Apollo Medical Holdings, Inc.
Form 10-K
May 08, 2014

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

(Mark One)

x ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(D) OF THE SECURITIES

EXCHANGE ACT OF 1934

For the fiscal year ended January 31, 2014

o TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(D) OF THE SECURITIES

EXCHANGE ACT

For the transition period from _____ to _____

Commission File No.

000-25809

Apollo Medical Holdings, Inc.

(Exact name of registrant as specified in its charter)

Delaware **20-8046599**
State of Incorporation IRS Employer Identification No.

700 North Brand Blvd., Suite 220

Glendale, California 91203

(Address of principal executive offices)

(818) 396-8050

(Issuer's telephone number)

Securities Registered Pursuant to Section 12(b) of the Act:

Title of each Class	Name of each Exchange on which Registered
	None

Securities Registered Pursuant to Section 12(g) of the Act:

Common Stock, $.001 Par Value

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act

Yes ¨ No x

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act.

Yes ¨ Nox

Check whether the issuer (1) filed all reports required to be filed by Section 13 or 15(d) of the Exchange Act during the past 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.

Yes x No¨

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate website, if any, every interactive data file required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that registrant was required to submit and post such files).

Yes x No¨

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (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. (Check one):

Large accelerated filer ¨ Accelerated filer ¨ Non-accelerated filer ¨ Smaller reporting company x

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Yes ¨ Nox

The aggregate market value of the shares of voting common stock held by non-affiliates of the Registrant computed by reference to the price at which the common stock was last sold on OTCQB on July 31, 2013, the last business day of the Registrant's most recently completed second fiscal quarter, was $8,073,400. Solely for purposes of the foregoing calculation, all of the registrant's directors and officers as of July 31, 2013 are deemed to be affiliates. This determination of affiliate status for this purpose does not reflect a determination that any persons are affiliates for any other purpose.

As of April 30, 2014, there were 49,134,549 shares of common stock, $.001 par value per share, issued and outstanding.

APOLLO MEDICAL HOLDINGS, INC.

FORM 10-K

FOR THE YEAR ENDED JANUARY 31, 2014

TABLE OF CONTENTS

PART I

Introductory Comment

Unless the context dictates otherwise, references in this Annual Report on Form 10-K (the "Report") to the "Company," "we," "us," "our", "Apollo" and similar words are to Apollo Medical Holdings, Inc., and its wholly owned subsidiaries and affiliated medical groups:

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

Disclosure Regarding Forward-Looking Statements - Cautionary Statement

We caution readers that this Report contains "forward-looking statements". Forward-looking statements, written, oral or otherwise, are based on the Company's current expectations or beliefs rather than historical facts concerning future events, and they are indicated by words or phrases such as, but not limited to "anticipate,""could,""may,""might,""potential,""predict,""should,""estimate,""expect,""project,""believe,""think,""intend,""p or "will" and similar words or phrases or comparable terminology. Forward-looking statements involve risks and uncertainties. The Company cautions that these statements are further qualified by important economic, competitive, governmental and technological factors that could cause the Company's business, strategy, or actual results or events to differ materially, or otherwise, from those in the forward-looking statements. We have based such forward-looking statements on our current expectations, assumptions, estimates and projections, and therefore there can be no assurance that any forward-looking statement contained herein, or otherwise made by the Company, will prove to be accurate. The Company assumes no obligation to update the forward-looking statements.

The Company has a relatively limited operating history compared to others in the same business and is operating in a rapidly changing industry environment; as a result its ability to predict results or the actual effect of future plans or strategies, based on historical results or trends or otherwise, is inherently uncertain. While we believe that these forward-looking statements are reasonable, they are merely predictions or illustrations of potential outcomes, and they involve known and unknown risks and uncertainties, many beyond our control, that are likely to cause actual results, performance, or achievements to be materially different from those expressed or implied by such forward-looking statements. Factors that could have a material adverse effect on the operations and future prospects of the Company on a condensed basis include those factors discussed under Item 1A "Risk Factors" and Item 7, "Management's Discussion and Analysis or Plan of Operation" in this Report, and include, but are not limited to, the following:

¨Our ability to raise capital when needed and on acceptable terms and conditions;

¨The effect of laws and regulations that apply to our operations and industry;

¨The intensity of competition; and

¨General economic conditions.

All written and oral forward-looking statements made in connection with this Report that are attributable to us or persons acting on our behalf are expressly qualified in their entirety by these cautionary statements. Given the uncertainties that surround such statements, you are cautioned not to place undue reliance on such forward-looking statements.

ITEM 1. DESCRIPTION OF BUSINESS

Business Overview

Apollo Medical Holdings, Inc. and its managed affiliated physician groups ("ApolloMed", "we", "our" or the "Company") are a physician centric, integrated healthcare delivery system serving Medicare, Commercial and Medi-Cal beneficiaries in California. ApolloMed's businesses operate primarily under risk and value-based contracts with health plans, Independent Physician Associations ("IPAs"), Hospitals and the Centers for Medicare and Medicaid Services' ("CMS") Medicare Shared Savings Program. We believe each major constituent of the healthcare delivery system, including patients, families, primary care physicians, specialists, acute care hospitals, alternative sites of inpatient care, physician groups and health plans can benefit from better coordinated care. We are positioned to assist and provide "Best in Class" care coordination services to each of these constituents and assist in finding solutions to many of the challenges associated with patient care in the inpatient and outpatient settings.

The predecessor business to ApolloMed was incorporated in California on November 14, 2006 beginning operations at Glendale Memorial Hospital as a hospital based physician group, and through a reverse merger became a publicly held company in 2008. The Company was organized around the admission and care of patients at inpatient facilities such as a hospital. We have successfully grown our inpatient strategy in a competitive market by providing high quality care for our patients and innovative solutions for our hospital and managed care clients by focusing on improving the inefficiencies associated with inpatient care and reducing readmissions and improving outcomes through better care coordination. Currently, we provide inpatient services at over 28 hospitals and long-term acute care facilities in Los Angeles and Central California where we have contracted with over 50 Hospitals, IPAs and health plans to provide a range of inpatient services including hospitalist, intensivist, physician advisor and consulting services.

In 2012, the Company formed an Accountable Care Organization ("ACO"), ApolloMed Accountable Care Organization, Inc. ("ApolloMed ACO"), to participate in CMS' Medicare Shared Savings Program. The ACO program is designed to work together with payors by aligning provider incentives. This alignment of provider incentives is intended to improve quality and medical outcomes for patients across the ACO and achieve cost savings for Medicare. We believe ApolloMed ACO is unique in that it leverages our best in class inpatient and outpatient capabilities. In 2013 ApolloMed formed Maverick Medical Group, Inc. a risk-bearing entity that participates in the Medicare Advantage, HMO-Medicaid and dual eligible markets.

As of April 30, 2014, ApolloMed has developed a network of over 700 hospitalists, primary care physicians and specialist physicians through our owned and affiliated physician groups.

Our Strategic Objectives

- Patient satisfaction
- Quality care
- Cost efficiency

Our Strategy

The principal components of our strategy are to:

· Engage the patients we serve to help them make better decisions about their healthcare, clinically and economically

· Employ our medical management and care coordination capabilities to improve the health and well-being of the patients we serve through improved outcomes and reduced inefficiencies in the healthcare delivery chain

· Work in collaboration at the local level with physicians and other healthcare providers to help them participate in a changing healthcare landscape and provide them the knowledge and IT tools to achieve measurably better quality and lower costs

· Grow our inpatient business through expansion of services and geographic expansion

· Expand our relationships with healthcare providers and facilities across the US to develop additional capabilities to participate in the growing Medicare, Medicaid and dual eligible markets

· Acquire and develop additional capabilities to participate in the growing healthcare market, especially the Medicare and dual eligible segments, under both risk-bearing and value-based contracts

Opportunities in Healthcare

Inpatient Opportunity

We believe that attractive growth opportunities exist for our hospitalists' inpatient business due to the increasing need for improved efficiencies in the hospital from both payors and hospital management teams. Our physicians work closely with our partners to improve the care given to patients and their families and enhance how care is coordinated within the hospital and upon discharge of the patient. We have designed programs for some of the largest health plans and hospital chains in California to improve outcomes, reduce overutilization, reduce Medi-Cal denial rates, optimize lengths of stay (LOS), optimize senior and commercial bed-days, improve HCAHPS scores, improve hospital core measures, improve documentation and reduce 30-day readmissions. In addition, our physicians consult with the hospital management teams to assist in Medi-Cal denial reviews, case management and improving discharge management.

Accountable Care Organizations

In March 2010, President Barrack Obama signed into law The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010, which we collectively refer to as the Affordable Care Act. The Affordable Care Act established Accountable Care Organizations as a tool to improve quality and lower costs through increased care coordination in the Medicare Fee-for-Service program, which covers approximately 75% of Medicare recipients, approximately 36 million eligible Medicare beneficiaries. The program allows certain providers and suppliers (including hospitals, physicians and other designated professionals) to voluntarily form ACOs and work together along with other ACO participants to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. CMS established the Medicare Shared Savings Program (MSSP) to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an ACO. ACOs receive payment from Medicare on a fee-for-service basis and may receive additional "shared savings" payments or be at-risk for "shared losses" based on an increase or decrease in annual fee-for-service payments to the ACO.

The Shared Savings Program will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care. Under the final Medicare Shared Savings Program, or MSSP rules, Medicare will continue to pay individual providers and suppliers for specific items and services as it currently does under the FFS payment methodologies. The Shared Savings Program rules require CMS to develop a benchmark for savings to be achieved by each ACO if the ACO is to receive shared savings or for ACOs that have elected to accept responsibility for losses. An ACO that meets the program's quality performance standards will be eligible to receive a share of the savings to the extent its assigned beneficiary medical expenditures are below its own medical expenditure benchmark provided by CMS.

We have partnered with primary care physicians and specialists to form ApolloMed ACO, a majority owned subsidiary of ApolloMed, which has been approved by CMS for participation in the Medicare Shared Savings Program. We estimate that our ACO currently includes approximately 700 participating providers in California. We aim to provide enhanced care coordination, population health management, data analytics and reporting, information technology and other administrative capabilities to enable participating providers to deliver better care, improved health and lower healthcare costs for their Medicare fee-for-service beneficiaries.

Senior Market Opportunity—Medicare Advantage

Medicare Advantage is an alternative to the traditional FFS Medicare program, which permits Medicare beneficiaries to receive benefits from a managed care health plan. Medicare Advantage plans contract with CMS to provide benefits at least comparable to those offered under the traditional FFS Medicare program in exchange for a fixed monthly premium payment per member from CMS. The monthly premium varies based on the county in which the member resides, as adjusted to reflect the plan members' demographics and the members' risk scores.

Individuals who elect to participate in the Medicare Advantage program typically receive greater benefits than traditional FFS Medicare Part B beneficiaries, including additional preventive services, vision, dental and prescription drug benefits, and typically have lower deductibles and co-payments than traditional FFS Medicare.

We believe that significant growth opportunities exist for patient-focused, physician-centric integrated groups in serving the growing senior market. At present, approximately 51 million Americans are eligible for Medicare, the federal program that offers basic hospital and medical insurance to people over 65 years old and some disabled people under the age of 65. According to the U.S. Census Bureau, more than 2 million Americans turn 65 in the United States each year, and this number is expected to grow as the so-called baby boomers continue to turn 65. In addition, many large employers that traditionally provided medical and prescription drug coverage to their retirees have begun to curtail these benefits. Finally, the passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, known as the MMA, increased the healthcare options available to Medicare beneficiaries through the expansion of Medicare managed care plans through the Medicare Advantage program. In 2013 we formed Maverick Medical Group, Inc. an independent physician association and risk-bearing entity that participates in the Medicare Advantage, HMO-Medicaid and dual -eligible markets.

Medicaid Program and Dual Eligibles

Established in 1965, Medicaid is the largest publicly funded program in the United States, and provides health insurance to low-income families and individuals with disabilities. Authorized by Title XIX of the Social Security Act, Medicaid is an entitlement program funded jointly by the federal and state governments and administered by the states. The majority of funding is provided at the federal level. Each state establishes its own eligibility standards, benefit packages, payment rates and program administration within federal standards. Eligibility is based on a combination of household income and assets, often determined by an income level relative to the federal poverty level. Historically, children have represented the largest eligibility group.

Due to the Medicaid expansion provisions under the Affordable Care Act, CMS projects that Medicaid expenditures will increase from approximately $450 billion in 2012 to approximately $900 billion by 2020. In addition, as part of the Affordable Care Act, approximately 20 million additional people are expected to qualify for Medicaid beginning in 2014.

A portion of Medicaid beneficiaries are “dual- eligibles”, comprised of low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. Based on CMS and Kaiser Family Foundation data, we estimate there are approximately 9 million dual eligible enrollees with annual spending of approximately $320 billion. Only a small portion of the total spending on dual- eligibles is administered by managed care organizations across the US. Dual- eligibles tend to consume more healthcare services due to their tendency to have more chronic health issues. We believe this represents a significant opportunity for companies like ours that have the capabilities to effectively manage this sicker population.

Competition

The healthcare industry is highly competitive. We compete for customers with many other healthcare providers, including local physicians and practice groups as well as local, regional and national networks of physicians and healthcare companies.

In-patient Business

The market for hospitalists within this industry is highly fragmented. The Company faces competition from numerous small inpatient practices as well as large physician groups. Some of our competitors operate on a national level, such as Emcare, Team Health, IPC The Hospitalist Company, DaVita Health Care Partners and may have greater financial and other resources available to them. In addition, because the market for hospitalist services is highly fragmented and the ability of individual physicians to provide services in any hospital where they have certain credentials and privileges, competition for growth in existing and expanding markets is not limited to our largest competitors.

Accountable Care Organizations

We believe that competition for customers is generally based upon the reputation of the physician treating the customer, the physician's expertise, the physician's demeanor and manner of engagement with the customer. We also compete with hospitals, sophisticated provider groups, payors, and management service organizations in the creation, administration, and management of ACOs.

Healthcare Reform

The Affordable Care Act enacted significant changes to various aspects of the U.S. health insurance industry. There are many important provisions of the legislation that will require additional guidance and clarification in form of regulations and interpretations in order to fully understand the impact of the legislation on our overall business, which we expect to occur over the next several years.

Certain significant provisions of the Affordable Care Act that will impact our business include, among others, establishment of ACO's, reduced Medicare Advantage reimbursement rates, implementation of quality bonus for Star Ratings, stipulated minimum medical loss ratios, non-deductible federal premium taxes assessed to health insurers and coding intensity adjustments with mandatory minimums. The health care reform legislation is discussed more fully in the "Risk Factors" section of this report.

In June 2012, the United States Supreme Court upheld the constitutionality of the Affordable Care Act, with one limited exception relating to its Medicaid expansion provision. The Supreme Court held that States could not be required to expand Medicaid or risk the loss of federal funding for existing Medicaid programs. Beginning in January 2014, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level, subject to the States' elections. The federal government will pay the entire costs for Medicaid coverage for newly eligible beneficiaries for three years, from 2014 through 2016. The federal share declines to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and subsequent years.

Geographic Coverage

As of January 31, 2014, through our managed physician practices, we provide hospitalist services at 28 acute-care hospitals and long-term acute care facilities in Los Angeles and the Central Valley of California, and operate four primary care medical clinics in the Los Angeles area. Maverick Medical Group, Inc. (“MMG”) an independent physician association, provides primary and specialist care through its physician members located in the greater Los Angeles area.

Professional Liability and Other Insurance Coverage

Our business has an inherent risk of claims of medical malpractice against our affiliated physicians and us. We and our independent physician contractors pay premiums for third-party professional liability insurance that indemnifies us and our affiliated hospitalists on a claims-made basis for losses incurred related to medical malpractice litigation.

Professional liability coverage is required in order for our affiliated hospitalists to maintain hospital privileges. All of our physicians carry first dollar coverage with limits of coverage with limits of liability equal to $1,000,000 for all claims based on occurrence up to an aggregate of $3,000,000 per year.

We believe that our insurance coverage is appropriate based upon our claims experience and the nature and risks of our business. In addition to the known incidents that have resulted in the assertion of claims, we cannot be certain that our insurance coverage will be adequate to cover liabilities arising out of claims asserted against us, our affiliated professional organizations or our affiliated hospitalists in the future where the outcomes of such claims are unfavorable. We believe that the ultimate resolution of all pending claims, including liabilities in excess of our insurance coverage, will not have a material adverse effect on our financial position, results of operations or cash flows; however, there can be no assurance that future claims will not have such a material adverse effect on our business.

We also maintain worker’s compensation, director and officer, and other third-party insurance coverage subject to deductibles and other restrictions in accordance with industry standards. We believe that our insurance coverage is appropriate based upon our claims experience and the nature and risks of our business. However, we cannot assure that any pending or future claim will not be successful or if successful will not exceed the limits of available insurance coverage.

Regulatory Matters

Significant Federal and State Healthcare Laws Governing Our Business

As a healthcare company, our operations and relationships with healthcare providers such as hospitals, other healthcare facilities, and healthcare professionals are subject to extensive and increasing regulation by numerous federal, state, and local government entities. These laws and regulations often are interpreted broadly and enforced aggressively by multiple government agencies, including the U.S. Department of Health and Human Services Office of the Inspector General, or the ("OIG"), the U.S. Department of Justice, Centers for Medicare and Medicaid (“CMS”), and various state authorities. We have included brief descriptions of some, but not all, of the laws and regulations that affect our business.

Imposition of sanctions associated with a violation of any of these healthcare laws and regulations could have a material adverse effect on our business, financial condition and results of operations. The Company cannot guarantee that its arrangements or business practices will not be subject to government scrutiny or be found to violate certain healthcare laws. Government investigations and prosecutions, even if we are ultimately found to be without fault, can be costly and disruptive to our business. Moreover, changes in healthcare legislation or government regulation may restrict our existing operations, limit the expansion of our business or impose additional compliance requirements and costs, any of which could have a material adverse effect on our business, financial condition and results of operations.

False Claims Acts

The federal False Claims Act imposes civil liability on individuals or entities that submit false or fraudulent claims for payment to the federal government. The False Claims Act provides, in part, that the federal government may bring a lawsuit against any person whom it believes has knowingly or recklessly presented, or caused to be presented, a false or fraudulent request for payment from the federal government, or who has made a false statement or used a false record to get a claim for payment approved. Private parties may initiate *qui tam* whistleblower lawsuits against any person or entity under the False Claims Act in the name of the government and may share in the proceeds of a successful suit.

The federal government has used the False Claims Act to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare and state healthcare programs. By way of illustration, these prosecutions may be based upon alleged coding errors, billing for services not rendered, billing services at a higher payment rate than appropriate, and billing for care that is not considered medically necessary. The government and a number of courts also have taken the position that claims presented in violation of certain other statutes, including the federal Anti-Kickback Statute or the Stark Law, can be considered a violation of the False Claims Act based on the theory

that a provider impliedly certifies compliance with all applicable laws, regulations, and other rules when submitting claims for reimbursement.

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

A number of states have enacted false claims acts that are similar to the federal False Claims Act. Even more states are expected to do so in the future because Section 6031 of the Deficit Reduction Act of 2005 ("DRA"), amended the federal law to encourage these types of changes, along with a corresponding increase in state initiated false claims enforcement efforts. Under the DRA, if a state enacts a false claims act that is at least as stringent as the federal statute and that also meets certain other requirements, the state will be eligible to receive a greater share of any monetary recovery obtained pursuant to certain actions brought under the state’s false claims act. The OIG, in consultation with the Attorney General of the United States, is responsible for determining if a state’s false claims act complies with the statutory requirements. Currently, 19 states, including California have some form of state false claims act.

Anti-Kickback Statutes

The federal Anti-Kickback Statute is a provision of the Social Security Act that prohibits as a felony offense the knowing and willful offer, payment, solicitation or receipt of any form of remuneration in return for, or to induce, (1) the referral of a patient for items or services for which payment may be made in whole or part under Medicare, Medicaid or other federal healthcare programs, (2) the furnishing or arranging for the furnishing of items or services reimbursable under Medicare, Medicaid or other federal healthcare programs or (3) the purchase, lease, or order or arranging or recommending the purchasing, leasing or ordering of any item or service reimbursable under Medicare, Medicaid or other federal healthcare programs. The Affordable Care Act amended section 1128B of the Social Security Act to make it clear that a person need not have actual knowledge of the statute, or specific intent to violate the statute, as a predicate for a violation. The OIG, which has the authority to impose administrative sanctions for violation of the statute, has adopted as its standard for review a judicial interpretation which concludes that the statute prohibits any arrangement where even one purpose of the remuneration is to induce or reward referrals. A violation of the Anti-Kickback Statute is a felony punishable by imprisonment, criminal fines of up to $25,000, civil fines of up to $50,000 per violation and three times the amount of the unlawful remuneration. A violation also can result in exclusion from Medicare, Medicaid or other federal healthcare programs. In addition, pursuant to the changes of The Affordable Care Act, a claim that includes items or services resulting from a violation of the Anti-Kickback Statute is a false claim for purposes of the False Claims Act.

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

Some states have enacted statutes and regulations similar to the Anti-Kickback Statute, but which may be applicable regardless of the payer source for the patient. These state laws may contain exceptions and safe harbors that are different from and/or more limited than those of the federal law and that may vary from state to state. Although we have established policies and procedures to ensure that our arrangements with physicians comply with current laws and applicable regulations, we cannot assure you that regulatory authorities that enforce these laws will not determine that some of these arrangements violate the Anti-Kickback Statute or other applicable laws. An adverse determination could subject us to liabilities under the Social Security Act, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal health care programs, any of which could have a material adverse effect on our business, financial condition or results of operations.

Federal Stark Law

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

The penalties for violating the Stark Law can include the denial of payment for services ordered in violation of the statute, mandatory refunds of any sums paid for such services and civil penalties of up to $15,000 for each violation, double damages, and possible exclusion from future participation in the governmental healthcare programs. A person who engages in a scheme to circumvent the Stark Law’s prohibitions may be fined up to $100,000 for each applicable arrangement or scheme.

Some states have enacted statutes and regulations similar to the Stark Law, but which may be applicable to the referral of patients regardless of their payer source and which may apply to different types of services. These state laws may contain statutory and regulatory exceptions that are different from those of the federal law and that may vary from state to state.

Because the Stark Law and its implementing regulations continue to evolve, we do not always have the benefit of significant regulatory or judicial interpretation of this law and its regulations. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and we cannot be certain that every relationship complies fully with the Stark Law. In addition, in the July 2008 final Stark rule, CMS indicated that it will continue to enact further regulations tightening aspects of the Stark Law that it perceives allow for Medicare program abuse, especially those regulations that still permit physicians to profit from their referrals of ancillary services. There can be no assurance that the arrangements entered into by us with physicians and facilities will be found to be in compliance with the Stark Law, as it ultimately may be implemented or interpreted.

Health Information Privacy and Security Standards

Among other directives, the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), required the Department of Health and Human Services, or the HHS, to adopt standards to protect the privacy and security of certain health-related information. The HIPAA privacy regulations contain detailed requirements concerning the use and disclosure of individually identifiable health information by “HIPAA covered entities,” which include entities like the Company, our affiliated hospitalists, and practice groups.

In addition to the privacy requirements, HIPAA covered entities must implement certain administrative, physical, and technical security standards to protect the integrity, confidentiality and availability of certain electronic health information received, maintained, or transmitted. HIPAA also implemented the use of standard transaction code sets and standard identifiers that covered entities must use when submitting or receiving certain electronic healthcare transactions, including activities associated with the billing and collection of healthcare claims.

The American Recovery and Reinvestment Act enacted on February 18, 2009, included the Health Information Technology for Economic and Clinical Health Act (HITECH) which modified the HIPAA legislation significantly. Pursuant to HITECH, certain provisions of the HIPAA privacy and security regulations become directly applicable to “HIPAA business associates”.

Violations of the HIPAA privacy and security standards may result in civil and criminal penalties. Historically, these included: (1) civil money penalties of $100 per incident, to a maximum of $25,000, per person, per year, per standard

violated and (2) depending upon the nature of the violation, fines of up to $250,000 and imprisonment for up to ten years. The passage of HITECH significantly modified the enforcement structure, creating a tiered system of civil money penalties that range from $100 to $50,000 per violation, with a cap of $1.5 million per year for identical violations. We must also comply with the “breach notification” regulations, which implement certain provisions of HITECH. Under these regulations, in addition to reasonable remediation, covered entities must promptly notify affected individuals in the case of a breach of “unsecured PHI,” which is defined by HHS guidance, as well as the HHS Secretary and the media in cases where a breach affects more than 500 individuals. Breaches affecting fewer than 500 individuals must be reported to the HHS Secretary on an annual basis. The regulations also require business associates of covered entities to notify the covered entity of breaches at or by the business associate. Formal enforcement of the new breach notification regulations began on February 22, 2010.

We expect increased federal and state HIPAA privacy and security enforcement efforts. Under HITECH, State Attorney Generals now have the right to prosecute HIPAA violations committed against residents of their states. In addition, HITECH mandates that the Secretary of HHS conduct periodic compliance audits of HIPAA covered entities and business associates. It also tasks HHS with establishing a methodology whereby harmed individuals who were the victims of breaches of unsecured PHI may receive a percentage of the Civil Monetary Penalty fine or monetary settlement paid by the violator. This methodology for compensation to harmed individuals is required to be in place by February 17, 2012.

Many states also have laws that protect the privacy and security of confidential, personal information. These laws may be similar to or even more stringent than the federal provisions. Not only may some of these state laws impose fines and penalties upon violators, but some may afford private rights of action to individuals who believe their personal information has been misused.

Financial Information and Privacy Standards

In addition to privacy and security laws focused on health care data, multiple other federal and state laws regulate the use and disclosure of consumer's financial information ("Personal Information"). Many of these laws also require administrative, technical, and physical safeguards to prevent unauthorized use or disclosure of Personal Information, including mandated processes and timeframes for notification of possible or actual breaches of Personal Information to the affected individual. The Federal Trade Commission primarily oversees compliance with the federal laws relevant to us, while state laws are addressed by the state attorney general or other respective state agencies. As with HIPAA, enforcement of laws protecting financial information is increasing. Examples of relevant federal laws include the Fair Credit Reporting Act, the Electronic Communications Privacy Act, and the Computer Fraud and Abuse Act.

Fee-Splitting and Corporate Practice of Medicine

Some states, including California, have laws that prohibit business entities, such as our Company and its subsidiaries, from practicing medicine, employing physicians to practice medicine, exercising control over medical decisions by physicians, also known collectively as the corporate practice of medicine, or engaging in certain arrangements, such as fee-splitting, with physicians. In these states, a violation of the corporate practice of medicine prohibition constitutes the unlawful practice of medicine, which is a public offense punishable by fines and other criminal penalties. In addition, any physician who participates in a scheme that violates the state's corporate practice of medicine prohibition may be punished for aiding and abetting a lay entity in the unlawful practice of medicine. The Company operates by maintaining long-term management contracts with affiliated professional organizations, which are each owned and operated by physicians and which employ or contract with additional physicians to provide hospitalist services. Under these arrangements, we perform only non-medical administrative services, do not represent that we offer medical services, and do not exercise influence or control over the practice of medicine by the physicians or the affiliated professional organizations. The California Medical Board, as well as other state regulatory bodies, have taken the position that certain physician practice management agreements that confer too much control over a physician practice violate the prohibition against corporate practice of medicine.

The Company operates by maintaining long-term management contracts with affiliated professional organizations, which are each owned and operated by physicians and which employ or contract with additional physicians to provide hospitalist services. Under these arrangements, we perform only non-medical administrative services, do not represent that we offer medical services, and do not exercise influence or control over the practice of medicine by the physicians or the affiliated professional organizations.

For financial reporting purposes, however, we consolidate the revenues and expenses of all our practice groups that we own or manage because we have a controlling financial interest in these practices based on applicable accounting rules and as described in our accompanying consolidated financial statements. In states where fee-splitting is prohibited between physicians and non-physicians, the fees that we receive through our management contracts have been established on a basis that we believe complies with the applicable state laws.

Some of the relevant laws, regulations, and agency interpretations in the State of California and other states that have corporate practice prohibitions have been subject to limited judicial and regulatory interpretation. Moreover, state laws are subject to change and regulatory authorities and other parties, including our affiliated physicians, may assert that, despite these arrangements, we are engaged in the prohibited corporate practice of medicine or that our arrangements constitute unlawful fee-splitting. If this occurred, we could be subject to civil or criminal penalties, our contracts could be found legally invalid and unenforceable (in whole or in part), or we could be required to restructure our contractual arrangements. If we were required to restructure our operating structures due to determination that a corporate practice of medicine violation existed, such a restructuring might include revisions of our management services agreements, which might include a modification of the management fee, and/ or establishing an alternative structure.

Deficit Reduction Act of 2005

Among other mandates, the Deficit Reduction Act of 2005, or the DRA, created a new Medicaid Integrity Program designed to enhance federal and state efforts to detect Medicaid fraud, waste and abuse. Additionally, section 6032 of the DRA requires entities that make or receive annual Medicaid payments of $5.0 million or more from any one state to provide their employees, contractors and agents with written policies and employee handbook materials on federal and state False Claims Acts and related statues. At this time, we are not required to comply with section 6032 because we receive less than $5.0 million in Medicaid payments annually from any one state. However, we may likely be required to comply in the future as our Medicaid billings increase.

Other Federal Healthcare Compliance Laws

We are also subject to other federal healthcare laws.

In 1995, Congress amended the federal criminal statutes set forth in Title 18 of the United States Code by defining additional federal crimes that could have an impact on our business, including “Health Care Fraud” and “False Statements Relating to Health Care Matters.” The Health Care Fraud provision prohibits any person from knowingly and willfully executing, or attempting to execute, a scheme to defraud any healthcare benefit program. As defined in this provision of Title 18, a “healthcare benefit program” can be either a government or private payer plan. violation of this statute may be charged as a felony offense and may result in fines, imprisonment or both. The Affordable Care Act amended section 1347 of Title 18 to provide that a person may be convicted under the Health Care Fraud provision even in the absence of proof that the person had actual knowledge of, or specific intent to violate, the statute.

The False Statements Relating to Health Care Matters provision prohibits, in any matter involving a federal health care program, anyone from knowingly and willfully falsifying, concealing or covering up, by any trick, scheme or device, a material fact, or making any materially false, fictitious or fraudulent statement or representation, or making or using any materially false writing or document knowing that it contains a materially false or fraudulent statement. A violation of this statute may be charged as a felony offense and may result in fines, imprisonment or both.

Under the Civil Monetary Penalties law of the Social Security Act, a person, including any individual or organization, may be subject to civil monetary penalties, treble damages and exclusion from participation in federal health care programs for certain specified conduct. One provision of the Civil Monetary Penalties law precludes any person (including an organization) from knowingly presenting or causing to be presented to any United States officer, employee, agent, or department, or any state agency, a claim for payment for medical or other items or services that the person knows or should know (a) were not provided as described in the coding of the claim, (b) is a false or

fraudulent claim, (c) is for a service furnished by an unlicensed physician, (d) is for medical or other items or service furnished by a person or an entity that is in a period of exclusion from the program or (e) are medically unnecessary items or services. Violations of the law may result in penalties of up to $10,000 per claim, treble damages, and exclusion from federal healthcare programs. In addition, the OIG may impose civil monetary penalties against any physician who knowingly accepts payment from a hospital (as well as against the hospital making the payment) as an inducement to reduce or limit services provided to Medicare or Medicaid program beneficiaries.

Other State Healthcare Compliance Provisions

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

Knox-Keene Act and Other State Insurance Laws

Some of the medical groups and IPAs that have entered into management services agreements with us, have historically contracted with health plans and other payors to receive a per member per month ("PMPM") or percentage of premium ("POP") capitation payment for professional (physician) services and assumed the financial responsibility for professional services. In many of these cases, the health plans or other payors separately enter into contracts with hospitals that directly receive payment (either a capitation or fee-for-service payment) and assume some type of contractual financial responsibility for their institutional (hospital) services. In some instances, the Company's managed medical groups and IPAs have been paid by their contracting payor for the financial outcome of managing the care dollars associated with both the professional and institutional services received by the medical groups' and IPAs' members. In the case of institutional services, the medical groups and IPAs have recognized a percentage of the surplus of institutional revenues less institutional expense as the medical groups' and IPAs' net revenues and has also been responsible for some percentage of any short-fall in the event that institutional expenses exceed institutional revenues. Notwithstanding, neither the Company nor any of its managed medical groups or IPAs are contractually obligated to pay claims to any hospitals or other institutions under these arrangements. The California Department of Managed Health Care ("DMHC") licenses and regulates health care service plans pursuant to the Knox-Keene Act. We do not hold a limited Knox-Keene license. If DMHC were to determine that we have been inappropriately taking risk for institutional and professional services as a result of our various hospital and physician arrangements without having a limited Knox-Keene license, we may be required to obtain a limited Knox-Keene license to resolve such violations and we could be subject to civil and criminal liability, any of which could have a material adverse effect on our business, financial condition or results of operations.

Fair Debt Collection Practices Act

Some of our operations may be subject to compliance with certain provisions of the Fair Debt Collection Practices Act and comparable state statutes. Under the Fair Debt Collection Practices Act, a third-party collection company is restricted in the methods it uses to contact consumer debtors and elicit payments with respect to placed accounts. Requirements under state collection agency statutes vary, with most requiring compliance similar to that required under the Fair Debt Collection Practices Act.

U.S. Sentencing Guidelines

The U.S. Sentencing Guidelines are used by federal judges in determining sentences in federal criminal cases. The guidelines are advisory, not mandatory. With respect to corporations, the guidelines state that having an effective ethics and compliance program may be a relevant mitigating factor in determining sentencing. To comply with the guidelines, the compliance program must be reasonably designed, implemented, and enforced such that it is generally effective in preventing and detecting criminal conduct. The guidelines also state that a corporation should take certain steps such as periodic monitoring and appropriately responding to detected criminal conduct. We have yet to develop

a formal ethics and compliance program.

Licensing, Certification, Accreditation and Related Laws and Guidelines

Our clinical personnel are subject to numerous federal, state and local licensing laws and regulations, relating to, among other things, professional credentialing and professional ethics. Since the Company performs services at hospitals and other types of healthcare facilities, it may indirectly be subject to laws applicable to those entities as well as ethical guidelines and operating standards of professional trade associations and private accreditation commissions, such as the American Medical Association and The Joint Commission. There are penalties for non-compliance with these laws and standards, including loss of professional license, civil or criminal fines and penalties, loss of hospital admitting privileges, and exclusion from participation in various governmental and other third-party healthcare programs. Our ability to operate profitably will depend, in part, upon our ability and the ability of our affiliated physician organizations to obtain and maintain all necessary licenses and other approvals and operate in compliance with applicable health care laws and regulations, including any new laws and regulations or new interpretations of existing laws and regulations.

Professional Licensing Requirements

The Company's affiliated hospitalists must satisfy and maintain their professional licensing in the states where they practice medicine. Activities that qualify as professional misconduct under state law may subject them to sanctions, or to even lose their license and could, possibly, subject us to sanctions as well. Some state boards of medicine impose reciprocal discipline, that is, if a physician is disciplined for having committed professional misconduct in one state where he or she is licensed, another state where he or she is also licensed may impose the same discipline even though the conduct occurred in another state. Professional licensing sanctions may also result in exclusion from participation in governmental healthcare programs, such as Medicare and Medicaid, as well as other third-party programs. . Our ability to operate profitably will depend, in part, upon our ability and the ability of our affiliated physician organizations to obtain and maintain all necessary licenses and other approvals and operate in compliance with applicable health care laws and regulations, including any new laws and regulations or new interpretations of existing laws and regulations.

Employees

As of January 31, 2014, we had 30 full-time employees. None of our full-time employees is a member of a labor union, and we have never experienced a work stoppage.

ITEM 1A. RISK FACTORS

If any of the following risks occur, our business, financial condition or results of operations could be materially harmed. The risks and uncertainties described below are not the only ones facing the Company. Additional risks and uncertainties may also impair its business operations or financial condition. You should consider carefully the following factors, in addition to the other information concerning the Company and its business, before you decide to buy or hold shares of our common stock.

Risk Relating to Our Business

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

The Company has historically incurred significant losses, and we may require additional equity or debt financing for additional working capital or to meet our liabilities. In the event of additional financing being unavailable to us, we may be unable to operate or continue in existence, and the price of our common stock may decline and we may be or be made bankrupt.

The Company has a limited operating history that makes it difficult to reliably predict future growth and operating results.

The predecessor to ApolloMed was incorporated on October 18, 2006, and served initially as the management company for our affiliated medical group, ApolloMed Hospitalists. In addition, ApolloMed was awarded its ACO license under CMS' MSSP in June 2012. ApolloMed has limited experience operating an ACO or managed care organization. Accordingly, we have a limited operating history upon which you can evaluate our business prospects, which makes it difficult to forecast ApolloMed's future operating results. The evolving nature of the current medical services industry increases these uncertainties. You must consider the Company's business prospects in light of the risks, uncertainties and problems frequently encountered by companies with limited operating histories. Our ability to predict growth at any time in the future may be limited.

The growth strategy of the Company may not prove viable and expected growth and value may not be realized.

Our business strategy is to rapidly grow by managing a network of medical groups providing certain hospital-based services and integrated inpatient and outpatient physician network. Where permitted by local law, we may also acquire such medical groups. Identifying quality acquisition candidates is a time-consuming and costly process. There can be no assurance that we will be successful in identifying and establishing relationships with these and other candidates. If the Company is successful in identifying and acquiring other businesses, there is no assurance that it will be able to manage the growth of such businesses effectively.

The success of the Company's growth strategy depends on the successful identification, completion and integration of acquisitions.

The Company's future success will depend on the ability to identify, complete, and integrate the acquired businesses with its existing operations. The growth strategy will result in additional demands on our infrastructure, and will place further strain on limited management, administrative, operational, financial and technical resources. Acquisitions involve numerous risks, including, but not limited to:

- the possibility that we will not able to identify suitable acquisition candidates or consummate acquisitions on acceptable terms, if at all;

- possible decreases in capital resources or dilution to existing stockholders;

13

- difficulties and expenses incurred in connection with an acquisition;
- the diversion of management's attention from other business concerns;
- the difficulties of managing an acquired business;
- the potential loss of key employees and customers of an acquired business; and
- in the event that the operations of an acquired business do not meet expectations, we may be required to restructure the acquired entity or write-off the value of some or all of the assets of the acquisition.

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

Our success depends to a significant extent on the continued contributions of our key management personnel, including our Chief Executive Officer, Warren Hosseinion, M.D., for the management of our business and implementation of our business strategy. We have entered into employment agreements with Dr. Hosseinion and we hold a $5 million key man life insurance policy. The loss of Dr. Hosseinion or other key management personnel could have a material adverse effect on our business, financial condition and results of operations.

The healthcare industry is complex and intensely regulated at the federal, state, and local levels and government authorities may determine that we have failed to comply with applicable laws or regulations.

As a company involved in the provision of healthcare services, we are subject to a myriad of federal, state, and local laws and regulations. There are significant costs involved in complying with these laws and regulations. Moreover, if we are found to have violated any applicable laws or regulations, we could be subject to civil and/or criminal damages, fines, sanctions, or penalties, including exclusion from participation in governmental healthcare programs, such as Medicare and Medicaid. We may also be required to change our method of operations. These consequences could be the result of current conduct or even conduct that occurred a number of years ago. We also could incur significant costs merely if we become the subject of an additional investigation or legal proceeding alleging a violation of these laws and regulations. We cannot predict whether a federal, state, or local government will determine that we are not operating in accordance with law, or whether the laws will change in the future and impact our business. Any of these actions could have a material adverse effect on our business, financial condition and results of operations.

The following is a non-exhaustive list of some of the more significant healthcare laws and regulations that affect us:

- federal laws, including the federal False Claims Act, that provide for penalties against entities and individuals which knowingly or recklessly make claims to Medicare, Medicaid, and other governmental healthcare programs, as well as third-party payors, that contain or are based upon false or fraudulent information;

- a provision of the Social Security Act, commonly referred to as the "Anti-Kickback Statute," that prohibits the knowing and willful offering, payment, solicitation or receipt of any bribe, kickback, rebate or other remuneration, in cash or in kind, in return for the referral or recommendation of patients for items and services covered, in or in part, by federal healthcare programs such as Medicare and Medicaid;

- a provision of the Social Security Act, commonly referred to as the Stark Law or physician self-referral law, that (subject to limited exceptions) prohibits physicians from referring Medicare patients to an

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

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

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

- state law provisions pertaining to anti-kickback, self-referral and false claims issues, which typically are not limited to relationships involving governmental payors;

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

- provisions of HIPAA and HITECH limiting how covered entities, business associates and business associate sub-contractors may use and disclose PHI and the security measures that must be taken in connection with protecting that information and related systems, as well as similar or more stringent state laws;

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

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

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

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

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

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

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

ApolloMed's operations are dependent on a few payors and hospital contracts

For the year ended January 31, 2014 the Company had three payors, including hospital contracts, that represented approximately 48% of consolidated revenues, The Company expects that, going forward, substantially all of its revenue will continue to be derived from these and other payors. Each payor may immediately terminate any of our contracts and/or any individual credentialed physician upon the occurrence of certain events. They may also amend the material terms of the contracts under certain circumstances. Failure to maintain the contracts on favorable terms, for any reason, would materially and adversely affect our results of operations and financial condition. A material decline in the number of members could also have a material adverse effect on our results of operations.

Risk-sharing arrangements that Maverick Medical Group, Inc. has with health plans and hospitals could result in their costs exceeding the corresponding revenues, which could reduce or eliminate any shared risk profitability

MMG's agreements with health plans contain risk-sharing arrangements under which MMG can earn additional compensation from the health plans by coordinating the provision of quality, cost-effective healthcare to members. However, such arrangements may require the physician group to assume a portion of any loss sustained from these arrangements, thereby worsening our consolidated results of operations. Under these risk-sharing arrangements, MMG is responsible for a portion of the cost of hospital services or other services that are not capitated. The terms of the particular risk-sharing arrangement allocate responsibility to the respective parties when the cost of services exceeds the related revenue, which results in a deficit, or permit the parties to share in any surplus amounts when actual costs are less than the related revenue. The amount of non-capitated medical and hospital costs in any period could be affected by factors beyond the control of MMG, such as changes in treatment protocols, new technologies, longer lengths of stay by the patient, and inflation. To the extent that such non-capitated medical and hospital costs are higher than anticipated, revenue may not be sufficient to cover the risk-sharing deficits the health plans and MMG are responsible for, which could reduce our revenues and profitability.

Providers in the healthcare industry are the subject of federal and state investigations, as well as payor audits.

Due to our participation in government and private healthcare programs, we are sometimes involved in inquiries, reviews, audits and investigations by governmental agencies and private payors of our business practices, including assessments of our compliance with coding, billing and documentation requirements. Federal and state government agencies have active civil and criminal enforcement efforts that include investigations of healthcare companies, and their executives and managers. Under certain circumstances, these investigations can also be initiated by private individuals under whistleblower provisions which may be incentivized by the possibility for private recoveries. The DRA revised federal law to further encourage these federal, state and individually-initiated investigations against healthcare companies.

Responding to these audit and enforcement activities can be costly and disruptive to our business operations, even when the allegations are without merit. If we are subject to an audit or investigation and a finding is made that we were incorrectly reimbursed, we may be required to repay these agencies or private payors, or we may be subjected to pre-payment reviews, which can be time-consuming and result in non-payment or delayed payment for the services we provide. We also may be subject to other financial sanctions or be required to modify our operations.

We do not have a limited Knox-Keene License.

We do not hold a limited Knox-Keene license. If DMHC were to determine that we have been inappropriately taking risk for institutional and professional services as a result of our various hospital and physician arrangements without having a limited Knox-Keene license, we may be required to obtain a limited Knox-Keene license to resolve such violations and we could be subject to civil and criminal liability, any of which could have a material adverse effect on our business, financial condition or results of operations.

Our revenue may be negatively impacted by the failure of our affiliated hospitalists to appropriately document services they provide.

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

Economic conditions or changing consumer preferences could adversely impact our business.

A downturn in economic conditions in one or more of the Company's markets could have a material adverse effect on its results of operations, financial condition, business and prospects. Although we attempt to stay informed of customer preferences, any sustained failure to identify and respond to trends could have a material adverse effect on our results of operations, financial condition, business and prospects.

We may be unable to scale our operations successfully.

Our growth strategy will place significant demands on our management and financial, administrative and other resources. Operating results will depend substantially on the ability of our officers and key employees to manage changing business conditions and to implement and improve our financial, administrative and other resources. If the Company is unable to respond to and manage changing business conditions, or the scale of its operations, then the quality of its services, its ability to retain key personnel, and its business could be harmed.

The Company's success depends upon the ability to adapt to a changing market and continued development of additional services.

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

Changes associated with reimbursement by third-party payers for the Company's services may adversely affect operating results and financial condition.

The medical services industry is undergoing significant changes with third-party payers that are taking measures to reduce reimbursement rates or in some cases, denying reimbursement altogether. There is no assurance that third-party payers will continue to pay for the services provided by our affiliated medical groups. Failure of third party payers to adequately cover the medical services so provided by the Company will have a material adverse effect on our results of operations, financial condition, business and prospects.

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

We must comply with numerous federal and state laws and regulations governing the collection, dissemination, access, use, security and confidentiality of patient health information ("PHI"), including HIPAA and HITECH. As part of our medical record keeping, third-party billing, and other services, we collect and maintain PHI in paper and electronic format. Therefore, new privacy or security laws, whether implemented pursuant to federal or state action, could have a significant effect on the manner in which we handle healthcare-related data and communicate with payors. In addition, compliance with these standards could impose significant costs on us or limit our ability to offer services, thereby negatively impacting the business opportunities available to us. Despite our efforts to prevent security and privacy breaches, they may still occur. If any non-compliance with existing or new laws and regulations related to PHI results in privacy or security breaches, we could be subject to monetary fines, civil suits, civil penalties or even criminal sanctions.

As a result of the expanded scope of HIPAA through HITECH, we may incur significant costs in order to minimize the amount of "unsecured PHI" we handle and retain or to implement improved administrative, technical or physical safeguards to protect PHI. We may incur significant costs in order to demonstrate and document whether there is a low probability that the PHI has been compromised in order to overcome the presumption that an impermissible use or disclosure of PHI results in a reportable breach. We may incur significant costs to notify the relevant individuals, government entities, and, in some cases, the media in the event of a breach and to provide appropriate remediation and monitoring to mitigate the possible damage done by any such breach.

Providers must be properly enrolled in governmental healthcare programs, such as Medicare and Medicaid, before they can receive reimbursement for providing services, and there may be delays in the enrollment process.

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

We may face malpractice and other lawsuits that may not be covered by insurance.

Malpractice lawsuits are common in the healthcare industry. The medical malpractice legal environment varies greatly by state. The status of tort reform, availability of non-economic damages or the presence or absence of other statutes, such as elder abuse or vulnerable adult statutes, influence the incidence and severity of malpractice litigation. We may also be subject to other types of lawsuits which may involve large claims and significant defense costs. Many states have joint and several liability for all healthcare providers who deliver care to a patient and are at least partially liable. As a result, if one healthcare provider is found liable for medical malpractice for the provision of care to a particular patient, all other healthcare providers who furnished care to that same patient, including possibly our affiliated hospitalists, may also share in the full liability which may be substantial.

We currently maintain liability insurance coverage to cover professional liability and other claims. We cannot be certain that our insurance coverage will be adequate to cover liabilities arising out of claims asserted against us, our affiliated professional organizations or our affiliated hospitalists, and we cannot provide assurance that any future liabilities will not have a material adverse impact on our results of operations, cash flows or financial position. Liabilities in excess of our insurance coverage, including coverage for professional liability and other claims, could have a material adverse effect on our business, financial condition, and results of operations. In addition, our professional liability insurance coverage generally must be renewed annually and may not continue to be available to us in future years at acceptable costs and on favorable terms.

We have established reserves for potential medical malpractice liability losses which are subject to inherent uncertainties and a deficiency in the established reserves may lead to a reduction in our net income.

Our professional liability insurance policy is written on a claims-made basis providing first dollar coverage up to our policy limits on new claims reported in the policy period. We record estimates for our liabilities, on an undiscounted basis, for claims incurred and reported and claims incurred but not reported during the policy period, based on actuarial loss projections using historical loss patterns. These insurance reserves are inherently subject to uncertainty as they could be significantly affected if current and future occurrences differ from historical claim trends and expectations. While claims are monitored closely when estimating reserves, the complexity of the claims and wide range of potential outcomes often hampers timely adjustments to the assumptions used in these estimates. The unpredictable nature of the reporting of claims could result in significant fluctuations in the loss estimate from period to period. It is possible that actual losses and related expenses may differ, perhaps substantially, from the reserve estimates reflected in our financial statements. If subsequent actual paid claims exceed our estimated reserves, we may be required to increase reserves, which would lead to a reduction in our future net income.

Competition for hospitalists is intense, and we may not be able to hire and retain hospitalists to provide services.

We are dependent on our affiliated hospitalists to provide services and generate revenue. We compete with many types of healthcare providers, including teaching, research and government institutions, hospitals and other practice groups, for the services of clinicians. The limited number of residents entering the job market each year and the limited number of other licensed providers seeking to change employers makes it challenging to meet our hiring needs and may require us to contract locum tenens physicians or to increase hospitalist compensation in a manner that decreases our profit margins. The limited number of residents and other licensed providers also impacts our ability to recruit new hospitalists with the expertise necessary to provide services within our business and our ability to renew contracts with existing hospitalists on acceptable terms. If we do not do so, our ability to provide services could be adversely affected. Our hospitalist turnover rate has remained stable over the last three years. If the turnover rate were to increase significantly, our growth could be impeded.

We may not make appropriate acquisitions, may fail to integrate them into our business, and/or these acquisitions may alter our current payor mix.

Our business is partially dependent on locating and acquiring or partnering with medical practices or individual physicians to provide hospitalist services. As part of our acquisition strategy, we regularly review potential acquisition opportunities. We believe that there continue to be a number of acquisition opportunities that would be complementary to our business. We cannot predict whether we will be successful in pursuing such acquisition opportunities or what the consequences of any such acquisitions would be. If we are not successful in finding attractive acquisition candidates that we can acquire on satisfactory terms, or if we cannot successfully complete and efficiently integrate those acquisitions that we identify, we will not be able to realize the benefit of this part of our growth strategy. Furthermore, our acquisition strategy involves a number of risks and uncertainties, including:

- We may not be able to identify suitable acquisition candidates or strategic opportunities or successfully implement or realize the expected benefits of any suitable opportunities. In addition, we compete for acquisitions with other potential acquirers, some of which may have greater financial or operational resources than we do. This competition may intensify due to the ongoing consolidation in the healthcare industry, which may increase our acquisition costs.

- We may be unable to successfully and efficiently integrate completed acquisitions, including our recently completed acquisitions and such acquisitions may fail to achieve the financial results we expected. Integrating completed acquisitions into our existing operations involves numerous short-term and long-term risks, including diversion of our management’s attention, failure to retain key personnel, failure to retain payor contracts and failure of the acquired practice to be financially successful.

- We cannot be certain of the extent of any unknown or contingent liabilities of any acquired business, including liabilities for failure to comply with applicable laws. We may incur material liabilities for past activities of acquired businesses. Also, depending on the location of the acquisition, we may be required to comply with laws and regulations that may differ from those of the states in which our operations are currently conducted.

- We may acquire individual or group medical practices that operate with lower profit margins as compared with our current or expected profit margins or which have a different payor mix than our other practice groups, which would reduce our profit margins. Depending upon the nature of the local healthcare market, we may not be able to implement our business model, which may negatively impact our revenues and profitability.

- If we finance acquisitions by issuing equity securities or securities convertible into equity securities, our existing stockholders could be diluted, which, in turn, could adversely affect the market price of our stock. If we finance an acquisition with debt, it could result in higher leverage and interest costs. As a result, if we fail to evaluate and execute acquisitions properly, we might not achieve the anticipated benefits of these acquisitions, and we may increase our acquisition costs.

Changes in the rates or methods of third-party reimbursements may adversely affect our operations.

We derive the majority of our revenue from direct billings to governmental healthcare programs, such as Medicare and Medicaid, and private health insurance companies. As a result, any negative changes in the rates or methods of reimbursement for the services we provide would have a significant adverse impact on our revenue and financial results. Government funding for healthcare programs, in particular, is subject to unpredictable statutory and regulatory changes, administrative rulings, interpretations of policy and determinations by intermediaries, and governmental funding restrictions, all of which could materially impact program coverage and reimbursements for our services.

The Medicare program reimburses for our services based upon the rates set forth in the annually updated Medicare Physician Fee Schedule, which relies, in part, on the SGR. Many private payors use the Medicare Physician Fee Schedule to determine their own reimbursement rates. Based on the SGR, the annual Medicare Physician Fee Schedule update is adjusted to reflect the comparison of actual expenditures to target expenditures. Because one of the factors for calculating the SGR is linked to the growth in the U.S. GDP, the SGR formula may result in a negative payment update if growth in Medicare beneficiaries' use of services exceeds GDP growth, a situation which has occurred every year since 2002 and the reoccurrence of which we cannot predict. Congress has repeatedly intervened to delay the implementation of the negative SGR payment update. With the enactment of the Bipartisan Budget Act of 2013 on December 26, 2013, the 20.1 percent cut that was to occur was replaced with a 0.5 percent increase for services provided through March 31, 2014. However, there is no guarantee that Congress will continue to postpone implementation of the negative SGR payment in the future.

Moreover, the existing methodology may result in significant yearly fluctuations in the Medicare Physician Fee Schedule amounts, which may be unrelated to changes in the actual costs of providing physician services. Unless Congress enacts a permanent change in the SGR methodology, the uncertainty regarding reimbursement rates and fluctuation will continue to exist.

Another provision that affects physician payments is an adjustment under the Medicare statute to reflect the geographic variation in the cost of delivering physician services, by comparing those costs to the national average. This concerns the "work" component of the GPCI. If Congress does not block this adjustment, payments would be decreased to any geographic area with an index of less than 1.0. President Obama signed the "Protecting Access to Medicare Act of 2014" (Public Law No. 113.93) into law on April 1, 2014. Notable provisions included the Medicare Work Geographic Practice Cost Index (GPCI) Floor (§102). This provision provides a one-year extension of the Medicare GPCI floor through March 31, 2015, increasing physician reimbursement rates in primarily rural areas. However, there is no guarantee that Congress will block the adjustment in the future, which could result in a decrease in payments we receive for physician services.

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 BCA established a Joint Select Committee on Deficit Reduction, which was tasked with achieving a reduction in the federal debt level of at least $1.2 trillion. That Committee did not draft a proposal by the BCA's deadline. As a result, automatic cuts (sequestration) in various federal programs were scheduled to take place, beginning in January 2013, although the American Taxpayer Relief Act of 2012 delayed the BCA's automatic cuts until March 1, 2013. While the Medicare program's eligibility and scope of benefits are generally exempt from these cuts, Medicare payments to providers are not exempt. The BCA did, however, provide that the Medicare cuts to providers would not exceed two percent. President Obama issued the sequestration order on March 1, 2013, with cuts going into effect on April 1, 2013. Additionally, the Bipartisan Budget Act of 2013 extended the two percent sequestration for Medicare for another two years, through 2023.

In fact, the situation with the federal budget remains in flux. From October 1, 2013 through October 16, 2013, the U.S. federal government ceased the majority of its operations after Congress failed to enact legislation appropriating funds

for fiscal year 2014. On October 17, 2013, President Obama signed into law the Continuing Appropriations Act of 2014, which included a continuing resolution to fund the government until January 15, 2014 and suspended the statutory debt ceiling until February 7, 2014. After extending the government funding expiration date to January 18, 2014, Congress passed a $1.1 trillion spending bill that was signed into law on January 17, 2014 and funds the government through September 30, 2014. However, this new law is a temporary measure that does not resolve the debt-limit issue. Many Members of Congress have made public statements indicating that some or all of these budget-related deadlines should be used as leverage to negotiate additional cuts in federal spending. The Medicare program is frequently mentioned as a target for spending cuts.

The magnitude of Medicare cuts that may be made through budget agreements is unclear, including with respect to physician reimbursement. However, under our provider compensation plan, any decrease in reimbursement rates would reduce our physician incentive payments. For example, the BCA’s automatic two percent net reduction in Medicare reimbursement rates for the codes applicable to the services performed by our affiliated hospitalists could reduce our net income.

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 we charge for our services. 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 business and financial operations may be materially affected by these developments.

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

Individuals and entities can be excluded from participating in the Medicare and Medicaid programs for violating certain laws and regulations, or for other reasons such as the loss of a license in any state, even if the individual retains other licensure. This means that they (and all others) are prohibited from receiving payment for their services rendered to Medicare or Medicaid beneficiaries, and if the excluded individual is a physician, all services ordered (not just provided) by such physician are also non-covered and non-payable. Entities which employ or contract with excluded individuals are prohibited from billing the Medicare or Medicaid programs for the excluded individual's services, and are subject to civil monetary penalties if they do. The OIG maintains a list of excluded individuals and entities. Although we have instituted policies and procedures through our compliance program to minimize the risks, there can be no assurance that we will not inadvertently hire or contract with an excluded person, or that any of our current employees or contracts will not become excluded in the future without our knowledge. If this occurs, we may be subject to substantial repayments and civil penalties and the hospitals at which we furnish services also may be subject to repayments and sanctions, for which they may seek recovery from us.

The hospitalist industry is competitive.

There are other companies and individuals currently providing hospitalist services. We compete directly with national, regional and local providers of inpatient healthcare, and other companies could enter the market in the future and divert some or all of our business. On a national basis our competitors include Team Health and Envision, each of which may have greater financial and other resources available to them. We also compete with hospitalist groups and privately-owned hospitalist companies in each of our local markets. Existing or future competitors also may seek to compete with us for acquisitions, which could have the effect of increasing the price and reducing the number of suitable acquisitions, which would have an adverse impact on our growth strategy. Since there are virtually no capital expenditures required to enter the industry, there are few financial barriers to entry. Individual physicians, physician groups and companies in other healthcare industry segments, including hospitals with which we have contracts, some of which have greater financial, marketing and staffing resources, may become competitors in providing hospitalist services and this competition may have a material adverse effect on our business operations and financial position.

Because patients do not typically select their hospitalists, we are completely reliant on referrals from third parties.

Our business is based on referrals for our services. We receive referrals from community medical providers, emergency departments, payors, and hospitals in the same manner as other medical professionals receive patient referrals. We do not provide compensation or other remuneration to our referral sources for referring patients to us. A decrease in these referrals due to competition, concerns about the quality of our services, and other factors could result in a significant decrease in our revenues and adversely impact our financial condition. Similarly, we cannot assure that

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

Hospitals and other inpatient and post-acute care facilities (collectively "facilities") may terminate their agreements with us or reduce the fees they pay us.

We currently derive approximately 81% of our net revenue for hospitalist services from contracts directly with facilities. Our current partner facilities may decide not to renew our contracts, introduce unfavorable terms, or reduce fees paid to us. Any of these events may impact the ability of our practice groups to operate at such facilities, which would negatively impact our revenue and profitability.

Some of the hospitals where our affiliated hospitalists provide services may have their medical staff closed to non-contracted hospitalists.

In general, our affiliated hospitalists may only provide services in a hospital where they have certain credentials, called privileges, which are granted by the medical staff and controlled by legally binding medical staff bylaws of the hospital. The medical staff decides who will receive privileges, and the medical staff of the hospitals where we currently provide services or wish to provide services could decide that non-contracted hospitalists can no longer receive privileges to practice there. Such a decision would limit our ability to furnish services in a hospital, decrease the number of our affiliated hospitalists who could provide services, or preclude us from entering new hospitals. In addition, hospitals may attempt to enter into exclusive contracts for hospitalist services, which would reduce access to certain populations of patients within the hospital.

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

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

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

We derive significant revenue from third-party payors, and delays in payment or audits leading to refunds to payors may impact our net revenue. We assume the financial risks relating to uncollectible and delayed payments. In the current healthcare environment, payors are continuing their efforts to control expenditures for healthcare, including proposals to revise coverage and reimbursement policies. We may experience difficulties in collecting our revenue because third-party payors may seek to reduce or delay payment to which we believe we are entitled. If we are not paid fully and in a timely manner for such services or there is a finding that we were incorrectly paid, our revenues, cash flows, and financial condition could be materially adversely affected.

Certain federal and state laws may limit our effectiveness at collecting monies owed to us from patients.

We utilize third parties to collect from patients any co-payments and other payments for services that our hospitalists provide to patients. The federal Fair Debt Collection Practices Act restricts the methods that third-party collection companies may use to contact and seek payment from consumer debtors regarding past due accounts. State laws vary with respect to debt collection practices, although most state requirements are similar to those under the Fair Debt Collection Practices Act. If our collection practices or those of our collection agencies are inconsistent with these standards, we may be subject to actual damages and penalties. These factors and events could have a material adverse effect on our business, financial condition and results of operations.

If we are unable to effectively adapt to changes in the healthcare industry, our business may be harmed.

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

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

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

We may incur significant costs if we are required to adopt certain provisions under the Health Information Technology for Economic and Clinical Health Act.

HITECH was enacted into law on February 17, 2009 as part of the American Recovery and Reinvestment Act of 2009. Among the many provisions of HITECH are those relating to the implementation and use of certified Electronic Health Records (EHRs). Our patient medical records are maintained and under the custodianship of the healthcare facilities in which we operate. However, if we are required to adopt the use of EHRs utilized by these healthcare facilities, determine to adopt certain EHRs, or comply with any related provisions of HITECH, we may incur significant costs which could have a material adverse effect on our business operations and financial position.

The terms of our debt agreement could restrict our operations, particularly our ability to respond to changes in our business or to take specified actions.

Our existing secured debt agreement contains, and any future indebtedness would likely contain, a number of restrictive covenants that impose significant operating and financial restrictions on us, including restrictions on our ability to take actions that may be in our best interests. Our existing debt agreement includes covenants that generally:

- do not allow us to borrow additional amounts without the approval of our lender;
- require us to obtain the consent of our lender for acquisitions of $500,000 or more and grant security interests in newly-acquired companies;
- do not allow us to dispose of assets ; and
- require us to not impair our lender's security interests in our assets.

If we fail to remain current in our SEC reporting obligations, we could be removed from the OTCQB, which would adversely affect the market liquidity for our securities.

Companies trading on the OTCQB, such as us, must be reporting issuers under Section 12 of the Securities Exchange Act of 1934, as amended, and must be current in their reports under Section 13, in order to maintain price quotation privileges on the OTCQB. If we fail to remain current in our reporting requirements, we could be removed from the OTCQB. As a result, the market liquidity for our securities could be severely adversely affected by limiting the ability of broker-dealers to sell our securities and the ability of stockholders to sell their securities in the secondary market.

Our common stock is subject to the "penny stock" rules of the SEC, and trading in our securities is very limited, which makes transactions in our common stock cumbersome and may reduce the value of an investment in our securities.

The SEC has adopted Rule 3a51-1 of the Securities and Exchange Act of 1934, as amended, which establishes the definition of a "penny stock," for the purposes relevant to us, as any equity security that has a market price of less than $5.00 per share or with an exercise price of less than $5.00 per share, subject to certain exceptions. For any transaction involving a penny stock, unless exempt, Rule 15g-9 requires:

- a broker or dealer to approve a person's account for transactions in penny stocks; and
- a broker or dealer receives a written agreement for the transaction from the investor , setting forth the identity and quantity of the penny stock to be purchased.

In order to approve a person's account for transactions in penny stocks, the broker or dealer must:

- obtain financial information and investment experience objectives of the person; and

- make a reasonable determination that the transactions in penny stocks are suitable for that person and the person has sufficient knowledge and experience in financial matters to be capable of evaluating the risks of transactions in penny stocks.

The broker or dealer must also deliver, prior to any transaction in a penny stock, a disclosure schedule prescribed by the SEC relating to the penny stock market, which, among other things:

- sets forth the basis on which the broker or dealer made the suitability determination; and

- that the broker or dealer received a signed, written agreement from the investor prior to the transaction.

Disclosure also has to be made about the risks of investing in penny stocks in both public offerings and in secondary trading and about the commissions payable to both the broker-dealer and the registered representative, current quotations for the securities and the rights and remedies available to an investor in cases of fraud in penny stock transactions. Finally, monthly statements have to be sent disclosing recent price information for the penny stock held in the account and information on the limited market in penny stocks. Generally, brokers may be less willing to execute transactions in securities subject to the “penny stock” rules. This may make it more difficult for investors to dispose of our common stock and cause a decline in the market value of our stock.

Trading on the OTCQB may be volatile and sporadic, which could depress the market price of our common stock and make it difficult for our stockholders to resell their shares.

Our common stock is quoted on the OTCQB. Trading in stock quoted on the OTCQB is often thin and characterized by wide fluctuations in trading prices due to many factors that may have little to do with our operations or business prospects. This volatility could depress the market price of our common stock for reasons unrelated to operating performance. Moreover, the OTCQB is not a stock exchange, and trading of securities on the OTCQB is often more sporadic than the trading of securities listed on a stock exchange like NASDAQ or a New York Stock Exchange. Accordingly, our shareholders may have difficulty reselling any of their shares

We may write off intangible assets, such as goodwill.

Our intangible assets, which consist primarily of goodwill related to our acquisitions, are subject to annual impairment testing. Under current accounting standards, goodwill is tested for impairment on an annual basis and we may be subject to impairment losses as circumstances change after an acquisition. If we record an impairment loss related to our goodwill, it could have a material adverse effect on our results of operations for the year in which the impairment is recorded.

ACOs are new and unproven and CMS may discontinue, alter or radically change the MSSP program.

Company has invested resources in both acquiring the ACO license and in establishing initial infrastructure. Any material change to the MSSP program and ACO license requirements, governance and operating rules, could provide a significant financial risk for Company and alter the strategic direction of the Company thereby producing shareholder risk and uncertainty.

The Company operates in only one geographic state, California.

The Company's business and operations are currently limited to one state, California. Any material changes by California with respect to strategy, taxation and economics of healthcare delivery and reimbursements could produce an adverse effect on the continued business operations of Company.

ITEM 1B. UNRESOLVED STAFF COMMENTS

Not applicable.

ITEM 2. DESCRIPTION OF PROPERTIES

The Company's corporate headquarters is located at 700 North Brand Boulevard, Suite 220, Glendale, California 91203. The lease on our present corporate headquarters expires on January 14, 2017. We believe our present facilities are not adequate to meet our needs as we grow and we may need to lease additional space to accommodate growth, if it occurs.

ITEM 3. LEGAL PROCEEDINGS.

In the ordinary course of our business, we become involved in pending and threatened legal actions and proceedings, most of which involve claims of medical malpractice related to medical services provided by our affiliated hospitalists. We may also become subject to other lawsuits which could involve significant claims and/or significant defense costs.

We believe, based upon our review of pending actions and proceedings, that the outcome of such legal actions and proceedings will not have a material adverse effect on our business, financial condition, results of operations, or cash flows. The outcome of such actions and proceedings, however, cannot be predicted with certainty and an unfavorable resolution of one or more of them could have a material adverse effect on our business, financial condition, results of operations, or cash flows in a future period.

ITEM 4. MINE SAFETY DISCLOSURES.

Not applicable.

PART II

ITEM 5. MARKET FOR COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES.

Market Information

Our common stock is traded on the OTCQB under the symbol "AMEH". Following is a table presenting the closing sale prices for a share of our common stock by fiscal quarter for the fiscal years 2014 and 2013

	High	Low
Fiscal Year ended January 31, 2014		
First Quarter	$0.65	$0.65
Second Quarter	0.75	0.75
Third Quarter	0.60	0.60
Fourth Quarter	10.01	0.50

	High	Low
Fiscal Year ended January 31, 2013		
First Quarter	$0.19	$0.09
Second Quarter	0.63	0.10
Third Quarter	0.63	0.20
Fourth Quarter	1.38	0.47

Stockholders

As of April 30, 2014, as reported by the Company’s stock transfer agent, there were approximately 350 holders of record of our common stock. Within the holders of record of the Company's Common Stock are depositories such as Cede & Co., a nominee for The Depository Trust Company (or DTC), that hold shares of stock for brokerage firms which, in turn, hold shares of stock for one or more beneficial owners. Accordingly, the Company believes there are many more beneficial owners of its Common Stock whose shares are held in "street name", not in the name of the individual shareholder.

Dividends

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

Securities Authorized for Issuance under Equity Compensation Plans

The following table provides information about our common stock that may be issued upon the exercise of options, warrants and rights under all of our existing equity compensation plans and agreements as of January 31, 2014, including our 2010 Equity Incentive Plan (as amended) and our 2013 Equity Incentive Plan. The material terms of each of these plans and agreements are described in the notes to our January 31, 2014 consolidated financial statements, which are part of our Annual Report on Form 10-K for the year ended January 31, 2014. Each of these plans was approved by our stockholders.

Plan Category	Number of shares of common stock to be issued upon exercise of outstanding options, warrants, and rights	Weighted-average exercise price of outstanding options, warrants, and rights	Number of shares of common stock remaining available for future issuance under equity compensation plans (excluding securities reflected)
Equity compensation plans approved by stockholders	7,358,000	$ 0.17	1,818,000
Equity compensation plans not approved by stockholders	-	-	-
Total	7,358,000	$ 0.17	1,818,000

ITEM 6. SELECTED FINANCIAL DATA

Not applicable.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion highlights the principal factors that have affected our financial condition and results of operations as well as our liquidity and capital resources for the periods described. This discussion should be read in conjunction with our consolidated financial statements and the related notes included in this Report. This discussion contains forward-looking statements that are subject to known and unknown risks. Actual results and the timing of events may differ significantly from those expressed or implied in such forward-looking statements due to a number of factors, including those set forth in the section entitled "Risk Factors" and elsewhere in this Report.

Overview

Apollo Medical Holdings, Inc. and its affiliated physician groups are a physician centric, integrated healthcare delivery system serving Medicare, Commercial and Medi-Cal beneficiaries in California. As of April 30, 2014, ApolloMed's physician network consisted of over 700 hospitalist, primary care and specialist physicians primarily through our owned and affiliated physician groups.

Recent Developments

On January 31, 2013, the Company raised in a private placement offering of $880,000 in par value 9% Senior Subordinated Callable Convertible Promissory Notes maturing February 15, 2016 (the “9% Notes”). The 9% Notes bear interest at a rate of 9% per annum, payable semi-annually on August 15 and February 15. The principal of the 9% Notes plus any accrued yet unpaid interest is convertible at any time by the holder at a conversion price of $0.40 per share of Common Stock, subject to adjustment for stock splits, stock dividends and reverse stock splits, and is callable in full or in part by the Company at any time after January 31, 2015. The holders of the 9% Notes received warrants to purchase 660,000 shares of the Company’s common stock at an exercise price of $0.45 per share, subject to adjustment for stock splits, reverse stock splits and stock dividends which are exercisable at any date prior to January 31, 2018. The Company used the net proceeds (after issuance costs) of approximately $776,000 for general corporate purposes. During the year ended January 31, 2014, the Company issued additional units of the 9 % Notes for aggregate proceeds of $220,000 and warrants to purchase the Company’s common stock aggregating 165,000 shares. In addition, the Company issued 44,000 warrants to the placement agent associated with these additional proceeds.

In March 2013, the Company initiated a private placement of up to 7,500,000 shares of its common stock at a price per share of $ 0.40 (the “Equity Offering”), and during the year ended January 31, 2014, the Company issued 1,825,000 shares of common stock for proceeds of $730,000.

On December 20, 2013, the Company entered into a Settlement Agreement and Release (collectively, the “Settlement Agreements”) with each of the holders of 10% Notes to the First Amendment (each, a “Holder” and, collectively, the “Holders”), some or all of whom also hold other securities of the Company. Under the Settlement Agreements, the Company agreed to redeem for cash and or convert into shares of the Company’s Common Stock the Holders’ 10% Notes. Under the Settlement Agreements, in the aggregate, the Company redeemed and converted $1,250,000 in original principal amount of the 10% Notes, plus accrued interest thereon, for total cash payments of approximately $729,000 (including related accrued interest), and total issuances of 8,812,362 shares of the Company’s common stock (the “Conversion Shares”).

On October 15, 2013, the Company entered into a $ 2.0 million secured revolving credit facility (the “Credit Agreement”) with NNA of Nevada, Inc.(the “Lender” or “NNA”). The Company and its subsidiaries are guarantors of the Company’s obligations under the Credit Agreement. Loans drawn under the Credit Agreement are secured by all of the assets of the Company and its subsidiaries, including a security interest in the deposit accounts of the Company and its subsidiaries and a pledge of the shares in the Company’s subsidiaries. Amounts outstanding under the Credit Agreement accrue interest at a rate equal to the sum of (i) three month LIBOR and (ii) six percent (6.24% at January 31, 2014). Interest is payable on the last business day of each successive month, in arrears, commencing October 31, 2013, and at each month-end thereafter. The Credit Agreement requires the Company to pay the Lender a facility fee, on the last business day of each month, at a per annum rate of 1.0 % of the average daily unused portion of the revolving credit commitment under the Credit Agreement. The Credit Agreement matures June 30, 2014. The Company incurred direct costs related to the Credit Agreement aggregating $ 119,500 which were accounted for as deferred financing costs and are amortized using the straight line method to interest expense over the term thereof. On December 20, 2013, the Company entered into the First Amendment to the Credit Agreement (the “Amended Credit Agreement”), which increased the revolving credit facility from $2.0 million to $4.0 million. The proceeds of the Amended Credit Agreement were used by the Company to repay the $ 500,000 senior secured note (the “Senior Secured Note”) to SpaGus Apollo,LLC, and were used to pay or repay certain of the Company’s 10 % Notes, to refinance certain other indebtedness of the Company, and for working capital and for general corporate purposes. The Company entered into a new arrangement with NNA on March 28, 2014.

Factors Affecting Operating Results

Rate Changes by Government Sponsored Programs

The Medicare program reimburses for our services based upon the rates set forth in the annually updated Medicare Physician Fee Schedule, which relies, in part, on a target-setting formula system called the Sustainable Growth Rate

(SGR). Many private payors use the Medicare Physician Fee Schedule to determine their own reimbursement rates. On December 10, 2013, the Centers for Medicare and Medicaid Services (CMS) published its final Medicare Physician Fee Schedule for calendar year 2014. We are currently evaluating the impact of this proposed Medicare Physician Fee Schedule on our financial position, results of operations and cash flows.

The annual Medicare Physician Fee Schedule update, based on the SGR, is adjusted to reflect the comparison of actual expenditures to target expenditures. Because one of the factors for calculating the SGR is linked to the growth in the U.S gross domestic product (GDP), the SGR formula may result in a negative payment update if growth in Medicare beneficiaries' use of services exceeds GDP growth, a situation which has occurred every year since 2002 and the reoccurrence of which we cannot predict.

Congress has repeatedly intervened to delay the implementation of the negative SGR payment update. With the enactment of the Bipartisan Budget Act of 2013 on December 26, 2013, the 20.1 percent cut that was to occur was replaced with a 0.5 percent increase for services provided through March 31, 2014. However, there is no guarantee that Congress will continue to postpone implementation of the negative SGR payment in the future. Moreover, the existing methodology may result in significant yearly fluctuations in the Medicare Physician Fee Schedule amounts, which may be unrelated to changes in the actual costs of providing physician services. Unless Congress enacts a permanent change in the SGR methodology, the uncertainty regarding reimbursement rates and fluctuation will continue to exist.

Another provision that affects physician payments is an adjustment under the Medicare statute to reflect the geographic variation in the cost of delivering physician services, by comparing those costs to the national average. This concerns the "work" component of the Geographic Practice Cost Indices (GPCI). If Congress does not block this adjustment, payments would be decreased to any geographic area with an index of less than 1.0. President Obama signed the "Protecting Access to Medicare Act of 2014" (Public Law No. 113.93) into law on April 1, 2014. Notable provisions included the Medicare Work Geographic Practice Cost Index (GPCI) Floor (§102). This provision provides a one-year extension of the Medicare GPCI floor through March 31, 2015, increasing physician reimbursement rates in primarily rural areas. However, there is no guarantee that Congress will block the adjustment in the future, which could result in a decrease in payments we receive for physician services.

The Budget Control Act of 2011 (BCA) established a Joint Select Committee on Deficit Reduction, which was tasked with achieving a reduction in the federal debt level of at least $1.2 trillion. That Committee did not draft a proposal by the BCA's deadline. As a result, automatic cuts in various federal programs were scheduled to take place, beginning in January 2013. The American Taxpayer Relief Act of 2012 again delayed implementation of the BCA's automatic cuts until March 1, 2013, and on March 1, 2013, President Obama signed a sequestration order that triggered the BCA's automatic cuts, including a two percent cut in Medicare payments to providers that was implemented effective April 1, 2013 through 2021. Additionally, the Bipartisan Budget Act of 2013 extended sequestration for Medicare for another two years, through 2023. This two percent net reduction in Medicare reimbursement rates for the codes applicable to the services performed by our affiliated hospitalists may reduce our net revenue.

Several rules recently released by CMS are likely to also have implications on provider reimbursement. For example, on August 19, 2013, CMS published a final rule establishing that Medicare Part A payment for hospital inpatient services provided is generally inappropriate when a patient enters a hospital for a surgical procedure that is not specified by Medicare as inpatient only and the physician expects the patient to stay in the hospital for less than two midnights. In addition, on December 10, 2013, in its final Medicare Physician Fee Schedule for calendar year 2014, CMS finalized its proposal to, among other things, increase the number of quality measures that eligible professionals must report for claims- and registry-based reporting to receive the incentive payments and adjustments available under the Physician Quality Reporting System (PQRS). The impact of such modified measures on PQRS-based payment adjustments for hospitalists cannot be determined at this time.

In addition to these regulatory changes affecting government reimbursement for health care services, the current instability of the federal budget may lead to legislation that could result in further cuts in Medicare and Medicaid payments to providers. On January 17, 2014, President Obama signed into law a $1.1 trillion spending bill that funds the government through September 30, 2014. However, this new law is a temporary measure that does not resolve the debt-limit issue, and the Medicare program is frequently mentioned as a target for spending cuts.

Healthcare Reform

In March 2010, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, ACA) was enacted. The ACA includes a number of provisions that may affect our Company, although the impact of many of the changes will be unknown until they are finally implemented, which in some cases will not occur for a couple of years. The impact of some of these provisions have already proven to be positive, such as the Primary Care Incentive Payment Program (PCIP), which makes a ten percent Medicare bonus payment for primary care services (including outpatient and nursing home visits) furnished on or after January 1, 2011 and before January 1, 2016 to primary care practitioners for whom primary care services represented a minimum of 60 percent of Medicare allowed charges in a prior period, and the increase in Medicaid rates up to the level of Medicare rates (Medicaid parity) in 2013 and 2014 for primary care services. Another positive provision is the expected expansion in the number of individuals with health insurance starting in January 2014.

The impact of other provisions is unknown at this time, such as the establishment of an Independent Payment Advisory Board—designed to make proposals as early as 2014 to reduce the per capita rate of growth in Medicare spending in years when that growth exceeds established targets—which the U.S. Department of Health and Human Services generally would be required to implement unless Congress enacts superseding legislation. Fraud and abuse penalty increases and the expansion in the scope of the reach of the federal False Claims Act, and other government enforcement tools, may adversely impact entities in the healthcare industry, including our Company.

The impact of certain provisions will depend upon the ultimate method of implementation. For example, the ACA requires HHS to develop a budget neutral, value-based payment modifier that provides for differential payment under the Medicare Physician Fee Schedule for physicians or groups of physicians that is linked to quality of care furnished compared to cost. CMS has continued to implement the modifier through the Medicare Physician Fee Schedule rulemaking for 2014, by, among other things, finalizing its proposal to apply the value-based payment modifier to groups of physicians with 10 or more eligible professionals in calendar year 2016 and to expand the modifier to all physicians in calendar year 2017. The impact of this payment modifier cannot be determined at this time.

In addition, certain provisions of the ACA authorize voluntary demonstration projects, which include the development of bundling payments for acute, inpatient hospital services, physician services, and post-acute services for episodes of hospital care. The Bundled Payments for Care Improvement Initiative is currently underway and assesses four models of care linking payments for multiple services provided to beneficiaries during an episode of care. The impact of these projects on our Company cannot be determined at this time.

Professional Liability Rates

Medical malpractice insurance premium rates are affected by a variety of factors both internal, including our own loss experience and the associated defense costs, and external such as medical malpractice loss experience for internal medicine physicians, which varies greatly across different regions. Other factors include varying state laws covering tort reform, the local climate for large jury awards, the rate of investment income and reinsurance costs, all of which can result in wide variations in premium rates not only from region to region, but also from year to year. Although our malpractice premium rates have remained relatively stable over the last three years, the factors discussed above could lead to variations in future costs.

Critical Accounting Policies

A critical accounting policy is defined as one that is both material to the presentation of our financial statements and requires management to make difficult, subjective or complex judgments that could have a material effect on our financial condition and results of operations. Specifically, critical accounting estimates have the following attributes: (i) we are required to make assumptions about matters that are uncertain at the time of the estimate; and (ii) different estimates we could reasonably have used, or changes in the estimate that are reasonably likely to occur, would have a material effect on our financial condition or results of operations.

Estimates and assumptions about future events and their effects cannot be determined with certainty. We base our estimates on historical experience and on various other assumptions believed to be applicable and reasonable under the circumstances. These estimates may change as new events occur, as additional information is obtained and as our

operating environment changes. These changes have historically been minor and have been included in the consolidated financial statements as soon as they became known. Based on a critical assessment of our accounting policies and the underlying judgments and uncertainties affecting the application of those policies, management believes that our consolidated financial statements are fairly stated in accordance with accounting principles generally accepted in the United States (U.S. GAAP), and meaningfully present our financial condition and results of operations.

We believe the following critical accounting policies reflect our more significant estimates and assumptions used in the preparation of our consolidated financial statements:

Principles of Consolidation

Our consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America. The preparation of these financial statements requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses. Note 2 of Notes to Consolidated Financial Statements describes the significant accounting policies used in the preparation of the consolidated financial statements. Certain of these significant accounting policies are considered to be critical accounting policies, as defined below.

Our consolidated financial statements include the accounts of Apollo Medical Holdings, Inc. and its subsidiaries AMM, ApolloMedACO, PCCM, VMM, Aligned Healthcare, Inc. ("AHI") and PPCs managed under long-term management service agreements including AMH, MMG, ACC, LALC and Hendel. Some states have laws that prohibit business entities, such as Apollo, from practicing medicine, employing physicians to practice medicine, exercising control over medical decisions by physicians (collectively known as the corporate practice of medicine), or engaging in certain arrangements with physicians, such as fee-splitting. In California, we operate by maintaining long-term management service agreements with the PPCs, which are each owned and operated by physicians, and which employ or contract with additional physicians to provide hospitalist services. Under the management agreements, we provide and perform all non-medical management and administrative services, including financial management, information systems, marketing, risk management and administrative support. The management agreements typically have an initial term of 20 years unless terminated by either party for cause. The management agreements are not terminable by the PCCs, except in the case of gross negligence, fraud, or other illegal acts by Apollo, or bankruptcy of Apollo.

Through the management agreements and our relationship with the stockholders of the PPCs, we have exclusive authority over all non-medical decision making related to the ongoing business operations of the PPCs. Consequently, we consolidate the revenue and expenses of the PPCs from the date of execution of the management agreements.

All intercompany balances and transactions have been eliminated in consolidation.

Revenue Recognition

Revenue consists of contracted and fee-for-service revenue. Revenue is recorded in the period in which services are rendered. Our revenue is principally derived from the provision of healthcare staffing services to patients within healthcare facilities. The form of billing and related risk of collection for such services may vary by customer. The following is a summary of the principal forms of our billing arrangements and how net revenue is recognized for each.

Contracted revenue represents revenue generated under contracts in which we provide physician and other healthcare staffing and administrative services in return for a contractually negotiated fee. Contracted revenue represented approximately84% of our revenues in the year ended January 31, 2014. Contracted revenue consists primarily of billings based on hours of healthcare staffing provided at agreed-to hourly rates. Revenue in such cases is recognized as the hours are worked by our staff and contractors. Additionally, contracted revenue also includes supplemental revenue from hospitals where we may have a fee-for-service contract arrangement or provide physician advisory services to the medical staff at a specific facility. Contracted revenue for the supplemental billing in such cases is recognized based on the terms of each individual contract. Such contract terms generally either provides for a fixed monthly dollar amount or a variable amount based upon measurable monthly activity, such as hours staffed, patient visits or collections per visit compared to a minimum activity threshold. Such supplemental revenues based on variable arrangements are usually contractually fixed on a monthly, quarterly or annual calculation basis considering

the variable factors negotiated in each such arrangement. Such supplemental revenues are recognized as revenue in the period when such amounts are determined to be fixed and therefore contractually obligated as payable by the customer under the terms of the respective arrangement. Additionally, we derive a portion of our revenue as a contractual bonus from collections received by our partners and such revenue is contingent upon the collection of third-party billings. These revenues are not considered earned and therefore not recognized as revenue until actual cash collections are achieved in accordance with the contractual arrangements for such services.

Fee-for-service revenue represents revenue earned under contracts in which we bill and collect the professional component of charges for medical services rendered by our contracted and employed physicians. Under the fee-for-service arrangements, we bill patients for services provided and receive payment from patients or their third-party payers. Fee-for-service revenue is reported net of contractual allowances and policy discounts. All services provided are expected to result in cash flows and are therefore reflected as net revenue in the financial statements. Fee-for-service revenue is recognized in the period in which the services are rendered to specific patients and reduced immediately for the estimated impact of contractual allowances in the case of those patients having third-party payer coverage. The recognition of net revenue (gross charges less contractual allowances) from such visits is dependent on such factors as proper completion of medical charts following a patient visit, the forwarding of such charts to our billing center for medical coding and entering into our billing system and the verification of each patient's submission or representation at the time services are rendered as to the payer(s) responsible for payment of such services. Net revenue is recorded based on the information known at the time of entering of such information into our billing systems as well as an estimate of the revenue associated with medical services provided.

The Company through its subsidiary, ApolloMed ACO, participates in the Medicare Shared Savings Program ("MSSP") sponsored by the Centers for Medicare & Medicaid Services ("CMS"). The MSSP allows ACO participants to share in cost savings it generates in connection with rendering medical services to Medicare patients. Payments to ACO participants, if any, will be calculated by CMS on cost savings generated by the ACO participant based on a trailing 24 month medical service history. The MSSP is a newly formed program with no history of payments to ACO participants. The Company considers revenue, if any, under the MSSP, as contingent upon the realization of program savings as determined by CMS, and are not considered earned and therefore are not recognized as revenue until cash payments from CMS are received. For the years ended January 31, 2014 and 2013, the Company recorded no revenue related to the MSSP.

Medical Liability Costs

The Company is responsible for integrated care that the associated physicians and contracted hospitals provide to its enrollees. The Company provides integrated care to health plan enrollees through a network of contracted providers under sub-capitation and direct patient service arrangements, company-operated clinics and staff physicians. Medical costs for professional and institutional services rendered by contracted providers are recorded as cost of services in the consolidated statements of income. Costs for operating medical clinics, including the salaries of medical and non-medical personnel and support costs, are also recorded in cost of services.

An estimate of amounts due to contracted physicians, hospitals, and other professional providers is included in medical payables in the accompanying consolidated balance sheets. Medical payables include claims reported as of the balance sheet date and estimates of incurred but not reported claims ("IBNR") . Such estimates are developed using actuarial methods and are based on many variables, including the utilization of health care services, historical payment patterns, cost trends, product mix, seasonality, changes in membership, and other factors. The estimation methods and the resulting reserves are continually reviewed and updated. Many of the medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing

interpretations may not come to light until a substantial period of time has passed following the contract implementation. Any adjustments to reserves are reflected in current operations.

Accounts Receivable and Allowance for Doubtful Accounts

Accounts receivable primarily consists of amounts due from third-party payors, including government sponsored Medicare and Medicaid programs, insurance companies, and amounts due from hospitals and patients. Accounts receivable are recorded and stated at the amount expected to be collected.

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

Stock-Based Compensation

The Company maintains a stock-based compensation program for employees, directors and consultants. The value of stock-based awards so measured is recognized as compensation expense on a cumulative straight-line basis over the vesting terms of the awards, adjusted for expected forfeitures. The Company sells certain of its restricted common stock to its employees, directors and consultants with a right (but not obligation) of repurchase feature that lapses based on performance of services in the future. The Company accounts for the unvested portion of the related stock-based purchases expense as prepaid consulting. Prepaid consulting is amortized to stock-based compensation expense over the vesting period.

Goodwill and Other Intangible Assets

Under FASB ASC 350, *Intangibles – Goodwill and Other* (“ASC 350”), goodwill and indefinite-lived intangible assets are reviewed at least annually for impairment. Acquired intangible assets with definite lives are amortized over their individual useful lives.

At least annually, management assesses whether there has been any impairment in the value of goodwill by first comparing the fair value to the net carrying value. If the carrying value exceeds its estimated fair value, a second step is performed to compute the amount of the impairment. An impairment loss is recognized if the implied fair value of the asset being tested is less than its carrying value. In this event, the asset is written down accordingly. The fair values of goodwill are determined using valuation techniques based on estimates, judgments and assumptions management believes are appropriate in the circumstances. The fair value is evaluated based on market capitalization determined using average share prices within a reasonable period of time near the selected testing date (i.e., fiscal year-end).

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

Recently Adopted Accounting Principles

See Note 2 to the Consolidated Financial Statements for information regarding recently adopted accounting principles.

Results of Operations and Operating Data

Year Ended January 31, 2014 vs. Year Ended January 31, 2013

	2014	2013	Change	Percentage change	
Net revenues	$10,484,305	$7,776,131	$2,708,174	34.8	%
Cost of services	9,076,213	6,316,164	2,760,049	43.7	%
Gross profit	1,408,092	1,459,967	(51,875)	-3.6	%
Operating expenses:					
General and administrative	5,286,610	3,517,536	1,769,074	50.3	%
Depreciation	31,361	20,918	10,443	49.9	%
Total operating expenses	5,317,971	3,538,454	1,779,517	50.3	%
Loss from operations	$(3,909,879)	$(2,078,487)	$(1,831,392)	88.1	%

	% of Net revenues	
	2014	2013
Net revenues	100.0 %	100.0 %
Cost of services	86.6 %	81.2 %
Gross profit	13.4 %	18.8 %
Operating expenses:		
General and administrative	50.4 %	45.2 %
Depreciation	0.3 %	0.3 %
Total operating expenses	50.7 %	45.5 %
Loss from operations	-37.3 %	-26.7 %

Net revenues comprise net billings under the various fee structures from health plans, medical groups/IPAs and hospitals, and income from service fee agreements. The increase was attributable to:

$1,935,681	New hospital contracts, increased same-market area growth and expansion of services with existing medical group clients at new hospitals.
$145,505	Increase in MMG services due to increase in patient lives.
$284,353	Acquisition of medical clinics in fiscal 2014.
$342,635	Acquisition of VMM in August 2012.

Cost of services primarily comprise physician compensation and related expenses. The increase was attributable to:

$(1,954,087)	Increase in physician costs attributable to new physicians hired to support new contracts.
$(66,192)	Increase in physician stock-based compensation.
$(114,575)	Acquisition of VMM in August 2012.
$(279,652)	Increase in MMG and ACC services.
$(345,543)	Acquisition of medical clinics in fiscal 2014

Cost of services as a percentage of net revenues increased principally due to a mix of newly acquired primary care clinic service lines and the launch of Maverick Medical Group IPA in fiscal 2014.

General and administrative expenses comprise all salaries, benefits, supplies and operating expenses, including billing and collections functions, and the Company’s corporate management and overhead not specifically related to the day-to-day operations of our physician group practices. The increase was attributable to:

$(323,804)	Increase in board, legal and professional fees to support the continuing growth of our operations.
$(333,877)	Increase in personnel, services and related expenses related to the ACO initiative.
$(464,885)	Increase in administrative personnel and facilities costs to support growth in the business
$(97,393)	Increase in operating expenses due to the acquisition of VMM in August 2012.
$(420,554)	Increase in personnel and practice management fees to support growth in the MMG IPA.
$(70,999)	Increase in stock-based compensation to employees, directors and consultants
$(57,561)	Increase in other expenses due to business growth.

Loss from operations increased primarily due to spending on the MMG and ACO initiatives.

The decrease in loss on change in fair value of derivative liabilities reflects the change in the fair value of the Company's derivative liabilities as follows:

	2014	2013	Change
Loss on change in fair value of derivative liabilities	$ -	$5,853,855	$(5,853,855)

Interest expense decreased compared to 2013 due to higher discount amortization as a result of the bifurcation of the derivative liabilities that resulted in additional debt discount and additional discount amortization for the year ended January 31, 2013, partially offset by higher interest expense as a result of higher borrowings under Notes and Lines of Credit Payable and the 9% Convertible Notes.

	2014	2013	Change
Interest expense	$679,184	$930,176	$(250,992)

Net loss decreased primarily due to a lower loss on change in fair value of derivative liabilities and lower interest expense, partially offset by increase in spending associated with the ACO, MMG and ACC medical clinics.

	2014	2013	Change
Net loss	$4,558,874	$8,904,564	$(4,345,690)

Liquidity and Capital Resources

The Company had $1,451,407 in cash and cash equivalents at January 31, 2014. To date the Company has funded its operations from internally generated cash flow and external sources, including the proceeds from the issuance of debt and equity securities which have provided funds for near-term operations and growth. In October 2013, the Company entered into a credit agreement (as amended on December 20, 2013) with NNA of Nevada, Inc. (“NNA”) that provided for the Company to borrow up to $4,000,000. On March 28, 2014, the Company subsequently entered into an equity and debt arrangement with NNA to provide $12,000,0000 that included a $2,000,000 investment in Company common stock, $8,000,000 in term and revolving loans, and a $2,000,000 convertible note commitment. The Company intends to use the proceeds from NNA to refinance its existing indebtedness under the prior NNA $4,000,000 credit agreement, and for working capital and acquisitions. Prior to that, the Company sold 1.8 million shares of its common stock in a private placement at a price per share of $ 0.40 for aggregate proceeds of $730,000 during the fiscal year ended January 31, 2014. In addition, the Company raised through a private placement offering gross proceeds of $1,100,000 in par value 9 % Senior Subordinated Callable Convertible Promissory Notes maturing February 15, 2016 (the “9% Notes”).

Year ended January 31, 2014

For the year ended January 31, 2014, net cash used in operations was $1,478,205. This was substantially the result of net losses of $4,558,874, partially offset by cash provided by non-cash expenses of $2,581,365 and change in working capital of $524,087. Non-cash expenses primarily include depreciation expense, bad debt expense, and stock-based compensation expense, amortization of financing costs, and amortization of debt discount.

Cash provided by working capital was due to:

Decrease in Accounts receivable, net	$72,916
Decrease in Due from affiliates	$4,049
Decrease in Prepaid expenses and advances	$19,084
Increase in Accounts payable and accrued liabilities	$455,738

Cash used by working capital was due to:

Increase in Other assets	$(27,700)

For the year ended January 31, 2014, cash used in investing activities was $272,931 related primarily to the acquisition of three primary care medical clinics.

For the year ended January 31, 2014, net cash provided by financing activities was $2,025,816 related to $2,811,878 in proceeds from the NNA Credit Agreement, $730,000 in proceeds from the issuance of common stock, $220,000 in proceeds from the issuance of 9% convertible notes, partially offset by $707,911 in cash payments to note holders in connection with 10% convertible note redemption, $530,000 repayment of the senior secured note, $240,000 in distributions to non-controlling interest (LALC), and $258,511 in debt issuance costs related to the NNA Credit Agreement. Borrowings were used primarily to fund repayment of indebtedness, working capital requirements and technology investments.

Year ended January 31, 2013

For the year ended January 31, 2013, net cash provided by operations was $57,956. This was substantially the result of net losses of $8,904,564, offset by cash provided by non-cash expenses of $8,770,753 and working capital of $191,767. Non-cash expenses primarily include depreciation expense, bad debt expense, issuance of shares of common stock for services, stock option compensation expense, amortization of financing costs, amortization of debt discount, and loss on change in fair value of derivative liabilities.

Cash provided by working capital was due to:

Increase in Accounts payable and accrued liabilities	$764,208
Decrease in Other assets	$7,020
Decrease in Due from affiliates	$5,504

Cash used by working capital was due to:

Increase in Prepaid expenses and advances	$(23,666)
Increase in Accounts receivable	$(548,899)
Decrease in Due to Officers	$(12,400)

For the year ended January 31, 2013, cash used in investing activities was $31,865 related to $45,799 in investments in a new billing system, investment in ACO-related office and technology equipment, partially offset by the acquisition of VMM.

For the year ended January 31, 2013, net cash provided by financing activities was $986,095 related to $500,000 in proceeds from the Senior Secured Note, $775,581 in net proceeds from the issuance of 9% Senior Subordinated Convertible Notes, and $94,765 from other borrowings, partially offset by $400,000 in distributions to non-controlling interest (LALC). Borrowings were used primarily to fund working capital requirements and technology investments.

Debt Agreements

The following is an overview of the Company's total outstanding debt obligations as of January 31, 2014:

Description of Debt	Lender Name	Interest Rate		January 31, 2014
Line of credit	NNA of Nevada, Inc.	3 mo. LIBOR + 6.0	%	$2,811,878
Non- interest bearing seller notes	Various	-		272,050
8% Senior Subordinated Convertible Promissory Notes due February 1, 2015	Various	8.00	%	150,000
9% Senior Subordinated Convertible Notes due February 15, 2016	Various	9.00	%	950,522
Line of Credit	Union Bank	7.75	%	94,765
				$4,279,215

Off-Balance Sheet Arrangements

The Company had no off-balance sheet arrangements as of or for the year ended January 31, 2014.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Not applicable.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

The Company's financial statements for the fiscal year ended January 31, 2014 are included in this annual report, beginning on page F-1.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

Disclosure Controls and Procedures

As of the end of the period covered by this report, the Company has carried out an evaluation under the supervision and with the participation of its management, including its Chief Executive Officer and its Chief Financial Officer, of the effectiveness of the design and operation of its disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934. Based upon that evaluation, the Chief Executive Officer and Chief Financial Officer concluded that, at January 31, 2014, the Company's disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934) were not effective, at a reasonable assurance level, in ensuring that information required to be disclosed in the reports the Company files and submits under the Securities Exchange Act of 1934 are recorded, processed, summarized and reported as and when required. For a discussion of the reasons on which this conclusion was based, see "Management's Report on Internal Control over Financial Reporting" below.

Management’s Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as defined in Rule 13a-15(f) and Rule 15d-15(f) under the Exchange Act. Management must evaluate its internal controls over financial reporting, as required by Sarbanes-Oxley Act. The Company's internal control over financial reporting is a process designed under the supervision of the Company's management to provide reasonable assurance regarding the reliability of financial reporting and the preparation of the Company's financial statements for external purposes in accordance with U.S. generally accepted accounting principles (“GAAP”). Our management conducted an evaluation of the effectiveness of our internal control over financial reporting based on the criteria for effective internal control over financial reporting established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (“COSO”) and SEC guidance on conducting such assessments. Based on this evaluation, our management concluded that there were material weaknesses in our internal control over financial reporting as of January 31, 2014.

A material weakness is a significant control deficiency (within the meaning of the Public Company Accounting Oversight Board (PCAOB) Auditing Standard No. 2) or combination of significant control deficiencies that result in more than a remote likelihood that a material misstatement of the annual or interim financial statements will not be prevented or detected. Management has identified the following three material weaknesses in our disclosure controls and procedures, and internal controls over financial reporting:

1. We do not have written documentation of our internal control policies and procedures. Written documentation of key internal controls over financial reporting is a requirement of Section 404 of the Sarbanes-Oxley Act. Management evaluated the impact of our failure to have written documentation of our internal controls and procedures on our assessment of our disclosure controls and procedures, and concluded that the control deficiency that resulted represented a material weakness.

2. We do not have sufficient segregation of duties within accounting functions, which is a basic internal control. Due to our size and nature, segregation of all conflicting duties may not always be possible and may not be economically feasible. However, to the extent possible, the initiation of transactions, the custody of assets and the recording of transactions should be performed by separate individuals. Management evaluated the impact of our failure to have segregation of duties on our assessment of our disclosure controls and procedures, and concluded that the control deficiency that resulted represented a material weakness.

3. We do not have review and supervision procedures for financial reporting functions. The review and supervision function of internal control relates to the accuracy of financial information reported. The failure to review and supervise could allow the reporting of inaccurate or incomplete financial information. Due to our size and nature, review and supervision may not always be possible or economically feasible.

Based on the foregoing material weaknesses, we have determined that, as of January 31, 2014, our internal controls over our financial reporting are not effective. The Company is taking remediating steps to address each material weakness. We continue to add employees and consultants to address these issues and we will continue to broaden the scope of our accounting and billing capabilities and realigning responsibilities in our financial and accounting review functions.

It should be noted that any system of controls, however well designed and operated, can provide only reasonable and not absolute assurance that the objectives of the system are met. In addition, the design of any control system is based in part upon certain assumptions about the likelihood of certain events. Because of these and other inherent limitations of control systems, there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions, regardless of how remote.

This Annual Report on Form 10-K does not include an attestation report of our independent registered public accounting firm regarding internal control over financial reporting. Management’s report was not subject to attestation by our independent registered public accounting firm.

Changes in Internal Controls over Financial Reporting

There has been no change in our internal controls over financial reporting during our most recently completed fiscal quarter (i.e., the three-month period ended January 31, 2014) that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Name	Age	Title
Warren Hosseinion, M.D.	41	Chief Executive Officer, Director
Kyle Francis	40	Executive Vice President and Chief Financial Officer
Gary Augusta	47	Executive Chairman, Director
Mark Meyers	63	Chief Strategy Officer, Director
Ted Schreck	68	Chairman, Director
Suresh Nihalani	61	Director
Mitch Creem	54	Director
David Schmidt	66	Director

Warren Hosseinion, M.D. Dr. Hosseinion has been a director and our Company's Chief Executive Officer since July 2008. In 2001, Dr. Hosseinion founded ApolloMed Hospitalists in Los Angeles with Dr. Adrian Vazquez. Dr. Hosseinion received his medical degree from Georgetown University. Dr. Hosseinion's qualifications to serve on our Board of Directors include his position as our chief executive officer since the inception of the Company, his background as founder of the Company and leading physician within the medical community in Los Angeles. In addition, Dr. Hosseinion is currently a practicing hospitalist physician and brings to our Board of Directors and our Company a depth of understanding of physician culture and strong knowledge of the healthcare market.

Kyle Francis. Mr. Francis has been our Chief Financial Officer since December 31, 2010. From September 2008 to December 2010, Mr. Francis served as the Executive Vice President of Business Development and Strategy. Mr. Francis will continue to serve in that function as well as Chief Financial Officer. From April 2000 to September 2008, he was a member of the Healthcare Services Investment Banking Division of Oppenheimer & Co. and CIBC World Markets. From August 1999 to April 2000, Mr. Francis worked for Enron Corporation in various capacities. Mr. Francis holds a Bachelor of Commerce with a major in finance and accounting degree from McGill University.

Mark Meyers. Mr. Meyers was been our Chief Strategy Officer and a member of our Board of Directors since October 2012. From March 2010 until September 2012, he served as Senior Vice President of Operations for Dignity Health's Los Angeles Service Area while continuing to serve as President of Glendale Memorial Hospital and Health Centers, a position he was appointed to in March 2009. From 2001 to 2009, Mr. Meyers was President of California Hospital Medical Center, a 316-bed Dignity facility in Downtown Los Angeles which serves as a Level II trauma center. From 1987 to 2001 he worked for Tenet Healthcare Corporation or in hospital corporations that were acquired by Tenet, serving as CEO for several hospitals, including Garden Grove Hospital in Garden Grove, California, Western Medical Center in Anaheim, California, Coastal Communities Hospital in Santa Ana, California, Doctors Hospital of Santa Ana and Santa Ana Hospital Medical Center and Florida Medical Center, a 460-bed hospital in Broward County, Florida. Mr. Meyers received a Bachelor of Science in Psychology from the University of Pittsburgh

and a MPH from the University of Pittsburgh's Graduate School of Public Health. Mr. Meyer’s qualifications to serve on our Board of Directors include over 36 years of experience working as a senior executive in the healthcare industry.

Ted Schreck. Mr. Schreck was appointed to the Board in February 2012. From 2009 to 2012 Mr. Schreck was retired. From 2006 to 2008 he served as a consultant for the Legacy Health System, based in Portland, OR, which operates six hospitals, a research institute, and a network of clinics. From 1998 to 2006, he served as an executive with Tenet Healthcare including as CEO of USC’s Private Practice Hospitals, Regional Vice President of Operations for Los Angeles-area hospitals, and finally as Senior Vice President. From 1973 to 1988 he served with St. Joseph Health System, as CEO of Santa Rosa General Hospital and Senior Vice President of Santa Rosa Memorial Hospital. Schreck also served as the CEO of the Eden Township District Hospitals from 1992 to1998, and CEO of Delta Memorial Hospital from 1988-1992. He holds a BA degree from UCLA and Doctorate from USC. Mr. Schreck’s qualifications to serve on our Board of Directors include over 30 years of corporate experience working as a senior executive in the healthcare industry.

Suresh Nihalani. Mr. Nihalani joined the Company's Board of Directors in October 2008. Mr. Nihalani currently serves as a business consultant and advisor currently involved with many early stage ventures in the area of cloud computing, data centers, next generation storage and 4G backhaul wireless radios, consulting them in technology direction, business development and strategic business planning since 2008.. Mr. Nihalani was President and CEO of ClearMesh Network from 2005 to 2007. He also co-founded Nevis Networks, where he served as CEO from 2002 through 2005. From 1996 to 2001, he co-founded and served as CEO of Accelerated Networks. Prior to that he co-founded ACT Networks where he held various executive level positions. Mr. Nihalani holds a BS in Electrical Engineering from ITT Bombay and MSEE and MBA degrees from the Florida Institute of Technology. Mr. Nihalani's qualifications to serve on our Board of Directors include over 35 years of corporate experience working as a senior executive and director with both public and private organizations.

Gary Augusta. Mr. Augusta joined the Company's Board of Directors in March 2012 and has been our Executive Chairman since October 2013. In addition to Board responsibilities, Mr. Augusta focuses on capital and corporate development for the company. Mr. Augusta also serves as President of SpaGus Ventures LLC and SpaGus Capital Partners, growth funds that invest in healthcare and technology companies since January 2010. From March 2004 to December 2009, Mr. Augusta was President and CEO of OCTANe, an innovation development company. From June 1994 to March 2000, he was a Consultant and Principal for, AT Kearney, a leading consulting firm. From March 2001 to January 2004 he served as Corporate Development/ M&A Officer for Fluor Inc., a Fortune 500 company. He earned a BS in Mechanical Engineering from the University of Rhode Island and a Master of Science and Management (MSM) from Georgia Tech. Mr. Augusta's qualifications to serve on our Board of Directors includes his more than 20 years of experience as an executive focused on private equity, growth strategy and operations, corporate development and M&A.

Mitch Creem. Mr. Creem joined the Company's Board of Directors in October 2012. Mr. Creem has served as President of Bridgewater Healthcare Group, a hospital and health network management services and performance consulting firm since February 2012. From June 2008 to January 2012, Mr. Creem was the CEO for the Keck Hospital of USC and USC Norris Cancer Hospital where he led USC's acquisition of the hospitals from Tenet Healthcare. From 2004 to 2008 he was the Associate Vice Chancellor and Chief Financial Officer for the UCLA Medical Sciences. From 2000 to 2004, he served as CFO of Beth Israel Deaconess Medical Center and from 1996 to 2000 he served as CFO of Tufts Medical Center. Previously, he served as Manager with PriceWaterhouseCoopers in their healthcare consulting practice. He earned a BS in Accounting and Business Management from Boston University and an MHA in Hospital Administration from Duke University. Mr. Creem's qualifications to serve as Audit Committee financial expert include his experience as CFO of several major hospital systems and formal education in accounting. Mr. Creem's qualifications to serve on our Board of Directors include over 30 years of corporate experience working as a senior executive in the healthcare industry.

David Schmidt. Mr. Schmidt joined the Company's Board of Directors in May 2013. He has served as Principal of Schmidt & Associates, a consultancy practice that focuses on strategic planning and implementation in the healthcare industry, since January 2011. From August 2002 to December 2010, he served as the CEO and Member of the Board of SCAN Health Plan, the tenth largest Medicare Advantage plan in the country. From 2000 to 2002 he served as CEO of Medicheck, a firm that provided Internet-based financial service management to healthcare organizations, which was sold to Passport Health Communications. He served on Passport's Board from 2002 to 2006. From 1992 to

1998 he was the Senior Vice President of Sales and Customer Services for Care America/Blue Shield Health Plan and Regional Vice President for FHP Healthcare. He received a BA in Economics from UCLA and an MBA from The Anderson School of Management at UCLA. Mr. Schmidt's qualifications to serve as a member of the Company's Board of Directors include his 20 years of experience as a senior executive with several major healthcare companies. Prior to his healthcare experience he held senior management roles in manufacturing companies including Avery DenHe also serves on the board of Beacon Healthcare Systems. He, also, was a founding board member of the SCAN Foundation a 501(3)c corporation that is focused on Long Term Care in the United States.

Section 16(a) Beneficial Ownership Reporting Compliance

Section 16(a) of the Securities Exchange Act of 1934, as amended, requires our directors and executive officers, and persons who beneficially own more than 10% of our outstanding common stock, to file with the SEC, initial reports of ownership and reports of changes in ownership of our equity securities. Such persons are required by SEC regulations to furnish us with copies of all such reports they file, and we are required to identify Covered Persons that we know have failed to file or filed late Section 16(a) reports. To our knowledge, we believe that our Covered Persons complied with all Section 16(a) filing requirements applicable to them, except that: Messrs. Francis, Schreck, Augusta, Meyers, Creem, and Schmidt failed to file Forms 3 timely when they became obligated to commence Section 16(a) reporting; Messrs. Hosseinion, Francis, Nihalani and Augusta failed to file Forms 4 timely with respect to acquisitions of shares of our common stock; Messrs. Hosseinion, Meyers, and Vazquez failed to file Form 4s timely basis with respect to grants of stock options; Mr. Meyers failed to file Form 4 timely with respect to acquisition of warrants to purchase our common stock and a promissory note that is convertible into our common stock; and Messrs. Hosseinion, Francis, Schreck, Nihalani, Augusta, Meyers, Creem and Vazquez failed to file Forms 5 timely.

Code of Ethics

The Company has not yet adopted a code of ethics, in part because we have a limited number of employees. As the Company grows its business, and hires additional employees, we expect to adopt a code of ethics applicable to the conduct of our employees.

Committees of the Board of Directors

Our common stock is currently quoted on the OTCQB electronic trading platform, which does not maintain any standards requiring us to establish or maintain an Audit, Nominating or Compensation committee. As of January 31, 2014, our Board of directors did not maintain an audit committee established in accordance with Section 3(a)(58)(A) of the Exchange Act, a nominating committee nor a compensation committee. The entire Board of Directors is acting as the Company's audit committee as specified in section 3(a)(58)(B) of the Exchange Act, and the Board of Directors has determined that Mr. Mitch Creem, a current independent director, is an “audit committee financial expert” as defined by item 407 of Regulation S-K.

ITEM 11. EXECUTIVE COMPENSATION

The following table discloses the compensation awarded to, earned by, or paid to our executive officers for the fiscal years ended January 31, 2014 and 2013, respectively:

Summary Compensation Table

Name and Principal Position	Year	Salary($)	Bonus ($)	Stock Awards ($)(1)	Option Awards ($) (1)	Non-Equity Incentive Plan Earnings ($)	Non-Qualified Deferred Compensation Earnings ($)	All Other Compensation ($)	Total
Warren Hosseinion, M.D.	2014	467,500 (7)	-	-	-	-	-	126,451 (2)	593,951
Chief Executive Officer	2013	376,221 (7)	-	420,000	-	-	-	124,446 (2)	920,667
Kyle Francis	2014	140,625 (5)	-	135,000	-	-	-	64,662 (3)	340,279
Chief Financial Officer (5)	2013	-	-	269,500	-	-	-	208,890 (3)	478,390

Mark Meyers	2014	-	-	-	174,353	-	-	126,000	(6)	300,353
Chief Strategy Officer (4)	2013	-	-	168,000	55,617	-	-	42,000	(6)	265,617

(1) The amount shown in this column reflects the aggregate grant date fair value computed in accordance with FASB ASC Topic 718.

(2) Reflects personal benefits payments to Dr. Hosseinion for health, life, disability insurance premiums aggregating $43,483 (2014), $24,972 (2013),); vehicle allowance of $31,726 (2014), $24,972 (2013); and travel, meals, cell phone and other business expense-related allowances.

(3) Reflects payments made to Kaneohe Advisors, LLC pursuant to the consulting agreement with Kaneohe Advisors LLC dated March 15, 2009, as amended, of $49,500 (2014), $162,000 (2013); and personal benefits include payments to Mr. Francis of $15,162 (2014), $5,400 (2013) in health insurance premiums; and reimbursement of travel, meals, cell phone and other business related expenses.

(4) Mr. Meyers was appointed as Chief Strategy Officer effective October 17, 2012.

(5) On March 1, 2013, the Company entered into a direct employment agreement with Mr. Francis, which provides for salary of $225,000 per annum and reimbursement of health insurance premiums not to exceed $1,200 per month.

(6) On October 8, 2012 the Company entered into a consulting agreement with Mr. Mark Meyers to perform services as the Company’s Chief of Strategy and Business Development, pursuant to which Mr. Meyers received $10,000 per month and 50,000 vested options per month. The consulting agreement was amended in October 2013, pursuant to which Mr. Meyers received $10,000 per month and 60,000 vested options through December 31, 2013.

(7) Dr. Hosseinion's salary is for both patient care and non-clinical work in his role as the Company's Chief Executive Officer.

The following table summarizes the outstanding equity option awards held by each of our named executive officers as of January 31, 2014:

Outstanding Equity Awards at Fiscal Year End

	Option Awards					Stock Awards		
Name and Principal Position	**Grant Date**	**Number of Securities Underlying Unexercised Options-Exercisable**	**Number of Securities Underlying Unexercised Options-Unexercisable**	**Option Exercise Price (2)**	**Option Expiration Date**	**Number of Shares That Have Not Vested**	**Market Value of Shares That Have Not Vested**	**Equity Incentive Plan Awards: Unearned or Unvested Shares**
Warren Hosseinion, M.D. Chief Executive Officer	12/9/2010	300,000	-	$0.15	12/8/2020	-	-	-
Mark Meyers Chief Strategy Officer	(1)	660,000	-	$0.23	(1)	155,556 (3)	$65,000	-
Kyle Francis Chief Financial Officer	12/9/2010	150,000	-	$0.15	12/8/2020	-	-	-

(1) Mr. Meyers was granted 50,000 options per month from November 1, 2012 to October 1, 2013; and 60,000 options on October 22, 2013. Mr. Meyer's options expire 10 years from grant date.

(2) All options have been issued with an exercise price equal to the closing price of our common stock on the date of grant except 600,000 options granted to Mr. Meyers at an exercise price of $0.21 per share. The weighted average closing stock price for the 600,000 shares on the dates of grant was $0.62 per share.

(3) Reflects shares acquired by Mr. Meyers for $0.001 per share in which the Company’s right to repurchase has not lapsed. From date of purchase the shares lapses evenly on a monthly basis over 36 months.

No options were exercised during the fiscal year ended January 31, 2014.

Employment and Hospitalist Participation Service Agreements

Warren Hosseinion, M.D. In February 2009, the Company entered into a Second Amended and Restated Hospitalist Participation Agreement with Dr. Hosseinion, pursuant to which he provided physician services for ApolloMed Hospitalists. Effective February 2009, Dr. Hosseinion’s annual base salary was set at $360,000 payable in bimonthly installments. Dr. Hosseinion's salary was for physician services only and he did not receive any compensation to serve as Chief Executive Officer or for his services as a Director. He was eligible to receive equity awards, in each case as determined by the Board of Directors in accordance with the 2010 Equity Incentive Plan. The Company maintained Dr. Hosseinion’s professional liability insurance.

On March 28, 2014, Apollo Medical Holdings, Inc. (the "Company") entered into an equity and debt investment for up to $12.0 million with NNA of Nevada, Inc. ("NNA"). As part of the Investment, Apollo Medical Management, Inc. ("Apollo Management"), a subsidiary of the Company, entered into Employment Agreements with each of Warren Hosseinion, M.D., the Company's Chief Executive Officer (the "Hosseinion Employment Agreement") and Adrian Vazquez, M.D. (the "Vazquez Employment Agreement" and, together with the Hosseinion Employment Agreement, the "Employment Agreements"), pursuant to which Dr. Hosseinion and Dr. Vazquez have agreed to serve as senior executives of Apollo Management. The Employment Agreements provide for (i) base salary of $200,000 per year, (ii) participation in any incentive compensation plans and stock plans of Apollo Management that are available to other similarly positioned employees of Apollo Management, and (iii) reimbursement of expenses incurred on behalf of Apollo Management.

Apollo Management has the right under the Hosseinion Employment Agreement to terminate Dr. Hosseinion for cause if, among other things, there is a material and uncured breach by Dr. Hosseinion of any of the following: (i) the Hosseinion Hospitalist Participation Agreement (as defined below) or other employment agreement with ApolloMed Hospitalists, a California professional corporation ("AH"), (ii) that certain Shareholder Agreement dated as of March 28, 2014, by and among Dr. Hosseinion, the Company, Apollo Management, Adrian Vazquez, M.D. and Lender (the "Shareholder Agreement"), and (iii) various Physician Shareholder Agreements. Apollo Management has the right under the Vazquez Employment Agreement to terminate Dr. Vazquez for cause if, among other things, there is a material and uncured breach by Dr. Vazquez of either (i) the Vazquez Hospitalist Participation Agreement (as defined below) or other employment agreement with AH or (ii) the Shareholder Agreement. The Employment Agreements replaced, and thereby terminated, prior employment agreements with each of Dr. Hosseinion and Dr. Vazquez.

Also on March 28, 2014, AH entered into Hospitalist Participation Service Agreements with each of Dr. Hosseinion (the "Hosseinion Hospitalist Participation Agreement") and Dr. Vazquez (the "Vazquez Hospitalist Participation Agreement" and, together with the Hosseinion Hospitalist Participation Agreement, the "Hospitalist Participation Agreements"), pursuant to which Dr. Hosseinion and Dr. Vazquez provide physician services for AH. The Hospitalist Participation Agreements provide for (i) base salary of $195,000 per year, (ii) a $55,000 annual car and communications allowance, and (iii) reimbursement of reasonable business expenses. The Hospitalist Participation Agreements replaced, and thereby terminated, prior hospitalist participation service agreements between AH and each of Dr. Hosseinion and Dr. Vazquez.

As a condition of the Company causing its affiliates to enter into the Hospitalist Participation Agreements and the Employment Agreements, on March 28, 2014, the Company entered into Stock Option Agreements with each of Dr. Hosseinion (the "Hosseinion Stock Option Agreement") and Dr. Vazquez (the "Vazquez Stock Option Agreement" and, together with the Hosseinion Stock Option Agreement, the "Stock Option Agreements"). The Stock Option Agreements provide that each of Dr. Hosseinion and Dr. Vazquez grant the Company the option to purchase (at fair market value) all equity interests in the Company held by Dr. Hosseinion or Dr. Vazquez, as applicable, in the event that (i) either the applicable Hospitalist Participation Agreement or the applicable Employment Agreement is terminated by the Company for cause due to a willful or intentional breach by Dr. Hosseinion or Dr. Vazquez, as applicable, (ii) Dr. Hosseinion or Dr. Vazquez, as applicable, commits fraud or any felony against the Company or any of its affiliates, (iii) Dr. Hosseinion or Dr. Vazquez, as applicable, directly or indirectly solicits any patients, customers, clients, employees, agents or independent contractors of the Company or any of its affiliates for competitive purposes or (iv)

Dr. Hosseinion or Dr. Vazquez, as applicable, directly or indirectly Competes (as such term is defined in the Stock Option Agreements) with the Company or any of its affiliates.

On March 15, 2009, the Company entered into a Consulting Agreement with Kaneohe Advisors LLC (Kyle Francis) under which Mr. Francis became the Company's Executive Vice President, Business Development and Strategy. Under the terms of the Agreement, Mr. Francis was compensated at a rate of $8,000 per month. In addition, Mr. Francis received 350,000 shares of restricted stock at the date of the Agreement and was entitled to 350,000 additional restricted shares on the first and second anniversaries of the Agreement, provided the Agreement was not terminated. The initial 350,000 shares, along with 50,000 shares granted to Mr. Francis in the fiscal year ended January 31, 2009, were issued in the third quarter ended October 31, 2009. On March 15, 2011, the second anniversary of the Consulting Agreement, Mr. Francis was granted an additional 350,000 shares. Mr. Francis was named Chief Financial Officer on December 31, 2010. Mr. Francis' compensation was increased to $11,000 per month. On August 16, 2012, the Company entered into an amended consulting agreement with Kaneohe Advisors LLC, to serve as the Company's Executive Vice President, Business Development and Chief Financial Officer. The term of the agreement was on a month-to-month basis, and provided for Mr. Francis to receive $11,900 per month and the right to purchase 700,000 shares of the Company's common stock at $0.001 per share. The agreement could be terminated by either party at any time.

On March 1, 2013 the Company entered into an employment agreement with Mr. Francis whereby Mr. Francis receives a salary of $225,000 per annum, reimbursement of up to $1,200 per month in health insurance premiums, additional performance-based cash and stock compensation as determined by the Company's board of directors, and other standard benefits afforded to the Company's employees. If Mr. Francis' employment is terminated prior to the first anniversary for any reason other than gross negligence or misconduct, Mr. Francis is entitled to the remaining unpaid first year salary and health insurance reimbursement. The agreement was effective commencing June 1, 2013. Effective February 1, 2014, the Company's Board of Directors increased Mr. Francis' annual salary to $272,000.

On October 8, 2012 the Company entered into a consulting agreement with Mr. Mark Meyers to perform services as the Company's Chief of Strategy and Business Development, pursuant to which Mr. Meyers received $10,000 per month, the right to receive options to acquire 50,000 shares per month of the Company's common stock with an exercise price of $0.21 per share, and is eligible for performance-based compensation as determined by the Company's Board of Directors. Mr. Meyers has the option to convert all or a portion of the cash compensation to equity at a conversion price equal to a discount of 30% from the trailing 90 day average of the closing price of the Company's common stock. The agreement is terminable by either party without cause upon providing 90 days' notice. Effective October 1, 2013, the Company extended Mr. Meyers consulting agreement until December 31, 2013 under which Mr. Meyers received $10,000 per month, and 60,000 options of the Company's common stock with an exercise price equal to the fair value of the Company's common stock at the date of grant. Mr. Meyers' options vested on various dates through December 31, 2013.

Outstanding Equity Awards at Fiscal Year-End

On March 4, 2010, the Board of Directors of Apollo Medical Holdings, Inc. and three members of our Board that owned, in the aggregate, approximately 65% of the outstanding shares of our common stock, approved the adoption of the Apollo Medical Holdings, Inc., 2010 Equity Incentive Plan. Subject to the adjustment provisions of the Plan that

are applicable in the event of a stock dividend, stock split, reverse stock split or similar transaction, up to 5,000,000 shares of common stock may be issued under the Plan.

On August 31, 2012 the Company’s Board of Directors amended the 2010 Plan, which allowed the Board to grant an additional 7,000,000 shares up to 12,000,000 shares of the Company’s common stock. The Plan awards include incentive stock option, non-qualified options, restricted common stock, and stock appreciation rights and was approved by unanimous written consent of two stockholders that beneficially owned in the aggregate 57.0% of the outstanding shares of the Company’s common stock at the consent date.

On April 29, 2013 the Company's Board of Directors approved the Company's 2013 Equity Incentive Plan (the "2013 Plan"), pursuant to which 5,000,000 shares of the Company's common stock will be reserved for issuance there under. The Plan awards include incentive stock option, non-qualified options, restricted common stock, and stock appreciation rights and was approved by unanimous written consent of two stockholders that beneficially owned in the aggregate 54.0% of the outstanding shares of the Company's common stock at the consent date.

During the fiscal year ended January 31, 2013, 4,225,000 options were granted to management, directors and independent contractors of which 1,583,336 were exercisable as of January 31, 2013 at a weighted-average exercise price of $0.18 per share.

During the fiscal year ended January 31, 2014, 2,935,000 options were granted, including 1,020,250 options that were cancelled and reissued, to management, directors and independent contractors of which collectively 5,916,890 were exercisable as of January 31, 2014 at a weighted-average exercise price of $0.16 per share.

Director Compensation

Gary Augusta

Effective as of March 7, 2012, Gary Augusta was appointed to the Company's Board of Directors. In connection with his service to the Company as a director, Mr. Augusta entered into the Company's Director Agreement, which provided for Mr. Augusta to be a director and entitles Mr. Augusta to acquire 400,000 shares of the Company's Common Stock at a price of $.001 per share. The Company's right, but not obligation, to repurchase the shares lapses monthly at a rate of 1/36 per month over a three year time period. In connection with Mr. Augusta's service as a consultant to the Company, Mr. Augusta, through his entity, Augusta Advisors Inc., entered into a Consulting Agreement with the Company which became effective December 1, 2011. Pursuant to that agreement, various consulting services were provided to the Company in return for $10,000 per month in cash compensation and to acquire 100,000 shares of common stock for a price of $0.001 per share each month issued in the name of Gary Augusta monthly over the initial term of the agreement (totaling 700,000 shares of common stock) expiring June 20, 2012. Thereafter, the Company extended Mr. Augusta on month-to-month basis in return for $10,000 per month in cash compensation and eligibility for incentive stock awards as determined by the Board of Directors.

On November 18, 2013, the Company entered into a Consulting and Representation Agreement (the "Consulting Agreement") with Augusta Advisors, Inc. under which Mr. Augusta agreed to serve as Executive Chairman, and which is effective from October 1, 2013, supersedes the prior agreement with Mr. Augusta dated December 1, 2011, and terminates on December 31, 2014.

Pursuant to the Senior Secured Note agreement on February 1, 2012, as amended October 15, 2012, with SpaGus Capital Partners, LLC and SpaGus Apollo, LLC, of which Mr. Augusta is a member ("SpaGus"), SpaGus received 366,000 shares and interest and fees aggregating $60,695 from inception of the arrangement.

Edward "Ted" Schreck

Effective as of February 15, 2012, Edward "Ted" Schreck was appointed to the Company's Board of Directors was also appointed as the Chairman of the Board of Directors. In connection with his service to the Company as a director and Chairman, Mr. Schreck entered into the Company's Director Agreement which entitles such director to receive a combined $30,000 annual cash retainer for his board service as well as an initial option grant of 1,000,000 options. These options vest evenly over a 3-year period. Effective October 1, 2013 relinquished his position as Chairman upon appointment of Mr. Augusta as Executive Chairman. Mr. Schreck will receive a fee of $1,000 per board meeting attended, and will be reimbursed for reasonable and customary expenses incurred therewith.

Suresh Nihalani

In connection with his service to the Company as a director, Mr. Nihalani entered into the Company's Director Agreement on October 27, 2008 (as amended on July 16, 2010), which provided for Mr. Nihalani to be a director and entitled Mr. Nihalani to receive a restricted stock grant of 400,000 shares of the Company's common stock. On January 1, 2012 the Company amended the 2010 Director Agreement with Mr. Nihalani pursuant to which Mr. Nihalani received the right to purchase an additional 400,000 shares of the Company's restricted common stock for $0.001 per share which will vest monthly over 36 months. The Company has the right but not the obligation to repurchase the unvested portion of these shares at $0.001 per share. Mr. Nihalani receives a fee of $1,000 per board meeting attended, and will be reimbursed for reasonable and customary expenses incurred therewith.

Mitch Creem

On October 22, 2012 Mitchell R. Creem was elected to the Company's Board of Directors. In connection with his service to the Company as a director, Mr. Creem entered into the Company's Director Agreement which entitled Mr. Creem to receive 500,000 restricted shares of the Company's common stock for his board service which will vest monthly over 36 months. Mr. Creem receives a fee of $1,000 per board meeting attended, and will be reimbursed for reasonable and customary expenses incurred therewith.

David Schmidt

On May 22, 2013, the Board of Directors of the Company elected David G. Schmidt, 65, as a member of the Board. Mr. Schmidt entered into the Company's form of Director Agreement, which entitled him to receive a fee of $1,000 per Board meeting attended, as well as a grant of 400,000 restricted shares of the Company's common stock for his Board service. These restricted shares vest evenly on a monthly basis over a 36 month period.

The following Summary Compensation Table reflects the compensation awarded to, earned by, or paid to our outside directors for the year ended January 31, 2014.

Name	Fees Earned or Paid in Cash ($)	Stock Awards ($) (1)	Option Awards ($) (1)	Non-Equity Incentive Plan Earnings ($)	Non-Qualified Deferred Compensation Earnings ($)	All Other Compensation ($)	Total ($)
Gary Augusta	-	180,000 (2)	-	-	-	179,307 (3)	359,307
David Schmidt	6,000	-	69,464	-	-	-	75,464
Ted Schreck	23,000	-	-	-	-	2,721	25,721
Suresh Nihalani	10,000	-	-	-	-	1,211	11,211
Mitch Creem	10,000	-	-	-	-	-	10,000

(1) The amount shown in this column reflects the aggregate grant date fair value computed in accordance with FASB ASC Topic 718.

(2) Pursuant to a consulting agreement with Augusta Advisors Corporation dated December 1, 2011, Mr. Augusta received 300,000 shares of common with a grant date fair value of $135,000; and pursuant to the Senior Secured Note

agreement on February 1, 2012, as amended October 15, 2012, with SpaGus Apollo, LLC, of which Mr. Augusta is a member (“SpaGus”), SpaGus directly received 100,000 shares with a grant date fair value of $45,000. Mr. Augusta disclaims beneficial ownership of the shares held by SpaGus except to the extent of his pecuniary interest therein, and the filing of this report and inclusion of these shares in this table is not an admission that Mr. Augusta is the beneficial owner of these shares for purposes of Section 16 or for any other purpose.

(3) Pursuant to a consulting agreement with Augusta Advisors Corporation dated December 1, 2011, Mr. Augusta received cash compensation of $90,500; on November 18, 2013, the Company entered into a Consulting and Representation Agreement (the “Consulting Agreement”) with Augusta Advisors, Inc. (“Mr. Augusta”), in which Mr. Augusta agreed to provide business and strategic services and makes Mr. Augusta available as the Company’s Executive Chairman of the Board, which is effective from October 1, 2013, supersedes the December 1, 2011 agreement with Mr. Augusta, and terminates on December 31, 2014. Mr. Augusta is paid $15,000 per month and $2,000 per month for expenses $51,000 in 2014; and pursuant to the Senior Secured Note agreement on February 1, 2012, as amended October 15, 2012, with SpaGus Apollo, LLC, of which Mr. Augusta is a member (“SpaGus”), SpaGus directly received interest and fees aggregating $31,307. Mr. Augusta disclaims beneficial ownership of the shares held by SpaGus except to the extent of his pecuniary interest therein, and the filing of this report and inclusion of these shares in this table is not an admission that Mr. Augusta is the beneficial owner of these shares for purposes of Section 16 or for any other purpose.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The following table sets forth certain information as of April 30, 2014, with respect to (i) those persons known to us to beneficially own more than 5% of our voting securities, (ii) each of our directors, (iii) each of our executive officers, and (iv) all directors and executive officers as a group. The information is determined in accordance with Rule 13d-3 promulgated under the Exchange Act. Except as indicated below, the beneficial owners have sole voting and dispositive power with respect to the shares beneficially owned.

Name and Address of Beneficial Owner (1)	Shares Beneficially Owned (2)	Percent of Class (3)	
Certain Beneficial Owners:			
Adrian Vazquez, M.D.	9,423,387	19.2	%
NNA of Nevada, Inc. (5)	6,000,000	12.2	%
Tommy Maartensson (4)	2,873,996	5.8	%
Directors/Named Executive Officers:			
Warren Hosseinion, M.D.	10,423,387	21.2	%
Kyle Francis	2,250,000	4.6	%
Gary Augusta	1,766,000	3.6	%
Mark Meyers	1,485,000	3.0	%
Suresh Nihalani	800,000	1.6	%
Ted Schreck	1,000,000	2.0	%
Mitch Creem	500,000	1.0	%
David Schmidt	155,556	0.3	%
All Named Executive Officers and Directors as a group	18,379,943	37.4	%

(1) Unless otherwise indicated, the business address of each person listed is c/o Apollo Medical Holdings, Inc., 700 N. Brand Blvd., Suite 220, Glendale, California 91203.

(2) For purposes of this table, shares are considered beneficially owned if the person directly or indirectly has the sole or shared power to vote or direct the voting of the securities or the sole or shared power to dispose of or direct the disposition of the securities. Shares are also considered beneficially owned if a person has the right to acquire beneficial ownership of the shares within 60 days of April 30, 2014.

(3) The percentages are calculated based on the actual number of shares issued and outstanding as of April 30, 2014 which is 49,134,549.

(4) c/o Syndicated Capital 1299 Ocean Avenue, Suite 210, Santa Monica, CA 90401

(5) 920 Winter Street, Waltham, Massachusetts 02451. Excludes securities issuable to NNA under Convertible Note that has not been funded as of April 30, 2014.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

Transactions with Related Persons

On January 31, 2013 Mr. Mark Meyers, the Company’s Chief Strategy Officer and a director of the Company, purchased two units of $50,000 par value 9% Senior Subordinated Callable Convertible Promissory Notes due February 15, 2016, or $100,000 in the aggregate, which are convertible at any time into 250,000 shares of the Company’s common stock at an exercise price of $0.40 per share. Each unit received warrants to purchase 37,500 shares of the Company's common stock at an exercise price of $0.45 per share, and had a grant date fair value aggregating $21,238 computed in accordance with ASC Topic 718.

The Company entered into a Senior Secured Note ("Note") agreement on February 1, 2012 with SpaGus Capital Partners, LLC ("SpaGus") an entity in which Gary Augusta, a director and shareholder of the Company, holds an ownership interest. The terms of the Note provided for interest at 8.929% per annum, payments of principal of $135,000 on each of September 15, 2012 and October 15, 2012, and are secured by substantially all assets of the Company. The Company prepaid interest on the Note principal of $15,000 in accordance with the Note, and paid financing costs of $5,000 in cash and the issuance of 216,000 shares of the Company's common stock, which was valued at $25,661 at the date of issuance. On September 15, 2012, SpaGus agreed to allow the Company to defer payment of the scheduled principal payments due on September 15 and October 15, 2012, and amended the Note effective October 15, 2012 in which SpaGus Apollo, LLC agreed to provide additional principal to the Company in the amount of $230,000. The terms of the amended Note in the amount of $500,000 provided for borrowings to bear interest at 8.0 % per annum with accrued interest payable in arrears on each of December 28, 2012, March 31, 2013, June 30, 2013, and October 15, 2013. The amended Note was to have matured October 15, 2013, and could be prepaid at any time prior to September 29, 2013. The Company paid SpaGus Apollo, LLC financing costs of 100,000 restricted shares of the Company's common stock on the amendment date, which had a fair value of $50,000. On April 15, 2013, the Company issued an additional 100,000 restricted shares of the Company's common stock to SpaGus required under the terms of the amended Note, which had a fair value of $45,000 at the obligation date. The amended Note matured and was repaid, including accrued unpaid interest, on October 16, 2013.

Director Independence

Our common stock is quoted on the OTCQB electronic trading platform, which does not maintain any standards regarding the "independence" of the directors on our Company's Board, and we are not otherwise subject to the requirements of any national securities exchange or an inter-dealer quotation system with respect to the need to have a majority of our directors be independent. In the absence of such requirements, we have elected to use the definition for director independence under the NASDAQ stock market's listing standards, which defines an independent director as "a person other than an officer or employee of the Company or its subsidiaries or any other individual having a relationship, which in the opinion of our Board, would interfere with the exercise of independent judgment in carrying out the responsibilities of a director." The definition further provides that, among others, employment of a director by us (or any parent or subsidiary of ours) at any time during the past three years is considered a bar to independence regardless of the determination of our Board. Based on the foregoing standards, the Board has determined that Ted Schreck, Suresh Nihalani, Mitch Creem and David Schmidt are "independent" directors.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The aggregate fees for professional services rendered by Kabani and Company, Inc. to us for the fiscal years ended January 31, 2014 and January 31, 2013 were as follows:

	2014	2013

Audit fees (1)	$48,000	$44,000
Audit-related fees (2)	-	-
Tax fees (3)	-	-
All other fees	-	-
Total	$48,000	$44,000

(1) Audit fees represent fees for professional services provided in connection with the audit of our annual financial statements and the review of our financial statements included in our Forms 10-Q quarterly reports and services that are normally provided in connection with statutory or regulatory filings for the 2014 and 2013 fiscal years.

(2) Audit-related fees represent fees for assurance and related services that are reasonably related to the performance of the audit or review of our financial statements and not reported above under “Audit Fees.”

(3) Tax fees represent fees for professional services related to tax compliance, tax advice and tax planning.

Audit Committee Pre-Approval Policies and Procedures

The policy of our board of directors, acting as the audit committee, is to pre-approve all audit and permissible non-audit services provided by our independent auditors. These services may include audit services, audit-related services, tax services and other services. Pre-approval is generally provided for up to one year and any pre-approval is detailed as to the particular service or category of services. All services and fees described above for the years ended January 31, 2014 and 2013 were approved by our Board.