

RadNet, Inc.
Form 10-K
March 17, 2017
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington D.C. 20549

FORM 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2016

Commission File Number 001-33307

RadNet, Inc.

(Exact name of registrant as specified in its charter)

Delaware	13-3326724
<u>(State or other jurisdiction of</u>	<u>(I.R.S. Employer</u>
<u>incorporation or organization)</u>	<u>Identification No.)</u>

1510 Cotner Avenue	
Los Angeles, California	90025
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: (310) 478-7808

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

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<u>Title of Each Class</u>	<u>Name of each exchange on which registered</u>
Common Stock, \$.0001 par value	NASDAQ Global Market

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

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 Section 15(d) of the 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 and posted on its corporate Website, 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 No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) 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, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large Accelerated Filer <input type="checkbox"/>	Accelerated Filer <input checked="" type="checkbox"/>
Non-Accelerated Filer <input type="checkbox"/> (Do not check if a smaller reporting company)	Smaller Reporting Company <input type="checkbox"/>

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

The aggregate market value of the registrant's common stock held by non-affiliates of the registrant was approximately \$224,518,331 on June 30, 2016 (the last business day of the registrant's most recently completed second quarter) based on the closing price for the common stock on the NASDAQ Global Market on June 30, 2016.

The number of shares of the registrant's common stock outstanding on March 9, 2017, was 47,198,596

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive proxy statement for the 2017 Annual Meeting of Stockholders 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 pursuant to Regulation 14A not later than 120 days after the close of the registrant's fiscal year.

RADNET, INC.

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Cautionary Note Regarding Forward-Looking Statements

This annual report contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended and Section 21E of the Securities Exchange Act of 1934, as amended. Forward-looking statements reflect current views about future events and are based on our currently available financial, economic and competitive data and on current business plans. Actual events or results may differ materially depending on risks and uncertainties that may affect our operations, markets, services, prices and other factors.

Statements in this annual report concerning our ability to successfully acquire and integrate new operations, to grow our contract management business, our financial guidance, our future cost saving efforts, our increased business from new equipment or operations and our ability to finance our operations are forward-looking statements. In some cases, you can identify forward-looking statements by terminology such as “may,” “will,” “should,” “expect,” “intend,” “plan,” “anticipate,” “believe,” “estimate,” “predict,” “potential,” “continue,” “assumption” or the negative of these terms or other comparable terminology.

Forward-looking statements involve known and unknown risks, uncertainties and other factors that may cause our actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These risks include those factors listed in Item 1 — “Business,” Item 1A— “Risk Factors,” Item 3— “Legal Proceedings,” Item 7 — “Management’s Discussion and Analysis of Financial Condition and Results of Operations” and elsewhere in this annual report and in other reports that we file with the Securities and Exchange Commission.

We do not undertake any responsibility to release publicly any revisions to these forward-looking statements to take into account events or circumstances that occur after the date of this annual report or any unanticipated events which may cause actual results to differ from those expressed or implied by the forward-looking statements contained in this annual report, except to the extent required by law.

PART I

Item 1. Business

Business Overview

We are a leading national provider of freestanding, fixed-site outpatient diagnostic imaging services in the United States based on number of locations and annual imaging revenue. At December 31, 2016, we operated directly or indirectly through joint ventures with hospitals, 305 centers located in California, Delaware, Florida, Maryland, New Jersey, New York, and Rhode Island. Our centers provide physicians with imaging capabilities to facilitate the diagnosis and treatment of diseases and disorders and may reduce unnecessary invasive procedures, often reducing the cost and amount of care for patients. Our services include magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), nuclear medicine, mammography, ultrasound, diagnostic radiology (X-ray), fluoroscopy and other related procedures. The vast majority of our centers offer multi-modality imaging services, a key point of differentiation from our competitors. Our multi-modality strategy diversifies revenue streams, reduces exposure to reimbursement changes and provides patients and referring physicians one location to serve the needs of multiple procedures.

We seek to develop leading positions in regional markets in order to leverage operational efficiencies. Our scale and density within selected geographies provide close, long-term relationships with key payors, radiology groups and referring physicians. Each of our center-level and regional operations teams is responsible for managing relationships with local physicians and payors, meeting our standards of patient service and maintaining profitability. We provide training programs, standardized policies and procedures and sharing of best practices among the physicians in our regional networks.

In addition to our imaging services, one of our subsidiaries, eRAD, Inc., develops and sells computerized systems for the imaging industry, including Picture Archiving Communications Systems (“PACS”). Another one of our subsidiaries, Imaging On Call LLC, provides teleradiology services for remote interpretation of images on behalf of radiology groups, hospitals and imaging center customers. Teleradiology is the process of transmitting radiological patient images, such as X-rays, CTs, and MRIs, from one location to another for the purposes of interpretation and/or consultation. Teleradiology allows radiologists to provide services without actually having to be at the location of the patient and allows trained specialists to be available 24/7. In addition to providing alternative revenue sources for us, the capabilities of both eRAD and Imaging On Call are designed to make the RadNet imaging center operations more efficient and cost effective.

In December 2015 we entered into a multi-year strategic relationship with Imaging Advantage LLC. In the first quarter of 2016, BRMG transferred 75 physicians to Imaging Advantage LLC, and we now contract with those

physicians through Imaging Advantage LLC. We continue to collaborate with Imaging Advantage LLC in developing business models for radiology services. In addition, our relationship with the State of Qatar to help direct Screen for Life, a public-private partnership with the Qatari government to provide screening services, is on-going.

We derive substantially all of our revenue from fees charged for the diagnostic imaging services performed at our facilities. For the years ended December 31, 2016, 2015 and 2014, we performed 6,109,622, 5,638,979, and 4,828,488 diagnostic imaging procedures and generated net revenue of \$884.5 million, \$809.6 million, and \$717.6 million, respectively. Additional information concerning RadNet, Inc., including our consolidated subsidiaries, for each of the years ended December 31, 2016, 2015 and 2014 is included in the consolidated financial statements and notes thereto in this annual report.

We typically experience some seasonality to our business. During the first quarter of each year we generally experience the lowest volumes of procedures and the lowest level of revenue for any quarter during the year. This is primarily the result of two factors. First, our volumes and revenue are typically impacted by winter weather conditions in our northeastern operations. It is common for snowstorms and other inclement weather to result in patient appointment cancellations and, in some cases, imaging center closures. Second, in recent years, we have provided care to an increased number of patients participating in high deductible health plans. The patient deductible amount resets each January resulting in initially greater patient out of pocket expenditures until deductible limits are met. During this initial period of typically two to three months patients may defer medical service.

History of our Business

We became incorporated in Delaware in 2008 and have been in business since 1985.

We develop our medical imaging business through a combination of organic growth and acquisitions. For a discussion of acquisitions, see Item 7 - “Management’s Discussion and Analysis and Results of Operations—Recent Developments and Facility Acquisitions” below.

In addition to our imaging business, our eRAD, Inc. subsidiary is a provider of PACS and related workflow solutions to the radiology industry. Over 250 hospitals, teleradiology businesses, imaging centers and specialty physician groups use eRAD's technology to distribute, display, store and retrieve digital images taken from all diagnostic imaging modalities. eRAD has approximately 67 employees, including a research and development team of 21 software engineers in Budapest, Hungary.

We have also assembled an industry leading team of software developers, based out of Prince Edward Island, Canada, to create a workflow solution known as Radiology Information Systems ("RIS") focused exclusively on RadNet's internal use. All 22 members of this Canadian based team have significant software development expertise in radiology, and together with eRAD and its PACS technology, are creating fully integrated solutions to manage all aspects of RadNet's internal information needs.

Through our teleradiology business, Imaging On Call, LLC, located in Poughkeepsie, New York, we provide interpretation services to approximately 55 hospitals and hospital-based radiology groups.

References to "RadNet," "we," "us," "our" or the "Company" in this report refer to RadNet, Inc., its subsidiaries and affiliated entities. See "Management's Discussion and Analysis and Results of Operations—Overview."

Available Information

All reports we file with the Securities and Exchange Commission are available free of charge via EDGAR through the SEC website at www.sec.gov. In addition you may read and copy any materials that we file with the SEC at the SEC's Public Reference Room at 100 F Street, NE., Washington, DC 20549, and may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. We also maintain a website at www.radnet.com, where we make available, free of charge, our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and all amendments to those reports as soon as is reasonably practicable after the material is electronically filed with the Securities and Exchange Commission. References to our website in this report are provided as a convenience and the information contained on, or otherwise accessible through, the website is not incorporated by reference into, nor does it form a part of this annual report on Form 10-K or any other document that we file with the Securities and Exchange Commission.

Industry Overview

Diagnostic imaging involves the use of non-invasive procedures to generate representations of internal anatomy and function that can be recorded on film or digitized for display on a video monitor. Diagnostic imaging procedures facilitate the early diagnosis and treatment of diseases and disorders and may reduce unnecessary invasive procedures, often minimizing the cost and amount of care for patients. Diagnostic imaging procedures include MRI, CT, PET, nuclear medicine, ultrasound, mammography, X-ray and fluoroscopy.

While X-ray remains the most commonly performed diagnostic imaging procedure, the fastest growing and higher margin procedures are MRI, CT and PET. The rapid growth in PET scans is attributable to the increasing recognition of the efficacy of PET scans in the diagnosis and monitoring of cancer. The number of MRI and CT scans performed annually in the United States continues to grow due to their wider acceptance by physicians and payors, an increasing number of applications for their use and a general increase in demand due to the aging population.

Diagnostic Imaging Settings

Diagnostic imaging services are typically provided in one of the following settings:

Fixed-site, freestanding outpatient diagnostic facilities

These facilities range from single-modality to multi-modality facilities and are generally not owned by hospitals or clinics. These facilities depend upon physician referrals for their patients and generally do not maintain dedicated, contractual relationships with hospitals or clinics. In fact, these facilities may compete with hospitals or clinics that have their own imaging systems to provide services to these patients. These facilities bill third-party payors, such as managed care organizations, insurance companies, Medicare or Medicaid. All of our facilities are in this category.

Hospitals

Many hospitals provide both inpatient and outpatient diagnostic imaging services, typically on site. These inpatient and outpatient centers are owned and operated by the hospital or clinic, or jointly by both, and are primarily used by patients of the hospital or clinic. The hospital or clinic bills third-party payors, such as managed care organizations, insurance companies, Medicare or Medicaid.

Mobile Imaging

While many hospitals own or lease their own equipment, certain hospitals provide diagnostic imaging services by contracting with providers of mobile imaging services. Using specially designed trailers, mobile imaging service providers transport imaging equipment and provide services to hospitals and clinics on a part-time or full-time basis, thus allowing small to mid-size hospitals and clinics that do not have the patient demand to justify fixed on-site access to advanced diagnostic imaging technology. Diagnostic imaging providers contract directly with the hospital or clinic and are typically reimbursed directly by them.

Diagnostic Imaging Modalities

The principal diagnostic imaging modalities we use at our facilities are:

MRI

MRI has become widely accepted as the standard diagnostic tool for a wide and fast-growing variety of clinical applications for soft tissue anatomy, such as those found in the brain, spinal cord, abdomen, heart and interior ligaments of body joints such as the knee. MRI uses a strong magnetic field in conjunction with low energy electromagnetic waves that are processed by a computer to produce high-resolution, three-dimensional, cross-sectional images of body tissue. A typical MRI examination takes from 20 to 45 minutes. MRI systems are designed as either open or closed and have magnetic field strength of 0.2 Tesla to 3.0 Tesla and are priced in the range of \$0.6 million to \$2.5 million. As of December 31, 2016, we had 257 MRI systems in operation.

CT

CT provides higher resolution images than conventional X-rays, but generally not as well defined as those produced by MRI. CT uses a computer to direct the movement of an X-ray tube to produce multiple cross-sectional images of a particular organ or area of the body. CT is used to detect tumors and other conditions affecting bones and internal organs. It is also used to detect the occurrence of strokes, hemorrhages and infections. A typical CT examination takes from 15 to 45 minutes. CT systems are priced in the range of \$0.3 million to \$1.2 million. As of December 31, 2016, we had 157 CT systems in operation.

PET

PET scanning involves the administration of a radiopharmaceutical agent with a positron-emitting isotope and the measurement of the distribution of that isotope to create images for diagnostic purposes. PET scans provide the capability to determine how metabolic activity impacts other aspects of physiology in the disease process by correlating the reading for the PET with other tools such as CT or MRI. PET technology has been found highly effective and appropriate in certain clinical circumstances for the detection and assessment of tumors throughout the body, the evaluation of some cardiac conditions and the assessment of epilepsy seizure sites. The information provided by PET technology often obviates the need to perform further highly invasive or diagnostic surgical procedures. PET systems are priced in the range of \$0.8 million to \$2.5 million. In addition, we employ combined PET/CT systems that blend the PET and CT imaging modalities into one scanner. These combined systems are priced in the range of \$1.1 million to \$2.8 million. As of December 31, 2016, we had 47 PET or combination PET/CT systems in operation.

Nuclear Medicine

Nuclear medicine uses short-lived radioactive isotopes that release small amounts of radiation that can be recorded by a gamma camera and processed by a computer to produce an image of various anatomical structures or to assess the function of various organs such as the heart, kidneys, thyroid and bones. Nuclear medicine is used primarily to study anatomic and metabolic functions. Nuclear medicine systems are priced in the range of \$300,000 to \$400,000. As of December 31, 2016, we had 48 nuclear medicine systems in operation.

X-ray

X-rays use roentgen rays to penetrate the body and record images of organs and structures on film. Digital X-ray systems add computer image processing capability to traditional X-ray images, which provides faster transmission of images with a higher resolution and the capability to store images more cost-effectively. X-ray systems are priced in the range of \$95,000 to \$440,000. As of December 31, 2016, we had 479 X-ray systems in operation.

Ultrasound

Ultrasound imaging uses sound waves and their echoes to visualize and locate internal organs. It is particularly useful in viewing soft tissues that do not X-ray well. Ultrasound is used in pregnancy to avoid X-ray exposure as well as in gynecological, urologic, vascular, cardiac and breast applications. Ultrasound systems are priced in the range of \$90,000 to \$250,000. As of December 31, 2016, we had 551 ultrasound systems in operation.

Mammography

Mammography is a specialized form of radiology using low dosage X-rays to visualize breast tissue and is the primary screening tool for breast cancer. Mammography procedures and related services assist in the diagnosis of and treatment planning for breast cancer. Analog mammography systems are priced in the range of \$70,000 to \$100,000, and digital mammography systems are priced in the range of \$250,000 to \$400,000. As of December 31, 2016, we had 279 mammography systems in operation.

Fluoroscopy

Fluoroscopy uses ionizing radiation combined with a video viewing system for real time monitoring of organs. Fluoroscopy systems are priced in the range of \$100,000 to \$400,000. As of December 31, 2016, we had 104 fluoroscopy systems in operation.

Industry Trends

We believe the diagnostic imaging services industry will continue to grow as a result of a number of factors, including the following:

Escalating Demand for Healthcare Services from an Aging Population

Persons over the age of 65 comprise one of the fastest growing segments of the population in the United States. According to the United States Census Bureau, this group is expected to increase as much as 39% from 2010 to 2020.

Because diagnostic imaging use tends to increase as a person ages, we believe the aging population will generate more demand for diagnostic imaging procedures.

New Effective Applications for Diagnostic Imaging Technology

New technological developments are expected to extend the clinical uses of diagnostic imaging technology and increase the number of scans performed. Recent technological advancements include:

- MRI spectroscopy, which can differentiate malignant from benign lesions;
- MRI angiography, which can produce three-dimensional images of body parts and assess the status of blood vessels;
- enhancements in teleradiology systems, which permit the digital transmission of radiological images from one location to another for interpretation by radiologists at remote locations; and
- the development of combined PET/CT scanners, which combine the technology from PET and CT to create a powerful diagnostic imaging system.

Additional improvements in imaging technologies, contrast agents and scan capabilities are leading to new non-invasive diagnostic imaging application, including methods of diagnosing blockages in the heart's vital coronary arteries, liver metastases, pelvic diseases and vascular abnormalities without exploratory surgery. We believe that the use of the diagnostic capabilities of MRI and other imaging services will continue to increase because they are cost-effective, time-efficient and non-invasive, as compared to alternative procedures, including surgery, and that newer technologies and future technological advancements will further increase the use of imaging services. At the same time, the industry has increasingly used upgrades to existing equipment to expand applications, extend the useful life of existing equipment, improve image quality, reduce image acquisition time and increase the volume of scans that can be performed. We believe the use of equipment upgrades rather than equipment replacements will continue, as we do not foresee new imaging technologies on the near-term horizon that will displace MRI, CT or PET as the principal advanced diagnostic imaging modalities.

Wider Physician and Payor Acceptance of the Use of Imaging

During the last 30 years, there has been a major effort undertaken by the medical and scientific communities to develop higher quality, cost-effective diagnostic imaging technologies and to minimize the risks associated with the application of these technologies. The thrust of product development during this period has largely been to reduce the hazards associated with conventional X-ray and nuclear medicine techniques and to develop new, less harmful imaging technologies. As a result, the use of advanced diagnostic imaging modalities, such as MRI, CT and PET, which provide superior image quality compared to other diagnostic imaging technologies, has increased rapidly in recent years. These advanced modalities allow physicians to diagnose a wide variety of diseases and injuries quickly and accurately without exploratory surgery or other surgical or invasive procedures, which are usually more expensive, involve greater risk to patients and result in longer rehabilitation time. Because advanced imaging systems are increasingly seen as a tool for reducing long-term healthcare costs, they are gaining wider acceptance among payors.

Greater Consumer Awareness of and Demand for Preventive Diagnostic Screening

Diagnostic imaging, such as elective full-body scans, is increasingly being used as a screening tool for preventive care procedures. Consumer awareness of diagnostic imaging as a less invasive and preventive screening method has added to the growth in diagnostic imaging procedures. We believe that further technological advancements allowing for early diagnosis of diseases and disorders using less invasive procedures will create additional demand for diagnostic imaging.

Expansion of Teleradiology Services

As hiring radiologists has become more difficult, the use of teleradiology is expected to continue to expand to provide patients better, more specialized care and 24/7 services.

Our Competitive Strengths

Our Scale and Position as the Largest Provider of Freestanding, Fixed-site Outpatient Diagnostic Imaging Services in the United States, Based on Number of Centers and Revenue

As of December 31, 2016, we operated 305 centers in California, Delaware, Florida, Maryland, New Jersey, New York and Rhode Island. Our size and scale allow us to achieve operating, sourcing and administrative efficiencies, including equipment and medical supply sourcing savings and favorable maintenance contracts from equipment manufacturers and other suppliers. Our specific knowledge of our geographic markets drives strong relationships with key payors, radiology groups and referring physicians within our markets.

Our Comprehensive "Multi-Modality" Diagnostic Imaging Offering

The vast majority of our centers offer multiple types of imaging procedures, driving strong relationships with referring physicians and payors in our markets and a diversified revenue base. At each of our multi-modality facilities, we offer patients and referring physicians one location to serve their needs for multiple procedures. This prevents multiple patient visits or unnecessary travel between facilities, thereby increasing patient throughput and decreasing costs and time delays. Our revenue is generated by a broad mix of modalities. We believe our multi-modality strategy lessens our exposure to reimbursement changes in any specific modality.

Our Competitive Pricing

We believe our fees are generally lower than hospital fees for the services we provide.

Our Facility Density in Many Highly Populated Areas of the United States

The strategic organization of our diagnostic imaging facilities into regional networks concentrated in major population centers in seven states offers unique benefits to our patients, our referring physicians, our payors and us. We are able to increase the convenience of our services to patients by implementing scheduling systems within geographic regions, where practical. For example, many of our diagnostic imaging facilities within a particular region can access the patient appointment calendars of other facilities within the same regional network to efficiently allocate time available and to meet a patient's appointment, date, time, or location preferences. The grouping of our facilities within regional networks enables us to easily move technologists and other personnel, as well as equipment, from under-utilized to over-utilized facilities on an as-needed basis, and drive referrals. Our organization of referral networks results in increased patient throughput, greater operating efficiencies, better equipment utilization rates and improved response time for our patients. We believe our networks of facilities and tailored service offerings for geographic areas drives local physician referrals, makes us an attractive candidate for selection as a preferred provider by third-party payors, creates economies of scale and provides barriers to entry by competitors in our markets.

Our Strong Relationships with Payors and Diversified Payor Mix

Our revenue is derived from a diverse mix of payors, including private payors, managed care capitated payors and government payors, which should mitigate our exposure to possible unfavorable reimbursement trends within any one payor class. In addition, our experience with capitation arrangements has provided us with the expertise to manage utilization and pricing effectively, resulting in a predictable and recurring stream of revenue. We believe that third-party payors representing large groups of patients often prefer to enter into managed care contracts with providers that offer a broad array of diagnostic imaging services at convenient locations throughout a geographic area. In 2016, we received approximately 58% of our net service revenue before provision for bad debt from commercial insurance payors, 12% from managed care capitated payors, 20% from Medicare and 3% from Medicaid. With the exception of Blue Cross/Blue Shield, which are managed by different entities in each of the states in which we operate, and Medicare, no single payor accounted for more than 5% of our net revenue for the twelve months ended December 31, 2016.

Our Strong Relationships with Experienced and Highly Regarded Radiologists

Our contracted radiologists have outstanding credentials, strong relationships with referring physicians, and a broad mix of sub-specialties. The collective experience and expertise of these radiologists translates into more accurate and efficient service to patients. Our close relationship with Howard G. Berger, M.D., our President and Chief Executive Officer, and Beverly Radiology Medical Group (“BRMG”) in California and our long-term arrangements with radiologists outside of California enable us to better ensure that medical service provided at our facilities is consistent with the needs and expectations of our referring physicians, patients and payors.

Our Experienced and Committed Management Team

Our senior management group has more than 100 years of combined healthcare management experience. Our executive management team has created our differentiated approach based on their comprehensive understanding of the diagnostic imaging industry and the dynamics of our regional markets. We have a track record of successful acquisitions and integration of acquired businesses into RadNet, and have managed the business through a variety of economic and reimbursement cycles.

Our Technologically Advanced Imaging Systems

Our eRad subsidiary develops and sells computerized imaging systems for the industry and Imaging On Call provides teleradiology services for interpretation of images for radiology groups, hospitals and other medical groups. In addition, we have assembled an industry leading team of software developers to create radiology workflow solutions for our internal use.

Business Strategy

Maximize Performance at Our Existing Facilities

We intend to enhance our operations and increase scan volume and revenue at our existing facilities by expanding physician relationships and increasing the procedure offerings.

Expansion Into Related Businesses

With our acquisition of eRad we entered the business of the development and sale of software systems essential to the imaging industry. Similarly, with our acquisition of Imaging On Call, we entered the teleradiology business. We intend to regularly evaluate potential acquisitions of other businesses to the extent they complement our imaging business.

Focus on Profitable Contracting

We regularly evaluate our contracts with third-party payors, industry vendors and radiology groups, as well as our equipment and real property leases, to determine how we may improve the terms to increase our revenues and reduce our expenses. Because many of our contracts with third party payors are short-term in nature, we can regularly renegotiate these contracts, if necessary. We believe our position as a leading provider of diagnostic imaging services and our long-term relationships with physician groups in our markets enable us to obtain more favorable contract terms than would be available to smaller or less experienced imaging services providers.

Optimize Operating Efficiencies

We try to maximize our equipment utilization by adding, upgrading and re-deploying equipment where we experience excess demand. We will continue to trim excess operating and general and administrative costs where it is feasible to do so. We may also continue to use, where appropriate, highly trained radiology physician assistants to perform, under

appropriate supervision of radiologists, basic services traditionally performed by radiologists. We will continue to upgrade our advanced information technology system to create cost reductions for our facilities in areas such as image storage, support personnel and financial management.

Expand Our Networks

We intend to continue to expand the number of our facilities both organically and through targeted acquisitions, using a disciplined approach for evaluating and entering new areas, including consideration of whether we have adequate financial resources to expand. Our current plans are to strengthen our market presence in geographic areas where we currently have existing operations and to expand into neighboring and other areas where we believe we can compete effectively. We perform extensive due diligence before developing a new facility or acquiring an existing facility or entering into a joint venture with a hospital to manage a facility, including surveying local referral sources and radiologists, as well as examining the demographics, reimbursement environment, competitive landscape and intrinsic demand of the geographic market. We generally will only enter new markets where:

- there is sufficient patient demand for outpatient diagnostic imaging services;
- we believe we can gain significant market share;
- we can build key referral relationships or we have already established such relationships; and
- payors are receptive to our entry into the market.

Our Services

We offer a comprehensive set of imaging services including MRI, CT, PET, nuclear medicine, X-ray, ultrasound, mammography, fluoroscopy and other related procedures. We focus on providing standardized high quality imaging services, regardless of location, to ensure patients, physicians and payors consistency in service and quality. To ensure the high quality of our services, we monitor patient satisfaction, timeliness of services to patients and reports to physicians.

The key features of our services include:

- patient-friendly, non-clinical environments;
- a 24-hour turnaround on routine examinations;
- interpretations within one to two hours, if needed;
- flexible patient scheduling, including same-day appointments;
- extended operating hours, including weekends;
- reports delivered by courier, facsimile or email;
- availability of second opinions and consultations;
- availability of sub-specialty interpretations at no additional charge; and
- standardized fee schedules by region.

Radiology Professionals

In the states in which we provide services (except Florida), a lay person or any entity other than a professional corporation or similar professional organization is not allowed to practice medicine, including by employing professional persons or by having any ownership interest or profit participation in or control over any medical professional practice. This doctrine is commonly referred to as the prohibition on the “corporate practice” of medicine. In order to comply with this prohibition, we contract with radiologists to provide professional medical services in our facilities, including the supervision and interpretation of diagnostic imaging procedures. The radiology practice maintains full control over the physicians it employs. Pursuant to each management contract, we make available the imaging facility and all of the furniture and medical equipment at the facility for use by the radiology practice, and the practice is responsible for staffing the facility with qualified professional medical personnel. In addition, we provide management services and administration of the non-medical functions relating to the professional medical practice at the facility, including among other functions, provision of clerical and administrative personnel, bookkeeping and accounting services, billing and collection, provision of medical and office supplies, secretarial, reception and transcription services, maintenance of medical records, and advertising, marketing and promotional activities. As compensation for the services furnished under contracts with radiologists, we generally receive an agreed percentage of the medical practice billings for, or collections from, services provided at the facility, typically 75% of global net service fee revenue or collections after deduction of the professional component of the medical practice billings.

At all but 5 of our California facilities, we contract for the provision of professional medical services directly with BRMG, or indirectly through BRMG with other radiology groups.

Many states have also enacted laws prohibiting a licensed professional from splitting fees derived from the practice of medicine with an unlicensed person or business entity. We do not believe that the management, administrative, technical and other non-medical services we provide to each of our contracted radiology groups violate the corporate practice of medicine prohibition or that the fees we charge for such services violate the fee splitting prohibition. However, the enforcement and interpretation of these laws by regulatory authorities and state courts vary from state to state. If our arrangements with our independent contractor radiology groups are found to violate state laws prohibiting the practice of medicine by general business corporations or fee splitting, our business, financial condition and ability to operate in those states could be adversely affected.

BRMG and New York Groups

Howard G. Berger, M.D., is our President and Chief Executive Officer, a member of our Board of Directors, and also owns, indirectly, 99% of the equity interests in BRMG. BRMG is responsible for all of the professional medical services at nearly all of our facilities located in California under a management agreement with us, and employs physicians or contracts with various other independent physicians and physician groups to provide the professional medical services at most of our California facilities. We generally obtain professional medical services from BRMG in California, rather than provide such services directly or through subsidiaries, in order to comply with California's prohibition against the corporate practice of medicine. However, as a result of our close relationship with Dr. Berger and BRMG, we believe that we are able to better ensure that medical service is provided at our California facilities in a manner consistent with our needs and expectations and those of our referring physicians, patients and payors than if we obtained these services from unaffiliated physician groups.

We believe that physicians are drawn to BRMG and the other radiologist groups with whom we contract by the opportunity to work with the state-of-the-art equipment we make available to them, as well as the opportunity to receive specialized training through our fellowship programs, and engage in clinical research programs, which generally are available only in university settings and major hospitals.

As of December 31, 2016, BRMG employed or contracted for 137 full-time and 24 part-time radiologists. In addition to our BRMG staff, we contract 75 full-time physicians through our strategic relationship with Imaging Advantage LLC. Under our management agreement with BRMG, we are paid a percentage of the amounts collected for the professional services BRMG physicians render as compensation for our services and for the use of our facilities and equipment. For the year ended December 31, 2016, this percentage was 78%. The percentage may be adjusted, if necessary, to ensure that the parties receive the fair value for the services they render. The following are the other principal terms of our management agreement with BRMG:

The agreement expires on January 1, 2024. The agreement automatically renews for consecutive 10-year periods, unless either party delivers a notice of non-renewal to the other party no later than six months prior to the scheduled expiration date. Either party may terminate the agreement if the other party defaults under its obligations, after notice and an opportunity to cure. We may terminate the agreement if Dr. Berger no longer owns at least 60% of the equity of BRMG; as of December 31, 2016, he owned indirectly 99% of the equity interests of BRMG.

At its expense, BRMG employs or contracts with an adequate number of physicians necessary to provide all professional medical services at all of our California facilities, except for 5 facilities for which we contract with separate medical groups.

At our expense, we provide all furniture, furnishings and medical equipment located at the facilities and we manage and administer all non-medical functions at, and provide all nurses and other non-physician personnel required for the operation of, the facilities.

If BRMG wants to open a new facility, we have the right of first refusal to provide the space and services for the facility under the same terms and conditions set forth in the management agreement.

If we want to open a new facility in California, BRMG must use its best efforts to provide medical personnel under the same terms and conditions set forth in the management agreement. If BRMG cannot provide such personnel, we have the right to contract with other physicians to provide services at the facility.

BRMG must maintain medical malpractice insurance for each of its physicians with coverage limits not less than \$1 million per incident and \$3 million in the aggregate per year. BRMG also has agreed to indemnify us for any losses we suffer that arise out of the acts or omissions of BRMG and its employees, contractors and agents.

We contract with nine medical groups which provide professional medical services at all of our facilities in Manhattan and Brooklyn, New York. These contracts are similar to our contract with BRMG. Six of these groups are owned by John V. Crues, III, M.D., RadNet's Medical Director, a member of our Board of Directors, and a 1% owner of BRMG. Dr. Berger owns a controlling interest in two of these medical groups which provide professional medical services at one of our Manhattan facilities.

Non-BRMG and New York Groups entity locations

At the 5 centers in California where BRMG does not provide professional medical services, and at all of the centers which are located outside of California, with the exception of centers located in the New York, New York area, we have entered into long-term contracts with prominent third-party radiology groups in the area to provide physician services at those facilities. These arrangements also allow us to comply with the prohibition against the "corporate practice" of medicine in other states in which we operate (except in Florida which does not have an equivalent statute prohibiting the corporate practice of medicine).

These third-party radiology practice groups provide professional services, including supervision and interpretation of diagnostic imaging procedures, in our diagnostic imaging centers. The radiology practices maintain full control over the provision of professional services. The contracted radiology practices have outstanding physician and practice credentials and reputations; strong competitive market positions; a broad sub-specialty mix of physicians; a history of growth and potential for continued growth. In these facilities we have entered into long-term agreements (typically 10-40 years in length) under which, in addition to obtaining technical fees for the use of our diagnostic imaging equipment and the provision of technical services, we provide management services and receive a fee based on the practice group's professional revenue. We typically receive 100% of the technical reimbursements associated with imaging procedures plus certain fees paid to us for providing additional management services. The radiology practice groups retain the professional reimbursements associated with imaging procedures after deducting management service fees paid to us.

Additionally, we perform certain management services for a portion of the professional groups with whom we contract who provide professional radiology services at local hospitals. For performing these management services, which include billing, collecting, transcription and medical coding, we receive management fees.

Payors

The fees charged for diagnostic imaging services performed at our facilities are paid by a diverse mix of payors, as illustrated for the following periods presented in the table below:

	% of Net Revenue Before Bad Debt Provision		
	Year Ended December 31, 2016	Year Ended December 31, 2015	Year Ended December 31, 2014
Commercial Insurance ⁽¹⁾⁽²⁾	58%	57%	56%
Managed Care Capitated Payors	12%	12%	13%
Medicare & Medicaid	23%	23%	24%

⁽¹⁾ Includes Blue Cross/Blue Shield plans, which represented 21% of our net service fee revenue before provision for bad debt for the years ended December 31, 2016, and 20% for the years ended December 31 2015 and 2014.

⁽²⁾ Includes co-payments, direct patient payments and payments through contracts with physician groups and other non-insurance company payors.

We have described below the types of reimbursement arrangements we have with third-party payors.

Commercial Insurance

Generally, insurance companies reimburse us, directly or indirectly, including through BRMG in California or through the contracted radiology groups elsewhere, on the basis of agreed upon rates. These rates are negotiated and may differ materially with rates set forth in the Medicare Physician Fee Schedule for the particular service. The patients may be responsible for certain co-payments or deductibles.

Managed Care Capitation Agreements

Under these agreements, which are generally between BRMG in California and outside of California between the contracted radiology group (typically an independent physician group or other medical group) and the payor (which in most cases are large medical groups or Independent Practice Associations), the payor pays a pre-determined amount per-member per-month in exchange for the radiology group providing all necessary covered services to the managed care members included in the agreement. These contracts pass much of the financial risk of providing outpatient diagnostic imaging services, including the risk of over-use, from the payor to the radiology group and, as a result of our management agreement with the radiology group, to us.

We believe that through our comprehensive utilization management, or UM, program we have become highly skilled at assessing and moderating the risks associated with the capitation agreements, so that these agreements are profitable for us. Our UM program is managed by our UM department, which consists of administrative and nursing staff as well as BRMG medical staff who are actively involved with the referring physicians and payor management in both prospective and retrospective review programs. Our UM program includes the following features, all of which are designed to manage our costs while ensuring that patients receive appropriate care:

·Physician Education

At the inception of a new capitation agreement, we provide the new referring physicians with binders of educational material comprised of proprietary information that we have prepared and third-party information we have compiled, which are designed to address diagnostic strategies for common diseases. We distribute additional material according to the referral practices of the group as determined in the retrospective analysis described below.

·Prospective Review

Referring physicians are required to submit authorization requests for non-emergency high-intensity services: MRI, CT, special procedures and nuclear medicine studies. The UM medical staff, according to accepted practice guidelines, considers the necessity and appropriateness of each request. Notification is then sent to the imaging facility, referring physician and medical group. Appeals for cases not approved are directed to us. The capitated payor has the final authority to uphold or deny our recommendation.

·Retrospective Review

We collect and sort encounter activity by payor, place of service, referring physician, exam type and date of service. The data is then presented in quantitative and analytical form to facilitate understanding of utilization activity and to provide a comparison between fee-for-service and Medicare equivalents. Our Medical Director prepares a quarterly report for each payor and referring physician. When we find that a referring physician is over utilizing services, we work with the physician to modify referral patterns.

Medicare/Medicaid

Medicare is the federal health insurance program for people age 65 or older and people under age 65 with certain disabilities. Medicaid, funded by both the federal government and states, is a state-administered health insurance program for qualifying low-income and medically needy persons. For services for which we bill Medicare directly or indirectly, including through contracted radiologists, we are paid under the Medicare Physician Fee Schedule. Under the Protecting Access to Medicare Act of 2014, Congress introduced a new quality incentive program that, effective January 1, 2016, reduces Medicare payments for certain CT services reimbursed through the Medicare Physician Fee Schedule that are furnished using equipment that does not meet certain dose optimization and management standards. Medicare patients usually pay a 20% co-payment unless they have secondary insurance. Medicaid rates are set by the individual states for each state program and Medicaid patients may be responsible for a modest co-payment.

Contracts with Physician Groups and Other Non-Insurance Company Payors

For some of our contracts with physician groups and other providers, we do not bill payors, but instead accept agreed upon rates for our radiology services. These rates are typically at or below the rates set forth in the current Medicare Fee Schedule for the particular service. However, we often agree to a specified rate for MRI and CT procedures that is not tied to the Medicare Fee Schedule.

Facilities

We operate 138 fixed-site, freestanding outpatient diagnostic imaging facilities in California, 9 in Delaware, 3 in Florida, 59 in Maryland, 19 in New Jersey, 19 in the Rochester and Hudson Valley areas of New York, 53 in New York City as well as 5 in Rhode Island. We lease the premises at which these facilities are located.

Our facilities are primarily located in geographic networks that we refer to as regions. The majority of our facilities are multi-modality sites, offering various combinations of MRI, CT, PET, nuclear medicine, ultrasound, X-ray, fluoroscopy services and other related procedures. A portion of our facilities are single-modality sites, offering either X-ray or MRI services. Consistent with our regional network strategy, we locate our single-modality facilities near multi-modality facilities, to help accommodate overflow in targeted demographic areas.

The following table sets forth the number of our facilities for each year during the five-year period ended December 31, 2016:

	Year Ended December 31,				
	2012	2013	2014	2015	2016
Total facilities owned or managed (at beginning of the year)	233	246	250	259	300
Facilities added by:					
Acquisition	25	12	22	43	10
Internal development	—	—	—	1	8
Facilities closed or sold	-12	-8	-13	-3	-13
Total facilities owned (at year end)	246	250	259	300	305

Diagnostic Imaging Equipment

The following table indicates, as of December 31, 2016, the quantity of principal diagnostic equipment available at our facilities, by state:

MRI	Open/MRI	CT	PET/CT	Mammo	Ultrasound	X-ray	NucMed	Fluoroscopy	Total
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California	71	25	56	19	99	243	177	18	52	760
Florida	2	1	2	1	4	5	4	3	3	25
Delaware	6	–	6	–	5	11	23	2	2	55
New Jersey	20	3	16	3	21	29	34	2	9	137
New York	50	10	37	9	80	139	115	8	14	462
Maryland	61	5	37	15	67	120	119	15	24	463
Rhode Island	3	–	3	–	3	4	7	–	–	20
Total	213	44	157	47	279	551	479	48	104	1,922

The average age of our MRI and CT units is less than five years, and the average age of our PET units is less than four years. The useful life of our MRI, CT and PET units is typically ten years.

Facility Acquisitions

Information regarding our facility acquisitions can be found within Item 7 - “Management’s Discussion and Analysis of Financial Condition and Results of Operations”, as well as Note 4 to our consolidated financial statements included in this annual report on Form 10-K.

Information Technology

Our corporate headquarters and many of our facilities are interconnected through a state-of-the-art information technology system. This system, which is compliant with the Health Insurance Portability and Accountability Act of 1996, is comprised of a number of integrated applications and provides a single operating platform for billing and collections, electronic medical records, practice management and image management.

This technology has created cost reductions for our facilities in areas such as image storage, support personnel and financial management and has further allowed us to optimize the productivity of all aspects of our business by enabling us to:

- capture patient demographic, history and billing information at point-of-service;
- automatically generate bills and electronically file claims with third-party payors;
- record and store diagnostic report images in digital format;
- digitally transmit in real-time diagnostic images from one location to another, thus enabling networked radiologists to cover larger geographic markets by using the specialized training of other networked radiologists;
- perform claims, rejection and collection analysis; and
- perform sophisticated financial analysis, such as analyzing cost and profitability, volume, charges, current activity and patient case mix, with respect to each of our managed care contracts.

Diagnostic reports and images are currently accessible via the Internet by our California referring providers. We have worked with some of the larger medical groups in California with whom we have contracts to provide access to this content through their web portals. We are in the process of making such services available outside of California.

We have historically utilized third-party software for our front desk patient tracking system, which we refer to as a Radiology Information System, or RIS. We have developed our own RIS through our team of software development engineers and began running this internally developed system in the first quarter of 2015.

Personnel

At December 31, 2016, we had a total of 5,059 full-time, 618 part-time and 1,608 per diem employees, including those employed by BRMG. These numbers include 137 full-time and 24 part-time physicians and 1,641 full-time, 418 part-time and 1,050 per-diem technologists. In addition to our company personnel, we contract 75 full-time physicians through our strategic relationship with Imaging Advantage LLC.

We employ site managers who are responsible for overseeing day-to-day and routine operations at each of our facilities, including staffing, modality and schedule coordination, referring physician and patient relations and purchasing of materials. These site managers report to regional managers and directors, who are responsible for oversight of the operations of all facilities within their region, including sales, marketing and contracting. The regional managers and directors, along with our directors of contracting, marketing, facilities, management/purchasing and human resources all report to our chief operating officers. These officers, our chief financial officer, our director of information services and our medical director report to our chief executive officer.

None of our employees is subject to a collective bargaining agreement nor have we experienced any work stoppages. We believe our relationship with our employees is good.

Sales and Marketing

At December 31, 2016, our California sales and marketing team consisted of two directors of marketing and 48 customer service representatives, while our eastern marketing team consisted of two directors of marketing and 115 customer sales representatives. Our sales and marketing team employs a multi-pronged approach to marketing, including physician, payor and sports marketing programs.

Physician Marketing

Each customer service representative on our physician marketing team is responsible for marketing activity on behalf of one or more facilities. The representatives act as a liaison between the facility and referring physicians, holding meetings periodically and on an as-needed basis with them and their staff to present educational programs on new applications and uses of our systems and to address particular patient service issues that have arisen. In our experience, consistent hands-on contact with a referring physician and his or her staff generates goodwill and increases referrals to our facilities. The representatives also continually seek to establish referral relationships with new physicians and physician groups. In addition to a base salary, each representative receives a bonus based upon success.

Payor Marketing

Our marketing team regularly meets with managed care organizations and insurance companies to solicit contracts and meet with existing contracting payors to solidify those relationships. The comprehensiveness of our services, the geographic location of our facilities and the reputation of the physicians with whom we contract all serve as tools for obtaining new or repeat business from payors.

Sports Marketing Program

RadNet Inc. has a sports marketing division. We provide diagnostic digital X-ray services for the Los Angeles Lakers, Clippers, Kings and Sparks at the Staples Center. X-ray is performed at the Coliseum for the University of Southern California and the Los Angeles Rams football teams. In exchange for these services, each team provides RadNet with season tickets, parking and advertising space in the program book. RadNet also provides radiology services at many of our imaging centers for the Los Angeles Angels, Anaheim Ducks, Oakland Athletics and Los Angeles Kiss Arena Football.

In December 2013 we entered into a three year sponsorship agreement with the Baltimore Ravens of the National Football League which permits us to state “Proud Imaging Provider of the Baltimore Ravens”. The sponsorship agreement has been extended through 2019.

Suppliers

Historically, we have acquired our diagnostic imaging equipment from large suppliers such as Carestream, GE Medical Systems, Inc., Hologic, Hitachi, Phillips, Siemens and others, and we purchase medical supplies from various national vendors. We believe that we have excellent working relationships with all of our major vendors. There are several comparable vendors for our supplies that would be available to us if one of our current vendors becomes unavailable.

We primarily acquire our equipment with cash or through various financing arrangements with equipment vendors and third party equipment finance companies involving the use of capital leases with purchase options at minimal prices at the end of the lease term. At December 31, 2016, capital lease obligations, excluding interest, totaled approximately \$7.3 million through 2022, including current installments totaling approximately \$4.5 million. If we open or acquire additional imaging facilities, we may have to incur material capital lease obligations.

Timely, effective maintenance is essential for achieving high utilization rates of our imaging equipment. We have an arrangement with GE Medical Systems, Inc. under which it has agreed to be responsible for the maintenance and repair of a majority of our equipment for a fee that is based upon a percentage of our revenue, subject to a minimum payment.

Competition

The market for outpatient diagnostic imaging services is highly competitive. We compete locally for patients with groups of radiologists, established hospitals, clinics and other independent organizations that own and operate imaging equipment. Our competitors include Alliance Healthcare Services, Inc., to the extent it sells diagnostic services directly to outpatients, Diagnostic Imaging Group and several smaller regional competitors. In addition, some physician practices have established their own diagnostic imaging facilities within their group practices to compete with us. We experience additional competition as a result of those activities.

We compete principally on the basis of our reputation, our ability to provide multiple modalities at many of our facilities, the location of our facilities, the quality of our diagnostic imaging services and technologists and the ability to establish and maintain relationships with healthcare providers and referring physicians. See “Competitive Strengths” above. Some of our competitors may now or in the future have access to greater financial resources than we do and may have access to newer, more advanced equipment

Each of the non-BRMG contracted radiology practices has entered into agreements with its physician shareholders and full-time employed radiologists that generally prohibit those shareholders and radiologists from competing for a period of two years within defined geographic regions after they cease to be owners or employees, as applicable. In certain states, like California, a covenant not to compete is enforced in limited circumstances involving the sale of a business. In other states, a covenant not to compete will be enforced only:

- to the extent it is necessary to protect a legitimate business interest of the party seeking enforcement;
- if it does not unreasonably restrain the party against whom enforcement is sought; and
- if it is not contrary to public interest.

Enforceability of a non-compete covenant is determined by a court based on all of the facts and circumstances of the specific case at the time enforcement is sought. For this reason, it is not possible to predict whether or to what extent a court will enforce the contracted radiology practices’ covenants. The inability of the contracted radiology practices or us to enforce radiologist’s non-compete covenants could result in increased competition from individuals who are knowledgeable about our business strategies and operations.

Liability Insurance

We maintain insurance policies with coverage we believe is appropriate in light of the risks attendant to our business and consistent with industry practice. However, adequate liability insurance may not be available to us in the future at acceptable costs or at all. We maintain general liability insurance and professional liability insurance in commercially reasonable amounts. Additionally, we maintain workers' compensation insurance on all of our employees. Coverage is placed on a statutory basis and corresponds to individual state's requirements.

Pursuant to our agreements with physician groups with whom we contract, including BRMG, each group must maintain medical malpractice insurance for each physician in the group, having coverage limits of not less than \$1.0 million per incident and \$3.0 million in the aggregate per year.

California's medical malpractice cap further reduces our exposure. California places a \$250,000 limit on non-economic damages for medical malpractice cases. Non-economic damages are defined as compensation for pain, suffering, inconvenience, physical impairment, disfigurement and other non-pecuniary injury. The cap applies whether the case is for injury or death, and it allows only one \$250,000 recovery in a wrongful death case. No cap applies to economic damages. Other states in which we now operate do not have similar limitations and in those states we believe our insurance coverage to be sufficient.

Regulation

General

The healthcare industry is highly regulated, and we can give no assurance that the regulatory environment in which we operate will not change significantly in the future. Our ability to operate profitably will depend in part upon us, and the contracted radiology practices and their affiliated physicians obtaining and maintaining all necessary licenses and other approvals, and operating in compliance with applicable healthcare regulations. We believe that healthcare regulations will continue to change. Therefore, we monitor developments in healthcare law and modify our operations from time to time as the business and regulatory environment changes.

Licensing and Certification Laws

Ownership, construction, operation, expansion and acquisition of diagnostic imaging facilities are subject to various federal and state laws, regulations and approvals concerning licensing of facilities and personnel. In addition, free-standing diagnostic imaging facilities that provide services not performed as part of a physician office must meet Medicare requirements to be certified as an independent diagnostic testing facility before it can be authorized to bill the Medicare program. We have experienced a slowdown in the credentialing of our physicians over the last several years which has lengthened our billing and collection cycle.

Corporate Practice of Medicine

In the states in which we operate, other than Florida, a lay person or any entity other than a professional corporation or other similar professional organization is not allowed to practice medicine, including by employing professional persons or by having any ownership interest or profit participation in or control over any medical professional practice. The laws of such states also prohibit a lay person or a non-professional entity from exercising control over the medical judgments or decisions of physicians and from engaging in certain financial arrangements, such as splitting professional fees with physicians. We structure our relationships with the radiology practices, including the purchase of diagnostic imaging facilities, in a manner that we believe keeps us from engaging in the practice of medicine, exercising control over the medical judgments or decisions of the radiology practices or their physicians, or violating the prohibitions against fee-splitting.

Medicare and Medicaid Fraud and Abuse – Federal Anti-kickback Statute

During the year ended December 31, 2016, approximately 20% of our revenue before provision for bad debt generated at our diagnostic imaging centers was derived from federal government sponsored healthcare programs (Medicare) and 3% from state sponsored programs (Medicaid).

Federal law known as the Anti-kickback Statute prohibits the knowing and willful offer, payment, solicitation or receipt of any form of remuneration in return for, or to induce, (i) the referral of a person, (ii) the furnishing or arranging for the furnishing of items or services reimbursable under the Medicare, Medicaid or other governmental programs or (iii) the purchase, lease or order or arranging or recommending purchasing, leasing or ordering of any item or service reimbursable under the Medicare, Medicaid or other governmental programs. Enforcement of this anti-kickback law is a high priority for the federal government, which has substantially increased enforcement resources and is scheduled to continue increasing such resources. Noncompliance with the federal Anti-kickback Statute can result in exclusion from the Medicare, Medicaid or other governmental programs and civil and criminal penalties.

The Anti-kickback Statute is broad, and it prohibits many arrangements and practices that are lawful in businesses outside of the healthcare industry. Recognizing that the Anti-kickback Statute is broad and may technically prohibit many innocuous or beneficial arrangements within the healthcare industry, the Office of the Inspector General of the U.S. Department of Health and Human Services issued regulations in July of 1991, which the Department has referred to as “safe harbors.” These safe harbor regulations set forth certain provisions which, if met in form and substance, will assure healthcare providers and other parties that they will not be prosecuted under the federal Anti-kickback Statute. Additional safe harbor provisions providing similar protections have been published intermittently since 1991. Our arrangements with physicians, physician practice groups, hospitals and other persons or entities who are in a position to refer may not fully meet the stringent criteria specified in the various safe harbors. Although full compliance with these provisions ensures against prosecution under the federal Anti-kickback Statute, the failure of a transaction or arrangement to fit within a specific safe harbor does not necessarily mean that the transaction or arrangement is illegal or that prosecution under the federal Anti-kickback Statute will be pursued.

Although some of our arrangements may not fall within a safe harbor, we believe that such business arrangements do not violate the Anti-kickback Statute because we are careful to structure them to reflect fair value and ensure that the reasons underlying our decision to enter into a business arrangement comport with reasonable interpretations of the Anti-kickback Statute. However, even though we continuously strive to comply with the requirements of the Anti-kickback Statute, liability under the Anti-kickback Statute may still arise because of the intentions or actions of the parties with whom we do business. While we are not aware of any such intentions or actions, we have only limited knowledge regarding the intentions or actions underlying those arrangements. Conduct and business arrangements that do not fully satisfy one of these safe harbor provisions may result in increased scrutiny by government enforcement authorities such as the Office of the Inspector General.

Medicare and Medicaid Fraud and Abuse – Stark Law

Congress has placed significant legal prohibitions against physician referrals including the Ethics in Patient Referral Act of 1989 which is commonly known as the Stark Law. The Stark Law prohibits a physician from referring Medicare patients to an entity providing designated health services, as defined under the Stark Law, including, without limitation, radiology services, in which the physician (or immediate family member) has an ownership or investment interest or with which the physician (or immediate family member) has entered into a compensation arrangement. The Stark Law also prohibits the entity from billing for any such prohibited referral. The penalties for violating the Stark Law include a prohibition on payment by these governmental programs and civil penalties of as much as \$15,000 for each violation referral and \$100,000 for participation in a circumvention scheme. We believe that, although we receive fees under our service agreements for management and administrative services, we are not in a position to make or influence referrals of patients.

Under the Stark Law, radiology and certain other imaging services and radiation therapy services and supplies are services included in the designated health services subject to the self-referral prohibition. Such services include the professional and technical components of any diagnostic test or procedure using X-rays, ultrasound or other imaging services, CT, MRI, radiation therapy and diagnostic mammography services (but not screening mammography

services). PET and nuclear medicine procedures are also included as designated health services under the Stark Law. The Stark Law, however, excludes from designated health services: (i) X-ray, fluoroscopy or ultrasound procedures that require the insertion of a needle, catheter, tube or probe through the skin or into a body orifice; (ii) radiology procedures that are integral to the performance of, and performed during, non-radiological medical procedures; and (iii) invasive or interventional radiology, because the radiology services in these procedures are merely incidental or secondary to another procedure that the physician has ordered.

The Stark Law provides that a request by a radiologist for diagnostic radiology services or a request by a radiation oncologist for radiation therapy, if such services are furnished by or under the supervision of such radiologist or radiation oncologist pursuant to a consultation requested by another physician, does not constitute a referral by a referring physician. If such requirements are met, the Stark Law self-referral prohibition would not apply to such services. The effect of the Stark Law on the radiology practices, therefore, will depend on the precise scope of services furnished by each such practice's radiologists and whether such services derive from consultations or are self-generated.

We believe that, other than self-referred patients, all of the services covered by the Stark Law provided by the contracted radiology practices derive from requests for consultation by non-affiliated physicians. Therefore, we believe that the Stark Law is not implicated by the financial relationships between our operations and the contracted radiology practices. In addition, we believe that we have structured our acquisitions of the assets of existing practices, and we intend to structure any future acquisitions, so as not to violate the Anti-kickback Statute and Stark Law and regulations. Specifically, we believe the consideration paid by us to physicians to acquire the tangible and intangible assets associated with their practices is consistent with fair value in arms' length transactions and is not intended to induce the referral of patients or other business generated by such physicians. Should any such practice be deemed to constitute an arrangement designed to induce the referral of Medicare or Medicaid patients, then our acquisitions could be viewed as possibly violating anti-kickback and anti-referral laws and regulations. A determination of liability under any such laws could have a material adverse effect on our business, financial condition and results of operations.

Medicare and Medicaid Fraud and Abuse – General

The federal government embarked on an initiative to audit all Medicare carriers, which are the companies that adjudicate and pay Medicare claims. These audits are expected to intensify governmental scrutiny of individual providers. An unsatisfactory audit of any of our diagnostic imaging facilities or contracted radiology practices could result in any or all of the following: significant repayment obligations, exclusion from the Medicare, Medicaid or other governmental programs, and civil and criminal penalties.

Federal regulatory and law enforcement authorities have increased enforcement activities with respect to Medicare, Medicaid fraud and abuse regulations and other reimbursement laws and rules, including laws and regulations that govern our activities and the activities of the radiology practices. The federal government also has increased funding to fight healthcare fraud and is coordinating its enforcement efforts among various agencies, such as the U.S. Department of Justice, the U.S. Department of Health and Human Services Office of Inspector General, and state Medicaid fraud control units. The government may investigate our or the radiology practices' activities, claims may be made against us or the radiology practices and these increased enforcement activities may directly or indirectly have an adverse effect on our business, financial condition and results of operations.

State Anti-kickback and Physician Self-referral Laws

Many states have adopted laws similar to the federal Anti-kickback Statute. Some of these state prohibitions apply to referral of patients for healthcare services reimbursed by any source, not only the Medicare and Medicaid programs. Although we believe that we comply with both federal and state Anti-kickback laws, any finding of a violation of these laws could subject us to criminal and civil penalties or possible exclusion from federal or state healthcare programs. Such penalties would adversely affect our financial performance and our ability to operate our business.

Federal False Claims Act

The federal False Claims Act provides, in part, that the federal government may bring a lawsuit against any person who it believes has knowingly 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 approved. The federal False Claims Act further provides that a lawsuit thereunder may be initiated in the name of the United States by an individual, a "whistleblower," who is an original source of the allegations. The government has taken the position that claims presented in violation of the federal anti-kickback law or Stark Law may be considered a violation of the federal False Claims Act. Penalties include civil penalties of not less than \$5,500 and not more than \$11,000 for each false claim, plus three times the amount of damages that the federal government sustained because of the act of that person.

Further, on May 20, 2009, President Obama signed into law the Fraud Enforcement and Recovery Act of 2009 (FERA), which greatly expanded the types of entities and conduct subject to the False Claims Act. Also, various states are considering or have enacted laws modeled after the federal False Claims Act. Under the Deficit Reduction Act of 2005, or DRA, states are being encouraged to adopt false claims acts similar to the federal False Claims Act, which establish liability for submission of fraudulent claims to the State Medicaid program and contain whistleblower provisions. Even in instances when a whistleblower action is dismissed with no judgment or settlement, we may incur substantial legal fees and other costs relating to an investigation. Future actions under the False Claims Act may result in significant fines and legal fees, which would adversely affect our financial performance and our ability to operate our business.

We believe that we are in compliance with the rules and regulations that apply to the federal False Claims Act as well as its state counterparts.

Healthcare Reform Legislation

Healthcare reform legislation enacted in the first quarter of 2010 by the Patient Protection and Affordable Care Act or PPACA, specifically requires the U.S. Department of Health and Human Services, in computing physician practice expense relative value units, to increase the equipment utilization factor for advanced diagnostic imaging services (such as MRI, CT and PET) from a presumed utilization rate of 50% to 65% for 2010 through 2012, 70% in 2013, and 75% thereafter. Excluded from the adjustment are low-technology imaging modalities such as ultrasound, X-ray and fluoroscopy. The Health Care and Education Reconciliation Act of 2010 (H.R. 4872) or Reconciliation Act, which was passed by the Senate and approved by the President on March 30, 2010, amends the provision for higher presumed utilization of advanced diagnostic imaging services to a presumed rate of 75%. The higher utilization rate was fully implemented in the beginning of 2011 and replaced the phase-in approach provided in the PPACA. This utilization rate was further increased to 90% by the American Taxpayer Relief Act of 2012 (“ATRA”), effective as of January 1, 2014.

The aim of increased utilization of diagnostic imaging services is to spread the cost of the equipment and services over a greater number of scans, resulting in a lower cost per scan. These changes have precipitated reductions in federal reimbursement for medical imaging and result in decreased revenue for the scans we perform for Medicare beneficiaries. Other changes in reimbursement for services rendered by Medicare Advantage plans may also reduce the revenues we receive for services rendered to Medicare Advantage enrollees.

Following the 2016 U.S. general election, one party currently holds majorities in both Houses of Congress and the executive branch, which presents the possibility for further healthcare reform legislation to be enacted into law, including changes to, or the repeal of, the PPACA. These potential changes could affect reimbursement, coverage, and utilization of diagnostic imaging services in ways that are currently unpredictable.

Health Insurance Portability and Accountability Act of 1996

Congress enacted the Health Insurance Portability and Accountability Act of 1996, or HIPAA, in part, to combat healthcare fraud and to protect the privacy and security of patients' individually identifiable healthcare information.

HIPAA, among other things, amends existing crimes and criminal penalties for Medicare fraud and enacts new federal healthcare fraud crimes, including actions affecting non-government healthcare benefit programs. Under HIPAA, a healthcare benefit program includes any private plan or contract affecting interstate commerce under which any medical benefit, item or service is provided. A person or entity that knowingly and willfully obtains the money or property of any healthcare benefit program by means of false or fraudulent representations in connection with the delivery of healthcare services is subject to a fine or imprisonment, or potentially both. In addition, HIPAA authorizes the imposition of civil money penalties against entities that employ or enter into contracts with excluded Medicare or Medicaid program participants if such entities provide services to federal health program beneficiaries. A finding of liability under HIPAA could have a material adverse effect on our business, financial condition and results of operations.

Further, HIPAA requires healthcare providers and their business associates to maintain the privacy and security of individually identifiable protected health information ("PHI"). HIPAA imposes federal standards for electronic transactions, for the security of electronic health information and for protecting the privacy of PHI. The Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), signed into law on February 17, 2009, dramatically expanded, among other things, (1) the scope of HIPAA to now apply directly to "business associates," or independent contractors who receive or obtain PHI in connection with providing a service to a covered entity, (2) substantive security and privacy obligations, including new federal security breach notification requirements to affected individuals, DHHS and prominent media outlets, of certain breaches of unsecured PHI, (3) restrictions on marketing communications and a prohibition on covered entities or business associates from receiving remuneration in exchange for PHI, and (4) the civil and criminal penalties that may be imposed for HIPAA violations, increasing the annual cap in penalties from \$25,000 to \$1.5 million per year.

In addition, many states have enacted comparable privacy and security statutes or regulations that, in some cases, are more stringent than HIPAA requirements. In those cases it may be necessary to modify our operations and procedures to comply with the more stringent state laws, which may entail significant and costly changes for us. We believe that we are in compliance with such state laws and regulations. However, if we fail to comply with applicable state laws and regulations, we could be subject to additional sanctions.

We believe that we are in compliance with the current HIPAA requirements, as amended by HITECH, and comparable state laws, but we anticipate that we may encounter certain costs associated with future compliance. Moreover, we cannot guarantee that enforcement agencies or courts will not make interpretations of the HIPAA standards that are inconsistent with ours, or the interpretations of our contracted radiology practices or their affiliated physicians. A finding of liability under the HIPAA standards may result in significant criminal and civil penalties. Noncompliance also may result in exclusion from participation in government programs, including Medicare and Medicaid. These actions could have a material adverse effect on our business, financial condition, and results of operations.

U.S. Food and Drug Administration or FDA

The FDA has issued the requisite pre-market approval for all of the MRI and CT systems we use. We do not believe that any further FDA approval is required in connection with the majority of equipment currently in operation or proposed to be operated, except under regulations issued by the FDA pursuant to the Mammography Quality Standards Act of 1992, as amended by the Mammography Quality Standards Reauthorization Acts of 1998 and 2004 (collectively, the MQSA). All mammography facilities are required to meet the applicable MQSA requirements, including quality standards, be accredited by an approved accreditation body or state agency and certified by the FDA or an FDA-approved certifying state agency. Pursuant to the accreditation process, each facility providing mammography services must comply with certain standards that include, among other things, annual inspection of the facility's equipment, personnel (interpreting physicians, technologists and medical physicists) and practices.

Compliance with these MQSA requirements and standards is required to obtain Medicare payment for services provided to beneficiaries and to avoid various sanctions, including monetary penalties, or suspension of certification. Although the Mammography Accreditation Program of the American College of Radiology is an approved accreditation body and currently accredits all of our facilities which provide mammography services, and although we anticipate continuing to meet the requirements for accreditation, if we lose such accreditation, the FDA could revoke our certification. Congress has extended Medicare benefits to include coverage of screening mammography but coverage is subject to the facility performing the mammography meeting prescribed quality standards described above. The Medicare requirements to meet the standards apply to diagnostic mammography and image quality examination as well as screening mammography.

Radiologist Licensing

The radiologists providing professional medical services at our facilities are subject to licensing and related regulations by the states in which they provide services. As a result, we require BRMG and the other radiology groups with which we contract to require those radiologists to have and maintain appropriate licensure. We do not believe that such laws and regulations will either prohibit or require licensure approval of our business operations, although no assurances can be made that such laws and regulations will not be interpreted to extend such prohibitions or requirements to our operations.

Insurance Laws and Regulation

States in which we operate have adopted certain laws and regulations affecting risk assumption in the healthcare industry, including those that subject any physician or physician network engaged in risk-based managed care to applicable insurance laws and regulations. These laws and regulations may require physicians and physician networks to meet minimum capital requirements and other safety and soundness requirements. Implementing additional regulations or compliance requirements could result in substantial costs to the contracted radiology practices, limiting their ability to enter into capitated or other risk-sharing managed care arrangements and indirectly affecting our revenue from the contracted practices.

U.S. Federal Budget and Sequestration

We derive a substantial portion of our revenue from direct billings to governmental healthcare programs, such as Medicare and Medicaid, and private health insurance companies and/or health plans, including but not limited to those participating in the Medicare Advantage program. As a result, any negative changes in governmental capitation or fee-for-service rates or methods of reimbursement for the services we provide could have a significant adverse impact on our revenue and financial results.

Congress has a strong interest in reducing the federal debt, which may lead to new proposals designed to achieve savings by altering payment policies. The Budget Control Act of 2011 (“BCA”) established a Joint Select Committee on Deficit Reduction, which had the goal of achieving a reduction in the federal debt level of at least \$1.2 trillion. As a result of the Joint Select Committee’s failure to draft a proposal by the BCA’s deadline, automatic cuts in various federal programs (excluding cuts to Medicaid but including cuts to Medicare provider reimbursement in an amount not to exceed 2%) were scheduled to commence on January 1, 2013. However, as a result of the enactment of the American Taxpayer Relief Act of 2012, on January 2, 2013, any such cuts were delayed until March 1, 2013 so as to allow the Congress sworn in on January 3, 2013 to consider whether to allow sequestration to take place or replace it with other cuts in federal spending and/or higher taxes.

On March 1, 2013, the new Congress did not replace automatic cuts and a 2% cut to Medicare payments began April 1, 2013, which has negatively impacted our revenues. In addition, certain Congressional members have stated that the automatic federal spending cuts under the BCA are insufficient to achieve the BCA’s goals of reducing federal spending and, in turn, the federal deficit. Such members suggested additional cuts to federal entitlement programs, such as Medicare, to achieve the targeted deficit reductions. Therefore it is not possible at this time to estimate what further impact, if any, other federal Medicare provider reimbursement cuts will have on our integrated care business or results of operations.

Because governmental healthcare programs generally reimburse on a fee schedule basis rather than on a charge-related basis, we generally cannot increase our revenues from these programs by increasing the amount of charges for services. Moreover, if our costs increase, we may not be able to recover our increased costs from these programs. Government and private payors have taken and may continue to take steps to control the cost, eligibility for, use, and delivery of healthcare services as a result of budgetary constraints, cost containment pressures and other reasons. We believe that these trends in cost containment will continue. These cost containment measures, and other market changes in non-governmental insurance plans have generally restricted our ability to recover, or shift to non-governmental payors, any increased costs that we experience. Our integrated care business and financial operations may be materially affected by these developments.

Environmental Matters

The facilities we operate or manage generate hazardous and medical waste subject to federal and state requirements regarding handling and disposal. We believe that the facilities that we operate and manage are currently in compliance in all material respects with applicable federal, state and local statutes and ordinances regulating the handling and disposal of such materials. We do not believe that we will be required to expend any material additional amounts in order to remain in compliance with these laws and regulations or that compliance will materially affect our capital expenditures, earnings or competitive position.

Compliance Program

We maintain a program to monitor compliance with federal and state laws and regulations applicable to healthcare entities. We have a compliance officer who is charged with implementing and supervising our compliance program, which includes the adoption of (i) Standards of Conduct for our employees and affiliates and (ii) a process that specifies how employees, affiliates and others may report regulatory or ethical concerns to our compliance officer. We believe that our compliance program meets the relevant standards provided by the Office of Inspector General of the Department of Health and Human Services.

An important part of our compliance program consists of conducting periodic audits of various aspects of our operations and that of the contracted radiology practices. We also conduct mandatory educational programs designed to familiarize our employees with the regulatory requirements and specific elements of our compliance program.

Item 1A. Risk Factors

If BRMG or any of our other contracted radiology practices terminate their agreements with us, our business could substantially diminish.

Our relationship with BRMG is an integral part of our business. Through our management agreement, BRMG provides all of the professional medical services at 133 of our 138 California facilities. Professional medical services are provided at our other facilities through management contracts with other radiology groups. BRMG and these other radiology groups contract with various other independent physicians and physician groups to provide all of the professional medical services at most of our facilities, and they must use their best efforts to provide the professional medical services at any new facilities that we open or acquire in their areas of operation. In addition, BRMG and the other radiology groups' strong relationships with referring physicians are largely responsible for the revenue generated at the facilities they service. Although our management agreement with BRMG runs until 2024, with automatic

renewals for 10-year periods, and our management agreements with other groups are also for multiple years, BRMG and the other radiology groups have the right to terminate the agreements if we default on our obligations and fail to cure the default. Also, the various radiology groups' ability to continue performing under the management agreements may be curtailed or eliminated due to the groups' financial difficulties, loss of physicians or other circumstances. If the radiology groups cannot perform their obligations to us, we would need to contract with one or more other radiology groups to provide the professional medical services at the facilities serviced by the group. We may not be able to locate radiology groups willing to provide those services on terms acceptable to us, if at all. Even if we were able to do so, any replacement radiology group's relationships with referring physicians may not be as extensive as those of the terminated group. In any such event, our business could be seriously harmed. In addition, the radiology groups are party to substantially all of the managed care contracts from which we derive revenue. If we were unable to readily replace these contracts, our revenue would be negatively affected.

We may experience risks associated with the new strategic partnership with Imaging Advantage LLC

In December 2015, we entered into a multi-year strategic relationship with Imaging Advantage LLC. Under the terms of such agreement, we have agreed to collaborate to deploy innovative models of delivering radiology services. While we expect this strategic relationship to increase our profitability and expand our operations, we may never realize the anticipated benefits of such relationship.

Our ability to generate revenue depends in large part on referrals from physicians.

We derive substantially all of our net revenue, directly or indirectly, from fees charged for the diagnostic imaging services performed at our facilities. We depend on referrals of patients from unaffiliated physicians and other third parties who have no contractual obligations to refer patients to us for a substantial portion of the services we perform. If a sufficiently large number of these physicians and other third parties were to discontinue referring patients to us, our scan volume could decrease, which would reduce our net revenue and operating margins. Further, commercial third-party payors have implemented programs that could limit the ability of physicians to refer patients to us. For example, prepaid healthcare plans, such as health maintenance organizations, sometimes contract directly with providers and require their enrollees to obtain these services exclusively from those providers. Some insurance companies and self-insured employers also limit these services to contracted providers. These “closed panel” systems are now common in the managed care environment. Other systems create an economic disincentive for referrals to providers outside the system’s designated panel of providers. If we are unable to compete successfully for these managed care contracts, our results and prospects for growth could be adversely affected.

If our contracted radiology practices, including BRMG, lose a significant number of their radiologists, our financial results could be adversely affected.

At times, there has been a shortage of qualified radiologists in some of the regional markets we serve. In addition, competition in recruiting radiologists may make it difficult for our contracted radiology practices to maintain adequate levels of radiologists. If a significant number of radiologists terminate their relationships with our contracted radiology practices and those radiology practices cannot recruit sufficient qualified radiologists to fulfill their obligations under our agreements with them, our ability to maximize the use of our diagnostic imaging facilities and our financial results could be adversely affected. Increased expenses to BRMG will impact our financial results because the management fee we receive from BRMG, which is based on a percentage of BRMG’s collections, is adjusted annually to take into account the expenses of BRMG. Neither we, nor our contracted radiology practices, maintain insurance on the lives of any affiliated physicians.

We may become subject to professional malpractice liability, which could be costly and negatively impact our business.

The physicians employed by our contracted radiology practices are from time to time subject to malpractice claims. We structure our relationships with the practices under our management agreements in a manner that we believe does not constitute the practice of medicine by us or subject us to professional malpractice claims for acts or omissions of physicians employed by the contracted radiology practices. Nevertheless, claims, suits or complaints relating to services provided by the contracted radiology practices have been asserted against us in the past and may be asserted against us in the future. In addition, we may be subject to professional liability claims, including, without limitation, for improper use or malfunction of our diagnostic imaging equipment or for accidental contamination or injury from

exposure to radiation. We may not be able to maintain adequate liability insurance to protect us against those claims at acceptable costs or at all.

Any claim made against us that is not fully covered by insurance could be costly to defend, result in a substantial damage award against us and divert the attention of our management from our operations, all of which could have an adverse effect on our financial performance. In addition, successful claims against us may adversely affect our business or reputation. Although California places a \$250,000 limit on non-economic damages for medical malpractice cases, no limit applies to economic damages and no such limits exist in the other states in which we provide services.

We may not receive payment from some of our healthcare provider customers because of their financial circumstances.

Some of our healthcare provider customers do not have significant financial resources, liquidity or access to capital. If these customers experience financial difficulties they may be unable to pay us for the equipment and services that we provide. A significant deterioration in general or local economic conditions could have a material adverse effect on the financial health of certain of our healthcare provider customers. As a result, we may have to increase the amounts of accounts receivables that we write-off, which would adversely affect our financial condition and results of operations.

Capitation fee arrangements could reduce our operating margins.

For the year ended December 31, 2016, we derived approximately 11.6% of our net service fee revenue before provision from bad debt from capitation arrangements, and we intend to increase the revenue we derive from capitation arrangements in the future. Under capitation arrangements, the payor pays a pre-determined amount per-patient per-month in exchange for us providing all necessary covered services to the patients covered under the arrangement. These contracts pass much of the financial risk of providing diagnostic imaging services, including the risk of over-use, from the payor to the provider. Our success depends in part on our ability to negotiate effectively, on behalf of the contracted radiology practices and our diagnostic imaging facilities, contracts with health maintenance organizations, employer groups and other third-party payors for services to be provided on a capitated basis and to efficiently manage the utilization of those services. If we are not successful in managing the utilization of services under these capitation arrangements or if patients or enrollees covered by these contracts require more frequent or extensive care than anticipated, we would incur unanticipated costs not offset by additional revenue, which would reduce operating margins.

Changes in the method or rates of third-party reimbursement could have a negative impact on our results

From time to time, changes designed to contain healthcare costs have been implemented, some of which have resulted in decreased reimbursement rates for diagnostic imaging services that impact our business. For services for which we bill Medicare directly, we are paid under the Medicare Physician Fee Schedule, which is updated on an annual basis. Under the Medicare statutory formula, payments under the Physician Fee Schedule would have decreased for the past several years if Congress failed to intervene.

Medicare program reimbursements for physician services as well as other services to Medicare beneficiaries who are not enrolled in Medicare Advantage plans are based upon the fee-for-service rates set forth in the Medicare Physician Fee Schedule, which relies, in part, on a target-setting formula system called the SGR. Each year, on January 1st, the Medicare program updates the Medicare Physician Fee Schedule reimbursement rates. Many private payors use the Medicare Physician Fee Schedule to determine their own reimbursement rates.

On April 16, 2015, President Obama signed into law the Medicare Access and CHIP Reauthorization Act (H.R. 2), which provides for sweeping changes to how Medicare pays physicians, as well as averts the 21% reduction to Medicare payments under the Medicare Physician Fee Schedule that was scheduled to take effect on April 1, 2016. H.R. 2, among other things, repealed the Sustainable Growth Rate (“SGR”) formula. The SGR formula was enacted in 1997 and was linked to the growth in the U.S. gross domestic product, which led Congress to repeatedly intervene to mitigate the negative reimbursement impact associated with it. H.R. 2 provides that for services paid under the physician fee schedule and furnished during calendar years 2016 through 2019, Medicare’s payment rates will increase by 0.5% per year over calendar year 2015. Fees will remain at the 2019 level through 2025, but high performing providers participating in alternative payment models will have the opportunity for additional payments. Such payments will be based upon quality, resource use, clinical practice improvement activities and meaningful use of electronic health record technology. Given that the value-based payment mechanisms have yet to take effect, we cannot determine the impact of such payments models on our business at this time. However, in general, shifting to value-based care may decrease our revenue and require us to invest heavily in new IT infrastructure and analytic tools.

In 2013, Congress adjusted Medicare payment rates for physician imaging services in an attempt to better reflect actual usage, by revising upward the assumed usage rate for diagnostic imaging equipment costing more than \$1 million to 90% effective January 1, 2014. Additionally, under the Protecting Access to Medicare Act of 2014 (“PAMA”), Congress introduced a new quality incentive program that, effective January 1, 2016, reduces Medicare payment for certain CT services reimbursed through the Medicare Physician Fee Schedule that are furnished using equipment that does not meet certain dose optimization and management standards. Other changes in reimbursement for services rendered by Medicare Advantage plans may reduce the revenues we receive for services rendered to Medicare Advantage enrollees.

Pressure to control healthcare costs could have a negative impact on our results.

One of the principal objectives of health maintenance organizations and preferred provider organizations is to control the cost of healthcare services. Healthcare providers participating in managed care plans may be required to refer diagnostic imaging tests to certain providers depending on the plan in which a covered patient is enrolled. In addition, managed care contracting has become very competitive, and reimbursement schedules are at or below Medicare reimbursement levels. The expansion of health maintenance organizations, preferred provider organizations and other managed care organizations within the geographic areas covered by our network could have a negative impact on the utilization and pricing of our services, because these organizations will exert greater control over patients' access to diagnostic imaging services, the selections of the provider of such services and reimbursement rates for those services.

We experience competition from other diagnostic imaging companies and hospitals, and this competition could adversely affect our revenue and business.

The market for diagnostic imaging services is highly competitive. We compete principally for patients on the basis of our reputation, our ability to provide multiple modalities at many of our facilities, the location of our facilities and the quality of our diagnostic imaging services. We compete locally with groups of radiologists, established hospitals, clinics and other independent organizations that own and operate imaging equipment. Our competitors include Alliance Healthcare Services, Inc., to the extent it sells diagnostic imaging services directly to outpatients and several smaller regional competitors. Some of our competitors may now or in the future have access to greater financial resources than we do and may have access to newer, more advanced equipment. In addition, some physician practices have established their own diagnostic imaging facilities within their group practices and compete with us. We are experiencing increased competition as a result of such activities, and if we are unable to successfully compete, our business and financial condition would be adversely affected.

Our success depends in part on our key personnel and loss of key executives could adversely affect our operations. In addition, former employees and radiology practices we have previously contracted with could use the experience and relationships developed while employed or under contract with us to compete with us.

Our success depends in part on our ability to attract and retain qualified senior and executive management, and managerial and technical personnel. Competition in recruiting these personnel may make it difficult for us to continue our growth and success. The loss of their services or our inability in the future to attract and retain management and other key personnel could hinder the implementation of our business strategy. The loss of the services of Dr. Howard G. Berger, our President and Chief Executive Officer, and Norman R. Hames or Stephen M. Forthuber, our Chief Operating Officers, West Coast and East Coast, respectively, could have a significant negative impact on our operations. We believe that they could not easily be replaced with executives of equal experience and capabilities. We do not maintain key person insurance on the life of any of our executive officers. Additionally, if we lose the services of Dr. Berger, our relationship with BRMG could deteriorate, which would materially adversely affect our business.

Many of the states in which we operate do not enforce agreements that prohibit a former employee from competing with a former employer. As a result, many of our employees whose employment is terminated are free to compete with us, subject to prohibitions on the use of trade secret information and, depending on the terms of the employee's employment agreement, on solicitation of existing employees and customers (if enforceable). A former executive, manager or other key employee who joins one of our competitors could use the relationships he or she established with third party payors, radiologists or referring physicians while our employee and the industry knowledge he or she acquired during that tenure to enhance the new employer's ability to compete with us.

The agreements with most of our radiology practices contain non-compete provisions; however the enforceability of these provisions is determined by a court based on all the facts and circumstances of the specific case at the time enforcement is sought. Our inability to enforce radiologists' non-compete provisions could result in increased competition from individuals who are knowledgeable about our business strategies and operations.

Our failure to successfully, and in a timely manner, integrate similar businesses and/or new lines of businesses we acquire could reduce our profitability.

We may never realize expected synergies, business opportunities and growth prospects in connection with our acquisitions. We may not be able to capitalize on expected business opportunities, assumptions underlying estimates of expected cost savings may be inaccurate, or general industry and business conditions may deteriorate. In addition, integrating operations will require significant efforts and expenses on our part. Personnel may leave or be terminated because of an acquisition. Our management may have its attention diverted while trying to integrate an acquisition. If these factors limit our ability to integrate the operations of an acquisition successfully or on a timely basis, our expectations of future results of operations, including certain cost savings and synergies as a result of the acquisition, may not be met. In addition, our growth and operating strategies for a target's business may be different from the

strategies that the target company pursued prior to our acquisition. If our strategies are not the proper strategies, they could have a material adverse effect on our business, financial condition and results of operations.

In the past we have acquired, and may again in the future acquire, companies that create a new line of business. The process of integrating the acquired business, technology, service and research and development component into our business and operations and entry into a new line of business in which we are inexperienced may result in unforeseen operating difficulties and expenditures. In developing a new line of business we may invest significant time and resources that take away the attention of management that would otherwise be available for ongoing development of our business which may affect our results of operations and we may not be able to take full advantage of the business opportunities available to us as we expand a new lines of business. In addition, there can be no assurance that our new lines of business will ultimately be successful. The failure to successfully manage these risks in the development and implementation of new lines of business could have a material, adverse effect on the Company's business, financial condition, and results of operations.

We may not be able to successfully grow our business, which would adversely affect our financial condition and results of operations.

Historically, we have experienced substantial growth through acquisitions that have increased our size, scope and geographic distribution. During the past two fiscal years, we have completed 9 acquisitions. These acquisitions have added 39 centers to our fixed-site outpatient diagnostic imaging services. Our ability to successfully expand through acquiring facilities, developing new facilities, adding equipment at existing facilities, and directly or indirectly entering into contractual relationships with high-quality radiology practices depends upon many factors, including our ability to:

- identify attractive and willing candidates for acquisitions;
- identify locations in existing or new markets for development of new facilities;
- comply with legal requirements affecting our arrangements with contracted radiology practices, including state prohibitions on fee-splitting, corporate practice of medicine and self-referrals;
- obtain regulatory approvals where necessary and comply with licensing and certification requirements applicable to our diagnostic imaging facilities, the contracted radiology practices and the physicians associated with the contracted radiology practices;
- recruit a sufficient number of qualified radiology technologists and other non-medical personnel;
- expand our infrastructure and management; and
- compete for opportunities. We may not be able to compete effectively for the acquisition of diagnostic imaging facilities. Our competitors may have more established operating histories and greater resources than we do. Competition may also make any acquisitions more expensive.

Managing our recent acquisitions, as well as any other future acquisitions, will entail numerous operational and financial risks, including:

- inability to obtain adequate financing;
- failure to achieve our targeted operating results;
- diversion of management's attention and resources;
- failure to retain key personnel;
- difficulties in integrating new operations into our existing infrastructure; and
- amortization or write-offs of acquired intangible assets, including goodwill.

If we are unable to successfully grow our business through acquisitions it could have an adverse effect on our financial condition and results of operations. Further we cannot ensure we will be able to receive the required regulatory approvals for any future acquisitions, expansions or replacements, and the failure to obtain these approvals could limit the market for our services and have an adverse effect on our financial condition and results of operations.

We have experienced operating losses in the past. If we are unable to continue to generate sufficient income, we may be unable to pay our obligations.

We had net income attributable to RadNet common stockholders of \$7.2 million, \$7.7 million, and \$1.4 million for the years ended December 31, 2016, 2015, and 2014 respectively. As of December 31, 2016, our equity was \$52.1 million. As a whole, results have shown improvement over the past three years. However, if we cannot continue to generate income in sufficient amounts, we will not be able to pay our obligations as they become due, which could adversely impact our business, financial condition and results of operations.

Our substantial debt could adversely affect our financial condition and prevent us from fulfilling our obligations under our outstanding indebtedness.

Our current substantial indebtedness and any future indebtedness we incur could adversely affect our financial condition. We are highly leveraged. As of December 31, 2016, our total indebtedness excluding discount on term loan debt was \$655.5 million, \$646.9 million of which constituted guaranty indebtedness. Our substantial indebtedness could also:

- make it difficult for us to satisfy our payment obligations with respect to our outstanding indebtedness; require us to dedicate a substantial portion of our cash flow from operations to payments on our debt, reducing the availability of our cash flow to fund working capital, capital expenditures, acquisitions and other general corporate purposes;
- expose us to the risk of interest rate increases on our variable rate borrowings, including borrowings under our new senior secured credit facilities;
- increase our vulnerability to adverse general economic and industry conditions;
- limit our flexibility in planning for, or reacting to, changes in our business and the industry in which we operate;
- place us at a competitive disadvantage compared to our competitors that have less debt; and
- limit our ability to borrow additional funds on terms that are satisfactory to us or at all.

Increases in interest rates could increase the amount of our debt payments and reduce our operating cash flows.

We have incurred significant indebtedness that accrues interest at variable rate borrowing and we may incur additional debt in the future. Increases in interest rates on our current outstanding debt or any other debt we may incur will reduce our operating cash flows and if we need to repay any of our variable rate borrowing during period of high interest rates, we could be required to forgo other opportunities in order to repay the debt which may not permit us to realize future earnings of those forgone opportunities. To mitigate this risk, we have entered into an interest rate cap contract on our term loan debt facilities. See note 10 in the notes to financial statements contained herein.

We may not be able to finance future needs or adapt our business plan to changes because of restrictions placed on us by our credit facilities and instruments governing our other indebtedness.

Our credit facilities contain affirmative and negative covenants which restrict, among other things, our ability to:

- pay dividends or make certain other restricted payments or investments;
- incur additional indebtedness and certain disqualified equity interests;

- create liens (other than permitted liens) securing indebtedness or trade payables;
- sell certain assets or merge with or into other companies or otherwise dispose of all or substantially all of our assets;
- enter into certain transactions with affiliates;
- create restrictions on dividends or other payments by our restricted subsidiaries; and
- create guarantees of indebtedness by restricted subsidiaries.

All of these restrictions could affect our ability to operate our business and may limit our ability to take advantage of potential business opportunities as they arise. A failure to comply with these covenants and restrictions would permit the relevant creditors to declare all amounts borrowed under the applicable agreement governing such indebtedness, together with accrued interest and fees, to be immediately due and payable. If the indebtedness under our credit facilities is accelerated, we may not have sufficient assets to repay amounts due under the credit facilities or on other indebtedness then outstanding.

A restriction in our ability to make capital expenditures would restrict our growth and could adversely affect our business.

We operate in a capital intensive, high fixed-cost industry that requires significant amounts of capital to fund operations, particularly the initial start-up and development expenses of new diagnostic imaging facilities and the acquisition of additional facilities and new diagnostic imaging equipment. We incur capital expenditures to, among other things, upgrade and replace equipment for existing facilities and expand within our existing markets and enter new markets. If we open or acquire additional imaging facilities, we may have to incur material capital lease obligations. To the extent we are unable to generate sufficient cash from our operations, funds are not available from our lenders or we are unable to structure or obtain financing through operating leases, long-term installment notes or capital leases, we may be unable to meet our capital expenditure requirements to support the maintenance and continued growth of our operations.

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. Healthcare reform legislation will increase the participation of individuals in the Medicaid program in states that elect to participate in the expanded Medicaid coverage. A shift in payor mix from managed care and other private payors to government payors as well as an increase in the number of uninsured patients may result in a reduction in the rates of reimbursement or an increase in uncollectible receivables or uncompensated care, with a corresponding decrease in net revenue. Changes in the eligibility requirements for governmental programs such as the Medicaid program and state decisions on whether to participate in the expansion of such programs also could increase the number of patients who participate in such programs and the number of uninsured patients. Even for those patients who remain in private insurance plans, changes to those plans could increase patient financial responsibility, resulting in a greater risk of uncollectible receivables. Furthermore, changes to, or repeal of, the PPACA under the 115th Congress and new Administration may also affect reimbursement and coverage in ways that are currently unpredictable. These factors and events could have a material adverse effect on our business, financial condition, and results of operations.

Our business could be adversely impacted if there are deficiencies in our disclosure controls and procedures or internal control over financial reporting

The design and effectiveness of our disclosure controls and procedures and internal control over financial reporting may not prevent all errors, misstatements or misrepresentations. While management will review the effectiveness of our disclosure controls and procedures and internal control over financial reporting, there can be no guarantee that our disclosure controls and procedures or our internal control over financial reporting will be effective in accomplishing all control objectives all of the time. Deficiencies, including any material weakness, in our internal control over financial reporting that may occur in the future could result in misstatements of our results of operations, restatements of our financial statements, or otherwise adversely impact our financial condition, results of operations, cash flows, and our ability to satisfy our debt service obligations. As of December 31, 2016, we have identified a material weakness in internal controls with respect to our processes surrounding the occurrence and measurement of revenue and valuation of accounts receivable. See Item 9 for further information.

The regulatory framework in which we operate is uncertain and evolving.

Although we believe that we are operating in compliance with applicable federal and state laws, neither our current or anticipated business operations nor the operations of the contracted radiology practices have been the subject of judicial or regulatory interpretation. We cannot assure you that a review of our business by courts or regulatory authorities will not result in a determination that could adversely affect our operations or that the healthcare regulatory environment will not change in a way that restricts our operations. In addition, healthcare laws and regulations may change significantly in the future. We continuously monitor these developments and modify our operations from time

to time as the regulatory environment changes. We cannot assure you however, that we will be able to adapt our operations to address new regulations or that new regulations will not adversely affect our business.

Certain states have enacted statutes or adopted regulations affecting risk assumption in the healthcare industry, including statutes and regulations that subject any physician or physician network engaged in risk-based managed care contracting to applicable insurance laws and regulations. These laws and regulations, if adopted in the states in which we operate, may require physicians and physician networks to meet minimum capital requirements and other safety and soundness requirements. Implementing additional regulations or compliance requirements could result in substantial costs to us and the contracted radiology practices and limit our ability to enter into capitation or other risk-sharing managed care arrangements.

State and federal anti-kickback and anti-self-referral laws may adversely affect income.

Various federal and state laws govern financial arrangements among healthcare providers. The federal Anti-Kickback Law prohibits the knowing and willful offer, payment, solicitation or receipt of any form of remuneration in return for, or to induce, the referral of Medicare, Medicaid, or other federal healthcare program patients, or in return for, or to induce, the purchase, lease or order of items or services that are covered by Medicare, Medicaid, or other federal healthcare programs. Similarly, many state laws prohibit the solicitation, payment or receipt of remuneration in return for, or to induce the referral of patients in private as well as government programs. Violation of these Anti-Kickback Laws may result in substantial civil or criminal penalties for individuals or entities and/or exclusion from federal or state healthcare programs. We believe we are operating in compliance with applicable law and believe that our arrangements with providers would not be found to violate the Anti-Kickback Laws. However, these laws could be interpreted in a manner inconsistent with our operations.

Federal law prohibiting physician self-referrals, known as the Stark Law, prohibits a physician from referring Medicare or Medicaid patients to an entity for certain “designated health services” if the physician has a prohibited financial relationship with that entity, unless an exception applies. Certain radiology services are considered “designated health services” under the Stark Law. Although we believe our operations do not violate the Stark Law, our activities may be challenged. If a challenge to our activities is successful, it could have an adverse effect on our operations. In addition, legislation may be enacted in the future that further addresses Medicare and Medicaid fraud and abuse or that imposes additional requirements or burdens on us.

In addition, under the DRA, states enacting false claims statutes similar to the federal False Claims Act, which establish liability for submission of fraudulent claims to the State Medicaid program and contain qui tam or whistleblower provisions, receive an increased percentage of any recovery from a State Medicaid judgment or settlement. Adoption of new false claims statutes in states where we operate may impose additional requirements or burdens on us.

Federal and state privacy and information security laws are complex, and if we fail to comply with applicable laws, regulations and standards, or if we fail to properly maintain the integrity of our data, protect our proprietary rights to our systems, or defend against cybersecurity attacks, we may be subject to government or private actions due to privacy and security breaches, and our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

We must comply with numerous federal and state laws and regulations governing the collection, dissemination, access, use, security and privacy of PHI, including HIPAA and its implementing privacy and security regulations, as amended by the federal HITECH Act and collectively referred to as HIPAA. If we fail to comply with applicable privacy and security laws, regulations and standards, properly maintain the integrity of our data, protect our proprietary rights to our systems, or defend against cybersecurity attacks, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

Information security risks have significantly increased in recent years in part because of the proliferation of new technologies, the use of the internet and telecommunications technologies to conduct our operations, and the increased sophistication and activities of organized crime, hackers, terrorists and other external parties, including foreign state agents. Our operations rely on the secure processing, transmission and storage of confidential, proprietary and other information in our computer systems and networks.

We are continuously implementing multiple layers of security measures through technology, processes, and our people; utilize current security technologies; and our defenses are monitored and routinely tested internally and by external parties. Despite these efforts, our facilities and systems may be vulnerable to privacy and security incidents; security attacks and breaches; acts of vandalism or theft; computer viruses; coordinated attacks by activist entities; emerging cybersecurity risks; misplaced or lost data; programming and/or human errors; or other similar events. Emerging and advanced security threats, including coordinated attacks, require additional layers of security which may disrupt or impact efficiency of operations.

Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential information, including protected health information, financial data, competitively sensitive information, or other proprietary data, whether by us or a third party, could have a material adverse effect on our business, reputation, financial condition, cash flows, or results of operations. The occurrence of any of these events could result in interruptions, delays, the loss or corruption of data, cessations in the availability of systems or liability under privacy

and security laws, all of which could have a material adverse effect on our financial position and results of operations and harm our business reputation. If we are unable to protect the physical and electronic security and privacy of our databases and transactions, we could be subject to potential liability and regulatory action, our reputation and relationships with our patients and vendors would be harmed, and our business, operations, and financial results may be materially adversely affected. Failure to adequately protect and maintain the integrity of our information systems (including our networks) and data, or to defend against cybersecurity attacks, could subject us to monetary fines, civil suits, civil penalties or criminal sanctions and requirements to disclose the breach publicly, and may further result in a material adverse effect on our results of operations, financial position, and cash flows.

Complying with federal and state regulations is an expensive and time-consuming process, and any failure to comply could result in substantial penalties.

We are directly or indirectly, through the radiology practices with which we contract, subject to extensive regulation by both the federal government and the state governments in which we provide services, including:

- the federal False Claims Act;
- the federal Medicare and Medicaid Anti-Kickback Laws, and state anti-kickback prohibitions;
- federal and state billing and claims submission laws and regulations;
- the federal Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009, and comparable state laws;
- the federal physician self-referral prohibition commonly known as the Stark Law and the state equivalent of the Stark Law;
- state laws that prohibit the practice of medicine by non-physicians and prohibit fee-splitting arrangements involving physicians;
- federal and state laws governing the diagnostic imaging and therapeutic equipment we use in our business concerning patient safety, equipment operating specifications and radiation exposure levels; and
- state laws governing reimbursement for diagnostic services related to services compensable under workers compensation rules.

If our operations are found to be in violation of any of the laws and regulations to which we or the radiology practices with which we contract are subject, we may be subject to the applicable penalty associated with the violation, including civil and criminal penalties, damages, fines and the curtailment of our operations. Any penalties, damages, fines or curtailment of our operations, individually or in the aggregate, could adversely affect our ability to operate our business and our financial results. The risks of our being found in violation of these laws and regulations is increased by the fact that many of them have not been fully interpreted by the regulatory authorities or the courts, and their provisions are open to a variety of interpretations. Any action brought against us for violation of these laws or regulations, even if we successfully defend against it, could cause us to incur significant legal expenses and divert our management's attention from the operation of our business.

If we fail to comply with various licensure, certification and accreditation standards, we may be subject to loss of licensure, certification or accreditation, which would adversely affect our operations.

Ownership, construction, operation, expansion and acquisition of our diagnostic imaging facilities are subject to various federal and state laws, regulations and approvals concerning licensing of personnel, other required certificates for certain types of healthcare facilities and certain medical equipment. In addition, freestanding diagnostic imaging facilities that provide services independent of a physician's office must be enrolled by Medicare as an independent diagnostic treatment facility, or IDTF, to bill the Medicare program. Medicare carriers have discretion in applying the IDTF requirements and therefore the application of these requirements may vary from jurisdiction to jurisdiction. In addition, federal legislation requires all suppliers that provide the technical component of diagnostic MRI, PET/CT, CT, and nuclear medicine to be accredited by an accreditation organization designated by CMS (which currently include the American College of Radiology (ACR), the Intersocietal Accreditation Commission (IAC) and the Joint Commission) by January 1, 2012. Our MRI, CT, nuclear medicine, ultrasound and mammography facilities are currently accredited by the American College of Radiology. We may not be able to receive the required regulatory approvals or accreditation for any future acquisitions, expansions or replacements, and the failure to obtain these approvals could limit the opportunity to expand our services.

Our facilities are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensure and certification. If any facility loses its certification under the Medicare program, then the facility will be ineligible to receive reimbursement from the Medicare and Medicaid programs. For the year ended December 31, 2016, approximately 23% of our net service fee revenue before provision for bad debt came from the Medicare and Medicaid programs. A change in the applicable certification status of one of our facilities could adversely affect our other facilities and in turn us as a whole. Credentialing of physicians is required by our payors prior to commencing payment. We have experienced a slowdown in the credentialing of our physicians over the last several years which has lengthened our billing and collection cycle, and could negatively impact our ability to collect revenue from patients covered by Medicare.

Our agreements with the contracted radiology practices must be structured to avoid the corporate practice of medicine and fee-splitting.

State law prohibits us from exercising control over the medical judgments or decisions of physicians and from engaging in certain financial arrangements, such as splitting professional fees with physicians. These laws are enforced by state courts and regulatory authorities, each with broad discretion. A component of our business has been to enter into management agreements with radiology practices. We provide management, administrative, technical and other non-medical services to the radiology practices in exchange for a service fee typically based on a percentage of the practice's revenue. We structure our relationships with the radiology practices, including the purchase of diagnostic imaging facilities, in a manner that we believe keeps us from engaging in the practice of medicine or exercising control over the medical judgments or decisions of the radiology practices or their physicians, or violating the prohibitions against fee-splitting. There can be no assurance that our present arrangements with BRMG or the physicians providing medical services and medical supervision at our imaging facilities will not be challenged, and, if challenged, that they will not be found to violate the corporate practice of medicine or fee splitting prohibitions, thus subjecting us to potential damages, injunction and/or civil and criminal penalties or require us to restructure our arrangements in a way that would affect the control or quality of our services and/or change the amounts we receive under our management agreements. Any of these results could jeopardize our business.

Some of our imaging modalities use radioactive materials, which generate regulated waste and could subject us to liabilities for injuries or violations of environmental and health and safety laws.

Some of our imaging procedures use radioactive materials, which generate medical and other regulated wastes. For example, patients are injected with a radioactive substance before undergoing a PET scan. Storage, use and disposal of these materials and waste products present the risk of accidental environmental contamination and physical injury. We are subject to federal, state and local regulations governing storage, handling and disposal of these materials. We could incur significant costs and the diversion of our management's attention in order to comply with current or future environmental and health and safety laws and regulations. Also, we cannot completely eliminate the risk of accidental contamination or injury from these hazardous materials. Although we maintain professional liability insurance coverage in amounts we believe is consistent with industry practice in the event of an accident, we could be held liable for any resulting damages, and any liability could exceed the limits of or fall outside the coverage of our professional liability insurance.

Technological change in our industry could reduce the demand for our services and require us to incur significant costs to upgrade our equipment.

The development of new technologies or refinements of existing modalities may require us to upgrade and enhance our existing equipment before we may otherwise intend. Many companies currently manufacture diagnostic imaging equipment. Competition among manufacturers for a greater share of the diagnostic imaging equipment market may result in technological advances in the speed and imaging capacity of new equipment. This may accelerate the obsolescence of our equipment, and we may not have the financial ability to acquire the new or improved equipment and may not be able to maintain a competitive equipment base. In addition, advances in technology may enable physicians and others to perform diagnostic imaging procedures without us. If we are unable to deliver our services in the efficient and effective manner that payors, physicians and patients expect our revenue could substantially decrease.

Because we have high fixed costs, lower scan volumes per system could adversely affect our business.

The principal components of our expenses, excluding depreciation, consist of debt service, capital lease payments, compensation paid to technologists, salaries, real estate lease expenses and equipment maintenance costs. Because a majority of these expenses are fixed, a relatively small change in our revenue could have a disproportionate effect on our operating and financial results depending on the source of our revenue. Thus, decreased revenue as a result of lower scan volumes per system could result in lower margins, which could materially adversely affect our business.

We may be unable to effectively maintain our equipment or generate revenue when our equipment is not operational.

Timely, effective service is essential to maintaining our reputation and high use rates on our imaging equipment. Although we have an agreement with GE Medical Systems pursuant to which it maintains and repairs the majority of our imaging equipment, this agreement does not compensate us for loss of revenue when our systems are not fully operational and our business interruption insurance may not provide sufficient coverage for the loss of revenue. Also, GE Medical Systems may not be able to perform repairs or supply needed parts in a timely manner, which could result in a loss of revenue. Therefore, if we experience more equipment malfunctions than anticipated or if we are unable to promptly obtain the service necessary to keep our equipment functioning effectively, our ability to provide services would be adversely affected and our revenue could decline.

Disruption or malfunction in our information systems could adversely affect our business.

Our information technology system is vulnerable to damage or interruption from:

- earthquakes, fires, floods and other natural disasters;
- power losses, computer systems failures, internet and telecommunications or data network failures, operator negligence, improper operation by or supervision of employees, physical and electronic losses of data and similar events; and
- computer viruses, penetration by hackers seeking to disrupt operations or misappropriate information and other breaches of security.

We rely on our information systems to perform functions critical to our ability to operate, including patient scheduling, billing, collections, image storage and image transmission. We could face attempts by others to gain unauthorized access through the Internet or to introduce malicious software to our information technology systems. If a malicious hacker gained unauthorized access to our systems and network, it could have a material adverse impact on our business or operations. Such incidents, whether or not successful, could result in our incurring significant costs related to, for example, rebuilding internal systems, defending against litigation, responding to regulatory inquiries or actions, paying damages, or taking other remedial steps with respect to third parties. In addition, these threats are constantly changing, thereby increasing the difficulty of successfully defending against them or implementing adequate preventive measures. Accordingly, an extended interruption in our information technology system's function could significantly curtail, directly and indirectly, our ability to conduct our business and generate revenue.

Adverse changes in general domestic and worldwide economic conditions and instability and disruption of credit markets could adversely affect our operating results, financial condition, or liquidity.

We are subject to risk arising from adverse changes in general domestic and global economic conditions, including recession or economic slowdown and disruption of credit markets. Continued concerns about the systemic impact of potential long-term and wide-spread recession, inflation, energy costs, geopolitical issues, the availability and cost of credit have contributed to increased market volatility and diminished expectations for the United States economy. The United States, and other western countries have responded to this economic situation by exercising monetary policy to keep interest rates low. Any significant change in economic conditions or change in fiscal monetary policy could result in material changes in interest rates.

Continued turbulence in domestic and international markets and economies may adversely affect our liquidity and financial condition, and the liquidity and financial condition of our patients. If these market conditions continue, they may increase expenses associated with borrowing, limit our ability, and the ability of our patients, to timely replace maturing liabilities, and access the capital markets to meet liquidity needs, resulting in adverse effects on our financial condition and results of operations.

Budget decisions by the California State Legislature could have an impact on our revenue.

138 of our 305 facilities are located in California and one to one-and-one-half percent (1% to 1.5%) of our revenues come from the California Medicaid program. To the extent California is unable to provide these payments on a timely basis, or at all, our revenues will be negatively impacted.

We are vulnerable to earthquakes, harsh weather and other natural disasters.

Our corporate headquarters and 138 of our facilities are located in California, an area prone to earthquakes and other natural disasters. Several of our facilities are located in areas of Florida and the east coast that have suffered from hurricanes and other harsh weather, including winter snow storms that have in the past caused us to close our facilities. An earthquake, harsh weather conditions or other natural disaster could decrease scan volume during affected periods and seriously impair our operations. Damage to our equipment or interruption of our business would adversely affect our financial condition and results of operations.

Possible volatility in our stock price could negatively affect us and our stockholders.

The trading price of our common stock on the NASDAQ Global Market has fluctuated significantly in the past. During the period from January 1, 2015 through December 31, 2016, the trading price of our common stock fluctuated from a high of \$9.40 per share to a low of \$4.66 per share. In the past, we have experienced a drop in stock price following an announcement of disappointing earnings or earnings guidance. Any such announcement in the future could lead to a similar drop in stock price. The price of our common stock could also be subject to wide fluctuations in the future as a result of a number of other factors, including the following:

- changes in expectations as to future financial performance or buy/sell recommendations of securities analysts; our, or a competitor's, announcement of new services, or significant acquisitions, strategic partnerships, joint ventures or capital commitments; and
- the operating and stock price performance of other comparable companies.

In addition, the U.S. securities markets have experienced significant price and volume fluctuations. These fluctuations often have been unrelated to the operating performance of companies in these markets. Broad market and industry factors may lead to volatility in the price of our common stock, regardless of our operating performance. Moreover, our stock has limited trading volume, and this illiquidity may increase the volatility of our stock price.

In the past, following periods of volatility in the market price of an individual company's securities, securities class action litigation often has been instituted against that company. The institution of similar litigation against us could result in substantial costs and a diversion of management's attention and resources, which could negatively affect our business, results of operations or financial condition.

Provisions of the Delaware General Corporation Law and our organizational documents may discourage an acquisition of us.

In the future, we could become the subject of an unsolicited attempted takeover of our company. Although an unsolicited takeover could be in the best interests of our stockholders, our organizational documents and the General Corporation Law of the State of Delaware both contain provisions that will impede the removal of directors and may discourage a third-party from making a proposal to acquire us. For example, the provisions:

- permit the board of directors to increase its own size, within the maximum limitations set forth in the bylaws, and fill the resulting vacancies;
- authorize the issuance of shares of preferred stock in one or more series without a stockholder vote;
- establish an advance notice procedure for stockholder proposals to be brought before an annual meeting of our stockholders, including proposed nominations of persons for election to the board of directors; and
- prohibit transfers and/or acquisitions of stock (without consent of the Board of Directors) that would result in any stockholder owning greater than 5% of the currently outstanding stock resulting in a limitation on net operating loss carryovers, capital loss carryovers, general business credit carryovers, alternative minimum tax credit carryovers and foreign tax credit carryovers, as well as any loss or deduction attributable to a “net unrealized built-in loss” within the meaning of Section 382 of the internal revenue code of 1986, as amended.

We are subject to Section 203 of the Delaware General Corporation Law, which could have the effect of delaying or preventing a change in control.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our corporate headquarters is located in adjoining premises at 1508, 1510 and 1516 Cotner Avenue, Los Angeles, California 90025, and approximately 21,500 square feet is occupied under these leases, which expire (with options to extend) on June 30, 2017. We also have a regional office of approximately 39,000 square feet in Baltimore, Maryland under a lease, which expires September 30, 2023. In addition, we lease approximately 62,000 square feet of warehouse space under leases nationwide, which expire at various dates, including options, through August 2031. As of December 31, 2016, total square footage under lease, including medical office, administrative and storage locations was approximately 2.3 million square feet.

We operate 138 fixed-site, freestanding outpatient diagnostic imaging facilities in California, 9 in Delaware, 3 in Florida, 59 in Maryland, 19 in New Jersey, 19 in the Rochester and Hudson Valley areas of New York, 53 in New York City as well as 5 in Rhode Island. We lease the premises at which these facilities are located. Our most common initial term varies in length from 5 to 15 years. Including renewal options negotiated with the landlord, we can have a total span of 10 to 25 years at the facilities we lease. We also lease smaller satellite X-Ray locations on mutually renewable terms, usually lasting one year. Rental increases can range from 1% to 7% on an annual basis, depending on the location and market conditions where we do business. We do not have options to purchase the facilities we rent.

Item 3. Legal Proceedings

We are engaged from time to time in the defense of lawsuits arising out of the ordinary course and conduct of our business. We believe that the outcome of our current litigation will not have a material adverse impact on our business, financial condition and results of operations. However, we could be subsequently named as a defendant in other lawsuits that could adversely affect us.

Item 4. Mine Safety Disclosures

Not applicable.

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

Our common stock is quoted on the NASDAQ Global Market under the symbol "RDNT". The following table indicates the high and low prices for our common stock for the periods indicated based upon information supplied by the NASDAQ Global Market.

Quarter Ended	Low	High
December 31, 2016	\$5.35	\$7.98
September 30, 2016	5.28	7.42
June 30, 2016	4.66	5.55
March 31, 2016	4.73	6.33
December 31, 2015	\$5.19	\$7.50
September 30, 2015	5.25	7.85
June 30, 2015	6.18	9.30
March 31, 2015	7.15	9.40

The last low and high prices for our common stock on the NASDAQ Global Market for the period from January 1 to March 9, 2017 were \$5.35 and \$6.77, respectively.

 Holders

As of March 9, 2017, the number of holders of record of our common stock was 835. However, Cede & Co., the nominee for The Depository Trust Company, the clearing agency for most broker-dealers, owned a substantial number of our outstanding shares of common stock of record on that date. Our management believes that the number of beneficial owners of our common stock is approximately 4,000.

 Dividends

We have never declared or paid cash dividends on our capital stock and we do not expect to pay any dividends in the foreseeable future. We currently intend to retain future earnings, if any, to finance the growth and development of our business. Our current credit facilities place restrictions on our ability to issue dividends. See discussion under “Liquidity and Capital Resources” regarding our current credit facilities. Payment of future dividends, if any, will be at the discretion of our board of directors and will depend on our financial condition, results of operations, capital requirements and such other factors as the board of directors deems relevant.

Equity Compensation Plans Information

The information required by this item will be contained in our definitive proxy statement, to be filed with the SEC in connection with our 2017 annual meeting of stockholders, which is expected to be filed not later than 120 days after the end of our fiscal year ended December 31, 2016, and is incorporated in this report by reference.

Stock Performance Graph

The following graph compares the yearly percentage change in cumulative total stockholder return of our common stock during the period from 2011 to 2016 with (i) the cumulative total return of the S&P 500 index and (ii) the cumulative total return of the S&P 500 – Healthcare Sector index. The comparison assumes \$100 was invested on December 31, 2011 in our common stock and in each of the foregoing indices and the reinvestment of dividends through December 31, 2016. The stock price performance on the following graph is not necessarily indicative of future stock price performance.

This graph shall not be deemed incorporated by reference by any general statement incorporating by reference this Form 10-K into any filing under the Securities Act or under the Exchange Act, except to the extent that RadNet specifically incorporates this information by reference, and shall not otherwise be deemed filed under the Securities Act or the Exchange Act.

Company / Index	ANNUAL RETURN PERCENTAGE				
	Years Ending				
	12/30/12	12/31/13	12/31/14	12/31/15	12/31/16
RadNet, Inc.	18.78	-33.99	411.38	-27.63	4.37
S&P 500 Index	16.00	32.39	13.69	1.38	11.96
S&P Health Care Sector	17.89	41.46	25.34	6.89	-2.69

Company / Index	Base Period	INDEXED RETURNS				
		Years Ending				
		12/30/12	12/31/13	12/31/14	12/31/15	12/31/16
RadNet, Inc.	100	118.78	78.40	400.94	290.14	302.82
S&P 500 Index	100	116.00	153.57	174.60	177.01	198.18
S&P Health Care Sector	100	117.89	166.76	209.02	223.42	217.41

Recent Sales of Unregistered Securities

None.

Item 6. Selected Consolidated Financial Data

The following table sets forth our selected historical consolidated financial data. The selected consolidated statements of operations data set forth below for the years ended December 31, 2016, 2015 and 2014, and the consolidated balance sheet data as of December 31, 2016 and 2015, are derived from our audited consolidated financial statements and notes thereto included elsewhere herein. The selected historical consolidated statements of operations data set forth below for the years ended December 31, 2013 and 2012, and the consolidated balance sheet data set forth below as of December 31, 2014, 2013 and 2012, are derived from our audited consolidated financial statements not included herein. This data should be read in conjunction with and is qualified in its entirety by reference to the audited consolidated financial statements and the related notes included elsewhere in this annual report and Item 7 -

“Management’s Discussion and Analysis of Financial Condition and Results of Operations.”

The financial data set forth below and discussed in this annual report are derived from the consolidated financial statements of RadNet, its subsidiaries and certain affiliates. As a result of the contractual and operational relationship among BRMG, Dr. Berger, the New York Groups, Dr. Crues and the Company, we are considered to have a controlling financial interest in BRMG and the New York Groups (collectively, the “Professional Entities”) pursuant to applicable accounting guidance. Due to the deemed controlling financial interest, we are required to include the Professional Entities as consolidated entities in our consolidated financial statements. This means, for example, that revenue generated by the Professional Entities from the provision of professional medical services to our patients, as well as the Professional Entities costs of providing those services, are included as net revenue and cost of operations in our consolidated statement of operations, whereas the management fee that the Professional Entities’ pay to us under our management agreement with the Professional Entities is eliminated as a result of the consolidation of our results with those of the Professional Entities. Also, because the Professional Entities are consolidated in our financial statements, any borrowings or advances we have received from or made to the Professional Entities have been eliminated in our consolidated balance sheet. If the Professional Entities were not treated as consolidated entities in our consolidated financial statements, the presentation of certain items in our income statement, such as net service fee revenue and costs and expenses, would change but our net income would not, because in operation and historically, the annual revenue of the Professional Entities from all sources closely approximates its expenses, including Dr. Berger’s and Dr. Crues’ compensation, fees payable to us and amounts payable to third parties.

Years Ended December 31,
2016 2015 2014 2013 2012

(in thousands, except per share data)

Statement of Operations Data:

Net revenue	\$884,535	\$809,628	\$717,569	\$702,986	\$647,153
Operating expenses:					
Cost of operations, excluding depreciation and amortization	775,801	708,289	602,652	598,655	542,993
Depreciation and amortization	66,610	60,611	59,258	58,890	57,740
Loss on sale and disposal of equipment, net	767	866	1,113	1,032	456
Gain on sale of imaging center and de-consolidation of joint venture	–	(5,434)	–	(2,108)	(2,777)
Gain on return of common stock	(5,032)	–	–	–	–
Meaningful use incentive	(2,808)	(3,270)	(2,034)	–	–
Loss on extinguishment of debt	–	–	15,927	–	–
Net income attributable to RadNet common stockholders	7,230	7,709	1,376	2,120	59,834
Basic income per share attributable to RadNet common stockholders	0.16	0.18	0.03	0.05	1.58
Diluted income per share attributable to RadNet common stockholders	0.15	0.17	0.03	0.05	1.52

Balance Sheet Data:

Cash and cash equivalents	\$20,638	\$446	\$307	\$8,412	\$362
Total assets	849,476	836,427	740,680	722,576	710,864

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Total long-term liabilities	642,082	643,007	599,708	601,977	598,507
Total liabilities	797,423	799,966	732,982	720,366	717,548
Working capital	62,573	72,410	58,746	57,955	36,859
Equity (deficit)	52,053	36,461	7,698	2,210	(6,684)

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

Overview

We are a leading national provider of freestanding, fixed-site outpatient diagnostic imaging services in the United States based on number of locations and annual imaging revenue. At December 31, 2016, we operated directly or indirectly through joint ventures, 305 centers located in California, Delaware, Florida, Maryland, New Jersey, New York and Rhode Island. Our centers provide physicians with imaging capabilities to facilitate the diagnosis and treatment of diseases and disorders and may reduce unnecessary invasive procedures, often reducing the cost and amount of care for patients. Our services include magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), nuclear medicine, mammography, ultrasound, diagnostic radiology (X-ray), fluoroscopy and other related procedures. As of December 31, 2016, we had in operation 257 MRI systems, 157 CT systems, 47 PET or combination PET/CT systems, 48 nuclear medicine systems, 479 X-ray systems, 279 mammography systems, 551 ultrasound systems, and 104 fluoroscopy systems.

We derive substantially all of our revenue from fees charged for the diagnostic imaging services performed at our facilities. For the years ended December 31, 2016, 2015 and 2014, we performed 6,109,622, 5,638,979, and 4,828,488 diagnostic imaging procedures and generated net revenue of \$884.5 million, \$809.6 million, and \$717.6 million, respectively. Additional information concerning RadNet, Inc., including our consolidated subsidiaries, for each of the years ended December 31, 2016, 2015 and 2014 is included in the consolidated financial statements and notes thereto in this annual report.

Our revenue is derived from a diverse mix of payors, including private payors, managed care capitated payors and government payors. We believe our payor diversity mitigates our exposure to possible unfavorable reimbursement trends within any one payor class. In addition, our experience with capitation arrangements over the last several years has provided us with the expertise to manage utilization and pricing effectively, resulting in a predictable stream of revenue. For the year ended December 31, 2016, we received net service fee revenue before provision for bad debt of approximately 70% of our payments from commercial insurance payors and from managed care capitated payors, 20% from Medicare, 3% from Medicaid, 4% from Workers Compensation programs and 3% from other sources. With the exception of Blue Cross/Blue Shield, which represents approximately 21% and government payors amounting to approximately 23% of revenues respectively, no single payor accounted for more than 5% of our net revenue for the twelve months ended December 31, 2016.

We have developed our medical imaging business through a combination of organic growth and acquisitions. For a discussion of acquisitions and dispositions of facilities, see "Recent Developments and Facility Acquisitions and Dispositions" below.

We typically experience some seasonality to our business. During the first quarter of each year we generally experience the lowest volumes of procedures and the lowest level of revenue for any quarter during the year. This is primarily the result of two factors. First, our volumes and revenue are typically impacted by winter weather conditions in our northeastern operations. It is common for snowstorms and other inclement weather to result in patient appointment cancellations and, in some cases, imaging center closures. Second, in recent years, we have observed greater participation in high deductible health plans by patients. As these high deductibles reset in January for most of these patients, we have observed that patients utilize medical services less during the first quarter, when securing medical care will result in significant out-of-pocket expenditures.

During 2016 we focused on strengthening our positions in the key markets of California and New York through small scale acquisitions and consolidation of facilities. In addition, we formed two new joint ventures with major hospitals to leverage our proven ability to provide management, technical, and accounting services.

We finished the year with cash and cash equivalents of \$20.6 million in cash and accounts receivable of \$164.2 million. Through a refinance of first lien our term loan debt, we also received a new revolving credit facility, which increased our borrowing capacity from \$101.25 to \$117.5 million. At December 31, 2016 we had no aggregate balance on the revolving credit line and the total borrowing capacity is available.

The consolidated financial statements in this annual report include the accounts of Radnet Management, BRMG and the New York Groups. The consolidated financial statements also include Radnet Management I, Inc., Radnet Management II, Inc., Radiologix, Inc., Radnet Management Imaging Services, Inc., Delaware Imaging Partners, Inc., New Jersey Imaging Partners, Inc. and Diagnostic Imaging Services, Inc. (DIS), all wholly owned subsidiaries of Radnet Management.

Accounting Standards Codification (ASC) 810-10-15-14, *Consolidation*, stipulates that generally any entity with a) insufficient equity to finance its activities without additional subordinated financial support provided by any parties, or b) equity holders that, as a group, lack the characteristics specified in the Codification which evidence a controlling financial interest, is considered a Variable Interest Entity (“VIE”). We consolidate all variable interest entities in which we own a majority voting interest and all VIEs for which we are the primary beneficiary. We determine whether we are the primary beneficiary of a VIE through a qualitative analysis that identifies which variable interest holder has the controlling financial interest in the VIE. The variable interest holder that has both of the following has the controlling financial interest and is the primary beneficiary: (1) the power to direct the activities of the VIE that most significantly impact the VIE’s economic performance and (2) the obligation to absorb losses of, or the right to receive benefits from, the VIE that could potentially be significant to the VIE. In performing our analysis, we consider all relevant facts and circumstances, including: the design and activities of the VIE, the terms of the contracts the VIE has entered into, the nature of the VIE’s variable interests issued and how they were negotiated with or marketed to potential investors, and which parties participated significantly in the design or redesign of the entity.

Facility Acquisitions and Assets Held for Sale

Facility acquisitions

In separate purchases occurring on July 1 and October 1 2016, we acquired for approximately \$1.2 million the remaining non-controlling interest of 47.6% in the Park West joint venture, thus increasing our ownership percentage from 52.4% to 100%. The difference between the consideration paid and the carrying value of the non-controlling interest purchased was recorded as additional paid-in capital.

On March 1, 2016 we completed our acquisition of certain assets of Advanced Radiological Imaging – Astoria P.C. consisting of two multi-modality imaging centers located in Astoria, NY for cash consideration of \$5.0 million. The facility provides MRI, PET/CT, Ultrasound and X-ray services. We have made a fair value determination of the acquired assets and approximately \$3.6 million of fixed assets, \$47,000 of prepaid assets, \$100,000 covenant not to compete, and \$1.3 million of goodwill were recorded.

On October 1, 2015 we completed our acquisition of certain assets of DIG consisting of seventeen multi-modality imaging centers located in the boroughs of Brooklyn and Queens, New York, for \$62.9 million detailed as follows: cash consideration of \$54.6 million (\$49.6 million paid at execution, \$5 million to be paid 18 months after acquisition or earlier if certain conditions are met), the assumption of \$2.1 million in equipment debt, and issuance of 1.5 million RadNet common shares valued at \$8.3 million on the acquisition date. The transaction also includes contingent consideration payable equal to five times the amount by which collections on the sellers’ historical revenue exceeds a defined threshold. During 2016, based on fair value determination of the assets and liabilities by a third party, we recorded certain measurement period adjustments associated with our acquisition. In the second quarter of 2016, these adjustments resulted in an increase to fixed assets acquired by \$1.1 million and the recognition of a net unfavorable

lease contract liability of \$1.0 million. In the third quarter of 2016, we recorded a decrease to our intangible and fixed assets of approximately \$121,000. Also, amounts previously owed to DIG of \$5.0 million were reduced to \$3.4 million on June 15, 2016 when we remitted a payment of \$1.6 million to a payor on behalf of DIG.

Assets held for sale

On November 4, 2016, the Board of Directors resolved to sell the ownership interest in all five of its Rhode Island imaging centers operating under the name The Imaging Institute within the upcoming 12 months. The following table summarizes the major categories of assets classified as held for sale in the accompanying Consolidated Balance Sheets at December 31, 2016 (in thousands):

Property and equipment, net	\$1,056
Other assets	21
Goodwill	1,126
Total assets held for sale	\$2,203

As the sale of these assets does not represent a strategic shift that will have a major effect on the Company's operations and financial results, it is not classified as a discontinued operation.

Results of Operations

The following table sets forth, for the periods indicated, the percentage that certain items in the statements of operations bears to net revenue before provision for bad debts.

	Years Ended December		
	31,		
	2016	2015	2014
NET REVENUE			
Service fee revenue, net of contractual allowances and discounts	88.4%	88.3%	89.7%
Provision for bad debts	-4.9%	-4.3%	-4.0%
Net service fee revenue	83.5%	84.0%	85.7%
Revenue under capitation arrangements	11.6%	11.7%	10.3%
Total net revenue	95.1%	95.7%	96.0%
OPERATING EXPENSES			
Cost of operations, excluding depreciation and amortization	83.4%	83.8%	80.6%
Depreciation and amortization	7.2%	7.2%	7.9%
Loss on sale and disposal of equipment	0.1%	0.1%	0.1%
Severance costs	0.3%	0.1%	0.2%
Total operating expenses	91.0%	91.1%	88.8%
INCOME FROM OPERATIONS	4.1%	4.6%	7.2%
OTHER INCOME AND EXPENSES			
Interest expense	4.6%	4.9%	5.7%
Meaningful use incentive	-0.3%	-0.4%	-0.3%
Equity in earnings of joint ventures	-1.1%	-1.1%	-0.9%
Gain on sale of imaging centers	0.0%	-0.6%	0.0%
Gain on return of common stock	-0.5%	0.0%	0.0%
Loss on early extinguishment of senior notes	0.0%	0.0%	2.1%
Other expenses	0.0%	0.0%	0.0%
Total other expenses	2.7%	2.8%	\$6.6%
INCOME BEFORE INCOME TAXES	1.4%	1.8%	0.6%
Provision for income taxes	-0.5%	-0.7%	-0.3%
NET INCOME	0.9%	1.1%	0.3%
Net income attributable to noncontrolling interests	0.1%	0.1%	0.0%
NET INCOME ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS	0.8%	1.0%	0.3%

Year Ended December 31, 2016 Compared to the Year Ended December 31, 2015

Service Fee Revenue, net of contractual allowances and discounts

Service fee revenue, net of contractual allowances and discounts for the year ended December 31, 2016 was \$821.6 million compared to \$746.8 million for the year ended December 31, 2015, an increase of \$74.8 million, or 10.0%.

Service fee revenue, net of contractual allowances and discounts, for only those centers in operation throughout the full fiscal years of both 2016 and 2015, increased \$17.6 million, or 2.6%. This comparison excludes revenue contributions from centers that were acquired subsequent to January 1, 2015. For the year ended December 31, 2016, service fee revenue, net of contractual allowances and discounts, from centers that were acquired subsequent to January 1, 2015 and excluded from the above comparison was \$122.1 million. For the year ended December 31, 2015, net revenue from centers that were acquired subsequent to January 1, 2015 and excluded from the above comparison was \$64.9 million.

Provision for bad debts

Provision for bad debts increased \$9.4 million, or 26.0%, to \$45.4 million, or 4.9% of net revenue, for the year ended December 31, 2016 compared to \$36.0 million, or 4.3% of net revenue, for the year ended December 31, 2015. The 26% increase was related to service fee revenue growth from our 2015 acquisition activity combined with additional reserves based on management determination that collection efforts for certain accounts appear to have been exhausted. We review our provision by the application of judgment based on factors such as contractual reimbursement rates, payor mix, the age of receivables, historical cash collection experience and other relevant information.

Revenue under capitation arrangements

Revenue under capitation arrangements for the year ended December 31, 2016 was \$108.3 million compared to \$98.9 million for the year ended December 31, 2015, an increase of \$9.4 million, or 9.5%.

Revenue under capitation arrangements, including only those centers which were in operation throughout the full fiscal years of both 2016 and 2015, increased \$1.7 million, or 1.7%. This comparison excludes revenue contributions from centers that were acquired subsequent to January 1, 2015. For the year ended December 31, 2016, revenue under capitation arrangements from centers that were acquired subsequent to January 1, 2015 and excluded from the above comparison was \$9.0 million. For the year ended December 31, 2015, net revenue from centers that were acquired subsequent to January 1, 2015 and excluded from the above comparison was \$1.3 million.

Operating expenses

Cost of operations for the year ended December 31, 2016 increased approximately \$67.5 million, or 9.5%, from \$708.3 million for the year ended December 31, 2015 to \$775.8 million for the year ended December 31, 2016. The following table sets forth our operating expenses for the years ended December 31, 2016 and 2015 (in thousands):

Years Ended	
December 31,	
2016	2015

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Salaries and professional reading fees, excluding stock-based compensation	\$407,571	\$376,407
Stock-based compensation	5,826	7,647
Building and equipment rental	74,214	71,666
Medical supplies	51,735	49,417
Other operating expenses *	236,455	203,152
Cost of operations	775,801	708,289
Depreciation and amortization	66,610	60,611
Loss on sale and disposal of equipment	767	866
Severance costs	2,877	745
Total operating expenses	\$846,055	\$770,511

* Includes billing fees, office supplies, repairs and maintenance, insurance, business tax and license, outside services, utilities, marketing, travel and other expenses.

·Salaries and professional reading fees, excluding stock-based compensation and severance

Salaries and professional reading fees increased \$31.2 million, or 8.3%, to \$407.6 million for the year ended December 31, 2016, compared to \$376.4 million for the year ended December 31, 2015.

Salaries and professional reading fees for only those centers in operation throughout the full fiscal years of both 2016 and 2015, increased \$4.2 million, or 1.2%. This comparison excludes contributions from centers that were acquired subsequent to January 1, 2015. For the year ended December 31, 2016, salaries and professional reading fees from centers that were acquired subsequent to January 1, 2015 and excluded from the above comparison was \$48.0 million. For the year ended December 31, 2015, salaries and professional reading fees from centers that were acquired subsequent to January 1, 2015, and excluded from the above comparison was \$21.0 million.

·Stock-based compensation

Stock-based compensation decreased \$1.8 million, or 23.8%, to \$5.8 million for the year ended December 31, 2016 compared to \$7.6 million for the year ended December 31, 2015. This decrease was driven by the lower fair value of stock based compensation awarded and vested in the year 2016 as compared to 2015.

·Building and equipment rental

Building and equipment rental expenses increased \$2.5 million, or 3.6%, to \$74.2 million for the year ended December 31, 2016, compared to \$71.7 million for the year ended December 31, 2015.

Building and equipment rental expenses, including only those centers which were in operation throughout the full fiscal years of both 2016 and 2015, decreased \$3.3 million, or 5.2%, mainly due to favorable lease negotiations at existing facilities. This comparison excludes contributions from centers that were acquired subsequent to January 1, 2016. For the year ended December 31, 2016, building and equipment rental expenses from centers that were acquired subsequent to January 1, 2015, and excluded from the above comparison, was \$12.9 million. For the year ended December 31, 2015, building and equipment rental expenses from centers that were acquired subsequent to January 1, 2015, and excluded from the above comparison, was \$7.1 million.

·Medical supplies

Medical supplies expense increased \$2.3 million, or 4.7%, to \$51.7 million for the year ended December 31, 2016, compared to \$49.4 million for the year ended December 31, 2015.

Medical supplies expense, including only those centers which were in operation throughout the full fiscal years of both 2016 and 2015, decreased \$2.2 million, or 4.6%. This 4.6% decrease is primarily due to renegotiation of our medical supplier contracts. This comparison excludes contributions from centers that were acquired or divested subsequent to January 1, 2016. For the year ended December 31, 2016, medical supplies expense from centers that were acquired subsequent to January 1, 2015, and excluded from the above comparison was \$7.1 million. For the year ended December 31, 2015, medical supplies expense from centers that were acquired subsequent to January 1, 2015, and excluded from the above comparison was \$2.6 million.

·Other operating expenses

Other operating expenses increased \$33.3 million, or 16.4%, to \$236.5 million for the year ended December 31, 2016 compared to \$203.2 million for the year ended December 31, 2015.

Other operating expenses, including only those centers which were in operation throughout the full fiscal years of both 2016 and 2015, increased \$9.5 million or 5.1%. The 5.1% increase was primarily related to insurance, temporary labor and legal expenses. This comparison excludes contributions from centers that were acquired or divested subsequent to January 1, 2015. For the year ended December 31, 2016, other operating expenses from centers that were acquired

subsequent to January 1, 2015, and excluded from the above comparison were \$43.5 million. For the year ended December 31, 2015, other operating expenses from centers that were acquired subsequent to January 1, 2015, and excluded from the above comparison were \$19.7 million.

·Depreciation and amortization expense

Depreciation and amortization expense increased \$6.0 million, or 9.9%, to \$66.6 million for the year ended December 31, 2016 when compared \$60.6 million for the year ended December 31, 2015.

Depreciation and amortization expense at those centers which were in operation throughout the full fiscal years of both 2016 and 2015, increased \$793,000 or 1.4%. This comparison excludes contributions from centers that were acquired or divested subsequent to January 1, 2015. For the year ended December 31, 2016, depreciation and amortization from centers that were acquired or divested subsequent to January 1, 2015 and excluded from the above comparison was \$10.0 million. For the year ended December 31, 2015, depreciation and amortization from centers that were acquired subsequent to January 1, 2015, and excluded from the above comparison was \$4.8 million.

·Loss on sale and disposal of equipment

Loss on sale of equipment was \$767,000 and \$866,000 for the years ended December 31, 2016 and 2015, respectively, and primarily related to the difference between the net book value of certain equipment sold and proceeds we received from the sale.

·Severance costs

During the year ended December 31, 2016, we had severance costs of \$2.9 million compared to \$745,000 recorded during the year ended December 31, 2015. In the third quarter of 2016, we incurred severance expenses of \$2.2 million specifically related to the integration of acquisitions in the state of New York.

Interest expense

Interest expense increased approximately \$1.8 million, or 4.3%, to \$43.5 million for the year ended December 31, 2016 compared to \$41.7 million for the year ended December 31, 2015. Interest expense for the year ended December 31, 2016 included \$4.3 million of amortization of deferred financing and discount on issuance of debt, as well as a write off of \$709,000 of deferred financing costs in relation to the Restatement Amendment and \$93,000 of other non cash interest. Interest expense for the year ended December 31, 2015 included \$5.4 million of amortization of deferred financing costs and discount on issuance of debt as well as \$61,000 in other non cash interest.

Excluding these adjustments to interest expense for each period, interest expense increased approximately \$2.1 million for the year ended December 31, 2016 compared to the year ended December 31, 2015. The increase was primarily due to higher interest rates on our term loan debt stemming from the Restatement Amendment and First Lien Credit Agreement. See “Liquidity and Capital Resources” below for more details on our financing activity during 2016.

Meaningful use incentive

For the year ended December 31, 2016, we recognized other income from meaningful use incentive in the amount of \$2.8 million. This amount was earned under a Medicare program to promote the use of electronic health record technology. See Note 2 to our consolidated financial statements contained herein for more detail regarding this meaningful use incentive.

Equity in earnings from unconsolidated joint ventures

Equity in earnings from our unconsolidated joint ventures increased \$840,000 or 9.4% to \$9.8 million for the year ended December 31, 2016 compared to \$8.9 million for the year ended December 31, 2015. The increase relates mainly to equity in earnings stemming from the September 30, 2015 sale of 10 wholly owned centers from our

subsidiary New Jersey Imaging Partners to New Jersey Imaging Networks, a joint venture where we hold a 49% non-controlling interest. See Note 4 to our consolidated financial statements contained herein for more details.

Gain on Sale of Imaging Center

On September 30, 2015, we recognized a gain on the sale of 10 wholly owned imaging centers to the New Jersey Imaging Networks in the amount of \$5.4 million. See Note 4 to our consolidated financial statements contained herein for more details.

Gain on return of common stock

We recorded a gain on return of common stock of \$5.0 million. See Note 2 to our consolidated financial statements contained herein for more details.

Other expenses / income

For the year ended December 31, 2016 we recorded approximately \$196,000 of other expenses. For the year ended December 31, 2014, we recorded \$419,000 of other expenses mainly related to acquisition activity.

Provision for income tax expense

For the years ended December 31, 2016 and December 31, 2015, we recorded income tax expense of \$4.4 million and \$6.0 million, respectively. See Note 11 to our consolidated financial statements contained herein for more details.

Year Ended December 31, 2015 Compared to the Year Ended December 31, 2014

Service Fee Revenue, net of contractual allowances and discounts

Service fee revenue, net of contractual allowances and discounts for the year ended December 31, 2015 was \$746.8 million compared to \$670.1 million for the year ended December 31, 2014, an increase of \$76.6 million, or 11.4%.

Service fee revenue, net of contractual allowances and discounts, including only those centers which were in operation throughout the full fiscal years of both 2015 and 2014, increased \$10.6 million, or 1.7%. This comparison excludes revenue contributions from centers that were acquired subsequent to January 1, 2014. For the year ended December 31, 2015, service fee revenue, net of contractual allowances and discounts, from centers that were acquired subsequent to January 1, 2014 and excluded from the above comparison was \$113.8 million. For the year ended December 31, 2014, net revenue from centers that were acquired subsequent to January 1, 2014 and excluded from the above comparison was \$47.7 million.

Provision for bad debts

Provision for bad debts increased \$6.2 million, or 20.9%, to \$36.0 million, or 4.3% of net revenue, for the year ended December 31, 2015 compared to \$29.8 million, or 4.0% of net revenue, for the year ended December 31, 2014.

Revenue under capitation arrangements

Revenue under capitation arrangements for the year ended December 31, 2015 was \$98.9 million compared to \$77.2 million for the year ended December 31, 2014, an increase of \$21.7 million, or 28.0%.

Revenue under capitation arrangements, including only those centers which were in operation throughout the full fiscal years of both 2015 and 2014, increased \$16.6 million, or 22.2%. This 22.2% increase is due to additional capitation contracts entered into during 2015 over 2014. This comparison excludes revenue contributions from centers that were acquired subsequent to January 1, 2014. For the year ended December 31, 2015, revenue under capitation arrangements from centers that were acquired subsequent to January 1, 2014 and excluded from the above comparison was \$7.3 million. For the year ended December 31, 2014, net revenue from centers that were acquired subsequent to January 1, 2014 and excluded from the above comparison was \$2.2 million.

Operating expenses

Cost of operations for the year ended December 31, 2015 increased approximately \$105.6 million, or 17.5%, from \$602.7 million for the year ended December 31, 2014 to \$708.3 million for the year ended December 31, 2015. The following table sets forth our operating expenses for the years ended December 31, 2015 and 2014 (in thousands):

	Years Ended December 31,	
	2015	2014
Salaries and professional reading fees, excluding stock-based compensation	\$376,407	\$329,394
Stock-based compensation	7,647	2,500
Building and equipment rental	71,666	64,492
Medical supplies	49,417	41,348
Other operating expenses *	203,152	164,918
Cost of operations	708,289	602,652
Depreciation and amortization	60,611	59,258
Loss on sale and disposal of equipment	866	1,113
Severance costs	745	1,241
Total operating expenses	\$770,511	\$664,264

* Includes billing fees, office supplies, repairs and maintenance, insurance, business tax and license, outside services, utilities, marketing, travel and other expenses.

· *Salaries and professional reading fees, excluding stock-based compensation and severance*

Salaries and professional reading fees increased \$47.0 million, or 14.3%, to \$376.4 million for the year ended December 31, 2015, compared to \$329.4 million for the year ended December 31, 2014.

Salaries and professional reading fees, including only those centers which were in operation throughout the full fiscal years of both 2015 and 2014, increased \$13.4 million, or 4.3%. This 4.3% increase driven by increases in volume resulting in staffing needs to service increased procedures. This comparison excludes contributions from centers that were acquired subsequent to January 1, 2014. For the year ended December 31, 2015, salaries and professional reading fees from centers that were acquired subsequent to January 1, 2014 and excluded from the above comparison was \$51.3 million. For the year ended December 31, 2014, salaries and professional reading fees from centers that were acquired subsequent to January 1, 2014, and excluded from the above comparison was \$17.7 million.

· *Stock-based compensation*

Stock-based compensation increased \$5.1 million, or 205.9%, to \$7.6 million for the year ended December 31, 2015 compared to \$2.5 million for the year ended December 31, 2014. This increase was driven by the higher fair value of stock based compensation awarded and vested in the year 2015 as compared to 2014.

· *Building and equipment rental*

Building and equipment rental expenses increased \$7.2 million, or 11.1%, to \$71.7 million for the year ended December 31, 2015, compared to \$64.5 million for the year ended December 31, 2014.

Building and equipment rental expenses, including only those centers which were in operation throughout the full fiscal years of both 2015 and 2014, decreased \$149,000, or 0.2%. This comparison excludes contributions from centers that were acquired subsequent to January 1, 2014. For the year ended December 31, 2015, building and equipment rental expenses from centers that were acquired subsequent to January 1, 2014, and excluded from the above comparison, was \$11.2 million. For the year ended December 31, 2014, building and equipment rental expenses from centers that were acquired subsequent to January 1, 2014, and excluded from the above comparison, was \$3.9 million.

· *Medical supplies*

Medical supplies expense increased \$8.1 million, or 19.5%, to \$49.4 million for the year ended December 31, 2015, compared to \$41.3 million for the year ended December 31, 2014.

Medical supplies expense, including only those centers which were in operation throughout the full fiscal years of both 2015 and 2014, increased \$3.4 million, or 8.7%. This 8.7% increase is primarily due to the increased procedure volumes of advanced imaging procedures such as MRIs, PET, and CT scans. This comparison excludes contributions from centers that were acquired or divested subsequent to January 1, 2014. For the year ended December 31, 2015, medical supplies expense from centers that were acquired subsequent to January 1, 2014, and excluded from the above comparison was \$6.7 million. For the year ended December 31, 2014, medical supplies expense from centers that were acquired subsequent to January 1, 2014, and excluded from the above comparison was \$2.0 million.

· Other operating expenses

Other operating expenses increased \$38.2 million, or 23.2%, to \$203.2 million for the year ended December 31, 2015 compared to \$164.9 million for the year ended December 31, 2014.

Other operating expenses, including only those centers which were in operation throughout the full fiscal years of both 2015 and 2014, increased \$22.7 million or 14.7%. The 14.7% increase relates to additional outside services to support the sub-contracting of imaging operations in areas where we do not have centers, repairs and maintenance of equipment post the initial warranty period, and additional administration expenses in support of the rollout of the RIS system.. This comparison excludes contributions from centers that were acquired or divested subsequent to January 1, 2014. For the year ended December 31, 2015, other operating expenses from centers that were acquired subsequent to January 1, 2014, and excluded from the above comparison were \$25.7 million. For the year ended December 31, 2014, other operating expenses from centers that were acquired subsequent to January 1, 2014, and excluded from the above comparison were \$10.1 million.

·Depreciation and amortization expense

Depreciation and amortization expense increased \$1.4 million, or 2.3%, to \$60.6 million for the year ended December 31, 2015 when compared to the same period last year.

Depreciation and amortization expense at those centers which were in operation throughout the full fiscal years of both 2015 and 2014, decreased \$2.2 million or 4.0%. This comparison excludes contributions from centers that were acquired or divested subsequent to January 1, 2014. For the year ended December 31, 2015, depreciation and amortization from centers that were acquired or divested subsequent to January 1, 2014 and excluded from the above comparison was \$7.9 million. For the year ended December 31, 2014, depreciation and amortization from centers that were acquired subsequent to January 1, 2014, and excluded from the above comparison was \$4.4 million.

·Loss on sale and disposal of equipment

Loss on sale of equipment was \$866,000 and \$1.1 million for the years ended December 31, 2015 and 2014, respectively, and primarily related to the difference between the net book value of certain equipment sold and proceeds we received from the sale.

·Severance costs

During the year ended December 31, 2015, we recorded severance costs of \$745,000 compared to \$1.2 million recorded during the year ended December 31, 2014. In each period, these costs were primarily associated with the integration of acquired operations and other cost saving measures.

Interest expense

Interest expense decreased approximately \$1.0 million, or 2.4%, to \$41.7 million for the year ended December 31, 2015 compared to \$42.7 million for the year ended December 31, 2014. Interest expense for the year ended December 31, 2015 included \$5.4 million of amortization of deferred financing costs and discount on issuance of debt. Interest expense for the year ended December 31, 2014 included \$5.1 million of amortization of deferred financing costs and discount on issuance of debt, as well as a write off of \$665,000 of deferred financing costs in relation to the early extinguishment of \$200 million in 10 3/8% senior unsecured notes due 2018. Excluding these adjustments to interest expense for each period, interest expense decreased approximately \$680,000 for the year ended December 31, 2015 compared to the year ended December 31, 2014. This decrease was primarily due to the 2014 Amendment and the Second Lien Credit Agreement. See "Liquidity and Capital Resources" below for more details on our financing activity

during 2015.

Meaningful use incentive

For the year ended December 31, 2015, we recognized other income from meaningful use incentive in the amount of \$3.3 million. This amount was earned under a Medicare program to promote the use of electronic health record technology. See Note 2 to our consolidated financial statements contained herein for more detail regarding this meaningful use incentive.

Equity in earnings from unconsolidated joint ventures

Equity in earnings from our unconsolidated joint ventures increased \$2.0 million or 28.1% to \$8.9 million for the year ended December 31, 2015 compared to \$7.0 million for the year ended December 31, 2014. The increase was mainly due to the sale of our imaging centers from our New Jersey reporting unit, New Jersey Imaging Partners, Inc. to one of our non-consolidated joint ventures for which we hold a 49% non-controlling interest, The New Jersey Imaging Network, L.L.C., during 2015. See Note 4 to our consolidated financial statements contained herein for more details.

Gain on sale of imaging center

We recognized a gain on the sale of 10 wholly owned imaging centers to The New Jersey Imaging Network, L.L.C. in the amount of \$5.4 million for the twelve months ended December 31, 2015. See Note 4 to consolidated financial statements contained herein for more details.

Other expenses / income

For the year ended December 31, 2015 we recorded approximately \$419,000 of other expenses, mainly related to acquisition activity. For the year ended December 31, 2014, we recorded \$3,000 of other expenses.

Provision for income tax expense

For the years ended December 31, 2015 and December 31, 2014, we recorded income tax expense of \$6.0 million and \$2.0 million, respectively. See Note 11 to our consolidated financial statements contained herein for more details.

Adjusted EBITDA

We use both GAAP and non-GAAP metrics to measure our financial results. We believe that, in addition to GAAP metrics, these non-GAAP metrics assist us in measuring our cash generated from operations and ability to service our debt obligations.

One non-GAAP measure we believe assists us is Adjusted EBITDA. We define Adjusted EBITDA as earnings before interest, taxes, depreciation and amortization, as adjusted to exclude losses or gains on the disposal of equipment, other income or loss, loss on debt extinguishments, bargain purchase gains, loss on de-consolidation of joint ventures and non-cash equity compensation. Adjusted EBITDA includes equity earnings in unconsolidated operations and subtracts allocations of earnings to non-controlling interests in subsidiaries, and is adjusted for non-cash or one-time events that take place during the period. We believe this information is useful to investory and other interested parties because we are highly leveraged and our Adjusted EBITDA metric removes non-cash and nonrecurring charges that occur in the affected period and provides a basis for measuring the Company's financial condition against other quarters.

Adjusted EBITDA is a non-GAAP financial measure used as an analytical indicator by us and the healthcare industry to assess business performance, and is a measure of leverage capacity and ability to service debt. Adjusted EBITDA should not be considered a measure of financial performance under GAAP, and the items excluded from Adjusted EBITDA should not be considered in isolation or as alternatives to net income, cash flows generated by operating, investing or financing activities or other financial statement data presented in the consolidated financial statements as an indicator of financial performance or liquidity. As Adjusted EBITDA is not a measurement determined in accordance with GAAP and is therefore susceptible to varying methods of calculation, this metric, as presented, may not be comparable to other similarly titled measures of other companies.

The following is a reconciliation of the nearest comparable GAAP financial measure, net income, to Adjusted EBITDA for the years ended December 31, 2016, 2015, and 2014, respectively (in thousands):

Years Ended December 31,

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	2016	2015	2014
Net income attributable to RadNet, Inc. common stockholders	\$7,230	\$7,709	\$1,376
Plus provision for income taxes	4,432	6,007	1,967
Plus other expenses	196	419	3
Plus loss on early extinguishment of Senior Notes	–	–	15,927
Plus interest expense	43,455	41,684	42,727
Plus severance costs	2,877	745	1,241
Plus loss on sale and disposal of equipment	767	866	1,113
Plus acquisition related working capital adjustment	6,072	–	–
Plus legal settlements	–	1,425	401
Plus refinancing fees	606	–	–
Less gain on sale of imaging center	–	(5,434)	–
Less gain on return of common stock	(5,032)		
Plus depreciation and amortization	66,610	60,611	59,258
Plus non-cash employee stock-based compensation	5,826	7,647	2,500
Adjusted EBITDA	\$133,039	\$121,679	\$126,513

Liquidity and Capital Resources

We had net income attributable to RadNet, Inc.'s common stockholders of \$7.2 million, \$7.7 million and \$1.4 million for the years ended December 31, 2016, 2015 and 2014, respectively. We had cash and cash equivalents of \$20.6 million and accounts receivable of \$164.2 million at December 31, 2016, compared to cash of \$446,000 and accounts receivable of \$162.8 million at December 31, 2015. We had a working capital balance of \$62.6 million and \$72.4 million at December 31, 2016 and 2015, respectively. We also had total equity of \$52.1 million and \$36.5 million at December 31, 2015 and 2014, respectively.

We operate in a capital intensive, high fixed-cost industry that requires significant amounts of capital to fund operations. In addition to operations, we require a significant amount of capital for the initial start-up and development of new diagnostic imaging facilities, the acquisition of additional facilities and new diagnostic imaging equipment. Because our cash flows from operations have been insufficient to fund all of these capital requirements, we have depended on the availability of financing under credit arrangements with third parties.

Based on our current level of operations, we believe that cash flow from operations and available cash, together with available borrowings from our senior secured credit facilities, will be adequate to meet our short-term liquidity needs. Our future liquidity requirements will be for working capital, capital expenditures, debt service and general corporate purposes. Our ability to meet our working capital and debt service requirements, however, is subject to future economic conditions and to financial, business and other factors, many of which are beyond our control. If we are not able to meet such requirements, we may be required to seek additional financing. There can be no assurance that we will be able to obtain financing from other sources on the terms acceptable to us, if at all.

On a continuing basis, we also consider various transactions to increase stockholder value and enhance our business results, including acquisitions, divestitures and joint ventures. These types of transactions may result in future cash proceeds or payments but the general timing, size or success of any acquisition, divestiture or joint venture effort and the related potential capital commitments cannot be predicted. We expect to fund any future acquisitions primarily with cash flow from operations and borrowings, including borrowing from amounts available under our senior secured credit facilities or through new equity or debt issuances.

We and our subsidiaries or affiliates may from time to time, in our or their sole discretion, continue to purchase, repay, redeem or retire any of our outstanding debt or equity securities in privately negotiated or open market transactions, by tender offer or otherwise. However, we have no formal plan of doing so at this time.

Sources and Uses of Cash

Cash provided by operating activities was \$91.6 million, \$67.0 million, and \$61.0 million, for the years ended December 31, 2016, 2015 and 2014, respectively.

Cash used in investing activities was \$65.4 million, \$96.8 million, and \$53.6 million, for the years ended December 31, 2016, 2015 and 2014, respectively. For the year ended December 31, 2016, we purchased property and equipment for approximately \$59.3 million, acquired the assets and businesses of additional imaging facilities for approximately \$6.6 million (see Note 4 of the consolidated financial statements of this annual report), and contributed \$1.4 million in equity to two of our non-consolidated joint ventures. Offsetting our cash used in investing activities was \$994,000 in cash received from joint venture partners, \$523,000 in proceeds from the sale of imaging equipment

and \$301,000 in outside sales of imaging software. See Note 4 to the consolidated financial statements of this annual report for more information on the sale to Baltimore County Radiology.

Cash used by financing activities was \$5.9 million for the year ended December 31, 2016, compared to cash provided by financing activities of \$29.9 million and cash used in financing activities of \$15.4 million for the years ended December 31, 2015 and December 31, 2014, respectively. The cash used by financing for the year ended December 31, 2016 consisted of \$476.5 million in new borrowings from the Restatement Amendment and First Lien Credit Agreement. See financing activity in 2016 below for a further description on this event. Payments on secured debt and revolver loans amounted to \$469.1 million, which included a full payoff of our old First Lien balance in relation to the refinancing, a \$12.0 million pay down on the Second Lien Credit and Guaranty Agreement, with contractual payments of equipment notes and capital leases totaled \$11.9 million.

At December 31, 2016, we had \$ 478.9 million aggregate principal amount of first lien term loans and \$168.0 million aggregate principal amount of second lien term loan debt outstanding and no principal borrowed under the revolving credit facility. The revolving credit facility provides for a maximum borrowing limit of \$117.5 million, subject to customary drawing conditions.

At December 31, 2016, our credit facilities were comprised of two tranches of term loans and a revolving credit facility. On July 1, 2016 (the "Restatement Effective Date"), we entered into Amendment No. 3 to Credit and Guaranty Agreement (the "Restatement Amendment") pursuant to which we amended and restated our then existing first lien credit facilities on the terms set forth in the Amended and Restated First Lien Credit and Guaranty Agreement dated July 1, 2016 (as amended from time to time, the "First Lien Credit Agreement"). Pursuant to the First Lien Credit Agreement, we have issued \$485 million of senior secured term loans (the "First Lien Term Loans") and established a \$117.5 million senior secured revolving credit facility (the "Revolving Credit Facility"). We have also entered into a Second Lien Credit and Guaranty Agreement dated March 25, 2014 (as amended from time to time, the "Second Lien Credit Agreement") pursuant to which we issued \$180 million of secured term loans (the "Second Lien Term Loans").

As of December 31, 2016, we were in compliance with all covenants under our credit facilities.

The following describes our 2016 financing activities:

Restatement Amendment and the First Lien Credit Agreement

On July 1, 2016, we entered into the Restatement Amendment pursuant to which we amended and restated our then existing credit facilities on the terms set forth in the First Lien Credit Agreement. As of the Restatement Effective Date, our first lien credit facilities consisted of a Credit and Guaranty Agreement that we entered into on October 10, 2012 (the “Original First Lien Credit Agreement”), as subsequently amended by a first amendment dated April 3, 2013 (the “2013 Amendment”), a second amendment dated March 25, 2014 (the “2014 Amendment”), and a joinder agreement dated April 30, 2015 (the “2015 Joinder” and collectively with the Original First Lien Credit Agreement, the 2013 Amendment and the 2014 Amendment, the “Prior First Lien Credit Agreement”). The First Lien Credit Agreement increased the aggregate principal amount of First Lien Term Loans to \$485.0 million and increased the Revolving Credit Facility to \$117.5 million. Proceeds from the First Lien Credit Agreement were used to repay the previously outstanding first lien loans under the Prior First Lien Credit Agreement, make a \$12.0 million principal payment of the Second Lien Term Loans, pay costs and expenses related to the First Lien Credit Agreement and provide approximately \$10.0 million for general corporate purposes.

Interest. The interest rates payable on the First Lien Term Loans are (a) the Adjusted Eurodollar Rate (as defined in the First Lien Credit Agreement) plus 3.75% per annum or (b) the Base Rate (as defined in the First Lien Credit Agreement) plus 2.75% per annum. As applied to the First Lien Term Loans, the Adjusted Eurodollar Rate has a minimum floor of 1.0%. The three month Adjusted Eurodollar Rate at December 31, 2016 was 1.0%.

Payments. The scheduled quarterly principal payments of the First Lien Term Loans is approximately \$6.1 million, beginning in December 2016, with the balance due at maturity. Prior to the Restatement Amendment, the quarterly principal payments on the first lien term loans under the Prior First Lien Credit Agreement were approximately \$6.2 million.

Maturity Date. The maturity date for the First Lien Term Loans shall be on the earliest to occur of (i) the seventh anniversary of the Restatement Effective Date, (ii) the date on which all First Lien Term Loans shall become due and payable in full under the First Lien Credit Agreement, whether by acceleration or otherwise, and (iii) September 25, 2020 if our indebtedness under the Second Lien Credit Agreement has not been repaid, refinanced or extended prior to such date.

Incremental Feature: Under the First Lien Credit Agreement, we can elect to request 1) an increase to the existing Revolving Credit Facility and/or 2) additional First Lien Term Loans, provided that the aggregate amount of such increases or additions does not exceed (A) an amount not in excess of \$100.0 million minus any incremental loans

requested under the similar provisions of the Second Lien Credit Agreement or (B) if the First Lien Leverage Ratio would not exceed 3.50:1.00 after giving effect to such incremental facilities, an uncapped amount, in each case subject to the conditions and limitations set forth in the First Lien Credit Agreement. Each lender approached to provide all or a portion of any incremental facility may elect or decline, in its sole discretion, to provide any incremental commitment or loan.

Revolving Credit Facility: The First Lien Credit Agreement provides for a \$117.5 million Revolving Credit Facility. The termination date of the Revolving Credit Facility is the earliest to occur of: (i) July 1, 2021, (ii) the date the Revolving Credit Facility is permanently reduced to zero pursuant to section 2.13(b) of the First Lien Credit Agreement, which addresses voluntary commitment reductions, (iii) the date of the termination of the Revolving Credit Facility due to specific events of default pursuant to section 8.01 of the First Lien Credit Agreement, and (iv) September 25, 2020 if our indebtedness under the Second Lien Credit Agreement has not been repaid, refinanced or extended prior to such date. Amounts borrowed under the Revolving Credit Facility bear interest based on types of borrowings as follows: (i) unpaid principal on loans under the Revolving Credit Facility at the Adjusted Eurodollar Rate (as defined in the First Lien Credit Agreement) plus 3.75% per annum or the Base Rate (as defined in the First Lien Credit Agreement) plus 2.75% per annum, (ii) letter of credit fees at 3.75% per annum and fronting fees for letters of credit at 0.25% per annum, in each case on the average aggregate daily maximum amount available to be drawn under all letters of credit issued under the First Lien Credit Agreement, and (iii) commitment fee of 0.5% per annum on the unused revolver balance.

Second Lien Credit Agreement:

On March 25, 2014, we entered into the Second Lien Credit Agreement to provide for, among other things, the borrowing of \$180.0 million of Second Lien Term Loans. The proceeds from the Second Lien Term Loans were used to redeem our 10 3/8% senior unsecured notes, due 2018, to pay the expenses related to the transaction and for general corporate purposes. On July 1, 2016, in conjunction with the Restatement Amendment, a \$12.0 million principal payment was made on the Second Lien Term Loans.

The Second Lien Credit Agreement provides for the following:

Interest. The interest rates payable on the Second Lien Term Loans are (a) the Adjusted Eurodollar Rate (as defined in the Second Lien Credit Agreement) plus 7.0% or (b) the Base Rate (as defined in the Second Lien Credit Agreement) plus 6.0%. The Adjusted Eurodollar Rate has a minimum floor of 1.0% on the Second Lien Term Loans. The three month Adjusted Eurodollar Rate at December 31, 2016 was 1.0%. The rate paid on the Second Lien Term Loan at December 31, 2016 was 8%.

Payments. There is no scheduled amortization of the principal of the Second Lien Term Loans. Unless otherwise prepaid as a result of the occurrence of certain mandatory prepayment events, all principal will be due and payable on the termination date described below.

Termination. The maturity date for the Second Lien Term Loans is the earlier to occur of (i) March 25, 2021, and (ii) the date on which the Second Lien Term Loans shall otherwise become due and payable in full under the Second Lien Credit Agreement, whether by voluntary prepayment per section 2.13(a) of the Second Lien Credit Agreement or events of default per section 8.01 of the Second Lien Credit Agreement as described below.

The following describes our financing activities on the retired Senior Notes:

Senior Notes:

On April 6, 2010, we issued and sold \$200 million of 10 3/8% senior unsecured notes due 2018 at a price of 98.680% (the "Senior Notes"). All payments of the Senior Notes, including principal and interest, were guaranteed jointly and severally on a senior secured basis by RadNet, Inc., and all of Radnet Management's current and future domestic wholly owned restricted subsidiaries. The Senior Notes were issued under an indenture dated April 6, 2010 (the "Indenture"), by and among Radnet Management, Inc., as issuer, RadNet, Inc., as parent guarantor, the subsidiary guarantors thereof and U.S. Bank National Association, as trustee. We paid interest on the senior notes on April 1 and October 1 of each year, commencing October 1, 2010, and they were scheduled to expire on April 1, 2018. On April 24, 2014, we completed the retirement of our \$200 million in Senior Notes on April 24, 2014 and following such retirement the Company completed the satisfaction and discharge of the Indenture. As a result of the transaction, we recorded a loss on the early extinguishment of debt of \$15.9 million.

Contractual Commitments

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Our future obligations for notes payable, equipment under capital leases, lines of credit, equipment and building operating leases and purchase and other contractual obligations for the next five years and thereafter include (dollars in thousands):

	2017	2018	2019	2020	2021	Thereafter	Total
Notes payable (1)	\$61,022	\$59,810	\$58,407	\$57,061	\$213,301	\$382,452	\$832,053
Capital leases (2)	4,764	2,163	359	201	81	15	7,583
Operating leases (3)	66,705	57,422	48,887	39,117	30,061	57,340	299,532
Total	\$132,491	\$119,395	\$107,653	\$96,379	\$243,443	\$439,807	\$1,139,168

- (1) Includes variable rate debt for which the contractual obligation was estimated using the applicable rate at December 31, 2016.
- (2) Includes interest component of capital lease obligations.
- (3) Includes all operating leases through the end of their main lease term, excluding options on facility leases.

We have an arrangement with GE Medical Systems under which it has agreed to be responsible for the maintenance and repair of a majority of our equipment for a fee that is based on the type and age of the equipment. Under this agreement, we are committed to minimum payments of approximately \$26.0 million per year through 2017.

Critical Accounting Policies

Use of Estimates

Our discussion and analysis of financial condition and results of operations are based on our consolidated financial statements that were prepared in accordance with U.S. generally accepted accounting principles, or GAAP. Management makes estimates and assumptions when preparing financial statements. These estimates and assumptions affect various matters, including:

- our reported amounts of assets and liabilities in our consolidated balance sheets at the dates of the financial statements;
- our disclosure of contingent assets and liabilities at the dates of the financial statements; and
- our reported amounts of net revenue and expenses in our consolidated statements of operations during the reporting periods.

These estimates involve judgments with respect to numerous factors that are difficult to predict and are beyond management's control. As a result, actual amounts could differ materially from these estimates.

The SEC defines critical accounting estimates as those that are both most important to the portrayal of a company's financial condition and results of operations and require management's most difficult, subjective or complex judgment, often as a result of the need to make estimates about the effect of matters that are inherently uncertain and may change in subsequent periods. In Note 2 to our consolidated financial statements, we discuss our significant accounting policies, including those that do not require management to make difficult, subjective or complex judgments or estimates. The most significant areas involving management's judgments and estimates are described below.

Revenues

Service fee revenue, net of contractual allowances and discounts, consists of net patient fees received from various payors and patients themselves based mainly upon established contractual billing rates, less allowances for contractual adjustments and discounts. As it relates to BRMG and the NY Groups centers, this service fee revenue includes payments for both the professional medical interpretation revenue recognized by BRMG and the NY Groups as well as the payment for all other aspects related to our providing the imaging services, for which we earn management fees from BRMG and the NY Groups. As it relates to non-BRMG and NY Groups centers, namely the affiliated physician groups, this service fee revenue is earned through providing the use of our diagnostic imaging equipment and the provision of technical services as well as providing administration services such as clerical and administrative

personnel, bookkeeping and accounting services, billing and collection, provision of medical and office supplies, secretarial, reception and transcription services, maintenance of medical records, and advertising, marketing and promotional activities.

Service fee revenues are recorded during the period the services are provided based upon the estimated amounts due from the patients and third-party payors. Third-party payors include federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies and employers. Estimates of contractual allowances under managed care health plans are based upon the payment terms specified in the related contractual agreements. Contractual payment terms in managed care agreements are generally based upon predetermined rates per discounted fee-for-service rates. We also record a provision for doubtful accounts (based primarily on historical collection experience) related to patients and copayment and deductible amounts for patients who have health care coverage under one of our third-party payors.

Under capitation arrangements with various health plans, we earn a per-enrollee amount each month for making available diagnostic imaging services to all plan enrollees under the capitation arrangement. Revenue under capitation arrangements is recognized in the period which we are obligated to provide services to plan enrollees under contracts with various health plans.

Our service fee revenue, net of contractual allowances and discounts, the provision for bad debts, and revenue under capitation arrangements for the years ended December 31, are summarized in the following table (in thousands):

	Years Ended December 31,		
	2016	2015	2014
Commercial insurance (1)	\$539,793	\$486,489	\$437,525
Medicare	187,941	168,545	159,562
Medicaid	28,170	23,948	24,499
Workers' compensation/personal injury	36,548	32,728	30,543
Other (2)	29,135	35,046	18,007
Service fee revenue, net of contractual allowances and discounts	821,587	746,756	670,136
Provision for bad debts	(45,387)	(36,033)	(29,807)
Net service fee revenue	776,200	710,723	640,329
Revenue under capitation arrangements	108,335	98,905	77,240
Total net revenue	\$884,535	\$809,628	\$717,569

(1) 21% of our net service fee revenue before provision for bad debt for the year ended December 31, 2016 and 20% for the years ended 2015 and 2014 were earned from a single payor.(2) Other consist of revenue from teleradiology services, consulting fees and software revenue.

Provision for Bad Debts

We provide for an allowance against accounts receivable that could become uncollectible to reduce the carrying value of such receivables to their estimated net realizable value. We estimate this allowance based on the aging of our accounts receivable by the historical payment patterns of each type of payor, write-off trends, and other relevant factors. A significant portion of our provision for bad debt relates to co-payments and deductibles owed to us from patients with insurance. Although we attempt to collect deductibles and co-payments due from patients with insurance at the time of service, this attempt to collect at the time of service is not an assessment of the patient's ability to pay nor are revenues recognized based on an assessment of the patient's ability to pay. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on the increased burden of co-payments and deductibles to be made by patients with insurance. These factors continuously change and can have an impact on collection trends and our estimation process. Our allowance for bad debts at December 31, 2016 and 2015 was \$20.7 million and \$20.8 million, respectively.

Depreciation and Amortization of Long-Lived Assets

We depreciate our long-lived assets over their estimated economic useful lives with the exception of leasehold improvements where we use the shorter of the assets useful lives or the lease term of the facility for which these assets are associated.

Deferred Tax Assets

We evaluate the realizability of the net deferred tax assets and assess the valuation allowance periodically. If future taxable income or other factors are not consistent with our expectations, an adjustment to our allowance for net deferred tax assets may be required. For net deferred tax assets we consider estimates of future taxable income, including tax planning strategies, in determining whether our net deferred tax assets are more likely than not to be realized.

Valuation of Goodwill and Indefinite Lived Intangible Assets

Goodwill at December 31, 2016 totaled \$239.5 million. Indefinite lived intangible assets at December 31, 2016 totaled \$7.9 million and are associated with the value of certain trade name intangibles. Goodwill and trade name intangibles are recorded as a result of business combinations. Management evaluates goodwill and trade name intangibles, at a minimum, on an annual basis and whenever events and changes in circumstances suggest that the carrying amount may not be recoverable. Impairment of goodwill is tested at the reporting unit level by comparing the reporting unit's carrying amount, including goodwill, to the fair value of the reporting unit. The fair value of a reporting unit is estimated using a combination of the income or discounted cash flows approach and the market approach, which uses comparable market data. If the carrying amount of the reporting unit exceeds its fair value, goodwill is considered impaired and a second step is performed to measure the amount of impairment loss, if any. Impairment of trade name intangibles is tested at the subsidiary level by comparing the subsidiary's trade name carrying amount to its respective fair value. We tested both goodwill and trade name intangibles for impairment on October 1, 2016, noting no impairment, and have not identified any indicators of impairment through December 31, 2016.

We evaluate our long-lived assets (property and equipment) and intangibles, other than goodwill, for impairment whenever indicators of impairment exist. Generally accepted accounting principles (GAAP) requires that if the sum of the undiscounted expected future cash flows from a long-lived asset or definite-lived intangible is less than the carrying value of that asset, an asset impairment charge must be recognized. The amount of the impairment charge is calculated as the excess of the asset's carrying value over its fair value, which generally represents the discounted future cash flows from that asset or in the case of assets we expect to sell, at fair value less costs to sell. No indicators of impairment were identified with respect to our long-lived assets as of December 31, 2016.

Recent Accounting Standards

During 2016, we adopted six accounting updates for guidance on stock compensation, income taxes, business combinations, imputation of interest and consolidation. The descriptions and effects of the adoption of these updates are described fully in Note 3 to our consolidated financial statements contained herein. Stated below are accounting policies which are under evaluation for their affect on our statement of operations and cash flows.

In January 2017, the FASB issued ASU No. 2017-04 ("ASU 2017-04"), *Simplifying the Test for Goodwill Impairment*. ASU 2017-04 eliminates the requirement to calculate the implied fair value of goodwill (i.e., Step 2 of the current goodwill impairment test) to measure a goodwill impairment charge. Instead, entities will record an impairment charge based on the excess of a reporting unit's carrying amount over its fair value (i.e., measure the charge based on the current Step 1). ASU 2017-04 is effective for annual and any interim impairment tests for periods beginning after December 15, 2019, with early adoption permitted. We are evaluating the effect of this guidance.

In January 2017, the FASB issued ASU No. 2017-01 ("ASU 2017-01"), *Clarifying the Definition of a Business*. ASU 2017-01 changes the definition of a business to assist entities with evaluating when a set of transferred assets and activities is considered a business. ASU 2017-01 is effective for annual periods beginning after December 31, 2017 including interim periods within those periods. We are evaluating the effect of this guidance.

In February 2016, the FASB issued ASU No. 2016-02 ("ASU 2016-02"), *Leases, (Topic 842): Amendments to the FASB Accounting Standards Codification*. ASU 2016-02 amends the existing accounting standards for lease accounting, including requiring lessees to recognize most leases on their balance sheets and making targeted changes to lessor accounting. The new standard requires a modified retrospective transition approach for all leases existing at, or entered into after, the date of initial application, with an option to use certain transition relief. The amendments in this update are effective for fiscal years (and interim reporting periods within fiscal years) beginning after December 15, 2018. Early adoption of the amendments is permitted for all entities. We are currently evaluating the impact this guidance will have on our consolidated financial statements, but expect this adoption will result in a significant increase in the assets and liabilities related to our leased properties and equipment.

In May 2014, the FASB issued ASU No. 2014-09 (“ASU 2014-09”), Revenue from Contracts with Customers, (Topic 606). ASU 2014-09 requires an entity to recognize revenue when it transfers promised goods or services to customers in an amount that reflects what it expects in exchange for the goods or services. It also requires more detailed disclosures to enable users of the financial statements to understand the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. The guidance will become effective for the Company on January 1, 2018. We are continuing to evaluate the effects the adoption of this standard will have on our financial statements and financial disclosures. We believe the most significant impact will be to the presentation of our statement of operations where the provision for bad debts will be recorded as a direct reduction to revenues and will not be presented as a separate line item. We expect to adopt the new standard using the full retrospective application.

Subsequent Events

On January 6, 2017, Image Medical Inc., a wholly owned subsidiary of RadNet, entered into a membership purchase agreement with ScriptSender, LLC, a partnership held by two individuals which provides secure data transmission services of medical information. Image Medical will contribute \$3.0 million for a 49% equity interest in the partnership. In a separate management agreement, Image Medical Inc. will provide management and accounting services to the operation in return for a set fee. Image Medical Inc. will account for the investment under the equity method.

On January 13, 2017, we completed our acquisition of certain assets of Resolution Medical Imaging Corporation, consisting of two multi modality imaging center located in Santa Monica, CA for cash consideration of \$2.1 million, the assumption of approximately \$1.7 million in equipment debt, and payoff of a small business administration loan of \$241,000. The facilities provide MRI, CT, Ultrasound, and X-Ray services.

On February 1, 2017, we completed our acquisition of certain assets of MRI Centers, Inc., consisting of one single-modality imaging center located in Torrance, CA for cash consideration of \$718,000. The facility provides MRI and sports medicine services.

On February 2, 2017, we entered into a fourth amendment to our first lien credit agreement and senior secured revolving facility. Pursuant to the fourth amendment, the interest rate charged for the applicable margin on both facilities was reduced by 50 basis points, from 3.75% to 3.25%. The minimum LIBOR rate underlying the senior secured term loans remains at 1.0%. Except for such reduction in the interest rate on credit extensions, this amendment did not result in any other material modifications to the amended and restated credit agreement evidencing the first lien term loans and the senior secured revolving credit facility.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Foreign Currency Exchange Risk. We receive payment for our services exclusively in United States dollars. As a result, our financial results are unlikely to be affected by factors such as changes in foreign currency, exchange rates or weak economic conditions in foreign markets.

We maintain research and development facilities in Prince Edward Island, Canada and Budapest, Hungary for which expenses are paid in the local currency. Accordingly, we do have currency risk resulting from fluctuations between such local currency and the United States Dollar. At the present time, we do not have any foreign exchange currency contracts to mitigate this risk. A hypothetical 1% increase in the rate of exchange of foreign currencies against the dollar for 2016 would have resulted in an increase of approximately \$31,000 in our operating expenses for the year.

Interest Rate Sensitivity We pay interest on various types of debt instruments to our suppliers and lending institutions. The agreements entail either fixed or variable interest rates. Instruments which have fixed rates are mainly leases on radiology equipment. Variable rate interest obligations relate primarily to amounts borrowed under our outstanding credit facilities. As described in the Liquidity and Capital Resources section above, we can elect Eurodollar or Base Rate interest rate options on the Restatement Amendment and the First Lien Credit Agreement and the Second Lien Credit Agreement.

At December 31, 2016, we had \$478.9 million outstanding subject to an Adjusted Eurodollar election on all first lien term loans under the Credit Agreement and \$168.0 million on the Second Lien Term Loans. With the Restatement Amendment and First Lien Credit Agreement, the Company has initially selected a 3 month LIBOR election. At December 31, 2016, the Adjusted Eurodollar Rate floor of 1% now equals the current spot rate of the 3 month Adjusted Eurodollar. Therefore, a hypothetical 1% increase in the borrowing rate would have resulted in an increase of \$6.5 million of interest expense on an annual basis under our first and second lien term loans. At December 31, 2016, an additional \$6.1 million in debt instruments is tied to the prime rate. A hypothetical 1% increase in the prime rate for 2015-2016 would have resulted in an annual increase in interest expense of approximately \$61,000.

To mitigate interest rate risk sensitivity, the Company entered into two forward interest rate cap agreements which are designated at inception as cash flow hedges of future cash interest payments associated with portions of the Company's variable rate bank debt. Under these arrangements, the Company purchased a cap on 3 month LIBOR at 2.0%. See Note 10 to the consolidated financial statements contained herein.

Item 8. Financial Statements and Supplementary Data

The Financial Statements are attached hereto and begin on page 51.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders of RadNet, Inc.

We have audited the accompanying consolidated balance sheets of RadNet, Inc. and subsidiaries (the “Company”) as of December 31, 2016 and 2015, and the related consolidated statements of operations, comprehensive income, equity (deficit), and cash flows for each of the three years in the period ended December 31, 2016. Our audits also included the financial statement schedule listed in the Index at Item 15(a)(2). These financial statements and schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of RadNet, Inc. and subsidiaries at December 31, 2016 and 2015, and the consolidated results of their operations and their cash flows for each of the three years in the period ended December 31, 2016, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related financial statement schedule, when considered in relation to the basic financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), RadNet Inc.'s internal control over financial reporting as of December 31, 2016, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated March 16, 2017, expressed an adverse opinion thereon.

/s/ Ernst & Young LLP

Los Angeles, California

March 16, 2017

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RADNET, INC. AND SUBSIDIARIES**CONSOLIDATED BALANCE SHEETS****(IN THOUSANDS EXCEPT SHARE AND PER SHARE DATA)**

	As of December 31,	
	2016	2015
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	\$20,638	\$446
Accounts receivable, net	164,210	162,843
Current portion of deferred tax assets	–	22,279
Due from affiliates	2,428	4,815
Prepaid expenses and other current assets	28,435	38,986
Assets held for sale	2,203	–
Total current assets	217,914	229,369
PROPERTY AND EQUIPMENT, NET	247,725	256,722
OTHER ASSETS		
Goodwill	239,553	239,408
Other intangible assets	42,682	45,253
Deferred financing costs, net of current portion	2,004	2,841
Investment in joint ventures	43,509	33,584
Deferred tax assets, net of current portion	50,356	24,685
Deposits and other	5,733	4,565
Total assets	\$849,476	\$836,427
LIABILITIES AND EQUITY		
CURRENT LIABILITIES		
Accounts payable, accrued expenses and other	\$111,166	\$113,813
Due to affiliates	13,141	6,564
Deferred revenue	1,516	1,598
Current portion of deferred rent	2,961	2,563
Current portion of notes payable	22,031	22,383
Current portion of obligations under capital leases	4,526	10,038
Total current liabilities	155,341	156,959
LONG-TERM LIABILITIES		
Deferred rent, net of current portion	24,799	26,865
Notes payable, net of current portion	609,445	599,914
Obligations under capital lease, net of current portion	2,730	6,385
Other non-current liabilities	5,108	9,843
Total liabilities	797,423	799,966
EQUITY		
RadNet, Inc. stockholders' equity:		

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Common stock - \$.0001 par value, 200,000,000 shares authorized; 46,574,904 and 46,281,189 shares issued and outstanding at December 31, 2016 and 2015, respectively	4	4
Additional paid-in-capital	198,387	197,297
Accumulated other comprehensive gain (loss)	306	(153)
Accumulated deficit	(150,211)	(164,571)
Total RadNet, Inc.'s stockholders' equity	48,486	32,577
Non-controlling interests	3,567	3,884
Total equity	52,053	36,461
Total liabilities and equity	\$ 849,476	\$ 836,427

The accompanying notes are an integral part of these financial statements.

RADNET, INC. AND SUBSIDIARIES**CONSOLIDATED STATEMENTS OF OPERATIONS****(IN THOUSANDS EXCEPT SHARE AND PER SHARE DATA)**

	Years Ended December 31,		
	2016	2015	2014
NET REVENUE			
Service fee revenue, net of contractual allowances and discounts	\$821,587	\$746,756	\$670,136
Provision for bad debts	(45,387)	(36,033)	(29,807)
Net service fee revenue	776,200	710,723	640,329
Revenue under capitation arrangements	108,335	98,905	77,240
Total net revenue	884,535	809,628	717,569
OPERATING EXPENSES			
Cost of operations, excluding depreciation and amortization	775,801	708,289	602,652
Depreciation and amortization	66,610	60,611	59,258
Loss on sale and disposal of equipment	767	866	1,113
Severance costs	2,877	745	1,241
Total operating expenses	846,055	770,511	664,264
INCOME FROM OPERATIONS	38,480	39,117	53,305
OTHER INCOME AND EXPENSES			
Interest expense	43,455	41,684	42,727
Meaningful use incentive	(2,808)	(3,270)	(2,034)
Equity in earnings of joint ventures	(9,767)	(8,927)	(6,970)
Gain on sale of imaging centers	–	(5,434)	–
Gain on return of common stock	(5,032)	–	–
Loss on early extinguishment of senior notes	–	–	15,927
Other expenses	196	419	3
Total other expenses	26,044	24,472	49,653
INCOME BEFORE INCOME TAXES	12,436	14,645	3,652
Provision for income taxes	(4,432)	(6,007)	(1,967)
NET INCOME	8,004	8,638	1,685
Net income attributable to noncontrolling interests	774	929	309
NET INCOME ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS	\$7,230	\$7,709	\$1,376
BASIC NET INCOME PER SHARE ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS	\$0.16	\$0.18	\$0.03
DILUTED NET INCOME PER SHARE ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS	\$0.15	\$0.17	\$0.03
WEIGHTED AVERAGE SHARES OUTSTANDING			
Basic	46,244,188	43,805,794	41,070,077
Diluted	46,655,032	45,171,372	43,149,196

The accompanying notes are an integral part of these financial statements.

RADNET, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

(IN THOUSANDS)

	Years Ended December		
	31,		
	2016	2015	2014
NET INCOME	\$8,004	\$8,638	\$1,685
Foreign currency translation adjustments	(49)	(41)	(62)
Change in fair value of cash flow hedge, net of taxes of \$310	508	-	-
COMPREHENSIVE INCOME	8,463	8,597	1,623
Less comprehensive income attributable to non-controlling interests	774	929	309
COMPREHENSIVE INCOME ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS	\$7,689	\$7,668	\$1,314

The accompanying notes are an integral part of these financial statements.

RADNET, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENT OF EQUITY (DEFICIT)

(IN THOUSANDS EXCEPT SHARE DATA)

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive (Loss) Gain	Accumulated Deficit	Radnet, Inc. Stockholders' Equity	Noncontrolling Interests	Total Equity
	Shares	Amount						
BALANCE - JANUARY 1, 2014	40,089,196	\$ 4	\$ 173,622	\$ (50)	\$(173,656)	\$ (80)	\$ 2,290	\$ 2,210
Issuance of common stock upon exercise of options/warrants	1,579,695	—	1,546	—	—	1,546	—	1,546
Stock-based compensation	—	—	2,463	—	—	2,463	—	2,463
Issuance of restricted stock and other awards	1,156,785	—	—	—	—	—	—	—
Purchase of non-controlling interests	—	—	119	—	—	119	(315)	(196)
Sale of non-controlling interests	—	—	—	—	—	—	200	200
Dividends paid to noncontrolling interests	—	—	—	—	—	—	(148)	(148)
Change in cumulative foreign currency translation adjustment	—	—	—	(62)	—	(62)	—	(62)
Net income	—	—	—	—	1,376	1,376	309	1,685
BALANCE - DECEMBER 31, 2014	42,825,676	\$ 4	\$ 177,750	\$ (112)	\$(172,280)	\$ 5,362	\$ 2,336	\$ 7,698
Issuance of common stock upon exercise of options/warrants	835,098	—	594	—	—	594	—	594
Stock-based compensation	—	—	7,635	—	—	7,635	—	7,635
Issuance of restricted stock and other awards	1,014,423	—	—	—	—	—	—	—
Forfeiture of restricted stock	(59,053)	—	—	—	—	—	—	—
Issuance of stock for acquisitions	1,665,045	—	9,241	—	—	9,241	—	9,241
Sale of non-controlling interests	—	—	2,077	—	—	2,077	1,348	3,425
	—	—	—	—	—	—	(729)	(729)

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Distributions paid to noncontrolling interests								
Change in cumulative foreign currency translation adjustment	–	–	–	(41)	–	(41)	–	(41)
Net income	–	–	–	–	7,709	7,709	929	8,638
BALANCE - DECEMBER 31, 2015	46,281,189	\$ 4	\$ 197,297	\$ (153)	\$ (164,571)	\$ 32,577	\$ 3,884	\$ 36,461
Cumulative effect of accounting change due to adoption of ASU 2016-09	–	–	–	–	7,130	7,130	–	7,130
Issuance of common stock upon exercise of options/warrants	314,448	–	150	–	–	150	–	150
Stock-based compensation	–	–	5,767	–	–	5,767	–	5,767
Issuance of restricted stock and other awards	937,803	–	–	–	–	–	–	–
Return of common stock	(958,536)	–	(5,032)	–	–	(5,032)	–	(5,032)
Purchase of noncontrolling interests	–	–	(495)	–	–	(495)	(599)	(1,094)
Sale of non-controlling interest	–	–	700	–	–	700	–	700
Distributions paid to noncontrolling interests	–	–	–	–	–	–	(492)	(492)
Change in cumulative foreign currency translation adjustment	–	–	–	(49)	–	(49)	–	(49)
Change in fair value cash flow hedge, net of taxes	–	–	–	508	–	508	–	508
Net income	–	–	–	–	7,230	7,230	774	8,004
BALANCE - DECEMBER 31, 2016	46,574,904	\$ 4	\$ 198,387	\$ 306	\$ (150,211)	\$ 48,486	\$ 3,567	\$ 52,053

The accompanying notes are an integral part of these financial statements.

RADNET, INC. AND SUBSIDIARIES**CONSOLIDATED STATEMENTS OF CASH FLOWS****(IN THOUSANDS)**

	Years Ended December 31,		
	2016	2015	2014
CASH FLOWS FROM OPERATING ACTIVITIES			
Net income	\$8,004	\$8,638	\$1,685
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	66,610	60,611	59,258
Provision for bad debts	45,387	36,033	29,807
Gain on return of common stock	(5,032)	–	–
Equity in earnings of joint ventures	(9,767)	(8,927)	(6,970)
Distributions from joint ventures	2,926	7,731	7,358
Amortization and write off of deferred financing costs and loan discount	5,045	5,369	5,732
Loss on sale and disposal of equipment	767	866	1,113
Loss on early extinguishment of senior notes	–	–	15,927
Gain on sale of imaging centers	–	(5,434)	–
Stock-based compensation	5,826	7,647	2,500
Changes in operating assets and liabilities, net of assets acquired and liabilities assumed in purchase transactions:			
Accounts receivable	(47,055)	(34,514)	(43,973)
Other current assets	11,038	(14,198)	(5,514)
Other assets	1,267	(3,813)	(281)
Deferred taxes	3,446	4,036	655
Deferred rent	(1,668)	7,011	2,180
Deferred revenue	(82)	(366)	620
Accounts payable, accrued expenses and other	4,929	(3,653)	(9,093)
Net cash provided by operating activities	91,641	67,037	61,004
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of imaging facilities	(6,641)	(90,792)	(9,428)
Purchase of property and equipment	(59,251)	(42,964)	(41,740)
Proceeds from sale of equipment	481	1,282	1,088
Proceeds from sale of imaging facilities	–	35,500	–
Proceeds from sale of internal use software	301	443	–
Cash contribution from partner in JV formation	994	–	–
Equity contributions in existing and purchase of interest in joint ventures	(1,374)	(265)	(3,562)
Net cash used in investing activities	(65,490)	(96,796)	(53,642)
CASH FLOWS FROM FINANCING ACTIVITIES			
Principal payments on notes and leases payable	(11,880)	(9,773)	(23,913)
Proceeds from borrowings	476,504	73,869	210,000
Payments on senior notes	(469,086)	(23,727)	(211,344)
Deferred financing costs	(945)	–	(6,650)

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Net (payments) proceeds on revolving credit facility	–	(15,300)	15,300
Dividends paid to noncontrolling interests	(492)	(729)	(148)
Proceeds from the sale of non-controlling interests	992	5,005	–
Purchase of non-controlling interests	(1,153)	–	(196)
Proceeds from issuance of common stock upon exercise of options/warrants	150	594	1,546
Net cash (used in) provided by financing activities	(5,910)	29,939	(15,405)
EFFECT OF EXCHANGE RATE CHANGES ON CASH	(49)	(41)	(62)
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	20,192	139	(8,105)
CASH AND CASH EQUIVALENTS, beginning of period	446	307	8,412
CASH AND CASH EQUIVALENTS, end of period	\$20,638	\$446	\$307
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION			
Cash paid during the period for interest	\$37,487	\$36,028	\$41,584
Cash paid during the period for income taxes	\$2,798	\$1,781	\$1,070

The accompanying notes are an integral part of these financial statements.

RADNET, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)

Supplemental Schedule of Non-Cash Investing and Financing Activities

We acquired equipment and certain leasehold improvements for approximately \$28.8 million, \$32.4 million, and \$19.4 million during the years ended December 31, 2016, 2015 and 2014, respectively, that we had not paid for as of December 31, 2016, 2015 and 2014, respectively. The offsetting amount due was recorded in our consolidated balance sheets under “accounts payable, accrued expenses and other.”

During the twelve months ended December 31, 2016, we added capital lease debt of approximately \$1.3 million relating to radiology equipment.

We recognized a non-cash gain on return of common stock of \$5.0 million in June 2016. See Note 2, Gain on Return of Common Stock.

We transferred \$2.7 million in fixed assets in June 2016 to our new joint venture, Glendale Advanced Imaging LLC, see Note 2, Investment in Joint Ventures.

RADNET, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1 – NATURE OF BUSINESS

We are a leading national provider of freestanding, fixed-site outpatient diagnostic imaging services in the United States based on number of locations and annual imaging revenue. At December 31, 2016, we operated directly or indirectly through joint ventures with hospitals, 305 centers located in California, Delaware, Florida, Maryland, New Jersey, New York, and Rhode Island. Our centers provide physicians with imaging capabilities to facilitate the diagnosis and treatment of diseases and disorders. Our services include magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), nuclear medicine, mammography, ultrasound, diagnostic radiology (X-ray), fluoroscopy and other related procedures. The vast majority of our centers offer multi-modality imaging services. Our multi-modality strategy diversifies revenue streams, reduces exposure to reimbursement changes and provides patients and referring physicians one location to serve the needs of multiple procedures.

The consolidated financial statements include the accounts of Radnet Management, Inc. (or “Radnet Management”) and Beverly Radiology Medical Group III, a professional partnership (“BRMG”). BRMG is a partnership of ProNet Imaging Medical Group, Inc., Breastlink Medical Group, Inc. and Beverly Radiology Medical Group, Inc. The consolidated financial statements also include Radnet Management I, Inc., Radnet Management II, Inc., Radiologix, Inc., Radnet Managed Imaging Services, Inc., Delaware Imaging Partners, Inc., New Jersey Imaging Partners, Inc. and Diagnostic Imaging Services, Inc. (“DIS”), all wholly owned subsidiaries of Radnet Management. All of these affiliated entities are referred to collectively as “RadNet”, “we”, “us”, “our” or the “Company” in this report.

Accounting Standards Codification (“ASC”) 810-10-15-14, *Consolidation*, stipulates that generally any entity with a) insufficient equity to finance its activities without additional subordinated financial support provided by any parties, or b) equity holders that, as a group, lack the characteristics specified in the ASC which evidence a controlling financial interest, is considered a Variable Interest Entity (“VIE”). We consolidate all VIEs in which we are the primary beneficiary. We determine whether we are the primary beneficiary of a VIE through a qualitative analysis that identifies which variable interest holder has the controlling financial interest in the VIE. The variable interest holder who has both of the following has the controlling financial interest and is the primary beneficiary: (1) the power to direct the activities of the VIE that most significantly impact the VIE’s economic performance and (2) the obligation to absorb losses of, or the right to receive benefits from, the VIE that could potentially be significant to the VIE. In performing our analysis, we consider all relevant facts and circumstances, including: the design and activities of the VIE, the terms of the contracts the VIE has entered into, the nature of the VIE’s variable interests issued and how they were negotiated with or marketed to potential investors, and which parties participated significantly in the design or redesign of the entity.

Howard G. Berger, M.D., is our President and Chief Executive Officer, a member of our Board of Directors, and also owns, indirectly, 99% of the equity interests in BRMG. BRMG is responsible for all of the professional medical services at nearly all of our facilities located in California under a management agreement with us, and employs physicians or contracts with various other independent physicians and physician groups to provide the professional medical services at most of our California facilities. We generally obtain professional medical services from BRMG in California, rather than provide such services directly or through subsidiaries, in order to comply with California's prohibition against the corporate practice of medicine. However, as a result of our close relationship with Dr. Berger and BRMG, we believe that we are able to better ensure that medical service is provided at our California facilities in a manner consistent with our needs and expectations and those of our referring physicians, patients and payors than if we obtained these services from unaffiliated physician groups.

We contract with nine medical groups which provide professional medical services at all of our facilities in Manhattan and Brooklyn, New York. These contracts are similar to our contract with BRMG. Six of these groups are owned by John V. Crues, III, M.D., RadNet's Medical Director, a member of our Board of Directors, and a 1% owner of BRMG. Dr. Berger owns a controlling interest in two of these medical groups which provide professional medical services at one of our Manhattan facilities.

RadNet provides non-medical, technical and administrative services to BRMG and the nine medical groups mentioned above ("NY Groups") for which it receives a management fee, pursuant to the related management agreements. Through the management agreements we have exclusive authority over all non-medical decision making related to the ongoing business operations of BRMG and the NY Groups and we determine the annual budget of BRMG and the NY Groups. BRMG and the NY Groups both have insignificant operating assets and liabilities, and de minimis equity. Through management agreements with us, substantially all cash flows of BRMG and the NY Groups after expenses including professional salaries, are transferred to us.

We have determined that BRMG and the NY Groups are variable interest entities, that we are the primary beneficiary, and consequently, we consolidate the revenue and expenses, assets and liabilities of each. BRMG and the NY Groups on a combined basis recognized \$135.7 million, \$113.1 million and \$89.3 million of revenue, net of management services fees to RadNet, for the years ended December 31 2016, 2015, and 2014, respectively and \$135.7 million, \$113.1 million and \$89.3 million of operating expenses for the years ended December 31 2016, 2015, and 2014, respectively. RadNet, Inc. recognized \$430.4 million, \$343.9 million and \$287.4 million of total billed net service fee revenue for the years ended December 31, 2016, 2015 and 2014, respectively, for management services provided to BRMG and the NY Groups relating primarily to the technical portion of billed revenue.

The cash flows of BRMG and the NY Groups are included in the accompanying consolidated statements of cash flows. All intercompany balances and transactions have been eliminated in consolidation. In our consolidated balance sheets at December 31, 2016 and December 31, 2015, we have included approximately \$100.0 million and \$89.8 million, respectively, of accounts receivable and approximately \$9.0 million and \$8.5 million of accounts payable and accrued liabilities related to BRMG and the NY Groups, respectively.

The creditors of BRMG and the NY Groups do not have recourse to our general credit and there are no other arrangements that could expose us to losses on behalf of BRMG and the NY Groups. However, RadNet may be required to provide financial support to cover any operating expenses in excess of operating revenues.

At all of our centers we have entered into long-term contracts with radiology groups in the area to provide physician services at those facilities. These radiology practices provide professional services, including supervision and interpretation of diagnostic imaging procedures, in our diagnostic imaging centers. The radiology practices maintain full control over the provision of professional services. In these facilities we enter into long-term agreements with radiology practice groups (typically 40 years). Under these arrangements, in addition to obtaining technical fees for the use of our diagnostic imaging equipment and the provision of technical services, we provide management services and receive a fee based on the value of the services we provide. Except in New York City, the fee is based on the practice group's professional revenue, including revenue derived outside of our diagnostic imaging centers. In New York City we are paid a fixed fee set in advance for our services. We own the diagnostic imaging equipment and, therefore, receive 100% of the technical reimbursements associated with imaging procedures. The radiology practice groups retain the professional reimbursements associated with imaging procedures after deducting management service fees paid to us and we have no financial controlling interest in the radiology practices. Because of the controlling relationship of Dr. Berger and Dr. Crues in the California and New York City practices as stated in detail above, we consolidate the revenue and expenses.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

PRINCIPLES OF CONSOLIDATION - The operating activities of subsidiaries are included in the accompanying consolidated financial statements from the date of acquisition. Investments in companies in which we have the ability

to exercise significant influence, but not control, are accounted for by the equity method. All intercompany transactions and balances, with our consolidated entities and the unsettled amount of intercompany transactions with our equity method investees, have been eliminated in consolidation. As stated in Note 1 above, the BRMG and NY Groups are variable interest entities and we consolidate the operating activities and balance sheets of each.

USE OF ESTIMATES - The preparation of the financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. These estimates and assumptions affect various matters, including our reported amounts of assets and liabilities in our consolidated balance sheets at the dates of the financial statements; our disclosure of contingent assets and liabilities at the dates of the financial statements; and our reported amounts of revenues and expenses in our consolidated statements of operations during the reporting periods. These estimates involve judgments with respect to numerous factors that are difficult to predict and are beyond management's control. As a result, actual amounts could materially differ from these estimates.

REVENUES - Service fee revenue, net of contractual allowances and discounts, consists of net patient fees received from various payors and patients themselves based mainly upon established contractual billing rates, less allowances for contractual adjustments and discounts. As it relates to BRMG and the NY Groups centers, this service fee revenue includes payments for both the professional medical interpretation revenue recognized by BRMG and the NY Groups as well as the payment for all other aspects related to our providing the imaging services, for which we earn management fees from BRMG and the NY Groups. As it relates to non-BRMG and NY Groups centers, namely the affiliated physician groups, this service fee revenue is earned through providing the use of our diagnostic imaging equipment and the provision of technical services as well as providing administration services such as clerical and administrative personnel, bookkeeping and accounting services, billing and collection, provision of medical and office supplies, secretarial, reception and transcription services, maintenance of medical records, and advertising, marketing and promotional activities.

Service fee revenues are recorded during the period the services are provided based upon the estimated amounts due from the patients and third-party payors. Third-party payors include federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies and employers. Estimates of contractual allowances are based on historical collection rates of payor reimbursement contract agreements. We also record a provision for doubtful accounts based primarily on historical collection rates related to patient copayments and deductible amounts for patients who have health care coverage under one of our third-party payors.

Under capitation arrangements with various health plans, we earn a per-enrollee amount each month for making available diagnostic imaging services to all plan enrollees under the capitation arrangement. Revenue under capitation arrangements is recognized in the period in which we are obligated to provide services to plan enrollees under contracts with various health plans.

Our service fee revenue, net of contractual allowances and discounts, the provision for bad debts, and revenue under capitation arrangements for the years ended December 31, are summarized in the following table (in thousands) :

	Years Ended December 31,		
	2016	2015	2014
Commercial insurance (1)	\$ 539,793	\$ 486,489	\$ 437,525
Medicare	187,941	168,545	159,562
Medicaid	28,170	23,948	24,499
Workers' compensation/personal injury	36,548	32,728	30,543
Other (2)	29,135	35,046	18,007
Service fee revenue, net of contractual allowances and discounts	821,587	746,756	670,136
Provision for bad debts	(45,387)	(36,033)	(29,807)
Net service fee revenue	776,200	710,723	640,329
Revenue under capitation arrangements	108,335	98,905	77,240
Total net revenue	\$ 884,535	\$ 809,628	\$ 717,569

(1) 21% of our net service fees revenue for the year ended December 31, 2016 and 20% for the years ended December 31, 2015 and 2014 were earned from a single payor.

(2) Other consists of revenue from teleradiology services, consulting fees and software revenue.

PROVISION FOR BAD DEBTS - We provide for an allowance against accounts receivable that could become uncollectible to reduce the carrying value of such receivables to their estimated net realizable value. We estimate this allowance based on the aging of our accounts receivable by the historical payment patterns of each type of payor,

write-off trends, and other relevant factors. A significant portion of our provision for bad debt relates to co-payments and deductibles owed to us from patients with insurance. Although we attempt to collect deductibles and co-payments due from patients with insurance at the time of service, this attempt to collect at the time of service is not an assessment of the patient's ability to pay nor are revenues recognized based on an assessment of the patient's ability to pay. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on the increased burden of co-payments and deductibles to be made by patients with insurance. These factors continuously change and can have an impact on collection trends and our estimation process. Our allowance for bad debts at December 31, 2016 and 2015 was \$20.7 million and \$20.8 million, respectively.

ACCOUNTS RECEIVABLE - Substantially all of our accounts receivable are due under fee-for-service contracts from third party payors, such as insurance companies and government-sponsored healthcare programs, or directly from patients. Services are generally provided pursuant to one-year contracts with healthcare providers. We continuously monitor collections from our payors and maintain an allowance for bad debts based upon specific payor collection issues that we have identified and our historical experience.

MEANINGFUL USE INCENTIVE - Under the American Recovery and Reinvestment Act of 2009, a program was enacted that provides financial incentives for providers that successfully implement and utilize electronic health record technology to improve patient care. Our software development team in Canada established an objective to build a Radiology Information System (RIS) software platform that has been awarded Meaningful Use certification. As this certified RIS system is implemented throughout our imaging centers, the radiologists that utilize this software can be eligible for the available financial incentives. In order to receive such incentive payments providers must attest that they have demonstrated meaningful use of the certified RIS in each stage of the program. We account for this meaningful use incentive under the Gain Contingency Model outlined in ASC 450-30. Under this model, we record within non-operating income, meaningful use incentive only after Medicare accepts an attestation from the qualified eligible professional demonstrating meaningful use. We recorded approximately \$2.8 million, \$3.3 million and \$2.0 million during the twelve months ended December 31, 2016, 2015 and 2014, respectively, relating to this incentive.

GAIN ON RETURN OF COMMON STOCK - In the second quarter of 2016, we determined that certain pre-acquisition financial information of Diagnostic Imaging Group (“DIG”) provided to us by the sellers contained errors. As a result of this, we negotiated and reached a settlement with the sellers of DIG in June 2016 for the return of 958,536 shares of common stock which had a fair value of \$5.0 million on the date of return. Such return has been recognized as a gain on return of common stock in our statement of operations.

SOFTWARE REVENUE RECOGNITION – Our subsidiary, eRAD, Inc., sells Picture Archiving Communications Systems (“PACS”) and related services, primarily in the United States. The PACS systems sold by eRAD are primarily composed of certain elements: hardware, software, installation and training, and support. Sales are made primarily through eRAD’s sales force. These sales are multiple-element arrangements that generally include hardware, software, software installation, configuration, system installation, training and first-year warranty support. Hardware, which is not unique or special purpose, is purchased from a third-party and resold to eRAD’s customers with a small mark-up.

We have determined that our core software products, such as PACS, are essential to most of our arrangements as hardware, software and related services are sold as an integrated package. Therefore, these transactions are accounted for under ASC 605-25, *Multiple-Element Arrangements* (as modified by ASU 2009-13). Non-essential software and related services, and essential software sold on a stand-alone basis without hardware, would continue to be accounted for under ASC 985-605, *Software*.

For the years ended December 31, 2016, 2015 and 2014, we recorded approximately \$6.2 million, \$6.1 million and \$5.5 million, respectively, in revenue related to our eRAD business which is included in net service fee revenue in our consolidated statement of operations. At December 31, 2016 we had a deferred revenue liability of approximately \$1.5 million associated with eRAD sales which we expect to recognize into revenue over the next 12 months.

SOFTWARE DEVELOPMENT COSTS - Costs related to the research and development of new software products and enhancements to existing software products all for resale to our customers are expensed as incurred.

We utilize a variety of computerized information systems in the day to day operation of our diagnostic imaging facilities. One such system is our front desk patient tracking system or Radiology Information System (“RIS”). We have historically utilized third party RIS software solutions and pay monthly fees to outside third party software vendors for the use of this software. We have developed our own RIS solution from the ground up through our wholly owned subsidiary, Radnet Management Information Systems (“RMIS”) and began utilizing this system beginning in the first quarter of 2015.

In accordance with ASC 350-40, *Accounting for the Costs of Computer Software Developed for Internal Use*, the costs incurred by RMIS toward the development of our RIS system, which began in August, 2010 and continued until

December 2014, were capitalized and are being amortized over its useful life which we determined to be 5 years. Total costs capitalized were approximately \$6.4 million. We began recording amortization of \$107,000 per month for our use of this software in January 2015.

We have entered into multiple agreements to license our RIS system to outside customers. For the twelve months December 31, 2016 and December 31, 2015, we received approximately \$301,000 and \$443,000 with respect to this licensing agreement, respectively. In accordance with ASC 350-40, we recorded the receipt of these funds against the capitalized software costs explained above. We intend to record any future proceeds in the same manner until the carrying value of our capitalized software costs are brought to zero. As of December 31, 2016, the net carrying value of our capitalized software costs was approximately \$3.1 million.

CONCENTRATION OF CREDIT RISKS - Financial instruments that potentially subject us to credit risk are primarily cash equivalents and accounts receivable. We have placed our cash and cash equivalents with one major financial institution. At times, the cash in the financial institution is temporarily in excess of the amount insured by the Federal Deposit Insurance Corporation, or FDIC. Substantially all of our accounts receivable are due under fee-for-service contracts from third party payors, such as insurance companies and government-sponsored healthcare programs, or directly from patients. Services are generally provided pursuant to one-year contracts with healthcare providers. We continuously monitor collections from our clients and maintain an allowance for bad debts based upon our historical collection experience.

CASH AND CASH EQUIVALENTS - We consider all highly liquid investments that mature in three months or less when purchased to be cash equivalents. The carrying amount of cash and cash equivalents approximates their fair market value.

DEFERRED FINANCING COSTS - Costs of financing are deferred and amortized on a straight-line basis over the life of the associated loan, which approximates the effective interest rate method. Deferred financing costs, net of accumulated amortization, were \$2.0 million and \$4.9 million, as of December 31, 2016 and 2015, respectively. In conjunction with our Restatement Amendment, a net addition of approximately \$237,000 was added to deferred financing costs, consisting of \$946,000 new additional costs from the amendment and a write off of \$709,000 due to a change in lender mix. See Note 8, Notes Payable, Line of Credit, and Capital Leases for more information.

INVENTORIES - Inventories, consisting mainly of medical supplies, are stated at the lower of cost or net realizable value with cost determined by the first-in, first-out method.

PROPERTY AND EQUIPMENT - Property and equipment are stated at cost, less accumulated depreciation and amortization. Depreciation and amortization of property and equipment are provided using the straight-line method over the estimated useful lives, which range from 3 to 15 years. Leasehold improvements are amortized at the lesser of lease term or their estimated useful lives, which range from 3 to 30 years. Maintenance and repairs are charged to expense as incurred.

BUSINESS COMBINATION - Accounting for acquisitions requires us to recognize separately from goodwill the assets acquired and the liabilities assumed at their acquisition date fair values. Goodwill as of the acquisition date is measured as the excess of consideration transferred over the net of the acquisition date fair values of the assets acquired and the liabilities assumed. While we use our best estimates and assumptions to accurately value assets acquired and liabilities assumed at the acquisition date, our estimates are inherently uncertain and subject to refinement. As a result, during the measurement period, which may be up to one year from the acquisition date, we record adjustments to the assets acquired and liabilities assumed with the corresponding offset to goodwill. Upon the conclusion of the measurement period or final determination of the values of assets acquired or liabilities assumed, whichever comes first, any subsequent adjustments are recorded to our consolidated statements of operations.

GOODWILL AND INDEFINITE LIVED INTANGIBLES - Goodwill at December 31, 2016 totaled \$239.6 million. Indefinite lived intangible assets at December 31, 2016 totaled \$7.9 million and are associated with the value of certain trade name intangibles. Goodwill and trade name intangibles are recorded as a result of business combinations. Management evaluates goodwill and trade name intangibles, at a minimum, on an annual basis and whenever events and changes in circumstances suggest that the carrying amount may not be recoverable. Impairment of goodwill is tested at the reporting unit level by comparing the reporting unit's carrying amount, including goodwill, to the fair value of the reporting unit. The fair value of a reporting unit is estimated using a combination of the income or discounted cash flows approach and the market approach, which uses comparable market data. If the carrying amount of the reporting unit exceeds its fair value, goodwill is considered impaired and a second step is performed to measure the amount of impairment loss, if any. Impairment of trade name intangibles is tested at the subsidiary level by comparing the subsidiary's trade name carrying amount to its respective fair value. We tested both goodwill and trade name intangibles for impairment on October 1, 2016, noting no impairment, and have not identified any indicators of impairment through December 31, 2016.

LONG-LIVED ASSETS - We evaluate our long-lived assets (property and equipment) and intangibles, other than goodwill, for impairment whenever indicators of impairment exist. Generally accepted accounting principles (GAAP) requires that if the sum of the undiscounted expected future cash flows from a long-lived asset or definite-lived intangible is less than the carrying value of that asset, an asset impairment charge must be recognized. The amount of the impairment charge is calculated as the excess of the asset's carrying value over its fair value, which generally represents the discounted future cash flows from that asset or in the case of assets we expect to sell, at fair value less costs to sell. No indicators of impairment were identified with respect to our long-lived assets as of December 31, 2016.

INCOME TAXES - Income tax expense is computed using an asset and liability method and using expected annual effective tax rates. Under this method, deferred income tax assets and liabilities result from temporary differences in the financial reporting bases and the income tax reporting bases of assets and liabilities. The measurement of deferred tax assets is reduced, if necessary, by the amount of any tax benefit that, based on available evidence, is not expected to be realized. When it appears more likely than not that deferred taxes will not be realized, a valuation allowance is recorded to reduce the deferred tax asset to its estimated realizable value. For net deferred tax assets we consider estimates of future taxable income in determining whether our net deferred tax assets are more likely than not to be realized. Income taxes are further explained in Note 11.

UNINSURED RISKS - On November 1, 2008 we obtained a fully funded and insured workers' compensation policy, thereby eliminating any uninsured risks for employee injuries occurring on or after that date. This fully funded policy remained in effect through November 1, 2013 and continues to cover any claims incurred through this date.

On November 1, 2013 we entered into a high-deductible workers' compensation insurance policy. We have recorded liabilities of \$2.9 million for the year ending December 31, 2016 and \$2.2 million for the year ended December 31, 2015, respectively, for the estimated future cash obligations associated with the unpaid portion of the workers compensation claims incurred.

We and our affiliated physicians carry an annual medical malpractice insurance policy that protects us for claims that are filed during the policy year and that fall within policy limits. The policy has a deductible for which is \$10,000 per incidence at December 31, 2016 and was \$24,000 per incidence at December 31, 2015.

In December 2008, in order to eliminate the exposure for claims not reported during the regular malpractice policy period, we purchased a medical malpractice tail policy, which provides coverage for any claims reported in the event that our medical malpractice policy expires. As of December 31, 2016, this policy remains in effect.

We have entered into an arrangement with Blue Shield to administer and process claims under a self-insured plan that provides health insurance coverage for our employees and dependents. We have recorded liabilities as of December 31, 2016 and 2015 of \$2.4 million and \$1.8 million, respectively, for the estimated future cash obligations associated with the unpaid portion of the medical and dental claims incurred by our participants. Additionally, we entered into an agreement with Blue Shield for a stop loss policy that provides coverage for any claims that exceed \$250,000 up to a maximum of \$1.0 million in order for us to limit our exposure for unusual or catastrophic claims.

LOSS AND OTHER UNFAVORABLE CONTRACTS – We assess the profitability of our contracts to provide management services to our contracted physician groups and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future revenue is compared to anticipated costs. If the

anticipated future cost exceeds the revenue, a loss contract accrual is recorded. In connection with the acquisition of Radiologix in November 2006, we acquired certain management service agreements for which forecasted costs exceeds forecasted revenue. As such, an \$8.9 million loss contract accrual was established in purchase accounting, and is included in other non-current liabilities. The recorded loss contract accrual is being accreted into operations over the remaining term of the acquired management service agreements. As of December 31, 2016 and 2015, the remaining accrual balance is \$5.6 million, and \$5.7 million, respectively.

As part of our ongoing acquisition activities, we have certain operating lease commitments for facilities that are not in use. Accordingly, we have recorded a loss contract accrual related to the remaining payments under these lease commitments. As of December 31, 2015, the remaining loss contract accrual for these leases was \$85,000 and was completely amortized during the 2016 fiscal year with no balance remaining as of December 31, 2016.

In addition and related to acquisition activity, we have certain operating lease commitments for facilities where the fair market rent differs from the lease contract rate. We have recorded an unfavorable contract liability representing the difference between the total value of the fair market rent and the contract rent over the current term of the lease applicable from the date of acquisition. As of December 31, 2016 and 2015, the unfavorable contract liability on these leases is \$1.6 million and \$581,000, respectively.

EQUITY BASED COMPENSATION – We have one long-term incentive plan which we refer to as the 2006 Plan, which we amended and restated as of April 20, 2015 (the “Restated Plan”). The Restated Plan was approved by our stockholders at our annual stockholders meeting on June 11, 2015. As of December 31, 2016, we have reserved for issuance under the Restated Plan 12,000,000 shares of common stock. We can issue options, stock awards, stock appreciation rights and cash awards under the Restated Plan. Certain options granted under the Restated Plan to employees are intended to qualify as incentive stock options under existing tax regulations. Stock options and warrants generally vest over three to five years and expire five to ten years from date of grant.

The compensation expense recognized for all equity-based awards is recognized over the awards' service periods. Equity-based compensation is classified in operating expenses within the same line item as the majority of the cash compensation paid to employees.

FOREIGN CURRENCY TRANSLATION - The functional currency of our foreign subsidiaries is the local currency. In accordance with ASC 830, *Foreign Currency Matters*, assets and liabilities denominated in foreign currencies are translated using the exchange rate at the balance sheet dates. Revenues and expenses are translated using average exchange rates prevailing during the reporting period. Any translation adjustments resulting from this process are shown separately as a component of accumulated other comprehensive income. Foreign currency transaction gains and losses are included in the determination of net income.

COMPREHENSIVE INCOME - ASC 220, *Comprehensive Income*, establishes rules for reporting and displaying comprehensive income and its components. Our unrealized gains or losses on foreign currency translation adjustments are included in comprehensive income. For the year ended December 31, 2016, we entered into an interest rate cap agreement, as discussed in Note 10, *Derivative Instruments*. Assuming perfect effectiveness, any unrealized gains or losses related to the cap agreement that qualify for cash flow hedge accounting are classified as a component of income. Any ineffectiveness is recognized in earnings. The components of comprehensive income for the three years in the period ended December 31, 2016 are included in the consolidated statements of comprehensive income.

FAIR VALUE MEASUREMENTS – Assets and liabilities subject to fair value measurements are required to be disclosed within a fair value hierarchy. The fair value hierarchy ranks the quality and reliability of inputs used to determine fair value. Accordingly, assets and liabilities carried at, or permitted to be carried at, fair value are classified within the fair value hierarchy in one of the following categories based on the lowest level input that is significant to a fair value measurement:

Level 1—Fair value is determined by using unadjusted quoted prices that are available in active markets for identical assets and liabilities.

Level 2—Fair value is determined by using inputs other than Level 1 quoted prices that are directly or indirectly observable. Inputs can include quoted prices for similar assets and liabilities in active markets or quoted prices for identical assets and liabilities in inactive markets. Related inputs can also include those used in valuation or other pricing models such as interest rates and yield curves that can be corroborated by observable market data.

Level 3—Fair value is determined by using inputs that are unobservable and not corroborated by market data. Use of these inputs involves significant and subjective judgment.

The table below summarizes the estimated fair values of certain of our financial assets that are subject to fair value measurements, and the classification of these assets on our consolidated balance sheets, as follows (in thousands):

	As of December 31, 2016			
	Level 1	Level 2	Level 3	Total
Current assets				
Interest Rate Contracts	\$-	\$818	\$-	\$818

The estimated fair value of these contracts, which are discussed in Note 10, was determined using Level 2 inputs. More specifically, the fair value was determined by calculating the value of the difference between the fixed interest rate of the interest rate swaps and the counterparty's forward LIBOR curve. The forward LIBOR curve is readily available in the public markets or can be derived from information available in the public markets.

The table below summarizes the estimated fair value and carrying amount of our long-term debt as follows (in thousands):

	As of December 31, 2016				
	Level 1	Level 2	Level 3	Total Fair Value	Total Face Value
First Lien Term Loans	\$-	\$483,129	\$-	\$483,129	\$478,938
Second Lien Term Loans	\$-	\$167,580	\$-	\$167,580	\$168,000

	As of December 31, 2015				
	Level 1	Level 2	Level 3	Total Fair Value	Total Face Value
First Lien Term Loans	\$-	\$444,258	\$-	\$444,258	\$451,023
Second Lien Term Loans	-	173,700	-	173,700	180,000

Our revolving credit facility had no aggregate principal amount outstanding as of December 31, 2016.

The estimated fair value of our long-term debt, which is discussed in Note 8, was determined using Level 2 inputs primarily related to comparable market prices.

We consider the carrying amounts of cash and cash equivalents, receivables, other current assets, current liabilities and other notes payables to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization or payment. Additionally, we consider the carrying amount of our capital lease obligations to approximate their fair value because the weighted average interest rate used to formulate the carrying amounts approximates current market rates.

EARNINGS PER SHARE - Earnings per share is based upon the weighted average number of shares of common stock and common stock equivalents outstanding, net of common stock held in treasury, as follows (in thousands except share and per share data):

	Years Ended December 31,		
	2016	2015	2014
Net income attributable to RadNet, Inc. common stockholders	\$7,230	\$7,709	\$1,376

BASIC NET INCOME PER SHARE ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS

Weighted average number of common shares outstanding during the period	46,244,188	43,805,794	41,070,077
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Basic net income per share attributable to RadNet, Inc. common stockholders	\$0.16	\$0.18	\$0.03
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DILUTED NET INCOME PER SHARE ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS

Weighted average number of common shares outstanding during the period	46,244,188	43,805,794	41,070,077
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Add nonvested restricted stock subject only to service vesting	220,416	865,326	994,610
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Add additional shares issuable upon exercise of stock options and warrants	190,428	500,252	1,084,509
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Weighted average number of common shares used in calculating diluted net income per share	46,655,032	45,171,372	43,149,196
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Diluted net income per share attributable to RadNet, Inc. common stockholders	\$0.15	\$0.17	\$0.03
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For the years ended December 31, 2016, 2015 and 2014 we excluded 165,000, 265,000, and 245,000, respectively, outstanding options, in the calculation of diluted earnings per share because their effect would be antidilutive.

INVESTMENT IN JOINT VENTURES – We have twelve unconsolidated joint ventures with ownership interests ranging from 35% to 55%. These joint ventures represent partnerships with hospitals, health systems or radiology practices and were formed for the purpose of owning and operating diagnostic imaging centers. Professional services at the joint venture diagnostic imaging centers are performed by contracted radiology practices or a radiology practice that participates in the joint venture. Our investment in these joint ventures is accounted for under the equity method, since RadNet does not have a controlling financial interest in such ventures. We evaluate our investment in joint ventures, including cost in excess of book value (equity method goodwill) for impairment whenever indicators of impairment exist. No indicators of impairment existed as of December 31, 2016.

Acquisition of new facilities

On August 15, 2016 our joint venture, Franklin Imaging, LLC, acquired a single multi-modality imaging center located in Rosedale, Maryland for cash consideration of \$1.0 million and the assumption of capital lease debt of \$241,000. Franklin Imaging, LLC made a fair value determination of the acquired assets and approximately \$600,000 of fixed assets, \$30,000 of other assets and goodwill of \$648,000 was recorded in respect to the transaction.

Formation of new joint ventures

On April 1, 2016, Community Imaging Partners Inc., a wholly owned subsidiary of RadNet, entered into a joint venture with Mt. Airy Health Services, LLC, a partnership of Frederick Memorial Hospital and Carroll Hospital Center. On August 31, 2016, Community Imaging Partners Inc. contributed \$200,000 for a 40% economic interest in the partnership and funded an additional \$440,000 in relation to a capital call. Mt. Airy Health Services, LLC, contributed \$300,000 for a 60% economic interest and an additional \$660,000 in relation to the capital call.

On May 9, 2016, RadNet, through a newly formed subsidiary, Glendale Advanced Imaging LLC, entered into a joint venture with Dignity Health, a California nonprofit public benefit corporation. On June 1, 2016, RadNet contributed net assets of \$2.2 million for a 55% economic interest and Dignity Health contributed net assets of \$1.8 million for a 45% economic interest.

Joint venture investment and financial information

The following table is a summary of our investment in joint ventures during the years ended December 31, 2016 and December 31, 2015 (in thousands):

Balance as of December 31, 2014	\$	32,123
Equity contributions in existing joint ventures		265
Equity in earnings in these joint ventures		8,927
		(7,731)

Distribution of earnings		
Balance as of December 31, 2015	\$	33,584
Equity contributions in existing joint ventures		3,084
Equity in earnings in these joint ventures		9,767
Distribution of earnings		(2,926)
Balance as of December 31, 2016	\$	43,509

We received management service fees from the centers underlying these joint ventures of approximately \$11.9 million for the year ended December 31, 2016 and \$9.3 million per year for the years ended December 31, 2015 and 2014, respectively. We eliminate any unrealized portion of our management service fees with our equity in earnings of joint ventures.

The following table is a summary of key financial data for these joint ventures as of December 31, 2016 and 2015, respectively, and for the years ended December 31, 2016, 2015 and 2014, respectively, (in thousands):

Balance Sheet Data:	December 31,	
	2016	2015
Current assets	\$40,093	\$28,186
Noncurrent assets	100,146	91,660
Current liabilities	(14,077)	(15,258)
Noncurrent liabilities	(44,405)	(44,059)
Total net assets	\$81,757	\$60,529
Book value of RadNet joint venture interests	\$38,538	\$28,397
Cost in excess of book value of acquired joint venture interests	4,970	4,970
Elimination of intercompany profit remaining on Radnet's consolidated balance sheet	–	217
Total value of Radnet joint venture interests	\$43,509	\$33,584
Total book value of other joint venture partner interests	\$43,219	\$32,132

	2016	2015	2014
Net revenue	\$160,134	\$125,544	\$101,189
Net income	\$21,933	\$19,485	\$14,854

NOTE 3 – RECENT ACCOUNTING STANDARDS

Accounting standards adopted

In March 2016, the Financial Accounting Standards Board (“FASB”) issued Accounting Standards Update (“ASU”) No. 2016-09 (“ASU 2016-09”), *Compensation—Stock Compensation*, (Topic 718): Improvements to Employee Share-Based Payment Accounting. ASU 2016-09 requires excess tax benefits and tax deficiencies, which arise due to differences between the measure of compensation expense and the amount deductible for tax purposes, to be recorded directly through the statement of operations when awards vest or are settled. In addition, cash flows related to excess tax benefits will no longer be classified separately as a financing activity apart from other tax cash flows. We elected to early adopt the new guidance for the year ended December 31, 2016. Upon adoption using the modified retrospective transition method, we recorded a cumulative effect adjustment to recognize previously unrecognized excess tax benefits which increased deferred tax assets and reduced accumulated deficit by \$7.1 million. The current net tax benefit for 2016 resulting from adoption of the new guidance is approximately \$400,000 and is reflected in our tax provision.

In November 2015, the FASB issued ASU No. 2015-17 (“ASU 2015-17”), *Income Taxes* (Topic 740): Balance Sheet Classification of Deferred Taxes. ASU 2015-17 changes the classification of deferred taxes to be a noncurrent asset or liability regardless of the classification of the related asset or liability for financial reporting. The prospective adoption resulted in a reclassification of \$22.3 million from current deferred tax assets to non-current deferred tax assets in our December 31, 2016 consolidated balance sheet, and had no impact on our consolidated statement of operations, comprehensive income, stockholders’ equity, and cash flows. Prior periods were not retrospectively adjusted.

In September 2015, the FASB issued ASU No. 2015-16 (“ASU 2015-16”), *Business Combinations*, (Topic 805): Simplifying the Accounting for Measurement-Period Adjustments, which we adopted prospectively in 2016. ASU 2015-16 eliminates the requirement to retrospectively apply adjustments made to provisional amounts recognized in a business combination. An entity will now recognize any adjustments in the reporting period in which the amounts are determined, calculated as if the accounting had been completed at the acquisition date. Disclosure is required for the portion of adjustments recorded in current-period earnings that would have been recorded in previous reporting periods had they been recognized as of the acquisition date. The update has had no material effect on our results of operations and cash flows.

In August 2015, the FASB issued ASU No. 2015-15 (“ASU 2015-15”), *Interest – Imputation of Interest*, (Subtopic 835-30): Presentation and Subsequent Measurement of Debt Issuance Costs Associated with Line-of-Credit Arrangements. ASU 2015-15 provides additional guidance to the presentation of debt issuance costs discussed originally in ASU No. 2015-03, which was issued in April 2015 and described below. ASU 2015-15 noted that ASU 2015-03 did not address the debt issue costs in regards to line-of-credit arrangements, which by their nature have fluctuating balances. ASU 2015-15 permits debt issuance costs specifically related to line-of-credit arrangements to be presented as an asset with subsequent amortization to interest expense ratably over the term of the line-of-credit arrangement, regardless of whether there are any outstanding borrowings on the arrangement. The update has had no material effect on our results of operations and cash flows.

In April 2015, the Financial Accounting Standards Board (the “FASB”) issued ASU No. 2015-03 (“ASU 2015-03”), *Interest – Imputation of Interest*, (Subtopic 835-30). ASU 2015-03 changes the accounting method for debt issuance costs from a deferred charge (i.e. an asset) to a contra liability in part because such costs provide no future economic benefit. Debt issue costs related to a recognized debt liability are to be presented in the balance sheet as a direct deduction from the carrying amount of the debt liability, consistent with the presentation of debt discounts. The update is effective for fiscal years (and interim reporting periods within fiscal years) beginning after December 15, 2015. As a result of adopting the update \$2.0 million was reclassified to debt discount in the first quarter of 2016. The impact on our December 31, 2015 consolidated balance sheet was as follows:

In thousands	As previously reported	Impact of adoption	As currently reported
Prepaid expenses and other current assets	\$ 40,139	(1,153)	38,986
Deferred financing costs, net of current portion	3,696	(855)	2,841
Others	794,600	–	794,600
Total assets	\$ 838,435	\$ (2,008)	\$ 836,427
Current portion of notes payable	23,076	(693)	22,383
Notes payable, net of current portion	601,229	(1,315)	599,914
Others	177,669	–	177,669
Total liabilities	801,974	(2,008)	799,966
Total equity	36,461	–	36,461
Total liabilities and equity	\$ 838,435	\$ (2,008)	\$ 836,427

In February 2015, the FASB issued ASU No. 2015-02 (“ASU 2015-02”), *Consolidation – Amendments to the Consolidation Analysis*, (Topic 810). ASU 2015-02 changes the analysis that a reporting entity must perform to determine whether it should consolidate certain types of legal entities. It is effective for annual reporting periods, and interim periods within those years, beginning after December 15, 2015. Adoption of this update in 2016 did not have a material effect on our results of operations and cash flows.

Accounting standards not yet adopted

In January 2017, the FASB issued ASU No. 2017-04 (“ASU 2017-04”), *Simplifying the Test for Goodwill Impairment*. ASU 2017-04 eliminates the requirement to calculate the implied fair value of goodwill (i.e., Step 2 of the current goodwill impairment test) to measure a goodwill impairment charge. Instead, entities will record an impairment charge based on the excess of a reporting unit’s carrying amount over its fair value (i.e., measure the charge based on the current Step 1). ASU 2017-04 is effective for annual and any interim impairment tests for periods beginning after December 15, 2019, with early adoption permitted. We are evaluating the effect of this guidance.

In January 2017, the FASB issued ASU No. 2017-01 (“ASU 2017-01”), *Clarifying the Definition of a Business*. ASU 2017-01 changes the definition of a business to assist entities with evaluating when a set of transferred assets and activities is considered a business. ASU 2017-01 is effective for annual periods beginning after December 31, 2017 including interim periods within those periods. We are evaluating the effect of this guidance.

In February 2016, the FASB issued ASU No. 2016-02 (“ASU 2016-02”), *Leases*, (Topic 842): Amendments to the FASB Accounting Standards Codification. ASU 2016-02 amends the existing accounting standards for lease accounting, including requiring lessees to recognize most leases on their balance sheets and making targeted changes to lessor accounting. The new standard requires a modified retrospective transition approach for all leases existing at, or entered into after, the date of initial application, with an option to use certain transition relief. The amendments in this update are effective for fiscal years (and interim reporting periods within fiscal years) beginning after December 15, 2018. Early adoption of the amendments is permitted for all entities. We are currently evaluating the impact this guidance will have on our consolidated financial statements, but expect this adoption will result in a significant increase in the assets and liabilities related to our leased properties and equipment.

In May 2014, the FASB issued ASU No. 2014-09 (“ASU 2014-09”), *Revenue from Contracts with Customers*, (Topic 606). ASU 2014-09 requires an entity to recognize revenue when it transfers promised goods or services to customers in an amount that reflects what it expects in exchange for the goods or services. It also requires more detailed disclosures to enable users of the financial statements to understand the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. The guidance will become effective for the Company on January 1, 2018. We are continuing to evaluate the effects the adoption of this standard will have on our financial statements and financial disclosures. We believe the most significant impact will be to the presentation of our statement of operations where the provision for bad debts will be recorded as a direct reduction to revenues and will not be presented as a separate line item. We expect to adopt the new standard using the full retrospective application.

NOTE 4 – FACILITY ACQUISITIONS, ASSETS HELD FOR SALE AND DISPOSITIONS

Acquisitions

In separate purchases occurring on July 1 and October 1 2016, we acquired for approximately \$1.2 million the remaining non-controlling interest of 47.6% in the Park West joint venture, thus increasing our ownership percentage from 52.4% to 100%. The difference between the consideration paid and the carrying value of the non-controlling interest purchased was recorded as additional paid-in capital.

On March 1, 2016 we completed our acquisition of certain assets of Advanced Radiological Imaging – Astoria P.C. consisting of two multi-modality imaging centers located in Astoria, NY for cash consideration of \$5.0 million. The facility provides MRI, PET/CT, Ultrasound and X-ray services. We have made a fair value determination of the acquired assets and approximately \$3.6 million of fixed assets, \$47,000 of prepaid assets, \$100,000 covenant not to compete, and \$1.3 million of goodwill were recorded.

On October 1, 2015 we completed our acquisition of certain assets of DIG consisting of seventeen multi-modality imaging centers located in the boroughs of Brooklyn and Queens, New York, for \$62.9 million detailed as follows: cash consideration of \$54.6 million (\$49.6 million paid at execution, \$5 million to be paid 18 months after acquisition or earlier if certain conditions are met), the assumption of \$2.1 million in equipment debt, and issuance of 1.5 million RadNet common shares valued at \$8.3 million on the acquisition date. The transaction also includes contingent consideration payable equal to five times the amount by which collections on the sellers' historical revenue exceeds a defined threshold. During 2016, based on fair value determination of the assets and liabilities by a third party, we recorded certain measurement period adjustments associated with our acquisition. In the second quarter of 2016, these adjustments resulted in an increase to fixed assets acquired by \$1.1 million and the recognition of a net unfavorable lease contract liability of \$1.0 million. In the third quarter of 2016, we recorded a decrease to our intangible and fixed assets of approximately \$121,000. Also, amounts previously owed to DIG of \$5.0 million were reduced to \$3.4 million on June 15, 2016 when we remitted a payment of \$1.6 million to a payor on behalf of DIG.

On October 1, 2015 we completed our acquisition of certain assets of Philip L. Chatham, M.D., Inc., an oncology practice with offices in the Los Angeles, CA area, for consideration of \$916,000, paid in shares of equal value of the common stock of RadNet, Inc. and \$300,000 in cash. We have made a fair value determination of the acquired assets and approximately \$26,000 of fixed assets, \$100,000 covenant not to compete intangible asset, \$300,000 of medical supplies and \$790,000 of goodwill were recorded with respect to this transaction.

On September 1, 2015 we completed our acquisition of certain assets of Murray Hill Radiology and Mammography, P.C. and Murray Hill MRI Holding, LLC, consisting of a single multi-modality imaging center located in Manhattan, New York for a cash consideration of \$5.8 million. The facility provides MRI, CT, Ultrasound and X-ray services. We have made a fair value determination of the acquired assets and approximately \$1.6 million of fixed assets, \$95,000 of prepaid assets and \$4.1 million of goodwill were recorded.

On August 3, 2015 we completed our acquisition of certain assets of Hanford Imaging, LP, consisting of a single multi-modality imaging center located in Hanford, CA for cash consideration of \$1.0 million. The facility provides MRI, CT, Ultrasound and X-ray services. We have made a fair value determination of the acquired assets and approximately \$215,000 of fixed asset and \$785,000 of goodwill were recorded.

On June 1, 2015 we completed our acquisition of certain assets of Healthcare Radiology and Diagnostic systems, PLLC, consisting of a single multi-modality imaging center located in the Bronx, NY area for cash consideration of

\$425,000. The facility provides MRI, CT, Ultrasound and X-ray services. We have made a fair value determination of assets acquired and approximately \$134,500 of fixed assets and \$290,500 of leasehold improvements were recorded

On May 1, 2015 we completed our acquisition of certain assets of California Radiology consisting of six multi-modality imaging centers located in Los Angeles, California for cash consideration of \$4.2 million. The facilities provide MRI, PET/CT, Ultrasound and X-ray services. We have made a fair value determination of the acquired assets and approximately \$217,000 of equipment, \$1.7 million of leasehold improvements, \$34,000 in other assets, \$100,000 of other intangible assets relating to a covenant not to compete contract and \$2.1 million of goodwill were recorded with respect to this transaction.

On April 15, 2015 we completed our acquisition of certain assets of New York Radiology Partners, consisting of eleven multi-modality imaging centers located in Manhattan, New York for cash consideration of \$29.8 million, a note to seller of \$1.5 million, and the assumption of equipment debt of \$2.3 million. The facilities provide a full range of radiology services including MRI, PET/CT, Mammography, Ultrasound, X-ray and other related services. With the use of an outside valuation expert, we have made a fair value determination of the acquired assets and assumed liabilities. In total, RadNet acquired assets of \$34.5 million and assumed current liabilities of \$891,000. Asset amounts acquired were \$6.9 million in equipment, \$11.6 million in leasehold improvements, \$9.9 million in goodwill, \$1.2 million in intangible assets, and \$4.9 million of accounts receivable and other assets. Current liabilities assumed related to accounts payable, payroll and other related short term obligations.

Assets held for sale

On November 4, 2016, the Board of Directors resolved to sell the Company's interest in five of its Rhode Island imaging centers operating under the name The Imaging Institute within the upcoming 12 months. The following table summarizes the major categories of assets classified as held for sale in the accompanying consolidated balance sheets at December 31, 2016 (in thousands):

Property and equipment, net	\$ 1,056
Other assets	21
Goodwill	1,126
Total assets held for sale	\$2,203

As the sale of these assets does not represent a strategic shift that will have a major effect on the Company's operations and financial results, it is not classified as a discontinued operation.

Dispositions

On September 30, 2015 we completed a sale of 10 wholly owned imaging centers to one of our non-consolidated joint ventures for which we hold a 49% non-controlling interest, The New Jersey Imaging Network, L.L.C., for approximately \$35.5 million. We recorded a gain of \$5.4 million with respect to this transaction.

On August 3, 2015 we sold a 25% non-controlling interest in one of our wholly owned entities, Baltimore County Radiology, LLC ("BCR") to Lifebridge Health for \$5.0 million. On the date of sale, the net book value of this 25% interest was \$1.3 million. In accordance with ASC 810-10-45-23, the proceeds in excess of this net book value amounting to \$3.7 million was recorded to equity. In addition to the proceeds initially received, the transaction included an earn out provision in which RadNet had the opportunity to receive approximately \$1.2 million in additional proceeds if certain operating performance targets of BCR were achieved within the 12 months following the transaction. In the third quarter of 2016, we recorded an increase to additional paid-in capital as a result of \$992,000 received as part of the earn out provision.

NOTE 5 – GOODWILL AND OTHER INTANGIBLE ASSETS

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Goodwill is recorded as a result of business combinations. Activity in goodwill for the years ended December 31, 2015 and 2016 is provided below (in thousands):

Balance as of December 31, 2014	\$200,304
Adjustment to our allocation of goodwill for the acquisition of Liberty Pacific	200
Goodwill acquired through the acquisition of California Radiology	2,107
Goodwill acquired through the acquisition of New York Radiology Partners	9,897
Goodwill disposed through the sale of New Jersey Imaging Partners	(18,833)
Goodwill acquired through the acquisition of Hanford Imaging, LP	785
Goodwill acquired through the acquisition of Murry Hill Radiology and MRI	4,123
Goodwill acquired through the acquisition of Phillip L Chatam, M.D., Inc.	790
Goodwill acquired through the acquisition of Diagnostic Imaging Group, LLC	40,035
Balance as of December 31, 2015	239,408
Goodwill acquired through the acquisition of Advanced Radiological Imaging	1,280
Adjustments to our preliminary allocation of the purchase price of Diagnostic Imaging Group, LLC	(47)
Goodwill acquired through the acquisition of Landmark Imaging, LLC	38
Goodwill allocated to assets held for sale	(1,126)
Balance as of December 31, 2016	\$239,553

The amount of goodwill from these acquisitions that is deductible for tax purposes as of December 31, 2016 is \$99.1 million.

Other intangible assets are primarily related to the value of management service agreements obtained through our acquisition of Radiologix, Inc. in 2006 and are recorded at a cost of \$57.5 million less accumulated amortization of \$23.4 million at December 31, 2016. Also included in other intangible assets is the value of covenant not to compete contracts associated with our facility acquisitions totaling \$5.9 million less accumulated amortization of \$5.3 million, as well as the value of trade names associated with acquired imaging facilities totaling \$10.2 million less accumulated amortization of \$1.5 million and dispositions of \$750,000. In connection with our purchase of eRAD is the \$4.0 million value of eRAD's developed technology and its customer relationships, which have been fully amortized as of December 31, 2016.

Total amortization expense for the years ended December 31, 2016, 2015 and 2014 was \$2.6 million, \$3.0 million, and \$3.1 million, respectively. Intangible assets are amortized using the straight-line method. Management service agreements are amortized over 25 years using the straight line method. Developed technology and customer relationships are amortized over 5 years using the straight line method.

The following table shows annual amortization expense, by asset classes that will be recorded over the next five years (in thousands):

	2017	2018	2019	2020	2021	Thereafter	Total	Weighted average amortization period remaining in years
Management Service Contracts	\$2,287	\$2,287	\$2,287	\$2,287	\$2,287	\$ 22,683	\$34,118	14.9
Covenant not to compete contracts	251	208	122	42	4	—	627	2.8
Trade Names*	—	—	—	—	—	7,937	7,937	—
Total Annual Amortization	\$2,538	\$2,495	\$2,409	\$2,329	\$2,291	\$ 30,620	\$42,682	

* These trade name intangibles have an indefinite life

NOTE 6 - PROPERTY AND EQUIPMENT

Property and equipment and accumulated depreciation and amortization are as follows (in thousands):

	December 31,	
	2016	2015
Land	\$250	\$250
Medical equipment	393,001	352,005
Computer and office equipment, furniture and fixtures	99,434	107,014
Software development costs	6,391	6,391
Leasehold improvements	252,595	232,550
Equipment under capital lease	26,758	29,796
Total property and equipment cost	778,429	728,006
Accumulated depreciation and amortization	(529,648)	(471,284)
Total net property and equipment	248,781	256,722

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Equipment held for sale	(1,056)	–
Total property and equipment	\$247,725	\$256,722

Depreciation and amortization expense of property and equipment, including amortization of equipment under capital leases, for the years ended December 31, 2016, 2015 and 2014 was \$64.0 million, \$57.6 million, and \$56.2 million, respectively.

NOTE 7 – ACCOUNTS PAYABLE AND ACCRUED EXPENSES

Accounts payable and accrued expenses were comprised of the following (in thousands):

	December 31,	
	2016	2015
Accounts payable	\$40,952	\$52,296
Accrued expenses	42,883	32,950
Accrued payroll and vacation	19,119	17,692
Accrued professional fees	8,212	10,875
Total	\$111,166	\$113,813

NOTE 8 - NOTES PAYABLE, REVOLVING CREDIT FACILITY AND CAPITAL LEASESNotes payable, revolving credit facility and capital lease obligations:

Our notes payable, line of credit and capital lease obligations consist of the following (in thousands):

	December 31,	
	2016	2015
Revolving lines of credit	\$-	\$-
First Lien Term Loans	478,938	451,023
Second Lien Term Loans	168,000	180,000
Discounts on term loans	(16,783)	(9,542)
Promissory note payable to the former owner of a practice acquired at an interest rate of 1.5% due through 2019	980	1,361
Promissory note payable to Healthcare Partners for imaging equipment acquired through acquisition at an interest rate of 5.25%	-	431
Equipment notes payable at interest rates ranging from 3.3% to 10.2%, due through 2020, collateralized by medical equipment	341	1,032
Obligations under capital leases at interest rates ranging from 2.5% to 10.8%, due through 2022, collateralized by medical and office equipment	7,256	16,423
Total debt obligations	638,732	640,728
Less: current portion	(26,557)	(33,114)
Long term portion debt obligations	\$612,175	\$607,614

The following is a listing of annual principal maturities of notes payable exclusive of all related discounts, capital leases and repayments on our revolving credit facilities for years ending December 31 (in thousands):

2017	\$24,784
2018	24,751
2019	24,526
2020	24,261
2021	192,250

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Thereafter	357,687
Total notes payable obligations	\$648,259

We lease equipment under capital lease arrangements. Future minimum lease payments under capital leases for years ending December 31 (in thousands) is as follows:

2017	\$4,764
2018	2,163
2019	359
2020	201
2021	81
Thereafter	15
Total minimum payments	7,583
Amount representing interest	(327)
Present value of net minimum lease payments	7,256
Less current portion	(4,526)
Long-term portion lease obligations	\$2,730

Term Loans and Financing Activity Information:

Included in our consolidated balance sheet at December 31, 2016 are \$630.2 million of senior secured term loan debt (net of unamortized discounts of \$16.8 million), broken down by loan agreement as follows (in thousands):

	As of December 31, 2016		
	Face Value	Discount	Total Carrying Value
First Lien Term Loans	\$478,938	\$(14,712)	\$464,226
Second Lien Term Loans	\$168,000	\$(2,071)	\$165,929
Total	\$646,938	\$(16,783)	\$630,155

Our revolving credit facility had no aggregate principal amount outstanding as of December 31, 2016.

At December 31, 2016, our credit facilities were comprised of two tranches of term loans and a revolving credit facility. On July 1, 2016 (the "Restatement Effective Date"), we entered into Amendment No. 3 to Credit and Guaranty Agreement (the "Restatement Amendment") pursuant to which we amended and restated our then existing first lien credit facilities on the terms set forth in the Amended and Restated First Lien Credit and Guaranty Agreement dated July 1, 2016 (as amended from time to time, the "First Lien Credit Agreement"). Pursuant to the First Lien Credit Agreement, we have issued \$485 million of senior secured term loans (the "First Lien Term Loans") and established a \$117.5 million senior secured revolving credit facility (the "Revolving Credit Facility"). We have also entered into a Second Lien Credit and Guaranty Agreement dated March 25, 2014 (as amended from time to time, the "Second Lien Credit Agreement") pursuant to which we issued \$180 million of secured term loans (the "Second Lien Term Loans").

As of December 31, 2016, we were in compliance with all covenants under our credit facilities.

The following describes our 2016 financing activities:

Restatement Amendment and the First Lien Credit Agreement

On July 1, 2016, we entered into the Restatement Amendment pursuant to which we amended and restated our then existing first lien credit facilities on the terms set forth in the First Lien Credit Agreement. As of the Restatement Effective Date, our first lien credit facilities consisted of a Credit and Guaranty Agreement that we entered into on October 10, 2012 (the "Original First Lien Credit Agreement"), as subsequently amended by a first amendment dated

April 3, 2013 (the “2013 Amendment”), a second amendment dated March 25, 2014 (the “2014 Amendment”), and a joinder agreement dated April 30, 2015 (the “2015 Joinder” and collectively with the Original First Lien Credit Agreement, the 2013 Amendment and the 2014 Amendment, the “Prior First Lien Credit Agreement”). The First Lien Credit Agreement increased the aggregate principal amount of First Lien Term Loans to \$485.0 million and increased the Revolving Credit Facility to \$117.5 million. Proceeds from the First Lien Credit Agreement were used to repay the previously outstanding first lien loans under the Prior First Lien Credit Agreement, make a \$12.0 million principal payment of the Second Lien Term Loans, pay costs and expenses related to the First Lien Credit Agreement and provide approximately \$10.0 million for general corporate purposes.

Interest. The interest rates payable on the First Lien Term Loans are (a) the Adjusted Eurodollar Rate (as defined in the First Lien Credit Agreement) plus 3.75% per annum or (b) the Base Rate (as defined in the First Lien Credit Agreement) plus 2.75% per annum. As applied to the First Lien Term Loans, the Adjusted Eurodollar Rate has a minimum floor of 1.0%. The three month Adjusted Eurodollar Rate at December 31, 2016 was 1.0%.

Payments. The scheduled quarterly principal payments of the First Lien Term Loans is approximately \$6.1 million, beginning in December 2016, with the balance due at maturity. Prior to the Restatement Amendment, the quarterly principal payments on the first lien term loans under the Prior First Lien Credit Agreement were approximately \$6.2 million.

Maturity Date. The maturity date for the First Lien Term Loans shall be on the earliest to occur of (i) the seventh anniversary of the Restatement Effective Date, (ii) the date on which all First Lien Term Loans shall become due and payable in full under the First Lien Credit Agreement, whether by acceleration or otherwise, and (iii) September 25, 2020 if our indebtedness under the Second Lien Credit Agreement has not been repaid, refinanced or extended prior to such date.

Incremental Feature: Under the First Lien Credit Agreement, we can elect to request 1) an increase to the existing Revolving Credit Facility and/or 2) additional First Lien Term Loans, provided that the aggregate amount of such increases or additions does not exceed (A) an amount not in excess of \$100.0 million minus any incremental loans requested under the similar provisions of the Second Lien Credit Agreement or (B) if the First Lien Leverage Ratio would not exceed 3.50:1.00 after giving effect to such incremental facilities, an uncapped amount, in each case subject to the conditions and limitations set forth in the First Lien Credit Agreement. Each lender approached to provide all or a portion of any incremental facility may elect or decline, in its sole discretion, to provide any incremental commitment or loan.

Revolving Credit Facility: The First Lien Credit Agreement provides for a \$117.5 million Revolving Credit Facility. The termination date of the Revolving Credit Facility is the earliest to occur of: (i) July 1, 2021, (ii) the date the Revolving Credit Facility is permanently reduced to zero pursuant to section 2.13(b) of the First Lien Credit Agreement, which addresses voluntary commitment reductions, (iii) the date of the termination of the Revolving Credit Facility due to specific events of default pursuant to section 8.01 of the First Lien Credit Agreement, and (iv) September 25, 2020 if our indebtedness under the Second Lien Credit Agreement has not been repaid, refinanced or extended prior to such date. Amounts borrowed under the Revolving Credit Facility bear interest based on types of borrowings as follows: (i) unpaid principal on loans under the Revolving Credit Facility at the Adjusted Eurodollar Rate (as defined in the First Lien Credit Agreement) plus 3.75% per annum or the Base Rate (as defined in the First Lien Credit Agreement) plus 2.75% per annum, (ii) letter of credit fees at 3.75% per annum and fronting fees for letters of credit at 0.25% per annum, in each case on the average aggregate daily maximum amount available to be drawn under all letters of credit issued under the First Lien Credit Agreement, and (iii) commitment fee of 0.5% per annum on the unused revolver balance.

Second Lien Credit Agreement:

On March 25, 2014, we entered into the Second Lien Credit Agreement to provide for, among other things, the borrowing of \$180.0 million of Second Lien Term Loans. The proceeds from the Second Lien Term Loans were used to redeem our 10 3/8% senior unsecured notes, due 2018, to pay the expenses related to the transaction and for general corporate purposes. On July 1, 2016, in conjunction with the Restatement Amendment, a \$12.0 million principal

payment was made on the Second Lien Term Loans.

The Second Lien Credit Agreement provides for the following:

Interest. The interest rates payable on the Second Lien Term Loans are (a) the Adjusted Eurodollar Rate (as defined in the Second Lien Credit Agreement) plus 7.0% or (b) the Base Rate (as defined in the Second Lien Credit Agreement) plus 6.0%. The Adjusted Eurodollar Rate has a minimum floor of 1.0% on the Second Lien Term Loans. The three month Adjusted Eurodollar Rate at December 31, 2016 was 1.0%. The rate paid on the Second Lien Term Loan at December 31, 2016 was 8%.

Payments. There is no scheduled amortization of the principal of the Second Lien Term Loans. Unless otherwise prepaid as a result of the occurrence of certain mandatory prepayment events, all principal will be due and payable on the termination date described below.

Termination. The maturity date for the Second Lien Term Loans is the earlier to occur of (i) March 25, 2021, and (ii) the date on which the Second Lien Term Loans shall otherwise become due and payable in full under the Second Lien Credit Agreement, whether by voluntary prepayment per section 2.13(a) of the Second Lien Credit Agreement or events of default per section 8.01 of the Second Lien Credit Agreement as described below.

The following describes our financing activities on the retired Senior Notes:

Senior Notes:

On April 6, 2010, we issued and sold \$200 million of 10 3/8% senior unsecured notes due 2018 at a price of 98.680% (the “Senior Notes”). All payments of the Senior Notes, including principal and interest, were guaranteed jointly and severally on a senior secured basis by RadNet, Inc., and all of Radnet Management’s current and future domestic wholly owned restricted subsidiaries. The Senior Notes were issued under an indenture dated April 6, 2010 (the “Indenture”), by and among Radnet Management, Inc., as issuer, RadNet, Inc., as parent guarantor, the subsidiary guarantors thereof and U.S. Bank National Association, as trustee. We paid interest on the senior notes on April 1 and October 1 of each year, commencing October 1, 2010, and they were scheduled to expire on April 1, 2018. On April 24, 2014, we completed the retirement of our \$200 million in Senior Notes on April 24, 2014 and following such retirement the Company completed the satisfaction and discharge of the Indenture. As a result of the transaction, we recorded a loss on the early extinguishment of debt of \$15.9 million.

NOTE 9 – COMMITMENTS AND CONTINGENCIES

Leases – We lease various operating facilities and certain medical equipment under operating leases with renewal options expiring through 2041. Certain leases contain renewal options from two to ten years and escalation based either on the consumer price index or fixed rent escalators. Leases with fixed rent escalators are recorded on a straight-line basis. We record deferred rent for tenant leasehold improvement allowances received from certain lessors and amortize the deferred rent expense over the term of the lease agreement. Minimum annual payments under operating leases for future years ending December 31 are as follows (in thousands):

	Facilities	Equipment	Total
2017	\$58,368	\$ 8,337	\$66,705
2018	49,638	7,784	57,422
2019	43,192	5,695	48,887
2020	35,276	3,841	39,117
2021	28,062	1,999	30,061
Thereafter	56,008	1,332	57,340
	\$270,544	\$ 28,988	\$299,532

Total rent expense, including equipment rentals, for the years ended December 31, 2016, 2015 and 2014 was \$74.2 million, \$71.7 million and \$64.5 million, respectively.

Litigation – We are engaged from time to time in the defense of lawsuits arising out of the ordinary course and conduct of our business. We believe that the outcome of our current litigation will not have a material adverse impact on our business, financial condition and results of operations. However, we could be subsequently named as a defendant in other lawsuits that could adversely affect us.

NOTE 10 – DERIVATIVE INSTRUMENTS

We are exposed to certain risks relating to our ongoing business operations. The primary risk managed by us using derivative instruments is interest rate risk.

Our credit facilities are comprised of two tranches of term loans. On July 1, 2016, we issued \$485 million of the First Lien Term Loans. We also previously entered into a Second Lien Credit Agreement pursuant to which we issued \$180 million of Second Lien Term Loans. Proceeds from the First Lien Term Loans were used in part to make a \$12 million principal payment of the Second Lien Term Loans to reduce the outstanding balance due to \$168 million. Both tranches of term loans have a LIBOR floor of 1% which serves as an interest rate floor based on our three month LIBOR rate election. See Note 8, Notes Payable, Revolving Credit Facility and Capital Leases for more information.

In the fourth quarter of 2016, the Company entered into two forward interest rate cap agreements ("2016 Caps"). The 2016 Caps will mature in September and October 2020. The 2016 Caps had notional amounts of \$150,000,000 and \$350,000,000, respectively, which were designated at inception as cash flow hedges of future cash interest payments associated with portions of the Company's variable rate bank debt. Under these arrangements, the Company purchased a cap on 3 month LIBOR at 2.0%. The Company is liable for a \$5.3 million premium to enter into the caps which is being accrued over the life of the agreements.

At inception, we designated our interest rate cap agreements as cash flow hedges of floating-rate borrowings. In accordance with ASC Topic 815, derivatives that have been designated and qualify as cash flow hedging instruments are reported at fair value. The gain or loss on the effective portion of the hedge (i.e., change in fair value) is initially reported as a component of accumulated other comprehensive income in the consolidated statement of equity (deficit). The remaining gain or loss, if any, is recognized currently in earnings. As of December 31, 2016, the cash flow hedges were deemed to be effective. No amount is expected to be reclassified into earnings in the next twelve months.

Below represents as of December 31, 2016 the fair value of our interest rate caps and gain recognized:

The fair value of derivative instruments as of December 31, 2016 is as follows (amounts in thousands):

Derivatives	Balance Sheet Location	Fair Value – Asset Derivatives
Interest rate contracts	Current assets	\$818

A tabular presentation of the effect of derivative instruments on our statement of comprehensive income is as follows (amounts in thousands):

Effective Interest Rate Cap	Amount of Gain Recognized on Derivative	Location of Gain Recognized in Income on Derivative
Interest rate contracts	\$818	Other Comprehensive Income

NOTE 11 – INCOME TAXES

For the years ended December 31, 2016, 2015 and 2014, we recognized income tax expense comprised of the following (in thousands):

	2016	2015	2014
Federal current tax	\$88	\$237	\$–
State current tax	914	1,705	1,283
Other current tax	28	28	29
Federal deferred tax	2,539	3,625	869
State deferred tax	863	412	(214)
Income tax expense	\$4,432	\$6,007	\$1,967

A reconciliation of the statutory U.S. federal rate and effective rates is as follows:

	2016	2015	2014
Federal tax	34.00%	34.00%	34.00%
State franchise tax, net of federal benefit	1.80%	8.50%	-3.64%
Other Non deductible expenses	-0.09%	-0.01%	0.00%
Meals and entertainment	2.10%	1.75%	4.85%
Noncontrolling Interest in Partnerships	-2.11%	-2.16%	-2.88%
Equity compensation	-4.05%	-1.74%	-8.72%
Changes in valuation allowance	4.70%	-17.32%	24.52%
Return-to-provision	0.22%	3.29%	-9.57%
Deferred true-ups and other	-25.25%	13.41%	16.34%
Uncertain tax positions	22.44%	0.01%	-3.67%
Expiring net operating losses	1.88%	1.28%	2.62%
Income tax expense	35.64%	41.01%	53.85%

Deferred income taxes reflect the net tax effects of temporary differences between carrying amounts of assets and liabilities for financial and income tax reporting purposes and operating loss carryforwards.

Our deferred tax assets and liabilities comprise the following (in thousands):

	At December 31,	
	2016	2015
Deferred tax assets:		
Net operating losses	\$84,509	\$78,912
Accrued expenses	4,400	4,125
Straight-Line Rent Adjustment	10,750	11,263
Unfavorable contract liability	2,114	2,142
Equity compensation	950	846
Allowance for doubtful accounts	6,033	4,341
Other	1,357	1,092
Valuation Allowance	(4,428)	(3,841)
Total Deferred Tax Assets	\$105,685	\$98,880
Deferred tax liabilities:		
Property Plant & Equipment	(6,994)	(8,582)
Goodwill	(23,350)	(18,617)
Intangibles	(12,066)	(12,088)
Non accrual experience method reserve	(8,483)	(7,882)
Other	(4,436)	(4,747)
Total Deferred Tax Liabilities	\$(55,329)	\$(51,916)

Net Deferred Tax Asset	\$50,356	\$46,964
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As of December 31, 2016, the Company had federal net operating loss carryforwards of approximately \$ 231.6 million, which expire at various intervals from the years 2017 to 2036. The Company also had state net operating loss carryforwards of approximately \$ 160.5 million, which expire at various intervals from the years 2017 through 2036. As of December 31, 2016, \$ 23.5 million of our federal net operating loss carryforwards acquired in connection with the 2011 acquisition of Raven Holdings U.S., Inc. are subject to limitations related to their utilization under Section 382 of the Internal Revenue Code. Future ownership changes as determined under Section 382 of the Internal Revenue Code could further limit the utilization of net operating loss carryforwards.

We considered all evidence available when determining whether deferred tax assets are more likely-than-not to be realized, including projected future taxable income, scheduled reversals of deferred tax liabilities, prudent tax planning strategies, and recent financial operations. The evaluation of this evidence requires significant judgment about the forecasts of future taxable income, based on the plans and estimates we are using to manage the underlying businesses. In evaluating the objective evidence that historical results provide, we consider three years of cumulative operating income. As of December 31, 2016, we have determined that deferred tax assets of \$105.7 million are more likely-than-not to be realized. We have also determined that deferred tax liabilities of \$ 23.4 million are required related to book basis in goodwill that has an indefinite life.

For the next five years, and thereafter, federal net operating loss carryforwards expire as follows (in thousands):

Year Ended	Total Net Operating Loss Carryforwards	Amount Subject to 382 limitation
2017	1,501	1,501
2018	10,968	–
2019	7,178	–
2020	–	–
2021	24,257	–
Thereafter	187,725	40,632
	\$ 231,629	\$ 42,133

For the next five years, and thereafter, California net operating loss carryforwards expire as follows (in thousands):

Year Ended	Total Net Operating Loss Carryforwards
2017	4,520
2018	–
2019	–
2020	–
2021	–
Thereafter	17,773
	\$ 22,293

We file consolidated income tax returns in the U.S. federal jurisdiction and various states and foreign jurisdictions. We continue to reinvest earnings of the non-US entities for the foreseeable future and therefore have not recognized any U.S. tax expense on these earnings. With limited exceptions, we are no longer subject to U.S. federal, state and local, or non-U.S. income tax examinations by tax authorities for years before 2012. We do not anticipate the results of any open examinations would result in a material change to its financial position.

At December 31 2016, the Company has unrecognized tax benefits of \$3.9 million of which \$2.8 million will affect the effective tax rate if recognized.

A reconciliation of the total gross amounts of unrecognized tax benefits for the years ended as follows (in thousands):

	December 31,		
	2016	2015	2014
Balance at beginning of year	\$94	\$3,761	\$3,970
Increases (Decreases) related to prior year tax positions	3,861	(3,667)	(209)
Expiration of the statute of limitations for the assessment of taxes	(94)	–	–
Balance at end of year	\$3,861	\$94	\$3,761

The Company recognizes accrued interest and penalties related to unrecognized tax benefits in income tax expense. During the year ended December 31, 2016 the Company accrued an insignificant amount of interest expense. As of December 31, 2016, accrued interest and penalties were insignificant.

NOTE 12 – STOCK-BASED COMPENSATION

Stock Incentive Plans

Options

We have one long-term equity incentive plan which we refer to as the 2006 Equity Incentive Plan, which we amended and restated as of April 20, 2015 (the “Restated Plan”). The Restated Plan was approved by our stockholders at our annual stockholders meeting on June 11, 2015. As of December 31, 2016, we have reserved for issuance under the Restated Plan 12,000,000 shares of common stock. We can issue options, stock awards, stock appreciation rights and cash awards under the Restated Plan. Certain options granted under the Restated Plan to employees are intended to qualify as incentive stock options under existing tax regulations. Stock options generally vest over three to five years and expire five to ten years from the date of grant.

As of December 31, 2016, we had outstanding options to acquire 375,626 shares of our Common Stock, of which options to acquire 205,000 shares were exercisable. During the twelve months ended December 31, 2016, we granted options to acquire 170,626 shares under our Restated Plan.

The following summarizes all of our option transactions during the year ended December 31, 2016:

Outstanding Options Under the 2006 Plan	Shares	Weighted Average Exercise price Per Common Share	Weighted Remaining Contractual Life (in years)	Aggregate Intrinsic Value
Balance, December 31, 2015	931,667	\$4.69		
Granted	170,626	6.01		
Exercised	(576,667)	2.96		
Canceled, forfeited or expired	(150,000)	7.51		
	375,626	6.82	4.45	\$252,238

Balance, December 31, 2016				
Exercisable at December 31, 2016	205,000	7.51	0.92	176,400

Aggregate intrinsic value in the table above represents the total pretax intrinsic value (the difference between our closing stock price on December 31, 2016 and the exercise price, multiplied by the number of in-the-money options as applicable) that would have been received by the holder had all holders exercised their options on December 31, 2016. Total intrinsic value of options exercised during the years ended December 31, 2016 and 2015 was approximately \$1.7 million and \$6.2 million, respectively. As of December 31, 2016, total unrecognized stock-based compensation expense related to non-vested employee awards was \$438,998, which is expected to be recognized over a weighted average period of approximately 3.0 years.

Restricted Stock Awards (“RSA’s”)

The Restated Plan permits the award of restricted stock awards (“RSA’s”). As of December 31, 2016, we have issued a total of 4,264,011 RSA’s of which 573,145 were unvested at December 31, 2016.

The following summarizes all unvested RSA's activities during the year ended December 31, 2016:

	RSA's	Weighted-Average Remaining Contractual Term (Years)	Weighted-Average Fair Value
RSA's unvested at December 31, 2015	771,342		\$5.17
Changes during the period			
Granted	802,803		\$6.16
Vested	(1,000,999)		\$5.13
Forfeited	—		\$0.00
RSA's unvested at December 31, 2016	573,145	0.57	\$6.18

We determine the fair value of all RSA's based of the closing price of our common stock on award date.

Other stock bonus awards

The Restated Plan also permits the award of stock bonuses not subject to any future service period. These awards are valued and expensed based on the closing price of our common stock on the date of award. During the year ended December 31, 2016 we issued 35,000 shares relating to these awards

In sum, of the 12,000,000 shares of common stock reserved for issuance under the Restated Plan, at December 31, 2016, we had issued 12,168,387 total shares between options, RSA's and other stock awards. With options cancelled and RSA's forfeited amounting to 2,975,009 and 59,053 shares, respectively, there remain 2,865,675 shares available under the Restated Plan for future issuance.

NOTE 13 – EMPLOYEE BENEFIT PLAN

We adopted a profit-sharing/savings plan pursuant to Section 401(k) of the Internal Revenue Code that covers substantially all non-professional employees. Eligible employees may contribute on a tax-deferred basis a percentage of compensation, up to the maximum allowable under tax law. Employee contributions vest immediately. The plan does not require a matching contribution by us through December 31, 2016.

NOTE 14 – QUARTERLY RESULTS OF OPERATIONS (unaudited)

The following table sets forth a summary of our unaudited quarterly operating results for each of the last eight quarters in the years ended December 31, 2016 and 2015. This quarterly data has been derived from our unaudited consolidated interim financial statements which, in our opinion, have been prepared on substantially the same basis as the audited financial statements contained elsewhere in this report and include all normal recurring adjustments necessary for a fair presentation of the financial information for the periods presented. These unaudited quarterly results should be read in conjunction with our financial statements and notes thereto, included elsewhere in this report. The operating results in any quarter are not necessarily indicative of the results that may be expected for any future period (in thousands except per share data).

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	2016 Quarter Ended				2015 Quarter Ended			
	Mar 31	June 30	Sept 30	Dec 31	Mar 31	June 30	Sept 30	Dec 31
Statement of Operations Data:								
Net revenue	\$216,388	\$218,565	\$224,643	\$224,939	\$181,267	\$204,289	\$208,366	\$215,706
Total operating expenses	213,405	210,487	212,192	209,971	183,213	190,905	191,137	205,256
Total other expenses	7,875	5,717	11,578	10,641	6,723	10,836	5,731	10,109
Equity in earnings of joint ventures	(2,279)	(3,274)	(2,576)	(1,638)	(1,102)	(3,207)	(1,992)	(2,626)
Benefit from (provision for) income taxes	1,180	(2,253)	(1,458)	(1,901)	3,091	(2,192)	(5,199)	(1,707)
Net (loss) income	(1,433)	3,382	1,991	4,064	(4,476)	3,563	8,291	1,260
Net income (loss) attributable to noncontrolling interests	290	(243)	344	383	78	168	304	379
Net (loss) income attributable to Radnet, Inc. common stockholders	\$(1,723)	\$3,625	\$1,647	\$3,681	\$(4,554)	\$3,395	\$7,987	\$881
Basic net (loss) income attributable to Radnet, Inc. common stockholders (loss) earnings per share:	\$(0.04)	\$0.08	\$0.04	\$0.08	\$(0.11)	\$0.08	\$0.18	\$0.02
Diluted net (loss) income attributable to Radnet, Inc. common stockholders (loss) earnings per share:	\$(0.04)	\$0.08	\$0.04	\$0.08	\$(0.11)	\$0.08	\$0.18	\$0.02
Weighted average shares outstanding								
Basic	46,581	46,559	45,869	45,967	42,747	43,370	43,637	45,454
Diluted	46,581	46,882	46,334	46,389	42,747	44,686	44,752	46,545

NOTE 15 – RELATED PARTY TRANSACTIONS

We use World Wide Express, a package delivery company owned by our western operations chief operating officer, to provide delivery services for us. For the years ended December 31, 2016, 2015 and 2014, we paid approximately \$670,000, \$693,000 and \$833,000, respectively, to World Wide Express for those services. At December 31, 2016 and 2015, we had outstanding amounts due to World Wide Express of \$273,000 and \$161,000, respectively.

NOTE 16 – SUBSEQUENT EVENTS

On January 6, 2017, Image Medical Inc., a wholly owned subsidiary of RadNet, entered into a membership purchase agreement with ScriptSender, LLC, a partnership held by two individuals which provides secure data transmission services of medical information. Image Medical will contribute \$3.0 million for a 49% equity interest in the partnership. In a separate management agreement, Image Medical Inc. will provide management and accounting services to the operation in return for a set fee.

On January 13, 2017, we completed our acquisition of certain assets of Resolution Medical Imaging Corporation, consisting of two multi modality imaging center located in Santa Monica, CA for cash consideration of \$2.1 million, the assumption of approximately \$1.7 million in equipment debt, and payoff of a small business administration loan of \$241,000. The facilities provide MRI, CT, Ultrasound, and X-Ray services.

On February 1, 2017, we completed our acquisition of certain assets of MRI Centers, Inc., consisting of one single-modality imaging center located in Torrance, CA for cash consideration of \$718,000. The facility provides MRI and sports medicine services.

On February 2, 2017, we entered into a fourth amendment to our first lien credit agreement and senior secured revolving facility. Pursuant to the fourth amendment, the interest rate charged for the applicable margin on both facilities was reduced by 50 basis points, from 3.75% to 3.25%. The minimum LIBOR rate underlying the senior secured term loans remains at 1.0%. Except for such reduction in the interest rate on credit extensions, this amendment did not result in any other material modifications to the amended and restated credit agreement evidencing the first lien term loans and the senior secured revolving credit facility.

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

Under the supervision of our management, including our Chief Executive Officer and Chief Financial Officer, we conducted an evaluation of the effectiveness of the design and operation of our disclosure controls and procedures under Rules 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended, as of December 31, 2016. Based on this evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were not effective as of December 31, 2016 because deficiencies in the design and operating effectiveness of several information technology dependent manual controls and certain information technology general controls (“ITGC’s”) related to the revenue and accounts receivable process caused a material weakness in our internal control over financial reporting as described in more detail below.

Management's 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 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 U.S. generally accepted accounting principles (“GAAP”). Internal control over financial reporting includes 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 financial statements in accordance with GAAP, and that receipts and expenditures of the Company are transacted 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 financial statements.

Our management, under the supervision of our Chief Executive Officer and Chief Financial Officer, conducted an assessment of the effectiveness of its internal control over financial reporting as of December 31, 2016 based on the criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (“COSO”). Based on this assessment, management concluded that our

internal control over financial reporting was not effective as of December 31, 2016 because of the material weakness described below.

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 existing policies or procedures may deteriorate. A material weakness is defined as “a deficiency, or a combination of deficiencies in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the Company’s annual or interim financial statements will not be prevented or detected on a timely basis.”

Based upon this assessment, management concluded that, as of December 31, 2016, the following control deficiencies related to the Company’s revenue and accounts receivable process aggregate to a material weakness in the Company’s internal control over financial reporting:

Certain information technology dependent manual controls which are (i) designed to ensure the completeness of revenue transaction processing, and (ii) designed to ensure a reasonable valuation of the Company’s accounts receivable balance were not performed timely, accurately or reviewed with sufficient precision

Certain user access, program change and operations control components of ITGCs pertaining to multiple systems which capture and bill revenue transactions were not operating effectively

The ineffective design and operation of these information technology dependent manual controls and ITGCs impacts a material portion of our revenue transactions.

Ernst & Young LLP, the Company’s independent registered public accounting firm, has audited the Company’s internal control over financial reporting as of December 31, 2016, as stated in their report, which is included in this Annual Report on Form 10-K.

Remediation Plan for Material Weakness

Our management, with oversight of our Audit Committee, has been actively engaged in developing and executing a remediation plan to address the material weakness reported as of December 31, 2016. The remediation efforts which are ongoing include the following:

Ensure that all revenue-related IT dependent manual controls are performed on a timely basis with a sufficient level of precision.

Continue our plan to streamline the number of systems with enhanced quality and functionality utilized by the Company for the capture and billing of revenue transactions

Implement effective user access controls across all revenue related systems to ensure proper user access and timely removal of terminated users, and improve documentation surrounding program change and information technology operations controls.

If the remedial measures described above are insufficient to address the material weakness described above, or are not implemented timely, or additional deficiencies arise in the future, material misstatements in our interim or annual financial statements may occur in the future and could have the effects described in “Item 1A. Risk Factors” in Part I of this Form 10-K.

Changes in Internal Control over Financial Reporting

Except as described above, management did not identify any change in internal control over financial reporting occurring during the fourth quarter that materially affected, or was reasonably likely to materially affect, the Company’s internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

Board of Directors and Stockholders of RadNet, Inc.

We have audited RadNet, Inc. and subsidiaries' (the "Company's") internal control over financial reporting as of December 31, 2016, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). 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 Management's 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 conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). 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, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion. 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.

A material weakness is a deficiency, or combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the company's annual or interim financial statements will not be prevented or detected on a timely basis. The following material weakness has been identified and included in management's assessment. Management has identified a material weakness in the design and operating effectiveness of information technology general controls and certain information technology dependent manual controls related to the Company's revenue and accounts receivables process. We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of RadNet, Inc. and subsidiaries as of December 31, 2016 and 2015 and the related consolidated statements of operations, comprehensive income, equity (deficit), and cash flows for each of the three years in the period ended December 31, 2016. This material weakness was considered in determining the nature, timing and extent of audit tests applied in our audit of the 2016 financial statements, and this report does not affect our report dated March 16, 2017, which expressed an unqualified opinion on those financial statements.

In our opinion, because of the effect of the material weakness described above on the achievement of the objectives of the control criteria, RadNet, Inc. and subsidiaries has not maintained effective internal control over financial reporting as of December 31, 2016, based on the COSO criteria.

/s/ Ernst & Young LLP

Los Angeles, California

March 16, 2017

Item 9B. Other Information.

None

PART III

Item 10. Directors, Executive Officers and Corporate Governance

The information required by this Item 10 will be included under the captions “Election of Directors,” “Executive Officers,” “Board of Directors and Corporate Governance,” and “Section 16(a) Beneficial Ownership Reporting Compliance” in our definitive Proxy Statement for the 2016 Annual Meeting of Stockholders to be filed with the SEC within 120 days after the end of our fiscal year (the “Proxy Statement”) and is incorporated herein by reference.

We have adopted a code of financial ethics applicable to our directors, officers and employees which is designed to deter wrongdoing and to promote:

- honest and ethical conduct;
 - full, fair, accurate, timely and understandable disclosure in reports and documents that we file with the SEC and in our other public communications;
- compliance with applicable laws, rules and regulations, including insider trading compliance; and
- accountability for adherence to the code and prompt internal reporting of violations of the code, including illegal or unethical behavior regarding accounting or auditing practices.

You may obtain a copy of our Code of Financial Ethics on our website at www.radnet.com under Investor Relations — Corporate Governance. The Audit Committee is responsible for reviewing the Code of Financial Ethics and amending as necessary. Any amendments will be disclosed on our website.

Item 11. Executive Compensation

The information required by this Item 11 will be included under the captions “Compensation of Directors,” “Compensation of Executive Officers,” “Compensation Discussion and Analysis,” “Compensation Committee Interlocks and Insider Participation,” and “Compensation Committee Report” in the Proxy Statement and 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 12 will be included under the captions “Security Ownership of Certain Beneficial Owners and Management” and “Equity Compensation Plan Information” in the Proxy Statement and is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The information required by this Item 13 will be included under the captions “Certain Relationships and Related Party Transactions” and “Board of Directors and Corporate Governance” in the Proxy Statement and is incorporated herein by reference.

Item 14. Principal Accountant Fees and Services

The information required by this Item 14 will be included under the caption “Independent Registered Public Accounting Firm Fees” in the Proxy Statement and is incorporated herein by reference.

PART IV**Item 15. Exhibits and Financial Statements
Schedule****(a) Documents filed as part of this annual report on Form 10-K****(1) Financial Statements Page No.**The following financial statements are included in this report

<u>Report of Independent Registered Public Accounting Firm</u>	51
<u>Consolidated Balance Sheets</u>	52
<u>Consolidated Statements of Operations</u>	53
<u>Consolidated Statements of Comprehensive Income</u>	54
<u>Consolidated Statements of Equity (Deficit)</u>	55
<u>Consolidated Statements of Cash Flows</u>	56
<u>Notes to Consolidated Financial Statements</u>	58 to 81

(2) Financial Statement Schedules

The following financial statement schedules are filed herewith:

SCHEDULE II – VALUATION AND QUALIFYING ACCOUNTS**RADNET, INC. AND SUBSIDIARIES**

Balance at Beginning of Year	Additional Charges Against Income	Deductions from Reserve	Balance at End of Year
\$ 20,794	\$ 45,387	\$ (45,507)	\$ 20,674

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Year Ended December 31, 2016

Accounts Receivable-Allowance for Bad Debts

Year Ended December 31, 2015

Accounts Receivable-Allowance for Bad Debts	\$ 15,109	\$ 36,033	\$ (30,348)	\$ 20,794
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Year Ended December 31, 2014

Accounts Receivable-Allowance for Bad Debts	\$ 12,735	\$ 29,807	\$ (27,433)	\$ 15,109
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All other schedules are omitted because they are not applicable or the required information is shown in the consolidated financial statements or notes thereto.

The following exhibits are filed herewith or incorporated by reference herein:

Exhibit No.	Description of Exhibit
2.1	Asset Purchase Agreement dated October 1, 2015 by and among Mid Rockland Imaging Partners, Inc., a Delaware corporation and a subsidiary of the registrant, Diagnostic Imaging Group LLC, a Delaware limited liability company, Diagnostic Imaging Group Holdings, LLC,, a Delaware limited liability company, New Primecare LLC, a Delaware limited liability company, and Flushing Medical Arts Building, Inc. (incorporated by reference to exhibit filed with Form 8-K on October 20, 2015).
3.1	Certificate of Incorporation of RadNet, Inc., a Delaware corporation (incorporated by reference to exhibit filed with Form 8-K on September 4, 2008).
3.2	Certificate of Amendment to Certificate of Incorporation of RadNet, Inc., a Delaware corporation, dated September 2, 2008 (incorporated by reference to exhibit filed with Form 8-K on September 4, 2008).
3.3	Bylaws of RadNet, Inc., a Delaware corporation (incorporated by reference to exhibit filed with Form 8-K on September 4, 2008).
10.1	Credit and Guaranty Agreement, dated October 10, 2012, by and among Radnet Management, Inc., RadNet, Inc., the guarantors thereunder, General Electric Capital Corporation, Deutsche Bank Securities, Inc., RBC Capital Markets and Barclays Bank PLC (incorporated

by reference to exhibit filed with Form 8-K on October 12, 2012).

10.2 Pledge and Security Agreement, dated October 10, 2012, by and among Radnet Management, Inc., RadNet, Inc., the guarantors thereunder, and Barclays Bank PLC (incorporated by reference to exhibit filed with Form 8-K on October 12, 2012).

10.3 Form of Trademark Security Agreement by and among the guarantors thereunder and Barclays Bank PLC (filed as an exhibit to the Pledge and Security Agreement, dated October 10, 2012, by among the guarantors thereunder and Barclays Bank PLC, included as Exhibit 10.2).

10.4 First Amendment Agreement dated April 3, 2013 to the Credit and Guaranty Agreement dated October 10, 2012, by and among RadNet Management, Inc., RadNet, Inc., certain subsidiaries and affiliates of RadNet Management, Inc., certain lenders identified therein and Barclays Bank PLC, as administrative agent and collateral agent. (incorporated by reference to Exhibit 99.1 filed with Form 8-K on April 4, 2013).

10.5 Second Amendment Agreement dated March 25, 2014 to the Credit and Guaranty Agreement, dated as of October 10, 2012 (as amended, by the First Amendment Agreement, dated as of April 3, 2013), by and among RadNet, Inc., Radnet Management, Inc., certain subsidiaries and affiliates of Radnet Management, Inc., certain lenders identified therein, and Barclays Bank PLC, as administrative agent and collateral agent. (incorporated by reference to Exhibit 99.1 filed with Form 8-K on March 31, 2014).

10.6

Second Lien Credit and Guaranty Agreement, dated as of March 25, 2014, by and among Radnet Management, Inc., RadNet, Inc., certain subsidiaries and affiliates of Radnet Management, Inc., the lenders party thereto from time to time, certain other financial institutions and Barclays Bank PLC, as administrative agent and collateral agent. (incorporated by reference to Exhibit 99.2 filed with Form 8-K on March 31, 2014).

10.7

Second Lien Pledge and Security Agreement, dated as of March 25, 2014, by and among Radnet Management, Inc., the Grantors identified therein, and Barclays Bank PLC, as collateral agent. (incorporated by reference to Exhibit 99.3 filed with Form 8-K on March 31, 2014).

10.8

Joinder Agreement, dated as of April 30, 2015, among Barclays Bank Plc, Radnet Management, Inc., a California corporation, Radnet Inc., a Delaware corporation, and certain affiliates and subsidiaries of Radnet Management Inc. (incorporated by reference to exhibit filed with Form 8-K on May 1, 2015).

10.9

Amendment No. 3 to Credit and Guaranty Agreement, dated as of July 1, 2016 by and among Radnet Management, Inc., Radnet, Inc. certain subsidiaries and affiliates of Radnet Management, Inc., the lenders party thereto from time to time, certain other financial institutions and Barclays Bank PLC, as administrative agent and collateral agent. (incorporated by reference to filed with Form 8-K/A on December 2, 2016).

- 10.10 Amendment No. 4 to Credit and Guaranty Agreement, dated as of February 2, 2017 by and among Radnet Management, Inc., Radnet, Inc. certain subsidiaries and affiliates of Radnet Management, Inc., the lenders party thereto from time to time, certain other financial institutions and Barclays Bank PLC, as administrative agent and collateral agent. (incorporated by reference to filed with Form 8-K on February 2, 2017).
- 10.11 RadNet, Inc. 2006 Equity Incentive Plan (Amended and Restated as of April 20, 2015) (incorporated by reference to exhibit filed with Proxy Statement on April 30, 2015).*
- 10.12 Form of Stock Option Agreement for the 2006 Equity Incentive Plan (incorporated by reference to exhibit filed with Form S-8 registration statement on August 12, 2015).*
- 10.13 Form of Restricted Stock Award for the 2006 Equity Incentive Plan (incorporated by reference to exhibit filed with Form 10-Q for the quarter ended March 31, 2012).*
- 10.14 Form of Indemnification Agreement between the registrant and each of its officers and directors (incorporated by reference to exhibit filed with Form 10-Q for the quarter ended March 31, 2008).*
- 10.15 Employment Agreement dated as of June 12, 1992 with Howard G. Berger, M.D. (incorporated by reference to exhibit filed with an amendment to Form 8-K report for June 12, 1992).*
- 10.16 Amendment to Employment Agreement dated January 30, 2004 with Howard G. Berger, M.D. (incorporated by reference to exhibit filed with Form 10-Q for the quarter ended January 31, 2004).*
- 10.17 Second Amendment to Employment Agreement dated November 16, 2015 with Howard G. Berger, M.D. (incorporated by reference to exhibit filed with Form 10-K on March 15, 2016).
- 10.18 Employment Agreement dated as of April 16, 2001 with Jeffrey L. Linden (incorporated by reference to exhibit filed with Form 10-K for the year ended October 31, 2001).*
- 10.19 Amendment to Employment Agreement dated January 30, 2004 with Jeffrey L. Linden (incorporated by reference to exhibit filed with Form 10-Q for the quarter ended January 31, 2004).*
- 10.20 Second Amendment to Employment Agreement dated November 16, 2015 with Jeffrey L. Linden. (incorporated by reference to exhibit filed with Form 10-K on March 15, 2016).
- 10.21 Employment Agreement dated as of May 1, 2001 with Norman R. Hames (incorporated by reference to exhibit filed with Form 10-K for the year ended October 31, 2001).*
- 10.22 Amendment to Employment Agreement dated January 30, 2004 with Norman R. Hames (incorporated by reference to exhibit filed with Form 10-Q for the quarter ended January 31, 2004).*
- 10.23 Second Amendment to Employment Agreement dated November 16, 2015 with Norman R. Hames. (incorporated by reference to exhibit filed with Form 10-K on March 15, 2016).
- 10.24 Employment Agreement with Mark Stolper effective January 1, 2009 (incorporated by reference to exhibit filed with Form 10-K for the year ended December 31, 2009).*
- 10.25

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First Amendment to Employment Agreement dated November 16, 2015 with Mark Stolper. (incorporated by reference to exhibit filed with Form 10-K on March 15, 2016).*

10.26 Retention Agreement with Stephen Forthuber dated November 15, 2006 (incorporated by reference to exhibit filed with Form 10-K/T for the year ended December 31, 2006).*

10.27 First Amendment to Retention Agreement dated November 16, 2015 with Stephen Forthuber. (incorporated by reference to exhibit filed with Form 10-K on March 15, 2016).*

10.28 Amended and Restated Management and Service Agreement between Radnet Management, Inc. and Beverly Radiology Medical Group III dated January 1, 2004 (incorporated by reference to exhibit filed with Form 10-K for the year ended October 31, 2003).

12.1 Computation of Ratios of Earnings to Fixed Charges.

21.1 List of Subsidiaries.

23.1 Consent of Registered Independent Public Accounting Firm.

24.1 Power of Attorney (included on signature page attached hereto).

31.1 CEO Certification pursuant to Section 302.

31.2 CFO Certification pursuant to Section 302.

32.1 CEO Certification pursuant to Section 906.

32.2 CFO Certification pursuant to Section 906.

101.INS XBRL Instance Document

101.SCH XBRL Schema Document

101.CAL XBRL Calculation Linkbase Document

101.LAB XBRL Label Linkbase Document

101.PRE XBRL Presentation Linkbase Document

101.DEF XBRL Definition Linkbase Document

* Indicates management contract or compensatory plan.

Certain schedules to this exhibit have been omitted in accordance with Regulation S-K Item 601(b)(2). The company agrees to furnish supplementally a copy of all omitted schedules to the SEC upon its request.

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.

RADNET, INC.

Date: March 16, 2017 /s/ HOWARD G. BERGER, M.D .
**Howard G. Berger, M.D., President,
Chief Executive Officer and Director**

POWER OF ATTORNEY

KNOW ALL PERSONS BY THESE PRESENTS, that each person whose signature appears below hereby severally constitutes and appoints Howard G. Berger, M.D. and Mark D. Stolper, and each of them, his true and lawful attorney-in-fact and agent, with full power of substitution and re-substitution for him and in his name, place and stead, in any and all capacities to sign any and all amendments to this report, and to file the same, with all exhibits thereto, and other documents in connection therewith, with the SEC, granting unto said attorney-in-fact and agents, and each of them, full power and authority to do and perform each and every act and thing requisite or necessary fully to all intents and purposes as he might or could do in person, hereby ratifying and confirming all that each 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 registrant in the capacities and on the dates indicated.

By/s/ HOWARD G. BERGER, M.D.
**Howard G. Berger, M.D., Director,
Chief Executive Officer and
President**

Date: March 16, 2017

By/s/ MARVIN S. CADWELL
Marvin S. Cadwell, Director

Date: March 16, 2017

By/s/ JOHN V. CRUES, III, M.D.
John V. Crues, III, M.D., Director

Date: March 16, 2017

By/s/ NORMAN R. HAMES
Norman R. Hames, Director

Date: March 16, 2017

By/s/ DAVID L. SWARTZ
David L. Swartz, Director

Date: March 16, 2017

By/s/ LAWRENCE L. LEVITT
Lawrence L. Levitt, Director

Date: March 16, 2017

By/s/ MICHAEL L. SHERMAN, M.D.
Michael L. Sherman, M.D., Director

Date: March 16, 2017

By/s/ MARK D. STOLPER
**Mark D. Stolper, Chief Financial
Officer** (Principal Accounting Officer)

Date: March 16, 2017