial reporting during our fourth quarter of 2019 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

Shareholders and Board of Directors
Apollo Medical Holdings, Inc.
Alhambra, California

Opinion on Internal Control over Financial Reporting

We have audited Apollo Medical Holdings, Inc.'s (the "Company's") internal control over financial reporting as of December 31, 2019, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (the "COSO criteria") In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2019, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) ("PCAOB"), the consolidated balance sheets of Apollo Medical Holdings, Inc. (the "Company") as of December 31, 2019 and 2018, the related consolidated statements of income, mezzanine and shareholders' equity, and cash flows for each of the three years in the period ended December 31, 2019, and the related notes (collectively referred to as the "consolidated financial statements") and our report dated March 16, 2020 expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying the accompanying Item 9A, Management's Annual Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit of internal control over financial reporting in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ BDO USA, LLP

Los Angeles, California

March 16, 2020

Item 9B. Other Information

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance

The information required by this Item will be contained in the Company's Proxy Statement for the 2020 Annual Meeting to be filed with the SEC not later than 120 days following the end of the Company's fiscal year ended December 31, 2019, which information is incorporated herein by reference.

Item 11. Executive Compensation

The information required by this Item will be contained in the Company's Proxy Statement for the 2020 Annual Meeting to be filed with the SEC not later than 120 days following the end of the Company's fiscal year ended December 31, 2019, which information is incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

The information required by this Item will be contained in the Company's Proxy Statement for the 2020 Annual Meeting to be filed with the SEC not later than 120 days following the end of the Company's fiscal year ended December 31, 2019, which information is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The information required by this Item will be contained in the Company's Proxy Statement for the 2020 Annual Meeting to be filed with the SEC not later than 120 days following the end of the Company's fiscal year ended December 31, 2019, which information is incorporated herein by reference.

Item 14. Principal Accounting Fees and Services

The information required by this Item will be contained in the Company's Proxy Statement for the 2020 Annual Meeting to be filed with the SEC not later than 120 days following the end of the Company's fiscal year ended December 31, 2019, which information is incorporated herein by reference.

PART IV

Item 15. Exhibits and Financial Statement Schedules

(a) The following documents are filed as part of this Annual Report on Form 10-K:

1. Consolidated financial statements

The consolidated financial statements and notes thereto contained herein are as listed on the "Index to Consolidated Financial Statements" in Part II, Item 8 of this Annual Report on Form 10-K.

2. Financial Statement Schedules

All financial statement schedules have been omitted, since the required information is not applicable or is not present in amounts sufficient to require submission of the schedule, or because the information required is included in the consolidated financial statements and notes thereto included in this Annual Report on Form 10-K.

3. Exhibits required by Item 601 of Regulation S-K.

Exhibit No.	Description
2.1†	Agreement and Plan of Merger, dated December 21, 2016, among Apollo Medical Holdings, Inc., Network Medical Management, Inc., Apollo Acquisition Corp. and Kenneth Sim, M.D. (incorporated herein by reference to Annex A to the joint proxy statement/prospectus filed pursuant to Rule 424(b)(3) on November 15, 2017 that is a part of a Registration Statement on Form S-4).
2.2	Amendment to the Agreement and Plan of Merger, dated March 30, 2017, among Apollo Medical Holdings, Inc., Network Medical Management, Inc., Apollo Acquisition Corp. and Kenneth Sim, M.D. (incorporated herein by reference to Annex A to the joint proxy statement/prospectus filed pursuant to Rule 424(b)(3) on November 15, 2017 that is a part of a Registration Statement on Form S-4).
2.3	Amendment No. 2 to the Agreement and Plan of Merger, dated October 17, 2017, among Apollo Medical Holdings, Inc., Network Medical Management, Inc., Apollo Acquisition Corp. and Kenneth Sim, M.D. (incorporated herein by reference to Annex A to the joint proxy statement/prospectus filed pursuant to Rule 424(b)(3) on November 15, 2017 that is a part of a Registration Statement on Form S-4).
2.4	Stock purchase agreement dated March 15, 2019 (incorporated herein by reference to Exhibit 2.4 to the Company's Quarterly Report on Form 10-Q filed on May 10, 2019).
3.1	Restated Certificate of Incorporation (incorporated herein by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on January 21, 2015).
3.2	Certificate of Amendment of Restated Certificate of Incorporation (incorporated herein by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on April 27, 2015).
3.3	Certificate of Amendment of Restated Certificate of Incorporation (incorporated herein by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on December 13, 2017).
3.4	Certificate of Amendment of Restated Certificate of Incorporation (incorporated herein by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed June 21, 2018).
3.5	Restated Bylaws (incorporated herein by reference to Exhibit 3.2 to the Company's Quarterly Report on Form 10-Q filed on November 16, 2015).

Exhibit No.	Description
3.6	Amendment to Sections 3.1 and 3.2 of Article III of Bylaws (incorporated herein by reference to Exhibit 3.2 to the Company's Current Report on Form 8-K filed on December 13, 2017).
3.7	Amendment to Sections 3.1 and 3.2 of Article III of Bylaws (incorporated herein by reference to Exhibit 3.2 to the Company's Current Report on Form 8-K filed on June 21, 2018).
4.1	Certificate of Designation of Series A Convertible Preferred Stock (incorporated herein by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on October 19, 2015).
4.2	Amended and Restated Certificate of Designation of Apollo Medical Holdings, Inc. (incorporated herein by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on April 4, 2016).
4.3	Form of Certificate for Common Stock of Apollo Medical Holdings, Inc., par value $0.001 per share (incorporated herein by reference to Exhibit 4.1 to the Company's Annual Report on Form 10-K filed on April 2, 2018).
4.4	Form of Warrant issued as Merger Consideration pursuant to the Merger Agreement for the purchase of Common Stock of Apollo Medical Holdings, Inc., exercisable at $11.00 per share (incorporated herein by reference to Exhibit 4.3 to the Company's Annual Report on Form 10-K filed on April 2, 2018).
4.5	Form of Warrant issued as Merger Consideration pursuant to the Merger Agreement for the purchase of Common Stock of Apollo Medical Holdings, Inc., exercisable at $10.00 per share (incorporated herein by reference to Exhibit 4.4 to the Company's Annual Report on Form 10-K filed on April 2, 2018).
4.6	Common Stock Purchase Warrant ("Series A Warrant") dated October 14, 2015, originally issued by Apollo Medical Holdings, Inc. to Network Medical Management, Inc. to purchase 1,111,111 shares of common stock and subsequently issued as Merger Consideration pursuant to the Merger Agreement (incorporated herein by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on October 19, 2015).
4.7	Form of Assignment of Series A Warrant as Merger Consideration pursuant to the Merger Agreement (incorporated herein by reference to Exhibit 4.6 to the Company's Annual Report on Form 10-K filed on April 2, 2018).
4.8	Common Stock Purchase Warrant ("Series B Warrant") dated March 30, 2016, originally issued by Apollo Medical Holdings, Inc. to Network Medical Management, Inc. to purchase 555,555 shares of common stock and subsequently issued as Merger Consideration pursuant to the Merger Agreement (incorporated herein by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on April 4, 2016).
4.9	Form of Assignment of Series B Warrant as Merger Consideration pursuant to the Merger Agreement (incorporated herein by reference to Exhibit 4.8 to the Company's Annual Report on Form 10-K filed on April 2, 2018).
4.10	Description of Registered Securities
10.1	2010 Equity Incentive Plan of the Company (incorporated herein by reference to Appendix A to Schedule 14C Information Statement filed on August 17, 2010).
10.2	2013 Equity Incentive Plan of the Company (incorporated herein by reference to Exhibit 10.13 to the Company's Annual Report on Form 10-K filed on May 8, 2014).
10.3*	2015 Equity Incentive Plan of the Company. (incorporated herein by reference to Exhibit 10.3 to the Company's Annual Report on Form 10-K filed on April 2, 2018).

Exhibit No.	Description
10.4+	Board of Directors Agreement dated May 22, 2013 by and between Apollo Medical Holdings, Inc., and David Schmidt (incorporated herein by reference to Exhibit 10.14 to the Company's Annual Report on Form 10-K filed on May 8, 2014).
10.5+	Board of Directors Agreement between Apollo Medical Holdings, Inc. and Thomas S. Lam, M.D. dated January 19, 2016 (incorporated herein by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed on January 19, 2016.
10.6+	Board of Directors Agreement dated January 12, 2016 between Apollo Medical Holdings, Inc. and Mark Fawcett (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K/A filed on February 2, 2016).
10.7+	Form of Board of Directors Agreement (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on December 13, 2017).
10.8+	Form of Director Proprietary Information Agreement (incorporated herein by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed on December 13, 2017).
10.9+	Form of Indemnification Agreement (incorporated herein by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K filed on December 13, 2017).
10.10	Investment Agreement, between Apollo Medical Holdings, Inc. and NNA of Nevada, Inc., dated March 28, 2014 (incorporated herein by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed on March 31, 2014).
10.11	Registration Rights Agreement, between Apollo Medical Holdings, Inc. and NNA of Nevada, Inc., dated March 28, 2014 (incorporated herein by reference to Exhibit 10.12 to the Company's Current Report on Form 8-K filed on March 31, 2014).
10.12	First Amendment and Acknowledgement, dated February 6, 2015, among Apollo Medical Holdings, Inc., NNA of Nevada, Inc., Warren Hosseinion, M.D. and Adrian Vazquez, M.D. (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on February 11, 2015).
10.13	Amendment to the First Amendment and Acknowledgement, dated May 13, 2015, among Apollo Medical Holdings, Inc., NNA of Nevada, Inc., Warren Hosseinion, M.D. and Adrian Vazquez, M.D. (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on May 15, 2015).
10.14	Amendment to the First Amendment and Acknowledgement, dated July 7, 2015, among Apollo Medical Holdings, Inc., NNA of Nevada, Inc., Warren Hosseinion, M.D. and Adrian Vazquez, M.D. (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on July 10, 2015).
10.15	Second Amendment and Conversion Agreement dated November 17, 2015 among Apollo Medical Holdings, Inc., NNA of Nevada, Inc., Warren Hosseinion, M.D. and Adrian Vazquez, M.D. (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on November 19, 2015).
10.16	Third Amendment between Apollo Medical Holdings, Inc. and NNA of Nevada, Inc., dated June 28, 2016 (incorporated herein by reference to Exhibit 10.71 to the Company's Annual Report on Form 10-K filed on June 29, 2016).
10.17	Fourth Amendment between Apollo Medical Holdings, Inc. and NNA of Nevada, Inc., dated April 26, 2017 (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on April 28, 2017).

Exhibit No.	Description
10.18	Fifth Amendment between Apollo Medical Holdings, Inc. and NNA of Nevada, Inc., dated July 26, 2017 (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on July 28, 2017).
10.19	Sixth Amendment between Apollo Medical Holdings, Inc. and NNA of Nevada, Inc., dated March 16, 2018 (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on March 20, 2018).
10.20	Stock Option Agreement, between Warren Hosseinion, M.D. and Apollo Medical Holdings, Inc., dated March 28, 2014 (incorporated herein by reference to Exhibit 10.17 to the Company's Current Report on Form 8-K/A filed on April 3, 2014).
10.21	Stock Option Agreement, between Adrian Vazquez, M.D. and Apollo Medical Holdings, Inc., dated March 28, 2014 (incorporated herein by reference to Exhibit 10.18 to the Company's Current Report on Form 8-K/A filed on April 3, 2014).
10.22	Physician Shareholder Agreement, granted and delivered by Warren Hosseinion, M.D., in favor of Apollo Medical Management, Inc. and Apollo Medical Holdings, Inc., for the account of ApolloMed Hospitalists, dated March 28, 2014 (incorporated herein by reference to Exhibit 10.24 to the Company's Current Report on Form 8-K/A filed on April 3, 2014).
10.23	Second Amendment to Lease Agreement dated October 14, 2014 by and between Apollo Medical Holdings, Inc. and EOP-700 North Brand, LLC (incorporated herein by reference to Exhibit 10.5 on Quarterly Report on Form 10-Q filed on November 14, 2014).
10.24	Lease Agreement, dated July 22, 2014, by and between Numen, LLC and Apollo Medical Management, Inc. (incorporated herein by reference to Exhibit 10.01 to the Company's Current Report on Form 8-K/A filed on December 8, 2014).
10.25	Lease Agreement, dated August 1, 2002, by and between Network Medical Management, Inc. and Medical Property Partner. (incorporated herein by reference to Exhibit 10.27 to the Company's Annual Report on Form 10-K filed on April 2, 2018).
10.26	Lease Agreement, dated August 1, 2002, by and between Network Medical Management, Inc. and Medical Property Partner. (incorporated herein by reference to Exhibit 10.28 to the Company's Annual Report on Form 10-K filed on April 2, 2018).
10.27	Lease Agreement Addendum, dated February 1, 2013, by and between Network Medical Management, Inc. and Medical Property Partner. (incorporated herein by reference to Exhibit 10.29 to the Company's Annual Report on Form 10-K filed on April 2, 2018).
10.28	Change in Terms Agreement and Business Loan Agreement, dated April 9, 2016, by and between Network Medical Management, Inc. and Preferred Bank. (incorporated herein by reference to Exhibit 10.30 to the Company's Annual Report on Form 10-K filed on April 2, 2018).
10.29*	Change in Terms Agreement and Business Loan Agreement, dated April 7, 2017, by and between Network Medical Management, Inc. and Preferred Bank. (incorporated herein by reference to Exhibit 10.31 to the Company's Annual Report on Form 10-K filed on April 2, 2018).
10.30+	Employment Agreement dated December 20, 2016 between Apollo Medical Management, Inc. and Adrian Vazquez, M.D. (incorporated herein by reference to Exhibit 99.4 to the Company's Current Report on Form 8-K filed on December 22, 2016).

Exhibit No.	Description
10.31+	Amended and Restated Hospitalist Participation Service Agreement made as of June 29, 2016 by and between ApolloMed Hospitalists, a Medical Corporation, and Warren Hosseinion, M.D. (incorporated herein by reference to Exhibit 10.69 to the Company's Annual Report on Form 10-K filed on June 29, 2016).
10.32+	Amended and Restated Hospitalist Participation Service Agreement made as of June 29, 2016 by and between ApolloMed Hospitalists, a Medical Corporation, and Adrian Vazquez, M.D. (incorporated herein by reference to Exhibit 10.70 to the Company's Annual Report on Form 10-K filed on June 29, 2016).
10.33	Next Generation ACO Model Participation Agreement (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on January 20, 2017).
10.34	Form of Stockholder Lock-Up Agreement (incorporated herein by reference to Annex D to the joint proxy statement/prospectus filed pursuant to Rule 424(b)(3) on November 15, 2017 that is a part of a Registration Statement on Form S-4).
10.35*	Convertible Secured Promissory Note made as of October 13, 2017 by George M. Jayatilaka, M.D. (incorporated herein by reference to Exhibit 10.40 to the Company's Annual Report on Form 10-K filed on April 2, 2018).
10.36+	Offer Letter, dated June 5, 2018, between Apollo Medical Holdings, Inc. and Eric Chin (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q filed on August 14, 2018).
10.37+	Board of Directors Agreement, dated June 21, 2018, between Apollo Medical Holdings, Inc. and Ernest A. Bates, M.D. (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on June 26, 2018).
10.38+	Board of Directors Agreement, dated January 11, 2019, between Apollo Medical Holdings, Inc. and Linda Marsh. (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on January 17, 2019).
10.39+	Board of Directors Agreement, dated January 11, 2019, between Apollo Medical Holdings, Inc. and John Chiang. (incorporated herein by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed on January 17, 2019).
10.40	Loan Agreement, dated May 10, 2019, by and between Apollo Medical Holdings, Inc., a Delaware corporation and AP-AMH Medical Corporation, a California professional medical corporation (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on May 13, 2019).
10.41	Tradename Licensing Agreement, dated May 10, 2019, by and between Apollo Medical Holdings, Inc., a Delaware corporation and AP-AMH Medical Corporation, a California professional medical corporation (incorporated herein by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K filed on May 13, 2019).
10.42	Administrative Services Agreement, dated May 10, 2019, by and between Network Medical Management, Inc., a California corporation and AP-AMH Medical Corporation, a California professional medical corporation (incorporated herein by reference to Exhibit 10.4 to the Company's Current Report on Form 8-K filed on May 13, 2019).
10.43	Physician Shareholder Agreement, dated May 10, 2019, by and between Thomas Lam, M.D., Apollo Medical Holdings, Inc., a Delaware corporation, Network Medical Management, Inc., a California corporation, and AP-AMH Medical Corporation, a California professional medical corporation (incorporated herein by reference to Exhibit 10.5 to the Company's Current Report on Form 8-K filed on May 13, 2019).

Exhibit No.	Description
10.44	Series A Preferred Stock Purchase Agreement, dated May 10, 2019, by and between AP-AMH Medical Corporation, a California professional medical corporation and Allied Physicians of California, a Professional Medical Corporation, a California professional medical corporation (incorporated herein by reference to Exhibit 10.6 to the Company's Current Report on Form 8-K filed on May 13, 2019).
10.45	Special Purpose Shareholder Agreement, dated May 10, 2019, by and between Allied Physicians of California, a Professional Medical Corporation, a California professional medical corporation and AP-AMH Medical Corporation, a California professional medical corporation (incorporated herein by reference to Exhibit 10.7 to the Company's Current Report on Form 8-K filed on May 13, 2019).
10.46	Stock Purchase Agreement, dated May 10, 2019, by and between Allied Physicians of California, a Professional Medical Corporation, a California professional medical corporation and Apollo Medical Holdings, Inc., a Delaware corporation (incorporated herein by reference to Exhibit 10.8 to the Company's Current Report on Form 8-K filed on May 13, 2019).
10.47	Form of Amendment to Stockholder Lock-up Agreement (incorporated herein by reference to Exhibit 10.10 to the Company's Quarterly Report on Form 10-Q filed on August 9, 2019).
10.48	First Amendment to the Stock Purchase Agreement dated August 26, 2019, by and between Allied Physicians of California, a California Professional Medical Corporation and Apollo Medical Holdings, Inc. (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on August 29, 2019).
10.49	First Amendment to the Series A Preferred Stock Purchase Agreement dated August 26, 2019, by and between Allied Physicians of California, a California Professional Medical Corporation and AP-AMH Medical Corporation, a Professional Medical Corporation (incorporated herein by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed on August 29, 2019).
10.50	First Amendment to the Loan Agreement dated August 26, 2019, by and between Apollo Medical Holdings, Inc. and AP-AMH Medical Corporation, a Professional Medical Corporation (incorporated herein by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K filed on August 29, 2019).
10.51	Credit Agreement dated as of September 11, 2019, by and among Apollo Medical Holdings, Inc., as Borrower, the Lenders from time to time party thereto, and SunTrust Bank, in its capacity as administrative agent for the Lenders, as issuing bank and as swingline lender (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on September 12, 2019).
10.52	Guaranty and Security Agreement dated as of September 11, 2019, by and among Apollo Medical Holdings, Inc., as Borrower, and Network Medical Management, Inc., as Guarantor, in favor of SunTrust Bank, as administrative agent for the Secured Parties (incorporated herein by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed on September 12, 2019).
10.53	Second Amendment to Series A Stock Purchase Agreement dated as of September 9, 2019, by and between Allied Physicians of California, a Professional Medical Corporation and AP-AMH Medical Corporation, a California professional medical corporation (incorporated herein by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K filed on September 12, 2019).
10.54	First Amendment to Special Purpose Shareholder Agreement, dated as of September 11, 2019, by and between Allied Physicians of California, a Professional Medical Corporation and AP-AMH Medical Corporation, a California professional medical corporation (incorporated herein by reference to Exhibit 10.4 to the Company's Current Report on Form 8-K filed on September 12, 2019).
10.55	First Amendment to Tradename Licensing Agreement, dated as of September 10, 2019, by and between Apollo Medical Holdings, Inc., a Delaware corporation, and AP-AMH Medical Corporation, a California professional medical corporation (incorporated herein by reference to Exhibit 10.5 to the Company's Current Report on Form 8-K filed on September 12, 2019).

Exhibit No.	Description
10.56	First Amendment to Administrative Services Agreement, dated as of September 10, 2019, by and between Network Medical Management, Inc., a California corporation, and AP-AMH Medical Corporation, a California professional medical corporation (incorporated herein by reference to Exhibit 10.6 to the Company's Current Report on Form 8-K filed on September 12, 2019).
10.57	Security Agreement, dated as of September 11, 2019, by and between Apollo Medical Holdings, Inc., a Delaware corporation, and AP-AMH Medical Corporation, a California professional medical corporation (incorporated herein by reference to Exhibit 10.7 to the Company's Current Report on Form 8-K filed on September 12, 2019).
10.58	Certificate of Determination of Preferences of Series A Preferred Stock of Allied Physicians of California, a Professional Medical Corporation (incorporated herein by reference to Exhibit 10.8 to the Company's Current Report on Form 8-K filed on September 12, 2019).
10.59	Voting and Registration Rights Agreement, dated as of September 11, 2019, by and between Apollo Medical Holdings, Inc., a Delaware corporation, and Allied Physicians of California, a Professional Medical Corporation (incorporated herein by reference to Exhibit 10.9 to the Company's Current Report on Form 8-K filed on September 12, 2019).
10.60	Second Amendment to Loan Agreement, dated September 11, 2019, by and between Apollo Medical Holdings, Inc., a Delaware corporation and AP-AMH Medical Corporation, a California professional medical corporation (incorporated herein by reference to Exhibit 10.10 to the Company's Current Report on Form 8-K filed on September 12, 2019).
10.61	Form of Amendment to Stockholder Lock-up Agreement entered into on or about September 26, 2019 (incorporated herein by reference to Exhibit 10.14 to the Company's Quarterly Report on Form 10-Q filed on November 8, 2019).
10.62+	Board of Directors Agreement, dated September 29, 2019, with Matthew Mazdyasni (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on September 30, 2019).
14.1*	The Company's Code of Ethics.
21.1*	Subsidiaries of Apollo Medical Holdings, Inc.
23.1*	Consent of BDO USA, LLP, Independent Registered Public Accounting Firm.
24.1*	Power of Attorney (included on the signatures page of this Annual Report on Form 10-K).
31.1*	Certification of Principal Executive Officer Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2*	Certification of Principal Executive Officer Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.3*	Certification of Principal Financial Officer Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32**	Certification of Principal Executive Officers and Principal Financial Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101.INS*	XBRL Instance Document

Exhibit No.	Description
101.SCH*	XBRL Taxonomy Extension Schema Document
101.CAL*	XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF*	XBRL Taxonomy Extension Definition Linkbase Document
101.LAB*	XBRL Taxonomy Extension Label Linkbase Document
101.PRE*	XBRL Taxonomy Extension Presentation Linkbase Document

* Filed herewith

** Furnished herewith

+ Management contract or compensatory plan, contract or arrangement

† The schedules and exhibits thereof have been omitted pursuant to Item 601(b)(2) of Regulation S-K. A copy of any omitted schedule or exhibit will be furnished to the SEC upon request.

Item 16. Form 10-K Summary

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

APOLLO MEDICAL HOLDINGS, INC.

Date: March 16, 2020	By:	/s/ Kenneth Sim, M.D. Kenneth Sim, M.D. Executive Chairman and Co-Chief Executive Officer (Principal Executive Officer)
Date: March 16, 2020	By:	/s/ Thomas Lam, M.D. Thomas Lam, M.D. Co-Chief Executive Officer and President (Principal Executive Officer)

POWER OF ATTORNEY

KNOW ALL PERSONS BY THESE PRESENTS, that each person whose signature appears below constitutes and appoints, jointly and severally, Kenneth Sim, M.D., and Thomas Lam, M.D., and each of them, as his true and lawful attorneys-in-fact and agents, with full power of substitution and resubstitution, for him and in his name, place and stead, in any and all capacities, to sign any and all amendments to this Annual Report on Form 10-K, and to file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, granting unto said attorneys-in-fact and agents, and each of them, full power and authority to do and perform each and every act and thing requisite and necessary to be done in connection therewith, as fully to all intents and purposes as he might or could do in person, hereby ratifying and confirming all that said attorneys-in-fact and agents, or any of them, or their or his substitute or substitutes, may lawfully do or cause to be done by virtue hereof.

Pursuant to the requirements of the Securities Exchange Act of 1934 this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

	SIGNATURE	TITLE	DATE
By:	/s/ Kenneth Sim, M.D Kenneth Sim, M.D	Executive Chairman, Co-Chief Executive Officer (Principal Executive Officer) and Director	March 16, 2020
By:	/s/ Thomas Lam, M.D. Thomas Lam, M.D.	President, Co-Chief Executive Officer (Principal Executive Officer) and Director	March 16, 2020
By:	/s/ Eric Chin Eric Chin	Chief Financial Officer (Principal Financial Officer and Principal Accounting Officer)	March 16, 2020
By:	/s/ Ernest Bates, M.D. Ernest Bates, M.D.	Director	March 16, 2020
By:	/s/ John Chiang John Chiang	Director	March 16, 2020
By:	/s/ Michael Eng Michael Eng	Director	March 16, 2020
By:	/s/ Mark Fawcett Mark Fawcett	Director	March 16, 2020
By:	/s/ Mitchell Kitayama Mitchell Kitayama	Director	March 16, 2020
By:	/s/ Linda Marsh Linda Marsh	Director	March 16, 2020
By:	/s/ Matthew Mazdyasni Matthew Mazdyasni	Director	March 16, 2020
By:	/s/ David Schmidt David Schmidt	Director	March 16, 2020
By:	/s/ Li Yu Li Yu	Director	March 16, 2020

Exhibit 4.10

DESCRIPTION OF THE REGISTRANT'S SECURITIES
REGISTERED PURSUANT TO SECTION 12 OF THE
SECURITIES EXCHANGE ACT OF 1934

The following description sets forth certain terms and provisions of our securities that are registered under Section 12 of the Securities Exchange Act of 1934, as amended. This description also summarizes relevant provisions of the General Corporation Law of Delaware (the "DGCL"). The following description is a summary and does not purport to be complete. It is subject to, and qualified in its entirety by reference to, the applicable provisions of the DGCL and our restated certificate of incorporation, as amended (our "Certificate of Incorporation"), and our restated bylaws, as amended (our "Bylaws"), each of which is incorporated by reference as an exhibit to the Annual Report on Form 10-K of which this Exhibit 4.12 is a part. We encourage you to read our Certificate of Incorporation, our Bylaws, and the applicable provisions of the DGCL for additional information.

General

We have 100,000,000 shares of common stock, par value $0.001 per share, and 5,000,000 shares of preferred stock, par value $0.001 per share, authorized for issuance, of which 1,111,111 shares are designated as Series A convertible preferred stock and 555,555 shares are designated as Series B convertible preferred stock. As of March 2, 2020, there were 52,804,187 shares of common stock, issued and outstanding and 1,111,111 shares of Series A preferred stock issued, none of which are outstanding, and 555,555 shares of Series B preferred stock issued, none of which are outstanding.

Only our common stock is registered under Section 12 of the Securities Exchange Act of 1934, as amended. Our common stock is listed on the NASDAQ Capital Market under the symbol "AMEH."

Common Stock

Voting

Holders of our common stock are entitled to one vote for each share for the election of directors and on all other matters submitted to a stockholder vote. Holders of our common stock do not have cumulative voting rights.

Dividends

Subject to the rights of preferred stockholders, if any, holders of our common stock are entitled to share in all dividends that our board of directors, in its discretion, declares from legally available funds. Holders of our shares of Series A preferred stock and Series B preferred stock are entitled to receive dividends, out of legally available assets, on parity with the holders of our shares of common stock.

Liquidation

In the event of a liquidation, dissolution or winding up, each outstanding share of our common stock entitles its holder to participate pro rata in all assets that remain after payment of all liabilities and the liquidation preferences of any of our outstanding shares of Series A preferred stock and Series B preferred stock. The Series A preferred stock and the Series B preferred stock each have a liquidation preference in the amount of $9.00 per share plus any declared and unpaid dividends.

Other Rights

Our common stock has no pre-emptive, subscription or conversion rights and there are no redemption provisions applicable to our common stock.

Anti-Takeover Provisions

The following provisions of our Certificate of Incorporation and our Bylaws, could have the effect of delaying or discouraging another party from acquiring control of us and could encourage persons seeking to acquire control of us to first negotiate with our board of directors:

- our Bylaws prohibit our stockholders from filling board vacancies
- our Bylaws require holders of no less than one-then of all shares entitled to vote at a meeting to call a special meeting of stockholders.
- our Bylaws provide that our board of directors will establish the authorized number of directors from time to time;
- our Certificate of Incorporation does not permit cumulative voting in the election of directors; and
- our Certificate of Incorporation permits our board of directors to determine the rights, privileges and preferences of any new series of preferred stock, some of which could impede the ability of a person to acquire control of our company.

In addition, we are subject to the provisions of Section 203 of the DGCL. Section 203 prohibits a publicly held Delaware corporation from engaging in a "business combination" with an "interested stockholder" for a period of three years after the date of the transaction in which the person became an interested stockholder, unless the business combination is approved in a prescribed manner. A "business combination" includes mergers, asset sales and other transactions resulting in a financial benefit to the interested stockholder. Subject to specified exceptions, an "interested stockholder" is a person who, together with affiliates and associates, owns, or within three years did own, 15% or more of the corporation's voting stock.

APOLLO MEDICAL HOLDINGS, INC.

CODE OF ETHICS

(adopted April 19, 2018)

Introduction

The Board of Directors of Apollo Medical Holdings, Inc. (the "Company") has adopted this Code of Ethics (this "Code") for its directors, officers and other employees (individually, an "Apollo Party" and collectively, "Apollo Parties"). As used herein, any principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions are sometimes also referred to as the "Senior Financial Officers."

This Code has been reasonably designed to deter wrongdoing and to promote:

- Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
- Full, fair, accurate, timely and understandable disclosure in reports and documents that a registrant files with, or submits to, the Securities and Exchange Commission and in other public communications made by the Company;
- Compliance with applicable governmental laws, rules and regulations;
- The prompt internal reporting to an appropriate person or persons identified in this Code of violations of this Code; and
- Accountability for adherence to this Code.

I. Honest and Ethical Conduct

Apollo Parties are expected to act and perform their duties ethically, honestly and with the utmost integrity. Honest conduct is free from fraud and deception. Ethical conduct conforms to accepted professional standards and includes the ethical handling of actual and apparent conflicts of interest between personal and professional relationships, as discussed in greater detail below.

II. Compliance with Laws, Rules and Regulations

It is the policy of the Company to comply with all applicable laws, rules and regulations, and it is the personal responsibility of each Apollo Party to adhere to all standards and restrictions imposed by these laws, rules and regulations. In particular, each Apollo Party will adhere to all laws, rules and regulations relating to accounting and auditing matters. Any Apollo Party with questions about applicability or interpretation of any law, rule or regulation should contact a member of the Company's upper management.

III. Conflicts of Interest

In performing their job duties, Apollo Parties are expected to use good judgment to act, at all times and in all ways, in the best interests of the Company. A "conflict of interest" exists where an Apollo Party's personal interest, or the interest of a family member, comes into conflict with or interferes with the best interests of the Company. For example, a conflict of interest may occur when an Apollo Party or family member receives a personal benefit as a result of the Apollo Party's position with the Company. A conflict of interest may also arise from an Apollo Party's business

or personal relationship with a competitor, supplier, customer, business partner or other Apollo Party if the relationship impairs the Apollo Party's objective business judgment, or from the receipt of gifts or services in certain situations.

Any Apollo Party who is aware of a conflict of interest, or is concerned that a conflict of interest might develop, must discuss the matter with a supervisor or a member of the Company's upper management promptly. Senior Financial Officers may, in addition, discuss the matter with the Audit Committee of the Board of Directors of the Company (the "Audit Committee").

IV. Insider Trading

Federal and state laws prohibit trading in securities by persons who have material information that is not generally known or available to the public. Apollo Parties may not (a) trade in stock or other securities while in possession of material nonpublic information, (b) pass such information on to others without the express authorization of the Company, or (c) recommend to others that they trade in stock or other securities of any company based on material nonpublic information.

The Company has adopted an Insider Trading Policy to implement this policy and assist in compliance with insider trading laws. All Apollo Parties are required to review and follow the Company's Insider Trading Policy, and certain Apollo Parties must comply with designated blackout periods for trading described in the Insider Trading Policy when trading in Company securities.

V. Discrimination and Harassment

The Company provides equal opportunity in all aspects of employment and will not tolerate any illegal discrimination or harassment of any kind.

VI. Health and Safety

The Company strives to provide a clean, safe and healthy work environment to all Apollo Parties. Each Apollo Party is responsible for maintaining a safe and healthy workplace for all other Apollo Parties by following safety and health rules and practices, and reporting any accidents or injuries, and any unsafe equipment, practices or conditions.

VII. Bribery; Payments to Government Personnel

Apollo Parties may not bribe anyone for any reason, whether in dealings with governments or in the private sector. The United States Foreign Corrupt Practices Act, and similar laws in other countries, prohibit offering or giving anything of value to government officials in order to secure business. Apollo Parties may not make any illegal payments to government personnel, whether directly or through a third party, and should contact a member of upper management for guidance when conducting business with government officials of any country.

VIII. Recordkeeping, Reporting and Financial Integrity

The Company's books, records, accounts and financial statements must be appropriately maintained in reasonable detail at all times, and must properly reflect the Company's transactions and conform to the Company's system of internal controls and applicable law. The Company's public financial reports must contain full, fair, accurate, timely and understandable disclosure, as required by law.

IX. Additional Provisions Applicable to Senior Financial Officers

Senior Financial Officers are responsible for ensuring that the disclosures in the Company's periodic reports are full, fair, accurate, timely, and understandable, as required by law. In doing so, Senior Financial Officers must take all such action reasonably necessary to (I) establish and comply with disclosure controls and procedures, as well as accounting and financial controls, that are designed to ensure that all material information related to the Company is made known to them; (ii) confirm that the Company's periodic reports comply with the requirements of Sections 13(a) and/or 15(d) of the Securities Exchange Act of 1934; and (iii) ensure that the information in the Company's periodic reports fairly presents in all material respects the financial condition and results of operations of the Company.

Senior Financial Officers shall not knowingly (I) make, or permit or direct any other person to make, materially false or misleading entries in the financial statements or records of the Company or any of its subsidiaries; (ii) sign, or permit or direct another person to sign, a document containing materially false and misleading information; or (iv) falsely respond, or fail to respond, to specific inquiries from the Company's independent auditor or outside counsel.

X. Internal Reporting

Apollo Parties shall take all appropriate actions to stop known misconduct by fellow Apollo Parties that violate this Code. Apollo Parties shall report any known or suspected misconduct to their supervisors or a member of the Company's upper management, or, in the case of misconduct by a Senior Financial Officer, to the Chair of the Audit Committee.

Apollo Parties are encouraged to report any breach of this Code. The Company will not retaliate or allow retaliation for any reports made in good faith.

XI. Accountability

All Apollo Parties will be held strictly accountable for adherence to this Code. Questions concerning this Code may be directed to a member of upper management or the Audit Committee. Violations of this Code may result in disciplinary action, including termination, and if warranted, legal proceedings. This Code is a statement of certain fundamental principles that govern the Apollo Parties in the conduct of the Company's business. It does not create any rights in any employee, customer, supplier, competitor, stockholder or any other person or entity. The Audit Committee will investigate violations and appropriate action will be taken in the event of any violation of this Code.

XII. Waivers and Amendments

The Board of Directors shall have the sole authority to approve any waiver or deviation from this Code for any Apollo Party, and any amendment or waiver of this Code shall be promptly disclosed as required by law. Specifically, any waiver or modification of this Code for a Senior Financial Officer will be promptly disclosed to stockholders as required by law, regulation or rule of a stock exchange on which the Company's securities are traded.

Exhibit 21.1

Subsidiaries

Entity	Jurisdiction of Incorporation
Network Medical Management, Inc.	California
Apollo Medical Management, Inc.	Delaware
APAACO, Inc.	Delaware
Apollo Care Connect, Inc.	Delaware
ApolloMed Accountable Care Organization, Inc.*	California
Allied Pacific Hospice, LLC	California
Allied Physicians ACO, LLC	California
APCN-ACO, Inc.	California
99 Medical Equipment, Healthcare Supplies & Wheelchair Center	California
Apollo Palliative Services, LLC	California
Best Choice Hospice Care, LLC	California
Holistic Care Home Health Agency, Inc.	California
Pulmonary Critical Care Management, Inc.	California
Verdugo Medical Management, Inc.	California

* 80% ownership

Consent of Independent Registered Public Accounting Firm

Apollo Medical Holdings, Inc.
Alhambra, California

We hereby consent to the incorporation by reference in the Registration Statements on Form S-4 (No. 333-219898), Form S-8 (No. 333-217719, 333-153138, 333-221915 and 333-221900), and Form S-3 (No. 333-228432, 333-229895 and 333-231109) of Apollo Medical Holdings, Inc. ("Company") of our reports dated March 16, 2020, relating to the consolidated financial statements, and the effectiveness of the Company's internal control over financial reporting, which appear in this Form 10-K.

/s/ BDO USA, LLP
Los Angeles, California

March 16, 2020

Exhibit 31.1

CERTIFICATION OF PRINCIPAL EXECUTIVE OFFICER

PURSUANT TO

SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Kenneth Sim, M.D., certify that:

1. I have reviewed this annual report on Form 10-K of Apollo Medical Holdings, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

DATE: March 16, 2020

/s/ Kenneth Sim, M.D.

Kenneth Sim, M.D.

Executive Chairman and
Co-Chief Executive Officer
(Principal Executive Officer)

Exhibit 31.2

CERTIFICATION OF PRINCIPAL EXECUTIVE OFFICER

PURSUANT TO

SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Thomas Lam, M.D., certify that:

1. I have reviewed this annual report on Form 10-K of Apollo Medical Holdings, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

DATE: March 16, 2020

/s/ Thomas Lam, M.D.

Thomas Lam, M.D.
Co-Chief Executive Officer and President
(Principal Executive Officer)

Exhibit 31.3

CERTIFICATION OF PRINCIPAL FINANCIAL OFFICER

PURSUANT TO

SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Eric Chin, certify that:

1. I have reviewed this annual report on Form 10-K of Apollo Medical Holdings, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

DATE: March 16, 2020 /s/ Eric Chin

Eric Chin
Chief Financial Officer
(Principal Executive Officer)

Exhibit 32

CERTIFICATION OF PRINCIPAL EXECUTIVE OFFICERS AND PRINCIPAL FINANCIAL OFFICER

PURSUANT TO

18 U.S.C. SECTION 1350.

AS ADOPTED PURSUANT TO

SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

I, Kenneth Sim, M.D., certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that the Annual Report on Form 10-K of Apollo Medical Holdings, Inc. for the year ended December 31, 2019, fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended, and that the information contained in such report fairly presents, in all material respects, the financial condition and results of operations of Apollo Medical Holdings, Inc.

DATE: March 16, 2020 /s/ Kenneth Sim, M.D.

Kenneth Sim, M.D.
Executive Chairman and
Co-Chief Executive Officer
(Principal Executive Officer)

I, Thomas Lam, M.D., certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that the Annual Report on Form 10-K of Apollo Medical Holdings, Inc. for the year ended December 31, 2019, fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended, and that the information contained in such report fairly presents, in all material respects, the financial condition and results of operations of Apollo Medical Holdings, Inc.

DATE: March 16, 2020 /s/ Thomas Lam, M.D.

Thomas Lam, M.D.
Co-Chief Executive Officer and President
(Principal Executive Officer)

I, Eric Chin, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that the Annual Report on Form 10-K of Apollo Medical Holdings, Inc. for the year ended December 31, 2019, fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended, and that the information contained in such report fairly presents, in all material respects, the financial condition and results of operations of Apollo Medical Holdings, Inc.

DATE: March 16, 2020 /s/ Eric Chin

Eric Chin
Chief Financial Officer
(Principal Financial Officer)