Apollo Medical Holdings, Inc.
Form 10-K
April 02, 2018

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

(Mark One)

x **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2017

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	**46-3837784**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

1668 S. Garfield Avenue, 2nd Floor, Alhambra, CA 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	Name of Each Exchange on Which Registered
Common Stock, par value $ 0.001	**The NASDAQ Stock Market LLC**

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 x

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 x

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 x No ¨

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted 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 and post such files). Yes x No ¨

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ¨

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 ¨ (Do not check if a smaller reporting company)	Smaller reporting company x
	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 x No

The aggregate market value of common stock of the registrant held by non-affiliates, based upon the closing sales price for the common stock, as reported on OTC Pink as of September 30, 2016, the last business day of the registrant’s most recently completed second fiscal quarter (before the registrant changed its fiscal year-end from March 31 to December 31 in December 2017), was $13,438,161. Solely for purposes of the foregoing calculation, shares of common stock held by each officer and director and by each person who owned 10% or more of the outstanding common stock as of September 30, 2017 have been excluded in that such persons may be deemed to be affiliates. This determination of affiliate status is not necessarily a conclusive determination for any other purpose.

As of March 28, 2018, there were 6,951,012 shares of common stock of the registrant, $0.001 par value per share, issued and outstanding. In addition, as of the date of this Annual Report on Form 10-K, 25,675,630 (net of 3,039,749 holdback shares and 1,682,110 treasury shares) shares of the registrant’s common stock and 1,750,000 warrants to purchase the registrant’s common stock issuable to former shareholders of Network Medical Management, Inc. (“NMM”), in connection with a reverse merger between the registrant and NMM, are subject to the registrant receiving from those former NMM shareholders a properly completed letter of transmittal (and related exhibits) before such former NMM shareholders may receive their pro rata portion of shares of the registrant’s common stock and warrants.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant’s definitive Proxy Statement for the 2018 annual meeting of the stockholders of the registrant (the “2018 Annual Meeting”) 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, 2017.

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INTRODUCTORY NOTE

Unless the context dictates otherwise, references in this Annual Report on Form 10-K (the "Report") to the "Company," "we," "us," "our," "Apollo," "ApolloMed" and similar words are to Apollo Medical Holdings, Inc., its wholly owned subsidiaries and affiliated entities, including 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 operations. 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") have not reviewed any statements contained in this Report, including statements describing the participation of APAACO, 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 Report 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 document 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 such as our outlook of our NGACO and 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," "expe "believe," "think," "plan," "envision," "intend," "continue," "target," "seek," "contemplate," "budgeted," "will," "would," and 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. Some of the key factors impacting these risks and uncertainties include, but are not limited to:

- risks related to our ability to successfully locate new strategic targets and integrate our operations following mergers, acquisitions or other strategic transactions, including that the integration may be more costly or more time consuming and complex than anticipated and that synergies anticipated to be realized may not be fully realized or may take longer to realize than expected.

- our dependence on a few key payors;

- changes in federal and state programs and policies regarding medical reimbursements and capitated payments for health services we provide;

- the success of our focus on our NGACO, to which we have devoted, and intend to continue to devote, considerable effort and resources, financial and otherwise, including whether we can manage medical costs for patients assigned to us within the capitation received from CMS and whether we can continue to participate in the All-Inclusive Population-Based Payment ("AIPBP") Mechanism of the NGACO Model as payments thereunder represent a significant part of our total revenues;

- general economic uncertainty;

- any adverse development in general market, business, economic, labor, regulatory and political conditions;

- any outbreak or escalation of acts of terrorism or natural disasters;

- changing government programs in which we participate for the provision of health services and on which we are also significantly dependent in generating revenue;

- changes in laws and regulations and other market-wide developments affecting our industry in general and our operations in particular, including the impact of any change to applicable laws and regulations relating to trade, monetary and fiscal policies, taxes, price controls, regulatory approval of new products, registration and licensure, healthcare reform and reimbursements for medical services from private insurance, on which we are significantly dependent in generating revenue and the impact, including additional costs, of mandates and other obligations that may be imposed upon us as a result of new or revised federal and state healthcare laws;

- risks related to our ability to raise capital as equity or debt to finance our growth and strategic transactions;

- our ability to retain key individuals, including members of senior management;

- the impact of rigorous competition in the healthcare industry generally;

- the impact of any potential future impairment of our assets;

- risks related to changes in accounting literature or accounting interpretations; and

- the fluctuations in the market value of our securities.

For a detailed description of these and other factors that could cause our actual results to differ materially from those expressed in any forward-looking statement, please see Item 1A entitled “Risk Factors,” of this Annual Report on Form 10-K. In light of the foregoing, investors are advised to carefully read this Annual Report on Form 10-K in connection with the important disclaimers set forth above and are urged not to rely on any forward-looking statements in reaching any conclusions or making any investment decisions about us or our securities. Except as required by law, we do not intend, and undertake no obligation, to update any statement, whether as a result of the receipt of new information, the occurrence of future events, the change of circumstances or otherwise. We further do not accept any responsibility for any projections or reports published by analysts, investors or other third parties.

PART I

Item 1. Business

Overview

We are a patient-centered and physician-centric, integrated health care delivery and management company focused on providing coordinated, outcomes-based medical care in a cost-effective manner. Led by a management team with several decades of experience, we have built a company and culture that is focused on population health management by coordinating high-quality medical care for patients in need. We believe that we are well-positioned to take advantage of changes in the rapidly evolving U.S. healthcare industry, as there is a growing national movement towards more results-oriented healthcare centered on the triple aim of patient satisfaction, high-quality care and cost efficiency. Our core pillars are: our robust network of physicians, our clinical expertise in population health management, our experience in taking on financial risk for these patients, and our technology infrastructure.

We serve 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, primarily through our owned and affiliated physician groups. We promote an integrated approach to medical care that places the physician at the center of patient care. We manage the delivery of healthcare services via a network of affiliated physician groups, hospitals, as well as other network primary care physicians and specialists. Together with case managers, registered nurses and other care coordinators, these medical professionals utilize a comprehensive data analysis engine, sophisticated risk management techniques and clinical protocols to provide high-quality, cost effective care to our managed care members.

We primarily operate from Los Angeles County, California. In December 2017, we completed a reverse merger with Network Medical Management, Inc. ("NMM"), a California corporation formed in 1994 (the "Merger"). As a result of the Merger, NMM became a wholly owned subsidiary of ApolloMed, former NMM shareholders own more than 80% of the issued and outstanding shares of ApolloMed's common stock. 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).

Immediately following the Merger, our board of directors approved a change in our fiscal year-end from March 31 to December 31, to correspond with the fiscal year-end of NMM prior to the Merger. Our first fiscal year-end following the Merger thus was December 31, 2017.

All of our revenue is derived from business operations in California. As of December 31, 2017, through capitation agreements with HMOs including some of the nation's leading health plans, we were responsible for coordinating primary and specialist care for approximately 800,000 covered patients primarily in southern and central California through a network of affiliated independent practice associations ("IPAs") and medical groups with over 4,000 contracted physicians. These covered patients are comprised of managed care members whose health coverage is provided through their employer or who have individually acquired health coverage directly from a health plan or are eligible for Medicaid or Medicare benefits. As of December 31, 2017, our affiliated medical groups provided hospitalist services at multiple acute-care hospitals, long-term acute care facilities and outpatient clinics. ApolloMed and its subsidiaries generate revenue by providing administrative, medical management and clinical services to affiliated IPAs and medical groups. The administrative services cover primarily billing, collection, accounting, administrative, quality assurance, marketing, compliance and education. In addition, our NGACO, which served over 29,000 beneficiaries through 2017, 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;
- Management service organizations ("MSOs"), which provide management, administrative and other support services to our affiliated physician groups such as IPAs;
- APAACO, which started operations on January 1, 2017, and previously, several accountable care organizations ("ACOs"), which participated in the Medicare Shared Savings Program (the "MSSP") sponsored by CMS and focused 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 cardiac clinic care and diagnostic testing center;
- Hospitalists, which includes our employed and contracted physicians who focus on the delivery of comprehensive medical care to hospitalized patients;

- Hospice/palliative care and home health services; 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 also integrates clinical data.

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

- Capitation payments;

- Risk pool settlements and incentives;

- Management fees, including stipends from hospitals and percentages of collections;

- Payments made by CMS from the NGACO Model, and, while we are transitioning from the MSSP to the NGACO Model, payments made by CMS, if any, from the MSSP; and

- FFS reimbursement.

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

Organization

Subsidiaries

We operate through our subsidiaries, primarily including:

- NMM;
- Apollo Medical Management, Inc. ("AMM");
- APAACO;

- Apollo Palliative Services, LLC ("APS"); and
- Apollo Care Connect, Inc. ("Apollo Care Connect").

Each of NMM and AMM operates as a 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 NMM or AMM, as applicable, manages certain non-medical services for the physician group and has 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. We operated two additional MSOs, Pulmonary Critical Care Management, Inc. and Verdugo Medical Management, Inc., which are no longer active to any material extent.

APAACO, jointly owned by NMM and AMM, participates in the NGACO Model of CMS as of 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.

We operated three ACOs that participated in the MSSP to serve the Medicare FFS population: ApolloMed Accountable Care Organization, Inc. ("Apollo-ACO"), majority owned by ApolloMed, as well as APCN-ACO, Inc. ("APCN-ACO") and Allied Physicians ACO, LLC ("AP-ACO"), wholly owned by NMM. As we are transitioning to the NGACO Model, patients and physicians with the three ACOs have substantially been transferred to APAACO.

APS, in which we have a majority interest, provides palliative care services to provide relief from the symptoms and stress of a serious illness to improve quality of life for both the patient and the patient's family and owns two Los Angeles-based companies, Best Choice Hospice Care LLC and Holistic Care Home Health Agency Inc.

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

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. 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 management services agreements 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 ("APC"). APC contracts with various HMOs or licensed health care service plans, each of which pays a fixed capitation payment 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. 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 is determined to be a variable interest entity ("VIE") of NMM as NMM is the primary beneficiary of APC with the ability, through majority representation on the APC Joint Planning Board, to direct the activities (excluding clinical decisions) that most significantly affect APC's economic performance.

Through AMM, we manage a number of our affiliates pursuant to their long-term MSAs with AMM, including: ApolloMed Hospitalists ("AMH"), a physician group that provides hospitalist, intensivist and physician advisor services, Southern California Heart Centers ("SCHC"), a specialty clinic that focuses on cardiac care and diagnostic testing, and Bay Area Hospitalist Associates ("BAHA"), which operates a hospitalist, intensivist and post-acute care practice with a presence at three acute care hospitals, one long-term acute care hospital and several skilled nursing facilities in San Francisco. Each of AMH, SCHC, and BAHA are VIEs of AMM as it was 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. Effective on October 31, 2017, 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. The results of operations of ICC from October 31, 2017 to

December 31, 2017 were de minimis.

APC, AMH, SCHC, BAHA, CDSC and ICC, therefore, are 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 its Medicare Advantage. Pacific Ambulatory Surgery Center, LLC ("PASC"), in which APC has a 40% non-controlling ownership interest, is a multi-specialty outpatient surgery center that is certified to participate in the Medicare program and accredited by the Accreditation Association for Ambulatory Health Care. APC also holds a 4.95% 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 non-controlling ownership interests in several medical corporations, including the IPA line of business of LaSalle Medical Associates ("LMA"), Pacific Medical Imaging and Oncology Center, Inc. ("PMIOC") and David C.P. Chen M.D., Inc. ("DMG"). The IPA line of business of LMA operates four neighborhood medical centers and serves patients across Fresno, Kings, Los Angeles, Madera, Riverside, San Bernardino and Tulare Counties, California, with which NMM has a management services agreement. PMIOC offers comprehensive diagnostic imaging services at its facilities. DMG, doing business as Diagnostic Medical Group, operates complete outpatient imaging centers to improve the detection and treatment of heart disease. Maverick Medical Group, Inc. ("MMG"), an IPA wholly owned by APC-LSMA, provided medical and business management services to its members and focuses on meeting special needs of the senior population.

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 5.6% from 2016 to 2025, and 4.7 percent per year on a per capita basis. Health spending is projected to grow 1.2% faster than the U.S. gross domestic product over the 2016-2025 projection period, and as a result, the healthcare share of gross domestic product is expected to rise from 17.8% in 2015 to 19.9 percent by 2025. CMS further reports that health spending growth by federal, state and local

governments is projected to outpace growth by private payors such businesses and households (5.9% compared to 5.4%, respectively, over the 2016-2025 projection period) in part due to ongoing strong enrollment growth in Medicare or Medicaid coupled with the continued governments subsidizing premiums for lower income 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 2017 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 $3.5 trillion in 2017, representing 17.9% of U.S. Gross Domestic Product (“GDP”). CMS projects healthcare spending in the U.S. to increase to approximately 20% of GDP by 2026. 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 have 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 us and our affiliated physician groups, are positioned to take advantage of industry trends, meet patient and government demands, and benefit from cost advantages due to 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 to 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 50,000 by 2016, making it one of the fastest-growing medical specialties, and the percentage of hospitals using hospitalists increased to more than 70% by 2014.

Hospice/Palliative Care and Home Health Care Companies

Hospice/palliative care companies serve chronically, terminally or seriously ill patients and their families. Comprehensive management of the healthcare services and products needed by such patients and their families are provided through the use of an interdisciplinary team. Depending upon his or her needs, each patient is assigned an interdisciplinary team comprised of a physician, nurse(s), home health aide(s), social worker(s), chaplain, dietary counselor and bereavement coordinator, as well as other care professionals. Hospice/palliative care services are provided primarily in the patient's home or other residence, such as an assisted living residence or nursing home, or in a hospital. Medicare's hospice benefit is designed for patients expected to live six months or less. Hospice/palliative care services for a patient can continue, however, for more than six months, as long as the patient remains eligible as reflected by a physician's certification. Home health care companies provide direct home nursing and therapy services in addition to nutrition and disease management education. These services are provided by licensed and Medicare-certified skilled nurses and other paraprofessional nursing personnel.

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 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 contracts 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 month 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 had been approved to participate in the NGACO Model. APAACO has begun 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. In connection with APAACO's participation in the NGACO Model, CMS and APAACO have entered into the Participation Agreement. The initial term of the Participation Agreement expires on December 31, 2018. CMS may offer to renew the Participation Agreement for an additional two performance years. Additionally, the Participation Agreement may be terminated sooner by CMS as specified therein, and CMS has the authority to alter or change the program over this time period.

In advance of its participation in the NGACO Model, APAACO entered into agreements with over 700 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 assigned Medicare beneficiaries. 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 shall 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 Fee For Service (“FFS”).
- Payment Mechanism #2: Normal FFS plus Infrastructure payments of $6 Per Beneficiary Per Month (“PBPM”).
- Payment Mechanism #3: Population-Based Payments (“PBP”). PBP payments 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 payment to be received by the ACO.
- Payment Mechanism #4: 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 patients and then pays that projected amount to APAACO in a per-beneficiary, per-month payment, and 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 2018, we continue to be eligible for receiving AIPBP payments (currently at a rate of approximately $7.3 million per month).

MSSP ACOs

We operated three MSSP ACOs that contracted with CMS to serve the Medicare FFS population. Our ACOs shared savings with CMS, if any, to the extent that the actual costs of serving aligned beneficiaries were below certain trended benchmarks of such beneficiaries and certain quality performance measures are achieved. As providers enrolling in our NGACO continue to increase and their patients become beneficiaries under the NGACO, we have gradually decreased the number of beneficiaries managed by our MSSP ACOs and transitioned their operations. AP-ACO terminated its participation in the MSSP effective as of December 31, 2016. APCN-ACO and Apollo-ACO terminated their participation in the MSSP effective as of December 31, 2017 but will still need to submit quality reports to CMS with respect to 2017 performance year and may qualify for shared savings for that year, if any. In 2017, APCN-ACO received approximately $2.8 million in shared savings for performance year 2016 while AP-ACO and Apollo-ACO did not received shared savings for performance year 2016.

Outpatient Clinics

Our affiliated outpatient clinics, including SCHC, CDSC, PASC, ICC and PMIOC, provide specialty care, such as ambulatory care, lab and imaging services and cardiology and pulmonary services. We have several affiliated imaging centers complete with magnetic resonance imaging (“MRI”), compound tomography (“CT”), cardiac echo, ultrasound, nuclear or exercise stress-test equipment. Some of our affiliated clinics focus on efficient delivery of ambulatory treatment and ancillary services, with an increasing emphasis on preventive care and managing chronic conditions. Some of our affiliated clinics serve as post-discharge centers for patients who left hospitals. Our affiliated clinics are mainly located in the greater Los Angeles area, have served their communities for many years, and attended more than 25,000 patient visits during 2017.

Hospitalist Services

Through our affiliated medical groups, including AMH, we provide hospitalist, intensivist and physician advisor services at hospitals and other facilities and for IPAs, medical groups and health plans. These services include admission, daily rounding and discharge of patients, emergency room evaluation and intensivist/ICU services. We expect to continue to enter into new agreements to provide comprehensive hospitalist services to patients in need.

Hospice/Palliative Care and Home Health Care Operations

Our hospice/palliative care and home health operations provide services for patients using an interdisciplinary team composed of physicians, nurses and other healthcare workers. For hospice services, depending on the needs of the specific patient in each case, our service team may include a physician, nurse, home health aide, medical social worker, chaplain, dietary counselor and bereavement coordinator. Our hospice/palliative care services are provided in the patient's home, assisted living or nursing home or in a hospital. Our home health services are provided directly in each patient’s home and may include nursing and therapy services, as well as specialty programs such as disease management education, nutrition and help with daily living activities.

Population Health Management Platform

Our proprietary cloud and mobile-based population health management platform, Apollo Care Connect, includes an inpatient dashboard, care management modules, digital care plans for patients with chronic illnesses and features that allow patients to view their health data, interact real-time with their physicians and care managers and extract clinical and claims data from multiple electronic health records and claims systems.

Our Revenue Streams

Our revenue reflected in the accompanying 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 types of our business operations in the following manners:

Capitation Revenue

Our capitation revenue consists primarily of capitated fees for medical services provided by us under provider service agreements (“PSAs”) or capitated arrangements with various managed care providers including HMOs. Capitated fees are typically prepaid monthly to us based on the number of enrollees electing us as their healthcare provider. Capitation is a fixed amount of money 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.

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Risk Pool Settlements and Incentives

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

We have full risk capitation arrangements with certain health plans and local hospitals, which are administered by third parties, where the hospital is responsible for providing, arranging and paying for institutional risk and the Company is responsible for providing, arranging and paying for professional risk. Under a full risk 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. Any deficits should not be payable until and unless we generate (and only to the extent of any) risk sharing surpluses, and at the termination of the risk sharing arrangement, any accumulated deficit should be extinguished. Advance settlement payments are typically made quarterly in arrears if there is a surplus. However, due to the uncertainty around the settlement of the related incurred but not reported ("IBNR") reserve, we recognize the risk pool settlement revenue when such amounts are known.

Under capitated arrangements with certain HMOs, we participate in one or more shared risk arrangements relating to the provision of institutional services to enrollees 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 the Company 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, should not be payable until and unless we generate (and only to the extent of any) risk sharing surpluses. At the termination of the HMO contract, any accumulated deficit should be extinguished. Due to the lack of access to information necessary to estimate the related costs, shared-risk amounts receivable from the HMOs are only recorded when such amounts are known. 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, some HMOs maintain incentive or "pay-for-performance" programs to compensate for improved quality of services and/or efficient use of pharmacy supplies, pursuant to which we may receive performance linked financial rewards based on their reported resource utilization rates. The incentive programs track specific performance measures and calculate payments to us based on the performance measures. These incentives for the prior contract years are generally recorded in the third or fourth quarter of the following year when such amounts are known.

Management Fee Income

Our 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. 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. Our management fee income also includes revenue sharing payments from our partners based on their non-medical services.

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 budget established with CMS. We are responsible to manage medical costs for these patients. The patients will receive services from physicians and other medical service providers that are both in-network and out-of-netw