RadNet, Inc.
Form 10-K
March 15, 2016

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2015

Commission File Number 001-33307

RadNet, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**13-3326724**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
1510 Cotner Avenue Los Angeles, California	**90025**
(Address of principal executive offices)	**(Zip Code)**

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

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

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

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes 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.

Large Accelerated Filer ¨	Accelerated Filer x
Non-Accelerated Filer ¨ (Do not check if a smaller reporting company)	Smaller Reporting Company ¨

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

The aggregate market value of the registrant's common stock held by non-affiliates of the registrant was approximately $266,105,775 on June 30, 2015 (the last business day of the registrant's most recently completed second quarter) based on the closing price for the common stock on the NASDAQ Global Market on June 30, 2015.

The number of shares of the registrant's common stock outstanding on March 10, 2016, was 47,193,286

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive proxy statement for the 2016 Annual Meeting of Stockholders are incorporated herein by reference in Part III of this annual report on Form 10-K to the extent stated herein. Such proxy statement will be filed with the Securities and Exchange Commission pursuant to Regulation 14A not later than 120 days after the close of the registrant's fiscal year.

RADNET, INC.

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Cautionary Note Regarding Forward-Looking Statements

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

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

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

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

PART I

Item 1. Business

Business Overview

We are a leading national provider of freestanding, fixed-site outpatient diagnostic imaging services in the United States based on number of locations and annual imaging revenue. At December 31, 2015, we operated directly or indirectly through joint ventures with hospitals, 300 centers located in California, Delaware, Florida, Maryland, New Jersey, New York, and Rhode Island. Our centers provide physicians with imaging capabilities to facilitate the diagnosis and treatment of diseases and disorders and may reduce unnecessary invasive procedures, often reducing the cost and amount of care for patients. Our services include magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), nuclear medicine, mammography, ultrasound, diagnostic radiology (X-ray), fluoroscopy and other related procedures. The vast majority of our centers offer multi-modality imaging services, a key point of differentiation from our competitors. Our multi-modality strategy diversifies revenue streams, reduces exposure to reimbursement changes and provides patients and referring physicians one location to serve the needs of multiple procedures.

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

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

In December 2015 we entered into a multi-year strategic relationship with Imaging Advantage LLC. We will collaborate to develop business models to deliver radiology services. In addition, the State of Qatar selected RadNet to

help direct Screen for Life, a public-private partnership with the Qatari government to provide screening services as part its national health strategy.

We derive substantially all of our revenue from fees charged for the diagnostic imaging services performed at our facilities. For the years ended December 31, 2015, 2014 and 2013, we performed 5,638,979, 4,828,488, and 4,525,490 diagnostic imaging procedures and generated net revenue of $809.6 million, $717.6 million, and $703.0 million, respectively. Additional information concerning RadNet, Inc., including our consolidated subsidiaries, for each of the years ended December 31, 2015, 2014 and 2013 is included in the consolidated financial statements and notes thereto in this annual report.

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

History of our Business

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

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

In addition to our imaging business, our eRAD, Inc. subsidiary is a provider of PACS and related workflow solutions to the radiology industry. Over 250 hospitals, teleradiology businesses, imaging centers and specialty physician groups use eRAD's technology to distribute, display, store and retrieve digital images taken from all diagnostic imaging modalities. eRAD has approximately 56 employees, including a research and development team of 19 software engineers in Budapest, Hungary.

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

In January 2011, we entered into a new line of business with the acquisition of Imaging On Call, LLC, a provider of teleradiology services to radiology groups, hospitals and imaging centers located in Poughkeepsie, New York. Through our teleradiology business, we provide interpretation services to approximately 50 hospitals and hospital-based radiology groups.

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

Available Information

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

Industry Overview

Diagnostic imaging involves the use of non-invasive procedures to generate representations of internal anatomy and function that can be recorded on film or digitized for display on a video monitor. Diagnostic imaging procedures facilitate the early diagnosis and treatment of diseases and disorders and may reduce unnecessary invasive procedures, often minimizing the cost and amount of care for patients. Diagnostic imaging procedures include MRI, CT, PET, nuclear medicine, ultrasound, mammography, X-ray and fluoroscopy. We estimate that the national imaging market in the United States is $100 billion annually and we project mid-single digit growth for MRI, CT and PET/CT over the next several years, driven by the aging of the U.S. population, wider physician and payor acceptance for imaging technologies, and greater consumer and physician awareness of diagnostic screening capabilities.

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

Diagnostic Imaging Settings

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

Fixed-site, freestanding outpatient diagnostic facilities

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

Hospitals

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

Mobile Imaging

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

Diagnostic Imaging Modalities

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

MRI

MRI has become widely accepted as the standard diagnostic tool for a wide and fast-growing variety of clinical applications for soft tissue anatomy, such as those found in the brain, spinal cord, abdomen, heart and interior ligaments of body joints such as the knee. MRI uses a strong magnetic field in conjunction with low energy electromagnetic waves that are processed by a computer to produce high-resolution, three-dimensional, cross-sectional images of body tissue. A typical MRI examination takes from 20 to 45 minutes. MRI systems are designed as either open or closed and have magnetic field strength of 0.2 Tesla to 3.0 Tesla and are priced in the range of $0.6 million to $2.5 million. As of December 31, 2015, we had 231 MRI systems in operation.

CT

CT provides higher resolution images than conventional X-rays, but generally not as well defined as those produced by MRI. CT uses a computer to direct the movement of an X-ray tube to produce multiple cross-sectional images of a particular organ or area of the body. CT is used to detect tumors and other conditions affecting bones and internal organs. It is also used to detect the occurrence of strokes, hemorrhages and infections. A typical CT examination takes from 15 to 45 minutes. CT systems are priced in the range of $0.3 million to $1.2 million. As of December 31, 2015, we had 144 CT systems in operation.

PET

PET scanning involves the administration of a radiopharmaceutical agent with a positron-emitting isotope and the measurement of the distribution of that isotope to create images for diagnostic purposes. PET scans provide the capability to determine how metabolic activity impacts other aspects of physiology in the disease process by correlating the reading for the PET with other tools such as CT or MRI. PET technology has been found highly effective and appropriate in certain clinical circumstances for the detection and assessment of tumors throughout the body, the evaluation of some cardiac conditions and the assessment of epilepsy seizure sites. The information provided by PET technology often obviates the need to perform further highly invasive or diagnostic surgical procedures. PET systems are priced in the range of $0.8 million to $2.5 million. In addition, we employ combined PET/CT systems that blend the PET and CT imaging modalities into one scanner. These combined systems are priced in the range of $1.1 million to $2.8 million. As of December 31, 2015, we had 46 PET or combination PET/CT systems in operation.

Nuclear Medicine

Nuclear medicine uses short-lived radioactive isotopes that release small amounts of radiation that can be recorded by a gamma camera and processed by a computer to produce an image of various anatomical structures or to assess the function of various organs such as the heart, kidneys, thyroid and bones. Nuclear medicine is used primarily to study anatomic and metabolic functions. Nuclear medicine systems are priced in the range of $300,000 to $400,000. As of December 31, 2015, we had 49 nuclear medicine systems in operation.

X-ray

X-rays use roentgen rays to penetrate the body and record images of organs and structures on film. Digital X-ray systems add computer image processing capability to traditional X-ray images, which provides faster transmission of images with a higher resolution and the capability to store images more cost-effectively. X-ray systems are priced in the range of $95,000 to $440,000. As of December 31, 2015, we had 393 X-ray systems in operation.

Ultrasound

Ultrasound imaging uses sound waves and their echoes to visualize and locate internal organs. It is particularly useful in viewing soft tissues that do not X-ray well. Ultrasound is used in pregnancy to avoid X-ray exposure as well as in gynecological, urologic, vascular, cardiac and breast applications. Ultrasound systems are priced in the range of $90,000 to $250,000. As of December 31, 2015, we had 498 ultrasound systems in operation.

Mammography

Mammography is a specialized form of radiology using low dosage X-rays to visualize breast tissue and is the primary screening tool for breast cancer. Mammography procedures and related services assist in the diagnosis of and treatment planning for breast cancer. Analog mammography systems are priced in the range of $70,000 to $100,000, and digital mammography systems are priced in the range of $250,000 to $400,000. As of December 31, 2015, we had 260 mammography systems in operation.

Fluoroscopy

Fluoroscopy uses ionizing radiation combined with a video viewing system for real time monitoring of organs. Fluoroscopy systems are priced in the range of $100,000 to $400,000. As of December 31, 2015, we had 105 fluoroscopy systems in operation.

Industry Trends

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

Escalating Demand for Healthcare Services from an Aging Population

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

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

New Effective Applications for Diagnostic Imaging Technology

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

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

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

Wider Physician and Payor Acceptance of the Use of Imaging

During the last 30 years, there has been a major effort undertaken by the medical and scientific communities to develop higher quality, cost-effective diagnostic imaging technologies and to minimize the risks associated with the application of these technologies. The thrust of product development during this period has largely been to reduce the hazards associated with conventional X-ray and nuclear medicine techniques and to develop new, less harmful imaging technologies. As a result, the use of advanced diagnostic imaging modalities, such as MRI, CT and PET,

which provide superior image quality compared to other diagnostic imaging technologies, has increased rapidly in recent years. These advanced modalities allow physicians to diagnose a wide variety of diseases and injuries quickly and accurately without exploratory surgery or other surgical or invasive procedures, which are usually more expensive, involve greater risk to patients and result in longer rehabilitation time. Because advanced imaging systems are increasingly seen as a tool for reducing long-term healthcare costs, they are gaining wider acceptance among payors.

Greater Consumer Awareness of and Demand for Preventive Diagnostic Screening

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

Expansion of Teleradiology Services

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

Our Competitive Strengths

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

As of December 31, 2015, we operated 300 centers in California, Delaware, Florida, Maryland, New Jersey, New York and Rhode Island. Our size and scale allow us to achieve operating, sourcing and administrative efficiencies, including equipment and medical supply sourcing savings and favorable maintenance contracts from equipment manufacturers and other suppliers. Our specific knowledge of our geographic markets drives strong relationships with key payors, radiology groups and referring physicians within our markets.

Our Comprehensive "Multi-Modality" Diagnostic Imaging Offering

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

Our Competitive Pricing

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

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

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

Our Strong Relationships with Payors and Diversified Payor Mix

Our revenue is derived from a diverse mix of payors, including private payors, managed care capitated payors and government payors, which should mitigate our exposure to possible unfavorable reimbursement trends within any one payor class. In addition, our experience with capitation arrangements has provided us with the expertise to manage utilization and pricing effectively, resulting in a predictable and recurring stream of revenue. We believe that third-party payors representing large groups of patients often prefer to enter into managed care contracts with providers that offer a broad array of diagnostic imaging services at convenient locations throughout a geographic area. In 2015, we received approximately 57% of our payments from commercial insurance payors, 12% from managed care capitated payors, 20% from Medicare and 3% from Medicaid. With the exception of Blue Cross/Blue Shield, which are managed by different entities in each of the states in which we operate, and Medicare, no single payor accounted for more than 5% of our net revenue for the twelve months ended December 31, 2015.

Our Strong Relationships with Experienced and Highly Regarded Radiologists

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

Our Experienced and Committed Management Team

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

Our Technologically Advanced Imaging Systems

In late 2010 and early 2011 we expanded our offering of imaging related services with our acquisition of eRad (development and sale of computerized imaging systems for the imaging industry) and Imaging On Call (teleradiology

services for interpretation of images for radiology groups, hospitals and others after business hours, for overflow and specialty work). In addition, we have assembled an industry leading team of software developers to create radiology workflow solutions for our internal use.

Business Strategy

Maximize Performance at Our Existing Facilities

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

Expansion Into Related Businesses

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

Focus on Profitable Contracting

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

Optimize Operating Efficiencies

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

upgrade our advanced information technology system to create cost reductions for our facilities in areas such as image storage, support personnel and financial management.

Expand Our Networks

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

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

Our Services

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

The key features of our services include:

- patient-friendly, non-clinical environments;
- a 24-hour turnaround on routine examinations;

- interpretations within one to two hours, if needed;

- flexible patient scheduling, including same-day appointments;

- extended operating hours, including weekends;

- reports delivered by courier, facsimile or email;

- availability of second opinions and consultations;

- availability of sub-specialty interpretations at no additional charge; and

- standardized fee schedules by region.

Radiology Professionals

In the states in which we provide services (except Florida), a lay person or any entity other than a professional corporation or similar professional organization is not allowed to practice medicine, including by employing professional persons or by having any ownership interest or profit participation in or control over any medical professional practice. This doctrine is commonly referred to as the prohibition on the “corporate practice” of medicine. In order to comply with this prohibition, we contract with radiologists to provide professional medical services in our facilities, including the supervision and interpretation of diagnostic imaging procedures. The radiology practice maintains full control over the physicians it employs. Pursuant to each management contract, we make available the imaging facility and all of the furniture and medical equipment at the facility for use by the radiology practice, and the practice is responsible for staffing the facility with qualified professional medical personnel. In addition, we provide management services and administration of the non-medical functions relating to the professional medical practice at the facility, including among other functions, provision of clerical and administrative personnel, bookkeeping and accounting services, billing and collection, provision of medical and office supplies, secretarial, reception and transcription services, maintenance of medical records, and advertising, marketing and promotional activities. As compensation for the services furnished under contracts with radiologists, we generally receive an agreed percentage of the medical practice billings for, or collections from, services provided at the facility, typically varying between 75% to 85% of global net service fee revenue or collections after deduction of the professional component of the medical practice billings.

At all but 13 of our California facilities, we contract for the provision of professional medical services directly with BRMG, or indirectly through BRMG with other radiology groups.

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

BRMG and New York Groups

BRMG, owned 99% indirectly by Dr. Berger, our President and CEO provides, directly or indirectly, all of the professional medical services at nearly all of our facilities located in California under a management agreement with us, and employs physicians or contracts with various independent physicians and physician groups to provide the professional medical services at most of our California facilities. We generally obtain professional medical services from BRMG in California, rather than provide such services directly or through subsidiaries, in order to comply with California's prohibition against the corporate practice of medicine. However, as a result of our close relationship with Dr. Berger and BRMG, we believe that we are able to better ensure that medical service is provided at our California facilities in a manner consistent with our needs and expectations and those of our referring physicians, patients and payors than if we obtained these services from unaffiliated physician groups. BRMG is a partnership of ProNet Imaging Medical Group, Inc., Breastlink Medical Group, Inc. and Beverly Radiology Medical Group, Inc..

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

As of December 31, 2015, BRMG employed or contracted for 209 full-time and 20 part-time radiologists. Under our management agreement with BRMG, we are paid a percentage of the amounts collected for the professional services BRMG physicians render as compensation for our services and for the use of our facilities and equipment. For the year ended December 31, 2015, this percentage was 78%. The percentage may be adjusted, if necessary, to ensure that the parties receive the fair value for the services they render. The following are the other principal terms of our management agreement with BRMG:

- The agreement expires on January 1, 2024. The agreement automatically renews for consecutive 10-year periods, unless either party delivers a notice of non-renewal to the other party no later than six months prior to the scheduled expiration date. Either party may terminate the agreement if the other party defaults under its obligations, after notice and an opportunity to cure. We may terminate the agreement if Dr. Berger no longer owns at least 60% of the equity of BRMG; as of December 31, 2015, he owned indirectly 99% of the equity of BRMG.

- At its expense, BRMG employs or contracts with an adequate number of physicians necessary to provide all professional medical services at all of our California facilities, except for 13 facilities for which we contract with separate medical groups.

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

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

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

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

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

Non-BRMG and New York Groups entity locations

At the 13 centers in California where BRMG does not provide professional medical services, and at all of the centers which are located outside of California, with the exception of centers located in the New York, New York area, we have entered into long-term contracts with prominent third-party radiology groups in the area to provide physician services at those facilities. These arrangements also allow us to comply with the prohibition against the "corporate practice" of medicine in other states in which we operate (except in Florida which does not have an equivalent statute prohibiting the corporate practice of medicine).

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

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

Payors

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

	% of Net Revenue		
	Year Ended December 31, 2015	Year Ended December 31, 2014	Year Ended December 31, 2013
Commercial Insurance [1][2]	57%	56%	55%
Managed Care Capitated Payors	12%	13%	13%
Medicare& Medicaid	23%	24%	24%

[1] Includes Blue Cross/Blue Shield plans, which represented 20% of our net service fee revenue for the years ended December 31, 2015, 2014, and 2013.

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

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

Commercial Insurance

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

Managed Care Capitation Agreements

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

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

- ***Physician Education***

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

- ***Prospective Review***

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

- ***Retrospective Review***

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

Medicare/Medicaid

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

Contracts with Physician Groups and Other Non-Insurance Company Payors

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

Facilities

We operate 139 fixed-site, freestanding outpatient diagnostic imaging facilities in California, 12 in Delaware, 3 in Florida, 54 in Maryland, 19 in New Jersey, 23 in the Rochester and Hudson Valley areas of New York, 45 in New York Cityas well as 5 in Rhode Island. We lease the premises at which these facilities are located.

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

The following table sets forth the number of our facilities for each year during the five-year period ended December 31, 2015:

	Year Ended December 31,				
	2011	2012	2013	2014	2015
Total facilities owned or managed (at beginning of the year)	201	233	246	250	259
Facilities added by:					
Acquisition	33	25	12	22	43
Internal development	2	–	–	–	1
Facilities closed or sold	-3	-12	-8	-13	-3
Total facilities owned (at year end)	233	246	250	259	300

Diagnostic Imaging Equipment

The following table indicates, as of December 31, 2015, the quantity of principal diagnostic equipment available at our facilities, by region:

	MRI	Open/MRI	CT	PET/CT	Mammo	Ultrasound	X-ray	NucMed	Fluoroscopy	Total
California	65	25	49	21	92	209	125	19	54	659
Florida	2	1	2	1	3	5	3	4	2	23
Delaware	6	–	6	–	5	14	20	3	2	56

New Jersey	18	1	14	3	17	29	25	2	10	119
New York	48	3	34	7	75	125	105	6	13	416
Maryland	53	6	36	14	66	112	111	15	24	437
Rhode Island	3	–	3	–	2	4	4	–	–	16
Total	195	36	144	46	260	498	393	49	105	1,726

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

Facility Acquisitions

Information regarding our facility acquisitions can be found within Item 7 - “Management’s Discussion and Analysis of Financial Condition and Results of Operations”, as well as Notes 4 and 5 to our consolidated financial statements included in this annual report on Form 10-K.

Information Technology

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

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

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

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

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

Personnel

At December 31, 2015, we had a total of 5,265 full-time, 815 part-time and 1,304 per diem employees, including those employed by BRMG. These numbers include 209 full-time and 20 part-time physicians and 1,230 full-time, 469 part-time and 664 per-diem technologists.

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

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

Sales and Marketing

At December 31, 2015, our California sales and marketing team consisted of one director of marketing and 47 customer service representatives, while our eastern marketing team consisted of one director of marketing and 116 customer sales representatives. Our sales and marketing team employs a multi-pronged approach to marketing, including physician, payor and sports marketing programs.

Physician Marketing

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

Payor Marketing

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

Sports Marketing Program

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

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

Suppliers

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

We primarily acquire our equipment with cash or through various financing arrangements with equipment vendors and third party equipment finance companies involving the use of capital leases with purchase options at minimal prices at the end of the lease term. At December 31, 2015, capital lease obligations, excluding interest, totaled approximately $16.4 million through 2021, including current installments totaling approximately $10.0 million. If we open or acquire additional imaging facilities, we may have to incur material capital lease obligations.

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

Competition

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

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

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

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

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

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Liability Insurance

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

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

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

Regulation

General

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

Licensing and Certification Laws

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

Corporate Practice of Medicine

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

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

During the year ended December 31, 2015, approximately 20% of our revenue generated at our diagnostic imaging centers was derived from federal government sponsored healthcare programs (Medicare) and 3% from state sponsored programs (Medicaid).

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

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

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

Medicare and Medicaid Fraud and Abuse – Stark Law

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

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

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

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

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

Medicare and Medicaid Fraud and Abuse – General

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

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

State Anti-kickback and Physician Self-referral Laws

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

Federal False Claims Act

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

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

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

Healthcare Reform Legislation

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

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

Health Insurance Portability and Accountability Act of 1996

Congress enacted the Health Insurance Portability and Accountability Act of 1996, or HIPAA, in part, to combat healthcare fraud and to protect the privacy and security of patients' individually identifiable healthcare information. HIPAA, among other things, amends existing crimes and criminal penalties for Medicare fraud and enacts new federal healthcare fraud crimes, including actions affecting non-government healthcare benefit programs. Under HIPAA, a healthcare benefit program includes any private plan or contract affecting interstate commerce under which any medical benefit, item or service is provided. A person or entity that knowingly and willfully obtains the money or property of any healthcare benefit program by means of false or fraudulent representations in connection with the delivery of healthcare services is subject to a fine or imprisonment, or potentially both. In addition, HIPAA authorizes the imposition of civil money penalties against entities that employ or enter into contracts with excluded Medicare or Medicaid program participants if such entities provide services to federal health program beneficiaries. A finding of liability under HIPAA could have a material adverse effect on our business, financial condition and results of operations.

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

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

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

U.S. Food and Drug Administration or FDA

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

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

Radiologist Licensing

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

Insurance Laws and Regulation

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

U.S. Federal Budget and Sequestration

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

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

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

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

Environmental Matters

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

Compliance Program

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

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

Item 1A. Risk Factors

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

Our relationship with BRMG is an integral part of our business. Through our management agreement, BRMG provides all of the professional medical services at 126 of our 139 California facilities. Professional medical services are provided at our other facilities through management contracts with other radiology groups. BRMG and these other radiology groups contract with various other independent physicians and physician groups to provide all of the professional medical services at most of our facilities, and they must use their best efforts to provide the professional medical services at any new facilities that we open or acquire in their areas of operation. In addition, BRMG and the other radiology groups' strong relationships with referring physicians are largely responsible for the revenue generated at the facilities they service. Although our management agreement with BRMG runs until 2024, with automatic

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

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

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

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

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

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

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

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

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

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

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

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

Capitation fee arrangements could reduce our operating margins.

For the year ended December 31, 2015, we derived approximately 11.7% of our net service fee revenue from capitation arrangements, and we intend to increase the revenue we derive from capitation arrangements in the future. Under capitation arrangements, the payor pays a pre-determined amount per-patient per-month in exchange for us providing all necessary covered services to the patients covered under the arrangement. These contracts pass much of the financial risk of providing diagnostic imaging services, including the risk of over-use, from the payor to the provider. Our success depends in part on our ability to negotiate effectively, on behalf of the contracted radiology practices and our diagnostic imaging facilities, contracts with health maintenance organizations, employer groups and other third-party payors for services to be provided on a capitated basis and to efficiently manage the utilization of those services. If we are not successful in managing the utilization of services under these capitation arrangements or if patients or enrollees covered by these contracts require more frequent or extensive care than anticipated, we would incur unanticipated costs not offset by additional revenue, which would reduce operating margins.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Historically, we have experienced substantial growth through acquisitions that have increased our size, scope and geographic distribution. During the past two fiscal years, we have completed 15 acquisitions. These acquisitions have added 66 centers to our fixed-site outpatient diagnostic imaging services. Our ability to successfully expand through acquiring facilities, developing new facilities, adding equipment at existing facilities, and directly or indirectly entering into contractual relationships with high-quality radiology practices depends upon many factors, including our ability to:

- identify attractive and willing candidates for acquisitions;

- identify locations in existing or new markets for development of new facilities;

- comply with legal requirements affecting our arrangements with contracted radiology practices, including state prohibitions on fee-splitting, corporate practice of medicine and self-referrals;

- obtain regulatory approvals where necessary and comply with licensing and certification requirements applicable to our diagnostic imaging facilities, the contracted radiology practices and the physicians associated with the contracted radiology practices;

- recruit a sufficient number of qualified radiology technologists and other non-medical personnel;

- expand our infrastructure and management; and

- compete for opportunities. We may not be able to compete effectively for the acquisition of diagnostic imaging facilities. Our competitors may have more established operating histories and greater resources than we do. Competition may also make any acquisitions more expensive.

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

- inability to obtain adequate financing;

- failure to achieve our targeted operating results;

- diversion of management's attention and resources;

- failure to retain key personnel;

- difficulties in integrating new operations into our existing infrastructure; and

- amortization or write-offs of acquired intangible assets, including goodwill.

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

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

We had net income attributable to RadNet common stockholders of $7.7 million, $1.4 million, and $2.1 million for the years ended December 31, 2015, 2014, and 2013 respectively. As of December 31, 2015, our equity was $36.5

million. As a whole, results have shown improvement over the past three years. However, if we cannot continue to generate income in sufficient amounts, we will not be able to pay our obligations as they become due, which could adversely impact our business, financial condition and results of operations.

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

Our current substantial indebtedness and any future indebtedness we incur could adversely affect our financial condition. We are highly leveraged. As of December 31, 2015, our total indebtedness was $640.7 million, $631.0 million of which constituted guaranty indebtedness. Our substantial indebtedness could also:

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

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

We have incurred significant indebtedness that accrues interest at variable rate borrowing and we may incur additional debt in the future. Increases in interest rates on our current outstanding debt or any other debt we may incur will reduce our operating cash flows and if we need to repay any of our variable rate borrowing during period of high interest rates, we could be required to forgo other opportunities in order to repay the debt which may not permit us to realize future earnings of those forgone opportunities.

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

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

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

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

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

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

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

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

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

The design and effectiveness of our disclosure controls and procedures and internal control over financial reporting may not prevent all errors, misstatements or misrepresentations. While management will review the effectiveness of our disclosure controls and procedures and internal control over financial reporting, there can be no guarantee that our disclosure controls and procedures or our internal control over financial reporting will be effective in accomplishing all control objectives all of the time. Deficiencies, including any material weakness, in our internal control over financial reporting that may occur in the future could result in misstatements of our results of operations, restatements of our financial statements, or otherwise adversely impact our financial condition, results of operations, cash flows, and our ability to satisfy our debt service obligations.

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

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

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

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

Various federal and state laws govern financial arrangements among healthcare providers. The federal Anti-Kickback Law prohibits the knowing and willful offer, payment, solicitation or receipt of any form of remuneration in return for, or to induce, the referral of Medicare, Medicaid, or other federal healthcare program patients, or in return for, or to

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

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

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

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

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

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

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

Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential information, including protected health information, financial data, competitively sensitive information, or other proprietary data, whether by us or a third party, could have a material adverse effect on our business, reputation, financial condition, cash flows, or results of operations. The occurrence of any of these events could result in interruptions, delays, the loss or corruption of data, cessations in the availability of systems or liability under privacy and security laws, all of which could have a material adverse effect on our financial position and results of operations and harm our business reputation. If we are unable to protect the physical and electronic security and privacy of our databases and transactions, we could be subject to potential liability and regulatory action, our reputation and relationships with our patients and vendors would be harmed, and our business, operations, and financial results may be materially adversely affected. Failure to adequately protect and maintain the integrity of our information systems (including our networks) and data, or to defend against cybersecurity attacks, could subject us to monetary fines, civil suits, civil penalties or criminal sanctions and requirements to disclose the breach publicly, and may further result in a material adverse effect on our results of operations, financial position, and cash flows.

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

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

- the federal False Claims Act;

- the federal Medicare and Medicaid Anti-Kickback Laws, and state anti-kickback prohibitions;

- federal and state billing and claims submission laws and regulations;

- the federal Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009, and comparable state laws;

- the federal physician self-referral prohibition commonly known as the Stark Law and the state equivalent of the Stark Law;

- state laws that prohibit the practice of medicine by non-physicians and prohibit fee-splitting arrangements involving physicians;

- federal and state laws governing the diagnostic imaging and therapeutic equipment we use in our business concerning patient safety, equipment operating specifications and radiation exposure levels; and

- state laws governing reimbursement for diagnostic services related to services compensable under workers compensation rules.

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

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

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

Our facilities are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensure and certification. If any facility loses its certification under the Medicare program, then the facility will be ineligible to receive reimbursement from the Medicare and Medicaid programs. For the year ended December 31, 2015, approximately 23% of our net service fee revenue came from the Medicare and Medicaid programs. A change in the applicable certification status of one of our facilities could adversely affect our other facilities and in turn us as a whole. Credentialing of physicians is required by our payors prior to commencing payment. We have experienced a slowdown in the credentialing of our physicians over the last several years which has lengthened our billing and collection cycle, and could negatively impact our ability to collect revenue from patients covered by Medicare.

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

State law prohibits us from exercising control over the medical judgments or decisions of physicians and from engaging in certain financial arrangements, such as splitting professional fees with physicians. These laws are enforced by state courts and regulatory authorities, each with broad discretion. A component of our business has been to enter into management agreements with radiology practices. We provide management, administrative, technical and other non-medical services to the radiology practices in exchange for a service fee typically based on a percentage of the practice's revenue. We structure our relationships with the radiology practices, including the purchase of diagnostic imaging facilities, in a manner that we believe keeps us from engaging in the practice of medicine or exercising control over the medical judgments or decisions of the radiology practices or their physicians, or violating the prohibitions against fee-splitting. There can be no assurance that our present arrangements with BRMG or the physicians providing medical services and medical supervision at our imaging facilities will not be challenged, and, if

challenged, that they will not be found to violate the corporate practice of medicine or fee splitting prohibitions, thus subjecting us to potential damages, injunction and/or civil and criminal penalties or require us to restructure our arrangements in a way that would affect the control or quality of our services and/or change the amounts we receive under our management agreements. Any of these results could jeopardize our business.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

139 of our 300 facilities are located in California and one to one-and-one-half percent (1% to 1.5%) of our revenues come from the California Medicaid program. To the extent California is unable to provide these payments on a timely basis, or at all, our revenues will be negatively impacted.

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

Our corporate headquarters and 139 of our facilities are located in California, an area prone to earthquakes and other natural disasters. Several of our facilities are located in areas of Florida and the east coast that have suffered from hurricanes and other harsh weather, including winter snow storms that have in the past caused us to close our facilities. An earthquake, harsh weather conditions or other natural disaster could decrease scan volume during affected periods and seriously impair our operations. Damage to our equipment or interruption of our business would adversely affect our financial condition and results of operations.

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

The trading price of our common stock on the NASDAQ Global Market has fluctuated significantly in the past. During the period from January 1, 2014 through December 31, 2015, the trading price of our common stock fluctuated from a high of $10.35 per share to a low of $1.50 per share. In the past, we have experienced a drop in stock price

following an announcement of disappointing earnings or earnings guidance. Any such announcement in the future could lead to a similar drop in stock price. The price of our common stock could also be subject to wide fluctuations in the future as a result of a number of other factors, including the following:

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

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

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

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

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

- permit the board of directors to increase its own size, within the maximum limitations set forth in the bylaws, and fill the resulting vacancies;

- authorize the issuance of shares of preferred stock in one or more series without a stockholder vote;

- establish an advance notice procedure for stockholder proposals to be brought before an annual meeting of our stockholders, including proposed nominations of persons for election to the board of directors; and

- prohibit transfers and/or acquisitions of stock (without consent of the Board of Directors) that would result in any stockholder owning greater than 5% of the currently outstanding stock resulting in a limitation on net operating loss carryovers, capital loss carryovers, general business credit carryovers, alternative minimum tax credit carryovers and foreign tax credit carryovers, as well as any loss or deduction attributable to a "net unrealized built-in loss" within the meaning of Section 382 of the internal revenue code of 1986, as amended.

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

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our corporate headquarters is located in adjoining premises at 1508, 1510 and 1516 Cotner Avenue, Los Angeles, California 90025, and approximately 21,500 square feet is occupied under these leases, which expire (with options to extend) on June 30, 2017. We also have a regional office of approximately 39,000 square feet in Baltimore, Maryland under a lease, which expires September 30, 2018. In addition, we lease approximately 60,000 square feet of warehouse space under leases nationwide, which expire at various dates, including options, through August 2031. As of December 31, 2015, total square footage under lease, including medical office, administrative and storage locations was approximately 2.2 million square feet.

We operate 139 fixed-site, freestanding outpatient diagnostic imaging facilities in California, 12 in Delaware, 3 in Florida, 54 in Maryland, 19 in New Jersey, 23 in the Rochester and Hudson Valley areas of New York, 45 in New York City, as well as 5 in Rhode Island. We lease the premises at which these facilities are located. Our facility lease terms vary in length from month to month to 15 years with renewal options upon prior written notice, from 1 year to 15 years depending upon the agreed upon terms with the local landlord. Rents under our facility lease amounts generally increase from 1% to 6% on an annual basis. We do not have options to purchase the facilities we rent.

Item 3. Legal Proceedings

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

Item 4. Mine Safety Disclosures

Not applicable.

PART II

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

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

	Low	High
Quarter Ended		
December 31, 2015	$5.19	$7.50
September 30, 2015	5.25	7.85
June 30, 2015	6.18	9.30
March 31, 2015	7.15	9.40
December 31, 2014	$6.36	$10.35
September 30, 2014	4.71	8.12
June 30, 2014	2.82	7.67
March 31, 2014	1.50	3.00

The last low and high prices for our common stock on the NASDAQ Global Market for the period from January 1 to March 10, 2016 were $4.87 and $6.33, respectively.

Holders

As of March 10, 2016, the number of holders of record of our common stock was 835. However, Cede & Co., the nominee for The Depository Trust Company, the clearing agency for most broker-dealers, owned a substantial number of our outstanding shares of common stock of record on that date. Our management believes that the number of beneficial owners of our common stock is approximately 4,000.

Dividends

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

Equity Compensation Plans Information

The information required by this item will be contained in our definitive proxy statement, to be filed with the SEC in connection with our 2016 annual meeting of stockholders, which is expected to be filed not later than 120 days after the end of our fiscal year ended December 31, 2015, and is incorporated in this report by reference.

Stock Performance Graph

The following graph compares the yearly percentage change in cumulative total stockholder return of our common stock during the period from 2010 to 2015 with (i) the cumulative total return of the S&P 500 index and (ii) the cumulative total return of the S&P 500 – Healthcare Sector index. The comparison assumes $100 was invested on December 31, 2010 in our common stock and in each of the foregoing indices and the reinvestment of dividends through December 31, 2015. The stock price performance on the following graph is not necessarily indicative of future stock price performance.

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

	ANNUAL RETURN PERCENTAGE				
	Years Ending				
Company / Index	12/30/11	12/31/12	12/31/13	12/31/14	12/31/15
RadNet, Inc.	-24.47	18.78	-33.99	411.38	-27,63
S&P 500 Index	2.11	16.00	32.39	13.69	1.38
S&P Health Care Sector	12.73	17.89	41.46	25.34	6.89

	Base	INDEXED RETURNS				
	Period	Years Ending				
Company / Index	**12/31/10**	12/30/11	12/31/12	12/31/13	12/31/14	12/31/15
RadNet, Inc.	**100**	75.53	89.72	59.22	302.84	219,15
S&P 500 Index	**100**	102.11	118.45	156.82	178.29	180.75
S&P Health Care Sector	**100**	112.73	132.90	188.00	235.63	251.87

Recent Sales of Unregistered Securities

None.

Item 6. Selected Consolidated Financial Data

The following table sets forth our selected historical consolidated financial data. The selected consolidated statements of operations data set forth below for the years ended December 31, 2015, 2014 and 2013, and the consolidated balance sheet data as of December 31, 2015 and 2014, are derived from our audited consolidated financial statements and notes thereto included elsewhere herein. The selected historical consolidated statements of operations data set forth below for the years ended December 31, 2012 and 2011, and the consolidated balance sheet data set forth below as of December 31, 2013, 2012 and 2011, are derived from our audited consolidated financial statements not included herein. This data should be read in conjunction with and is qualified in its entirety by reference to the audited consolidated financial statements and the related notes included elsewhere in this annual report and Item 7 - “Management’s Discussion and Analysis of Financial Condition and Results of Operations.”

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

	Years Ended December 31,				
	2015	2014	2013	2012	2011
	(in thousands, except per share data)				
Statement of Operations Data:					
Net revenue	$809,628	$717,569	$702,986	$647,153	$585,121
Operating expenses:					
Cost of operations, excluding depreciation and amortization	708,289	602,652	598,655	542,993	477,828
Depreciation and amortization	60,611	59,258	58,890	57,740	57,481
Loss (gain) on sale and disposal of equipment, net	866	1,113	1,032	456	(2,240)
Gain on sale of imaging center and de-consolidation of joint venture	(5,434)	–	(2,108)	(2,777)	–
Meaningful use incentive	(3,270)	(2,034)	–	–	–
Loss on extinguishment of debt	–	15,927	–	–	–
Net income attributable to RadNet common stockholders	7,709	1,376	2,120	59,834	7,231
Basic income per share attributable to RadNet common stockholders	0.18	0.03	0.05	1.58	0.19
Diluted income per share attributable to RadNet common stockholders	0.17	0.03	0.05	1.52	0.19
Balance Sheet Data:					
Cash and cash equivalents	$446	$307	$8,412	$362	$2,455
Total assets	838,435	740,680	722,576	710,864	619,188
Total long-term liabilities	644,322	599,708	601,977	598,507	566,615
Total liabilities	801,974	732,982	720,366	717,548	688,995

Working capital	72,870	58,746	57,955	36,859	29,947
Equity (deficit)	36,461	7,698	2,210	(6,684)	(69,807)

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

Overview

We are a leading national provider of freestanding, fixed-site outpatient diagnostic imaging services in the United States based on number of locations and annual imaging revenue. At December 31, 2015, we operated directly or indirectly through joint ventures, 300 centers located in California, Delaware, Florida, Maryland, New Jersey, New York and Rhode Island. Our centers provide physicians with imaging capabilities to facilitate the diagnosis and treatment of diseases and disorders and may reduce unnecessary invasive procedures, often reducing the cost and amount of care for patients. Our services include magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), nuclear medicine, mammography, ultrasound, diagnostic radiology (X-ray), fluoroscopy and other related procedures. As of December 31, 2015, we had in operation 231 MRI systems, 144 CT systems, 46 PET or combination PET/CT systems, 49 nuclear medicine systems, 393 X-ray systems, 260 mammography systems, 498 ultrasound systems, and 105 fluoroscopy systems.

We derive substantially all of our revenue from fees charged for the diagnostic imaging services performed at our facilities. For the years ended December 31, 2015, 2014 and 2013, we performed 5,638,979, 4,828,488, and 4,525,490 diagnostic imaging procedures and generated net revenue of $809.6 million, $717.6 million, and $703.0 million, respectively. Additional information concerning RadNet, Inc., including our consolidated subsidiaries, for each of the years ended December 31, 2015, 2014 and 2013 is included in the consolidated financial statements and notes thereto in this annual report.

Our revenue is derived from a diverse mix of payors, including private payors, managed care capitated payors and government payors. We believe our payor diversity mitigates our exposure to possible unfavorable reimbursement trends within any one payor class. In addition, our experience with capitation arrangements over the last several years has provided us with the expertise to manage utilization and pricing effectively, resulting in a predictable stream of revenue. For the year ended December 31, 2015, we received approximately 69% of our payments from commercial insurance payors and from managed care capitated payors, 20% from Medicare 3% from Medicaid, 4% from Workers Compensation programs and 4% from other sources. With the exception of Blue Cross/Blue Shield, which represents approximately 20% and government payors amounting to approximately 23% of revenues respectively, no single payor accounted for more than 5% of our net revenue for the twelve months ended December 31, 2015.

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

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

During 2015 we continued to focus on those core activities which have contributed to our success. We invested in or acquired a number of new facilities, adding a net of forty-one facilities over the number in operation at the beginning of the year. Those acquisitions were concentrated in our key markets of California and New York, and enhanced our position in those leading markets.

We finished the year with cash and cash equivalents of $446,000 and accounts receivable of $162.8 million. Working capital increased to $72.9 million at December 31, 2015 from $58.7 million at December 31, 2014. We continue to maintain our $101.25 million revolving credit facility. At December 31, 2015 we had no aggregate balance on the revolving credit line and the total borrowing capacity is available.

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

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

Facility Acquisitions and Dispositions

Acquisitions

On October 1, 2015 we completed our acquisition of certain assets of Diagnostic Imaging Group, LLC (DIG), consisting of seventeen multi-modality imaging centers located in the boroughs of Brooklyn and Queens, New York, for the following: cash consideration of $54.6 million ($49.6 million paid at execution, $5 million to be paid 18 months after acquisition or earlier if certain conditions are met), the assumption of $2.1 million in equipment debt, and issuance of 1.5 million RadNet common shares valued at $8.3 million on the acquisition date. The facilities provide a full range of radiology services including MRI, PET/CT, Mammography, Ultrasound, X-ray and other related services. The transaction also includes contingent consideration that is payable equal to five times the amount by which collections on the sellers' historical revenue exceeds a defined threshold. The estimated fair value of the liability on the acquisition date and as of December 31, 2015 is zero which is based on the probability of exceeding defined thresholds. Detail of the assets acquired and liabilities assumed are stated in Note 4 to our consolidated financial statements.

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

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

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

On June 1, 2015 we completed our acquisition of certain assets of Healthcare Radiology and Diagnostic systems, PLLC, consisting of a single multi-modality imaging center located in the Bronx, NY area for cash consideration of $425,000. The facility provides MRI, CT, Ultrasound and X-ray services. We have made a fair value determination of

net assets and acquired approximately $134,500 of fixed assets and $290,500 of leasehold improvements.

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

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

Dispositions

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

On August 3, 2015 we sold a 25% non-controlling interest in one of our wholly owned entities, Baltimore County Radiology, LLC ("BCR") to Lifebridge Health for $5.0 million. On the date of sale, the net book value of this 25% interest was $1.3 million. In accordance with ASC 810-10-45-23, *Consolidation*, the proceeds in excess of this net book value amounting to $3.7 million was recorded to equity. In addition to the proceeds already received, RadNet has the opportunity to receive approximately $1.2 million in additional proceeds if certain operating performance targets of BCR are achieved within the next 12 months following the effective date of the sale. Any additional amounts received under these contingent performance provisions will be recorded to equity accordingly.

Results of Operations

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

	Years Ended December 31,		
	2015	2014	2013
NET REVENUE			
Service fee revenue, net of contractual allowances and discounts	88.3%	89.7%	91.0%
Provision for bad debts	-4.3%	-4.0%	-3.8%
Net service fee revenue	84.0%	85.7%	87.2%
Revenue under capitation arrangements	11.7%	10.3%	9.0%
Total net revenue	95.7%	96.0%	96.2%
OPERATING EXPENSES			
Cost of operations, excluding depreciation and amortization	83.8%	80.6%	81.9%
Depreciation and amortization	7.2%	7.9%	8.1%
Loss on sale and disposal of equipment	0.1%	0.1%	0.1%
Severance costs	0.1%	0.2%	0.1%
Total operating expenses	91.1%	88.9%	90.2%
INCOME FROM OPERATIONS	4.6%	7.1%	6.0%
OTHER INCOME AND EXPENSES			

Interest expense	4.9%	5.7%	6.3%
Meaningful use incentive	-0.4%	-0.3%	0.0%
Equity in earnings of joint ventures	-1.1%	-0.9%	-0.8%
Gain on sale of imaging centers	-0.6%	0.0%	-0.3%
Loss on early extinguishment of senior notes	0.0%	2.1%	0.0%
Total other expenses	2.8%	6.6%	5.1%
INCOME BEFORE INCOME TAXES	1.8%	0.5%	0.8%
Provision for income taxes	-0.7%	-0.3%	-0.5%
NET INCOME	1.1%	0.2%	0.4%
Net income attributable to noncontrolling interests	0.1%	0.0%	0.0%
NET INCOME ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS	1.0%	0.2%	0.3%

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

Service Fee Revenue, net of contractual allowances and discounts

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

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

Provision for bad debts

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

Revenue under capitation arrangements

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

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

Operating expenses

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

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

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

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

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

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

· ***Stock-based compensation***

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

· ***Building and equipment rental***

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

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

· ***Medical supplies***

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

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

·***Other operating expenses***

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

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

·***Depreciation and amortization expense***

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

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

·***Loss on sale and disposal of equipment***

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

·***Severance costs***

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

Interest expense

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

during 2015.

Meaningful use incentive

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

Equity in earnings from unconsolidated joint ventures

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

Gain on sale of imaging center

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

Other expenses / income

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

Provision for income tax expense

For the years ended December 31, 2015 and December 31, 2014, we recorded income tax expense of $6.0 million and $2.0 million, respectively. See Note 10 to our consolidated financial statements contained herein for more details.

Year Ended December 31, 2014 Compared to the Year Ended December 31, 2013

Service fee revenue, net of contractual allowances and discounts

Service fee revenue, net of contractual allowances and discounts for the year ended December 31, 2014 was $670.1 million compared to $665.3 million for the year ended December 31, 2013, an increase of $4.8 million, or 0.7%.

Service fee revenue, net of contractual allowances and discounts, including only those centers which were in operation throughout the full fiscal years of both 2014 and 2013, decreased $10.6 million, or 1.6%. This 1.6% decrease is primarily the result of a slight reduction in procedure volumes as well as lower Medicare reimbursement rates beginning in March 2014. This comparison excludes revenue contributions from centers that were acquired subsequent to January 1, 2013. For the year ended December 31, 2014, service fee revenue, net of contractual allowances and discounts, from centers that were acquired subsequent to January 1, 2013 and excluded from the above comparison was $21.8 million. For the year ended December 31, 2013, net revenue from centers that were acquired subsequent to January 1, 2013 and excluded from the above comparison was $6.6 million.

Provision for bad debts

Provision for bad debts increased $1.9 million, or 6.8%, to $29.8 million, or 4.0% of net revenue, for the year ended December 31, 2014 compared to $27.9 million, or 3.8% of net revenue, for the year ended December 31, 2013.

Revenue under capitation arrangements

Revenue under capitation arrangements for the year ended December 31, 2014 was $77.2 million compared to $65.6 million for the year ended December 31, 2013, an increase of $11.7 million, or 17.8%.

Revenue under capitation arrangements, including only those centers which were in operation throughout the full fiscal years of both 2014 and 2013, increased $8.8 million, or 13.4%. This 13.4% increase is due to additional capitation contracts entered into subsequent to the year 2013. This comparison excludes revenue contributions from centers that were acquired subsequent to January 1, 2013. For the year ended December 31, 2014, revenue under capitation arrangements from centers that were acquired subsequent to January 1, 2013 and excluded from the above comparison was $3.1 million. For the year ended December 31, 2013, net revenue from centers that were acquired subsequent to January 1, 2013 and excluded from the above comparison was $176,000.

Operating expenses

Cost of operations for the year ended December 31, 2014 increased approximately $4.0 million, or 0.7%, from $598.7 million for the year ended December 31, 2013 to $602.7 million for the year ended December 31, 2014. The following table sets forth our operating expenses for the years ended December 31, 2014 and 2013 (in thousands):

	Years Ended December 31,	
	2014	2013
Salaries and professional reading fees, excluding stock-based compensation	$329,394	$322,080
Stock-based compensation	2,500	2,573
Building and equipment rental	64,492	64,998
Medical supplies	41,348	37,185
Other operating expenses *	164,918	171,819
Cost of operations	602,652	598,655
Depreciation and amortization	59,258	58,890
Loss on sale and disposal of equipment	1,113	1,032
Severance costs	1,241	806
Total operating expenses	$664,264	$659,383

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

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

Salaries and professional reading fees increased $7.3 million, or 2.3%, to $329.4 million for the year ended December 31, 2014, compared to $322.1 million for the year ended December 31, 2013.

Salaries and professional reading fees, including only those centers which were in operation throughout the full fiscal years of both 2014 and 2013, decreased $1.7 million, or 0.5%. This 0.5% decrease is in line with our decrease in procedure volumes at these centers. This comparison excludes contributions from centers that were acquired subsequent to January 1, 2013. For the year ended December 31, 2014, salaries and professional reading fees from centers that were acquired subsequent to January 1, 2013 and excluded from the above comparison was $12.1 million. For the year ended December 31, 2013, salaries and professional reading fees from centers that were acquired subsequent to January 1, 2013, and excluded from the above comparison was $3.1 million.

· ***Stock-based compensation***

Stock-based compensation decreased $73,000, or 2.8%, to $2.5 million for the year ended December 31, 2014 compared to $2.6 million for the year ended December 31, 2013.

· ***Building and equipment rental***

Building and equipment rental expenses decreased $506,000, or 0.8%, to $64.5 million for the year ended December 31, 2014, compared to $65.0 million for the year ended December 31, 2013.

Building and equipment rental expenses, including only those centers which were in operation throughout the full fiscal years of both 2014 and 2013, decreased $2.1 million, or 3.3%. This 3.3% decrease is due to the conversion of equipment operating leases to capital leases occurring in the first quarter of 2014. This comparison excludes contributions from centers that were acquired subsequent to January 1, 2013. For the year ended December 31, 2014, building and equipment rental expenses from centers that were acquired subsequent to January 1, 2013, and excluded from the above comparison, was $3.5 million. For the year ended December 31, 2013, building and equipment rental expenses from centers that were acquired subsequent to January 1, 2013, and excluded from the above comparison, was $1.9 million.

· ***Medical supplies***

Medical supplies expense increased $4.2 million, or 11.2%, to $41.3 million for the year ended December 31, 2014, compared to $37.2 million for the year ended December 31, 2013.

Medical supplies expense, including only those centers which were in operation throughout the full fiscal years of both 2014 and 2013, increased $3.9 million, or 10.7%. This 10.7% increase is primarily due to a combination of a $400,000 decrease in rebates we received from certain vendors in the first quarter of 2014 and no medical rebates received in the third quarter of 2014. This comparison excludes contributions from centers that were acquired or divested subsequent to January 1, 2013. For the year ended December 31, 2014, medical supplies expense from centers that were acquired subsequent to January 1, 2013, and excluded from the above comparison was $1.5 million. For the year ended December 31, 2013, medical supplies expense from centers that were acquired subsequent to January 1, 2013, and excluded from the above comparison was $1.2 million.

·***Other operating expenses***

Other operating expenses decreased $6.9 million, or 4.0%, to $164.9 million for the year ended December 31, 2014 compared to $171.8 million for the year ended December 31, 2013.

Other operating expenses, including only those centers which were in operation throughout the full fiscal years of both 2014 and 2013, decreased $9.2 million or 5.7%. The 5.7% decrease relates to higher employee health insurance contributions in 2014 as well as a decrease in licensing and other contractual fees. This comparison excludes contributions from centers that were acquired or divested subsequent to January 1, 2013. For the year ended December 31, 2014, other operating expenses from centers that were acquired subsequent to January 1, 2013, and excluded from the above comparison were $4.7 million. For the year ended December 31, 2013, other operating expenses from centers that were acquired subsequent to January 1, 2013, and excluded from the above comparison were $2.4 million.

· ***Depreciation and amortization expense***

Depreciation and amortization expense increased $368,000, or 0.6%, to $59.3 million for the year ended December 31, 2014 when compared to the same period last year.

Depreciation and amortization expense at those centers which were in operation throughout the full fiscal years of both 2014 and 2013, decreased $1.5 million or 2.5%. This comparison excludes contributions from centers that were acquired or divested subsequent to January 1, 2013. For the year ended December 31, 2014, depreciation and amortization from centers that were acquired or divested subsequent to January 1, 2013 and excluded from the above comparison was $2.8 million. For the year ended December 31, 2013, depreciation and amortization from centers that were acquired subsequent to January 1, 2013, and excluded from the above comparison was $969,000.

· ***Loss on sale and disposal of equipment***

Loss on sale of equipment was approximately $1.1 million and $1.0 million for the years ended December 31, 2014 and 2013, respectively, and primarily related to the difference between the net book value of certain equipment sold and proceeds we received from the sale.

· ***Severance costs***

During the year ended December 31, 2014, we recorded severance costs of $1.2 million compared to $806,000 recorded during the year ended December 31, 2013. In each period, these costs were primarily associated with the integration of acquired operations and other cost saving measures.

Interest expense

Interest expense decreased approximately $3.1 million, or 6.7%, to $42.7 million for the year ended December 31, 2014 compared to $45.8 million for the year ended December 31, 2013. Interest expense for the year ended December 31, 2014 included $5.1 million of amortization of deferred financing costs and discount on issuance of debt, as well as a write off of $665,000 of deferred financing costs in relation to the early extinguishment of $200 million in 10 3/8% senior unsecured notes due 2018. Interest expense for the year ended December 31, 2013 included $4.6 million of amortization of deferred financing costs and discount on issuance of debt. Excluding these adjustments to interest expense for each period, interest expense decreased approximately $4.3 million for the year ended December 31, 2014 compared to the year ended December 31, 2013. This decrease was primarily due to the 2014 Amendment and Second Lien Credit Agreement. See “Liquidity and Capital Resources” below for more details on our financing activity during 2014.

Meaningful use incentive

For the year ended December 31, 2014, we recognized other income from meaningful use incentive in the amount of $2.0 million. This amount was earned under a Medicare program to promote the use of electronic health record technology. See Note 2 to our consolidated financial statements contain herein for more detail regarding this meaningful use incentive.

Equity in earnings from unconsolidated joint ventures

Equity in earnings from our unconsolidated joint ventures increased $776,000 or 12.5% to $7.0 million for the year ended December 31, 2014 compared to $6.2 million for the year ended December 31, 2013.

Loss on early extinguishment of senior notes

For the year ended December 31, 2014, we recognized a $15.9 million loss on early extinguishment of debt through our tender offer for our senior notes. Completion of the tender was conditioned on the closing of the 2014 Amendment and the Second Lien Credit Agreement. See “Liquidity and Capital Resources” below and Note 8 to our consolidated financial statements contained herein for more details on our debt refinancing.

Other expenses / income

For the year ended December 31, 2014 we recorded approximately $3,000 of other expenses. For the year ended December 31, 2013, we recorded $228,000 of other expenses primarily relating to costs associated with our credit facilities. See “Liquidity and Capital Resources” below for more details on our debt refinancing.

Provision for income tax expense

For the years ended December 31, 2014 and December 31, 2013, we recorded income tax expense of $2.0 million and $3.5 million, respectively. See Note 10 to our consolidated financial statements contained herein for more details.

Adjusted EBITDA

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

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

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

not be comparable to other similarly titled measures of other companies.

The following is a reconciliation of the nearest comparable GAAP financial measure, net income, to Adjusted EBITDA for the years ended December 31, 2015, 2014, and 2013, respectively (in thousands):

	Years Ended December 31,		
	2015	2014	2013
Net income attributable to RadNet, Inc. common stockholders	$7,709	$1,376	$2,120
Plus provision for income taxes	6,007	1,967	3,510
Plus other expenses	419	3	228
Plus loss on early extinguishment of Senior Notes	–	15,927	–
Plus interest expense	41,684	42,727	45,791
Plus severance costs	745	1,241	806
Plus loss on sale and disposal of equipment	866	1,113	1,032
Plus legal settlements	1,425	401	–
Less gain on sale of imaging center	(5,434)	–	(2,108)
Plus depreciation and amortization	60,611	59,258	58,890
Plus non-cash employee stock-based compensation	7,647	2,500	2,574
Adjusted EBITDA	$121,679	$126,513	$112,843

Liquidity and Capital Resources

We had net income attributable to RadNet, Inc.'s common stockholders of $7.7 million, $1.4 million and $2.1 for the years ended December 31, 2015, 2014 and 2013, respectively. We had cash and cash equivalents of $446,000 and accounts receivable of $162.8 million at December 31, 2015, compared to cash of $307,000 million and accounts receivable of $148.2 million at December 31, 2014. We had a working capital balance of $72.9 million and $58.7 million at December 31, 2015 and 2014, respectively. We also had total equity of $36.5 million and $7.7 million at December 31, 2015 and 2014, respectively.

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

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

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

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

Sources and Uses of Cash

Cash provided by operating activities was $67.0 million, $61.0 million, and $66.4 million, for the years ended December 31, 2015, 2014 and 2013, respectively.

Cash used in investing activities was $96.8 million, $53.6 million, and $50.7 million, for the years ended December 31, 2015, 2014 and 2013, respectively. For the year ended December 31, 2015, we purchased property and equipment for approximately $43.0 million, acquired the assets and businesses of additional imaging facilities for approximately $90.8 million (see Notes 4 and 5 to the consolidated financial statements of this annual report), and contributed $265,000 to one of our non-consolidated joint ventures. Offsetting our cash used in investing activities was the $35.5 million sale of 10 wholly owned imaging centers in New Jersey, $1.3 million in proceeds from the sale of imaging equipment and $443,000 in outside sales of imaging software. See Note 4 to the consolidated financial statements of this annual report for more information on the New Jersey sale.

Cash provided by financing activities was $29.9 million for the year ended December 31, 2015, compared to cash used by financing activities of $15.4 million and $7.6 million for the years ended December 31, 2014 and December 31, 2013 respectively. The cash provided by financing for the year ended December 31, 2015 consisted of $75.0 million in new borrowings from the 2015 Incremental First Lien Term Loans (defined below). See financing activity in 2015 below for a further description on this event. Payments on secured debt and revolver loans amounted to $39.0 million, while contractual payments of equipment notes and capital leases totaled $9.8 million. The sale of a 25% of non-controlling interest in a wholly owned subsidiary netted $5.0 million. See Note 4 to the consolidated financial statement of this annual report for more information on this sale.

At December 31, 2015, we had $451.0 million aggregate principal amount of first lien term loans and $180.0 million aggregate principal amount of second lien term loan debt outstanding and no principal borrowed under the revolving credit facility. The revolving credit facility provides for a maximum borrowing limit of $101.25 million, subject to customary drawing conditions.

Our credit facilities are comprised of a Credit and Guaranty Agreement that we entered into on October 10, 2012 (the “Original Credit Agreement” and as amended by the 2013 Amendment (as defined below) and the 2014 Amendment (as defined below), (the “Credit Agreement”), as subsequently amended by a first amendment dated April 3, 2013 (the “2013 Amendment”), and a second amendment dated March 25, 2014 (the “2014 Amendment”). We also entered into a a Second Lien Credit and Guaranty Agreement dated March 25, 2014 (the “Second Lien Credit Agreement”). On April 30, 2015 we entered into a joinder agreement to the Credit Agreement (the “2015 Joinder”). Each of the foregoing is described in more detail below.

As of December 31, 2015, we were in compliance with all covenants under the Original Credit Agreement (as amended by the 2013 Amendment, the 2014 Amendment, and the 2015 Joinder) and the Second Lien Credit Agreement.

The following describes our 2015 financing activities:

2015 Incremental First Lien Term Loans:

On April 30, 2015, we entered into the 2015 Joinder to the Credit Agreement to provide for the borrowing of $75.0 million of incremental first lien term loans ("2015 Incremental First Lien Term Loans"). The 2015 Incremental First Lien Term Loans are treated as part of the same class as the existing tranche B term loans currently outstanding under the Credit Agreement. We used the proceeds from the 2015 Incremental First Lien Term Loans to repay all of the borrowings outstanding under the first lien revolving loan facility and to pay approximately $1.1 million of fees and expenses associated with the transaction.

Interest. The interest rates payable on the 2015 Incremental First Lien Term Loans are the same rates currently payable on the existing tranche B term loans under the Credit Agreement, which are (a) the Adjusted Eurodollar Rate (as defined in the Credit Agreement) plus 3.25% per annum or (b) the Base Rate (as defined in the Credit Agreement) plus 2.25% per annum. As applied to the first lien tranche B term loans, the Adjusted Eurodollar Rate has a minimum floor of 1.0%. The Adjusted Eurodollar Rate at December 31, 2015 was 0.85%.

Payments. The scheduled quarterly amortization of the 2015 Incremental First Lien Term Loans is approximately $987,000, beginning in June 2015. The scheduled quarterly amortization for all of the term loans under the Credit Agreement, including the 2015 Incremental First Lien Term Loans, was increased to approximately $6.2 million, beginning in June 2015.

Maturity Date. The maturity date for the 2015 Incremental First Lien Term Loans shall be on the earlier to occur of (i) October 10, 2018, and (ii) the date on which the 2015 Incremental First Lien Term Loans shall otherwise become due and payable in full under the Credit Agreement, whether by acceleration or otherwise.

Guarantees and Collateral. The obligations under the Credit Agreement, including the 2015 Incremental First Lien Term Loans, are guaranteed by RadNet, Inc., all of our current and future domestic subsidiaries and certain of our affiliates (other than certain excluded foreign subsidiaries). The obligations under the Credit Agreement, including the 2015 Incremental First Lien Term Loans, and the guarantees are secured by a perfected first priority security interest

(subject to certain permitted exceptions) in substantially all of Radnet Management's and the guarantors' tangible and intangible assets, including, but not limited to, pledges of equity interests of Radnet Management and all of our current and future domestic subsidiaries.

Restrictive Covenants. In addition to certain customary covenants, the Credit Agreement places limits on our ability to declare dividends or redeem or repurchase capital stock, prepay, redeem or purchase debt, incur liens and engage in sale-leaseback transactions, make loans and investments, incur additional indebtedness, amend or otherwise alter debt and other material agreements, engage in mergers, acquisitions and asset sales, enter into transactions with affiliates and alter the business we and our subsidiaries currently conduct.

Financial Covenants. The Credit Agreement contains financial covenants including a maximum total leverage ratio and a limit on annual capital expenditures.

Events of Default. In addition to certain customary events of default, events of default under the Credit Agreement include failure to pay principal of any loans as and on the date when due, failure to pay any interest on any loan or any fee or other amount payable under the Credit Agreement, as modified by the 2015 Joinder, within five days after the due date, failure of any loan party to comply with any covenant or agreement in the loan documents (subject to applicable grace periods and/or notice requirement), a representation or warranty contained in the loan documents is false in a material respect, events of bankruptcy and a change of control. The occurrence of an event of default could permit the lenders under the Credit Agreement to declare all amounts borrowed, together with accrued interest and fees, to be immediately due and payable and to exercise other default remedies.

The following describes our 2014 financing activities:

2014 Amendment to the Original Credit Agreement and Second Lien Credit and Guaranty Agreement:

On March 25, 2014, we simultaneously entered into two agreements which resulted in the creation of a direct financial obligation as follows:

2014 Amendment of the Original Credit Agreement. We entered into the 2014 Amendment to provide for, among other things, the borrowing of $30.0 million of additional first lien term loans (the "2014 First Lien Term Loans").

Second Lien Credit and Guaranty Agreement. We entered into the Second Lien Credit Agreement to provide for, among other things, the borrowing of $180.0 million of second lien term loans (the "Second Lien Term Loans"). The proceeds from the Second Lien Term Loans and the 2014 First Lien Term Loans were used to redeem the Senior Notes, as more fully described below under the heading "Senior Notes", to pay the expenses related to the transaction and for general corporate purposes.

Revolving Credit Facility. The $101.25 million revolving credit line established in the Credit Agreement was unaltered by the agreements above and remains in place. The termination date for the $101.25 million revolving credit facility is the earliest to occur of (i) October 10, 2017, (ii) the date the revolving credit facility is permanently reduced to zero pursuant to section 2.13(b) of the Credit Agreement, which addresses voluntary commitment reductions and (iii) the date of the termination of the revolving credit facility due to specific events of default pursuant to section 8.01 of the Credit Agreement. The revolving credit facility bears interest based on types of borrowings as follows: (i) unpaid principal at the Adjusted Eurodollar Rate (as defined in the Credit Agreement) plus 4.25% per annum or the Base Rate (as defined in the Credit Agreement) plus 3.25% per annum, (ii) letter of credit and fronting fees at 4.5% per annum, and (iii) commitment fee of 0.5% per annum on the unused revolver balance. The Adjusted Eurodollar Rate at December 31, 2015 was 0.85%.

The 2014 Amendment provided for the following:

Interest. The interest rates payable on the 2014 First Lien Term Loans are the same as the rates currently payable under the Original Credit Agreement, as amended by the 2013 Amendment, which are (a) the Adjusted Eurodollar Rate (as defined in the Credit Agreement) plus 3.25% or (b) the Base Rate (as defined in the Credit Agreement) plus 2.25%. With respect to all of the term loans under the Credit Agreement, the Adjusted Eurodollar Rate has a minimum floor of 1.0%. The Adjusted Eurodollar Rate at December 31, 2015 was 0.85%.

Payments. The scheduled amortization of the term loans under the Original Credit Agreement, as amended by the 2013 Amendment and the 2014 Amendment, was increased, starting in June 2014 from quarterly payments of $975,000 to quarterly payments of approximately $5.2 million, with the remaining balance to be paid at maturity. Scheduled amortization increased annually by $16.8 million from pre-2014 Amendment terms, representing a rise from 1% per annum to 5% per annum of the initial amount borrowed. This $16.8 million additional cash obligation will be partially offset by annual interest savings of approximately $5.0 million under the terms of the Second Lien Term Loan as compared to that under the retired Senior Notes. We expect to fund this approximately $11.8 million net increase in amortization payments from cash provided by operating activities.

The Second Lien Credit Agreement provides for the following:

Interest. The interest rates payable on the Second Lien Term Loans are (a) the Adjusted Eurodollar Rate (as defined in the Second Lien Credit Agreement) plus 7.0% or (b) the Base Rate (as defined in the Second Lien Credit Agreement) plus 6.0%. The Adjusted Eurodollar Rate has a minimum floor of 1.0% on the Second Lien Term Loans. The Eurodollar Rate at December 31, 2015 was 0.85%. The rate paid on the Second Lien Credit Agreement at December 31, 2015 was 8%.

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

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

Restrictive Covenants. In addition to certain customary covenants, the Second Lien Credit Agreement places limits on our ability declare dividends or redeem or repurchase capital stock, prepay, redeem or purchase debt, incur liens and engage in sale-leasebacktransactions, make loans and investments, incur additional indebtedness, amend or otherwise alter debt and other material agreements, engage in mergers, acquisitions and asset sales, enter into transactions with affiliates and alter the business we and our subsidiaries currently conduct.

Events of Default. In addition to certain customary events of default, events of default under the Second Lien Credit Agreement include failure to pay principal of any loans as and on the date when due, failure to pay any interest on any loan or any fee or other amount payable under the Second Lien Term Loans within five days after the due date, failure of any loan party to comply with any covenant or agreements in the loan documents (subject to applicable grace periods and/or notice requirements), a representation or warranty contained in the loan documents is false in a material respect, events of bankruptcy and a change of control. The occurrence of an event of default could permit the lenders under the Second Lien Credit Agreement to declare all amounts borrowed, together with accrued interest and fees, to be immediately due and payable and to exercise other default remedies.

Senior Notes

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

We completed the retirement of our $200 million in Senior Notes on April 24, 2014 and following such retirement the Company completed the satisfaction and discharge of the Indenture. The transactions leading to the retirement of the Senior Notes are described below:

Tender Offer and Exercise of Optional Redemption on March 7, 2014. On March 7, 2014, we commenced a tender offer to purchase for cash any and all outstanding Senior Notes. In connection with the tender offer, we also commenced a consent solicitation to amend the Indenture to eliminate or modify certain restrictive covenants. On March 25, 2014, we made a payment in cash for all Senior Notes tendered prior to 5:00 P.M., New York City time, on March 20, 2014 (the "Consent Payment Deadline"). As of the Consent Payment Deadline, we received tenders and consents in respect of $193,464,000 aggregate principal amount of the Senior Notes, representing 96.73% of the outstanding Senior Notes, all of which were accepted for purchase. The total consideration for each $1,000 principal amount of Senior Notes validly tendered and not withdrawn at or prior to the Consent Payment Deadline and accepted for purchase was $1,056.88, which amount included a consent payment (the "Consent Payment") of $30.00 per $1,000 principal amount of Senior Notes. In addition, all Senior Notes accepted for payment received accrued and unpaid interest in respect of such notes from the last interest payment date prior to the applicable settlement date to, but not including, the applicable settlement date. The tender offer expired on April 3, 2014 and between the Consent Payment Deadline and the expiration of the tender offer, no additional Senior Notes were tendered. With a net carrying amount including discount and unamortized issue costs of $189.2 million, a loss on early extinguishment of debt of $15.5 million was recorded in the first quarter of 2014.

Tender Offer and Exercise on Optional Redemption of March 25, 2014. On March 25, 2014, we called for redemption all of our remaining outstanding Senior Notes not purchased prior to the expiration of the tender offer described above, with a redemption date of April 24, 2014 (the "Redemption Date"). Upon redemption on April 24, 2014, the holders of the Senior Notes being redeemed received a redemption price equal to 105.188% of the outstanding principal amount of the Senior Notes being redeemed (or $1,051.88 per $1,000 in principal amount of the Senior Notes) in accordance with the terms of the Indenture, or approximately $6.9 million in total, including approximately $43,000 of accrued and unpaid interest up to, but excluding the Redemption Date. As of that date, we completed the satisfaction and discharge of the Indenture in accordance with its terms and no Senior Notes remained outstanding. With a net carrying amount including discount and unamortized issue costs of $6.4 million, a loss on early extinguishment of debt of $471,000 was recorded in the second quarter of 2014.

The following describes our key financing activities prior to 2014:

2013 Amendment to the Credit Agreement

On April 3, 2013, we entered into the 2013 Amendment. Pursuant to this amendment, we re-priced the balance of our term loan of $348.3 million and borrowed an additional $40.0 million for a new senior secured term loan total of $388.3 million. The proceeds from the amendment were used to: (i) repay in full all existing term loans under the Original Credit Agreement; (ii) repay outstanding revolving loans; (iii) repay premium, fees and expenses incurred; and (iv) general corporate purposes.

2012 Refinancing and Original Credit Agreement

On October 10, 2012 we completed the refinancing of our then existing credit facilities by entering into the Original Credit Agreement with a syndicate of banks and other financial institutions. The total amount of refinancing was $451.25 million, consisting of (i) a $350 million senior secured term loan and (ii) a $101.25 million senior secured revolving credit facility. The obligations under the Original Credit Agreement are guaranteed by RadNet, Inc. and our current and future domestic subsidiaries and certain of our affiliates (other than certain excluded foreign subsidiaries). The obligations under the Original Credit Agreement, including the guarantees, are secured by a perfected first-priority security interest in all of our tangible and intangible assets, including, but not limited to, pledges of equity interests of Radnet Management and all of our current and future domestic subsidiaries.

We used the net proceeds of the Original Credit Agreement to repay in full our then existing six year term loan facility for $277.9 million in principal amount outstanding, which would have matured on April 6, 2016, and our revolving credit facility for $59.8 million in principal amount outstanding, which would have matured on April 6, 2015.

Contractual Commitments

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

	2016	2017	2018	2019	2020	Thereafter	Total
Notes payable (1)	$60,136	$57,982	$430,021	$14,880	$14,651	$183,360	$761,030
Capital leases (2)	10,660	4,325	1,713	246	201	98	17,243
Operating leases (3)	66,587	58,145	48,633	39,170	29,932	80,304	322,771
Total	$137,383	$120,452	$480,367	$54,296	$44,784	$263,762	$1,101,044

(1) Includes variable rate debt for which the contractual obligation was estimated using the applicable rate at December 31, 2015.

(2) Includes interest component of capital lease obligations.

(3) Includes all operating leases through the end of their main lease term, excluding options on facility leases.

We have an arrangement with GE Medical Systems under which it has agreed to be responsible for the maintenance and repair of a majority of our equipment for a fee that is based on the type and age of the equipment. Under this agreement, we are committed to minimum payments of approximately $23.5 million per year through 2016.

Critical Accounting Policies

Use of Estimates

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

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

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

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

Revenues

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

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

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

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

	Years Ended December 31,		
	2015	2014	2013
Commercial insurance (1)	$486,489	$437,525	$430,735
Medicare	168,545	159,562	156,066
Medicaid	23,948	24,499	24,017
Workers' compensation/personal injury	32,728	30,543	34,821
Other (2)	35,046	18,007	19,668
Service fee revenue, net of contractual allowances and discounts	746,756	670,136	665,307
Provision for bad debts	(36,033)	(29,807)	(27,911)
Net service fee revenue	710,723	640,329	637,396
Revenue under capitation arrangements	98,905	77,240	65,590
Total net revenue	$809,628	$717,569	$702,986

(1) 20% of our net service fee revenue for each of the years ended December 31, 2015, 2014 and 2013 were earned from a single payor.

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

Provision for Bad Debts

We provide for an allowance against accounts receivable that could become uncollectible to reduce the carrying value of such receivables to their estimated net realizable value. We estimate this allowance based on the aging of our accounts receivable, historical payments pattern of each type of payor, write-off trends, and other relevant factors. A significant portion of our provision for bad debt relates to co-payments and deductibles owed to us from patients with insurance. Although we attempt to collect deductibles and co-payments due from patients with insurance at the time of service, this attempt to collect at the time of service is not an assessment of the patient's ability to pay nor are revenues recognized based on an assessment of the patient's ability to pay. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on the increased burden of co-payments and deductibles to be made by patients with insurance. These factors continuously change and can have an impact on collection trends and our estimation process. Our allowance for bad debts at December 31, 2015 and 2014 was $20.8 million and $15.1 million, respectively.

Depreciation and Amortization of Long-Lived Assets

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

Deferred Tax Assets

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

Valuation of Goodwill and Indefinite Lived Intangible Assets

Goodwill at December 31, 2015 totaled $239.4 million. Indefinite lived intangible assets at December 31, 2015 totaled $7.9 million and are associated with the value of certain trade name intangibles. Goodwill and trade name intangibles are recorded as a result of business combinations. Management evaluates goodwill and trade name intangibles, at a minimum, on an annual basis and whenever events and changes in circumstances suggest that the carrying amount

may not be recoverable. Impairment of goodwill is tested at the reporting unit level by comparing the reporting unit's carrying amount, including goodwill, to the fair value of the reporting unit. The fair value of a reporting unit is estimated using a combination of the income or discounted cash flows approach and the market approach, which uses comparable market data. If the carrying amount of the reporting unit exceeds its fair value, goodwill is considered impaired and a second step is performed to measure the amount of impairment loss, if any. Impairment of trade name intangibles is tested at the subsidiary level by comparing the subsidiary's trade name carrying amount to its respective fair value. We tested both goodwill and trade name intangibles for impairment on October 1, 2015, noting no impairment, and have not identified any indicators of impairment through December 31, 2015.

We evaluate our long-lived assets (property and equipment) and intangibles, other than goodwill, for impairment whenever indicators of impairment exist. Generally accepted accounting principles (GAAP) requires that if the sum of the undiscounted expected future cash flows from a long-lived asset or definite-lived intangible is less than the carrying value of that asset, an asset impairment charge must be recognized. The amount of the impairment charge is calculated as the excess of the asset's carrying value over its fair value, which generally represents the discounted future cash flows from that asset or in the case of assets we expect to sell, at fair value less costs to sell. No indicators of impairment were identified with respect to our long-lived assets as of December 31, 2015.

Recent Accounting Standards

In February 2016, the Financial Accounting Standards Board (the "FASB") issued Accounting Standards Update ("ASU") No. 2016-02 ("ASU 2016-02"), *Leases,* (Topic 842): Amendments to the FASB Accounting Standards Codification. ASU 2016-02 amends the existing accounting standards for lease accounting, including requiring lessees to recognize most leases on their balance sheets and making targeted changes to lessor accounting. The new standard requires a modified retrospective transition approach for all leases existing at, or entered into after, the date initial application, with an option to use certain transition relief. The amendments in this update are effective for fiscal years (and interim reporting periods within fiscal years) beginning after December 15, 2018. Early adoption of the amendments is permitted for all entities. We are currently evaluating the impact of the GAAP update on our results of operations and cash flows.

In November 2015, the FASB issued ASU No. 2015-17 ("ASU 2015-17), *Income Taxes* (Topic 740): Balance Sheet Classification of Deferred Taxes. ASU 2015-17 changes the classification of deferred taxes to be a noncurrent asset or liability regardless of the classification of the related asset or liability for financial reporting. The update is effective for fiscal years beginning after December 15, 2016. Early application is permitted at the beginning of an interim or annual reporting period. We are currently evaluating the impact of the GAAP update on our results of operations and cash flows.

In September 2015, the FASB issued ASU No. 2015-16 ("ASU 2015-16"), *Business Combinations,* (Topic 805): Simplifying the Accounting for Measurement-Period Adjustments. ASU 2015-16 eliminates the requirement to retrospectively apply adjustments made to provisional amounts recognized in a business combination. An entity will now recognize any adjustments in the reporting period in which the amounts are determined, calculated as if the accounting had been completed at the acquisition date. Disclosure is required for the portion of adjustments recorded in current-period earnings that would have been recorded in previous reporting periods had they been recognized as of the acquisition date. The update is effective for fiscal years (and interim reporting periods within fiscal years) beginning after December 15, 2015. Early adoption is permitted for financial statements that have not been previously issued. We are currently evaluating the impact of the GAAP update on our results of operations and cash flows.

In August 2015, the FASB issued ASU No. 2015-15 ("ASU 2015-15"), *Interest – Imputation of Interest*, (Subtopic 835-30): Presentation and Subsequent Measurement of Debt Issuance Costs Associated with Line-of-Credit Arrangements. ASU 2015-15 provides additional guidance to the presentation of debt issuance costs discussed originally in ASU No. 2015-03, which was issued in April 2015 and described below. ASU 2015-15 noted that ASU 2015-03 did not address the debt issue costs in regards to line-of-credit arrangements, which by their nature have fluctuating balances. ASU 2015-15 permits debt issuance costs specifically related to line-of-credit arrangements to be presented as an asset with subsequent amortization to interest expense ratably over the term of the line-of-credit arrangement, regardless of whether there are any outstanding borrowings on the arrangement. The update is effective for fiscal years (and interim reporting periods within fiscal years) beginning after December 15, 2015. Early adoption is permitted for financial statements that have not been previously issued. We are currently evaluating the impact of the GAAP update on our results of operations and cash flows.

In April 2015, the Financial Accounting Standards Board (the "FASB") issued ASU No. 2015-03 ("ASU 2015-03"), *Interest – Imputation of Interest*, (Subtopic 835-30). ASU 2015-03 changes the accounting method for debt issuance costs from a deferred charge (i.e. an asset) to a contra liability in part because such costs provide no future economic benefit. Debt issue costs related to a recognized debt liability are to be presented in the balance sheet as a direct deduction from the carrying amount of the debt liability, consistent with the presentation of debt discounts. The update is effective for fiscal years (and interim reporting periods within fiscal years) beginning after December 15, 2015. Early adoption is permitted for financial statements that have not been previously issued. We are currently evaluating the impact of the GAAP update on our results of operations and cash flows.

In February 2015, the FASB issued ASU No. 2015-02 ("ASU 2015-02"), *Consolidation – Amendments to the Consolidation Analysis,* (Topic 810). ASU 2015-02 changes the analysis that a reporting entity must perform to

determine whether it should consolidate certain types of legal entities. It is effective for annual reporting periods, and interim periods within those years, beginning after December 15, 2015. Early adoption is permitted, including adoption in an interim period. We are currently evaluating the impact of the GAAP update on our results of operations and cash flows.

In May 2014, the FASB issued ASU No. 2014-09 ("ASU 2014-09"), *Revenue from Contracts with Customers*, (Topic 606). ASU 2014-09 requires an entity to recognize revenue when it transfers promised goods or services to customers in an amount that reflects what it expects in exchange for the goods or services. It also requires more detailed disclosures to enable users of the financial statements to understand the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. The update was effective for fiscal years (and interim reporting periods within fiscal years) beginning after December 15, 2016, which has recently been extended to December 31, 2017. We are currently evaluating the impact of the GAAP update on our results of operations and cash flows.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

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

We maintain research and development facilities in Prince Edward Island, Canada and Budapest, Hungary for which expenses are paid in the local currency. Accordingly, we do have currency risk resulting from fluctuations between such local currency and the United States Dollar. At the present time, we do not have any foreign exchange currency contracts to mitigate this risk. A hypothetical 1% increase in the rate of exchange of foreign currencies against the dollar for 2015 would have resulted in an increase of approximately $32,000 in our operating expenses for the year.

Interest Rate Sensitivity We pay interest on various types of debt instruments to our suppliersand lending institutions. The agreements entail either fixed or variable interest rates. Instruments which have fixed rates are mainly leases on radiology equipment. Variable rate interest obligations relate primarily to amounts borrowed under our outstanding credit facilities. As described in the Liquidity and Capital Resources section above, we can elect Eurodollar or Base Rate interest rate options on the 2014 First Lien Term Loans, 2015 Incremental First Lien Term Loans and the Second Lien Credit Agreement.

At December 31, 2015, we had $444.8 million outstanding subject to an Adjusted Eurodollar election on all first lien tranche B term loans under the Credit Agreement and $180.0 million on the Second Lien Term Loans. As the Adjusted Eurodollar Rate floor exceeds the current spot rate of 6 month Adjusted Eurodollar, the spot rate would have to increase more than 15 basis points before an additional interest expense would be accrued. An increase of 115 basis points would be necessary to realize a hypothetical 1% increase in the borrowing rate and an annual increase of $6.2 million of interest expense under our first and second lien term loans. At December 31, 2015, an additional $12.4 million in debt instruments is tied to the prime rate. A hypothetical 1% increase in the prime rate for 2014-2015 would have resulted in an annual increase in interest expense of approximately $124,000.

Item 8. Financial Statements and Supplementary Data

The Financial Statements are attached hereto and begin on page 60.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders of RadNet, Inc.

We have audited the accompanying consolidated balance sheets of RadNet, Inc. and subsidiaries (the ”Company”) as of December 31, 2015 and 2014, and the related consolidated statements of operations, comprehensive income, equity (deficit), and cash flows for each of the three years in the period ended December 31, 2015. Our audits also included the financial statement schedule listed in the Index at Item 15(a)(2).These financial statements and schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and schedule based on our audits.

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

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of RadNet, Inc. and subsidiaries at December 31, 2015 and 2014, and the consolidated results of their operations and their cash flows for each of the three years in the period ended December 31, 2015, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related financial statement schedule, when considered in relation to the basic financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), RadNet Inc.’s internal control over financial reporting as of December 31, 2015, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated March 15, 2016, expressed an adverse opinion thereon.

/s/ Ernst & Young LLP

Los Angeles, California

March 15, 2016

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RADNET, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

(IN THOUSANDS EXCEPT SHARE AND PER SHARE DATA)

	As of December 31,	
	2015	2014
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$446	$307
Accounts receivable, net	162,843	148,235
Current portion of deferred tax assets	22,279	17,246
Due from affiliates	4,815	1,561
Prepaid expenses and other current assets	40,139	24,671
Total current assets	230,522	192,020
PROPERTY AND EQUIPMENT, NET	256,722	223,127
OTHER ASSETS		
Goodwill	239,408	200,304
Other intangible assets	45,253	47,624
Deferred financing costs, net of current portion	3,696	6,122
Investment in joint ventures	33,584	32,123
Deferred tax assets, net of current portion	24,685	35,334
Deposits and other	4,565	4,026
Total assets	$838,435	$740,680
LIABILITIES AND EQUITY		
CURRENT LIABILITIES		
Accounts payable, accrued expenses and other	$113,813	$97,816
Due to affiliates	6,564	6,289
Deferred revenue	1,598	1,964
Current portion of notes payable	23,076	19,468
Current portion of deferred rent	2,563	2,100
Current portion of obligations under capital leases	10,038	5,637
Total current liabilities	157,652	133,274
LONG-TERM LIABILITIES		
Deferred rent, net of current portion	26,865	20,965
Line of credit	–	15,300
Notes payable, net of current portion	601,229	551,059
Obligations under capital lease, net of current portion	6,385	6,143
Other non-current liabilities	9,843	6,241
Total liabilities	801,974	732,982
EQUITY		
RadNet, Inc. stockholders' equity:		
Common stock - $.0001 par value, 200,000,000 shares authorized; 46,281,189 and 42,825,676 shares issued and outstanding at December 31, 2015 and 2014, respectively	4	4

Paid-in-capital	197,297	177,750
Accumulated other comprehensive loss	(153)	(112)
Accumulated deficit	(164,571)	(172,280)
Total RadNet, Inc.'s stockholders' equity	32,577	5,362
Noncontrolling interests	3,884	2,336
Total equity	36,461	7,698
Total liabilities and equity	$838,435	$740,680

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

RADNET, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS

(IN THOUSANDS EXCEPT SHARE AND PER SHARE DATA)

	Years Ended December 31,		
	2015	2014	2013
NET REVENUE			
Service fee revenue, net of contractual allowances and discounts	$746,756	$670,136	$665,307
Provision for bad debts	(36,033)	(29,807)	(27,911)
Net service fee revenue	710,723	640,329	637,396
Revenue under capitation arrangements	98,905	77,240	65,590
Total net revenue	809,628	717,569	702,986
OPERATING EXPENSES			
Cost of operations, excluding depreciation and amortization	708,289	602,652	598,655
Depreciation and amortization	60,611	59,258	58,890
Loss on sale and disposal of equipment	866	1,113	1,032
Severance costs	745	1,241	806
Total operating expenses	770,511	664,264	659,383
INCOME FROM OPERATIONS	39,117	53,305	43,603
OTHER INCOME AND EXPENSES			
Interest expense	41,684	42,727	45,791
Meaningful use incentive	(3,270)	(2,034)	–
Equity in earnings of joint ventures	(8,927)	(6,970)	(6,194)
Gain on sale of imaging centers	(5,434)	–	(2,108)
Loss on early extinguishment of senior notes	–	15,927	–
Other expenses	419	3	228
Total other expenses	24,472	49,653	37,717
INCOME BEFORE INCOME TAXES	14,645	3,652	5,886
Provision for income taxes	(6,007)	(1,967)	(3,510)
NET INCOME	8,638	1,685	2,376
Net income attributable to noncontrolling interests	929	309	256
NET INCOME ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS	$7,709	$1,376	$2,120
BASIC NET INCOME PER SHARE ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS	$0.18	$0.03	$0.05
DILUTED NET INCOME PER SHARE ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS	$0.17	$0.03	$0.05
WEIGHTED AVERAGE SHARES OUTSTANDING			
Basic	43,805,794	41,070,077	39,140,480
Diluted	45,171,372	43,149,196	39,814,535

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

RADNET, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

(IN THOUSANDS)

	Years Ended December 31,		
	2015	2014	2013
NET INCOME	$8,638	$1,685	$2,376
Foreign currency translation adjustments	(153)	(62)	(89)
COMPREHENSIVE INCOME	8,485	1,623	2,287
Less comprehensive income attributable to non-controlling interests	929	309	256
COMPREHENSIVE INCOME ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS	$7,556	$1,314	$2,031

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

RADNET, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENT OF EQUITY (DEFICIT)

(IN THOUSANDS EXCEPT SHARE DATA)

	Common Stock		Paid-in	Accumulated	Accumulated Other Comprehensive	Total Radnet, Inc. Stockholders'	Noncontrolling	Total
	Shares	Amount	Capital	Deficit	Income (Loss)	Deficit) Equity	Interests	(Deficit) Equity
BALANCE - JANUARY 1, 2013	38,540,482	$ 4	$168,415	$(175,776)	$ 39	$ (7,318)	$ 634	$ (6,684)
Issuance of common stock upon exercise of options/warrants	898,714	–	469	–	–	469	–	469
Stock-based compensation	–	–	2,537	–	–	2,537	–	2,537
Sale of a noncontrolling interest in one of our consolidated joint ventures	–	–	2,201	–	–	2,201	439	2,640
Purchase of non-controlling interests	–	–	–	–	–	–	979	979
Issuance of restricted stock	650,000	–	–	–	–	–	–	–
Dividends paid to noncontrolling interests	–	–	–	–	–	–	(18)	(18)
Change in cumulative foreign currency translation adjustment	–	–	–	–	(89)	(89)	–	(89)
Net income	–	–	–	2,120	–	2,120	256	2,376
BALANCE - DECEMBER 31, 2013	40,089,196	$ 4	$173,622	$(173,656)	$ (50)	$ (80)	$ 2,290	$ 2,210
Issuance of common stock upon exercise of options/warrants	1,579,695	–	1,546	–	–	1,546	–	1,546
Stock-based compensation	–	–	2,463	–	–	2,463	–	2,463
Issuance of restricted stock and other awards	1,156,785	–	–	–	–	–	–	–
Purchase of non-controlling interests	–	–	119	–	–	119	(315)	(196)
Sale of non-controlling interests	–	–	–	–	–	–	200	200
	–	–	–	–	–	–	(148)	(148)

Dividends paid to noncontrolling interests								
Change in cumulative foreign currency translation adjustment	–	–	–	–	(62)	(62)	–	(62)
Net income	–	–	–	1,376	–	1,376	309	1,685
BALANCE - DECEMBER 31, 2014	42,825,676	$ 4	$ 177,750	$ (172,280)	$ (112)	$ 5,362	$ 2,336	$ 7,698
Issuance of common stock upon exercise of options/warrants	835,098	–	594	–	–	594	–	594
Stock-based compensation	–	–	7,635	–	–	7,635	–	7,635
Issuance of restricted stock and other awards	1,014,423	–	–	–	–	–	–	–
Forfeiture of restricted stock	(59,053)	–	–	–	–	–	–	–
Issuance of stock for acquisitions	1,665,045	–	9,241	–	–	9,241	–	9,241
Sale of non-controlling interests	–	–	2,077	–	–	2,077	1,348	3,425
Distributions paid to noncontrolling interests	–	–	–	–	–	–	(729)	(729)
Change in cumulative foreign currency translation adjustment	–	–	–	–	(41)	(41)	–	(41)
Net income	–	–	–	7,709	–	7,709	929	8,638
BALANCE - DECEMBER 31, 2015	46,281,189	$ 4	$ 197,297	$ (164,571)	$ (153)	$ 32,577	$ 3,884	$ 36,461

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

RADNET, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

(IN THOUSANDS)

	Years Ended December 31,		
	2015	2014	2013
CASH FLOWS FROM OPERATING ACTIVITIES			
Net income	$8,638	$1,685	$2,376
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	60,611	59,258	58,890
Provision for bad debts	36,033	29,807	27,911
Equity in earnings of joint ventures	(8,927)	(6,970)	(6,194)
Distributions from joint ventures	7,731	7,358	7,204
Amortization and write off of deferred financing costs and loan discount	5,369	5,732	4,565
Loss on sale and disposal of equipment	866	1,113	1,032
Loss on early extinguishment of senior notes	–	15,927	–
Gain on sale of imaging centers	(5,434)	–	(2,108)
Stock-based compensation	7,647	2,500	2,574
Changes in operating assets and liabilities, net of assets acquired and liabilities assumed in purchase transactions:			
Accounts receivable	(34,514)	(43,973)	(31,531)
Other current assets	(14,198)	(5,514)	(2,243)
Other assets	(3,813)	(281)	260
Deferred taxes	4,036	655	2,907
Deferred rent	7,011	2,180	3,871
Deferred revenue	(366)	620	71
Accounts payable , accrued expenses and other	(3,653)	(9,093)	(3,163)
Net cash provided by operating activities	67,037	61,004	66,422
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of imaging facilities	(90,792)	(9,428)	(7,223)
Purchase of property and equipment	(42,964)	(41,740)	(48,623)
Proceeds from sale of equipment	1,282	1,088	635
Proceeds from sale of imaging facilities	35,500	–	3,920
Proceeds from sale of joint venture interests	–	–	2,640
Proceeds from sale of internal use software	443	–	–
Equity contributions in existing and purchase of interest in joint ventures	(265)	(3,562)	(2,009)
Net cash used in investing activities	(96,796)	(53,642)	(50,660)
CASH FLOWS FROM FINANCING ACTIVITIES			
Principal payments on notes and leases payable	(9,773)	(23,913)	(9,764)
Proceeds from borrowings	74,400	210,000	35,122
Payments on senior notes	(23,727)	(211,344)	–
Deferred financing costs	(531)	(6,650)	(432)
Net (payments) proceeds on revolving credit facility	(15,300)	15,300	(33,000)
Dividends paid to noncontrolling interests	(729)	(148)	(18)

Proceeds from the sale of non-controlling interests	5,005	–	–
Purchase of non-controlling interests	–	(196)	–
Proceeds from issuance of common stock upon exercise of options/warrants	594	1,546	469
Net cash provided by (used in) financing activities	29,939	(15,405)	(7,623)
EFFECT OF EXCHANGE RATE CHANGES ON CASH	(41)	(62)	(89)
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	139	(8,105)	8,050
CASH AND CASH EQUIVALENTS, beginning of period	307	8,412	362
CASH AND CASH EQUIVALENTS, end of period	$446	$307	$8,412
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION			
Cash paid during the period for interest	$36,028	$41,584	$41,841
Cash paid during the period for income taxes	$1,781	$1,070	$1,142

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

RADNET, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)

Supplemental Schedule of Non-Cash Investing and Financing Activities

We acquired equipment and certain leasehold improvements for approximately $32.4 million, $19.4 million, and $16.7 million during the years ended December 31, 2015, 2014 and 2013, respectively, that we had not paid for as of December 31, 2015, 2014 and 2013, respectively. The offsetting amount due was recorded in our consolidated balance sheet under “accounts payable, accrued expenses and other.”

During the twelve months ended December 31, 2015, we added capital lease debt of approximately $7.8 million relating to radiology equipment.

Detail of investing activity related to acquisitions can be found in Note 4.

RADNET, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1 – NATURE OF BUSINESS

We are a national provider of freestanding, fixed-site outpatient diagnostic imaging services. At December 31, 2015, we operated directly or indirectly through joint ventures with hospitals, 300 centers located in California, Delaware, Flordia, Maryland, New Jersey, New York and Rhode Island. Our centers provide physicians with imaging capabilities to facilitate the diagnosis and treatment of diseases and disorders. Our services include magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), nuclear medicine, mammography, ultrasound, diagnostic radiology (X-ray), fluoroscopy and other related procedures. The vast majority of our centers offer multi-modality imaging services. Our multi-modality strategy diversifies revenue streams, reduces exposure to reimbursement changes and provides patients and referring physicians one location to serve the needs of multiple procedures. Our operations comprise a single segment for financial reporting purposes.

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

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

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

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

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

We have determined that BRMG and the NY Groups are variable interest entities, and that we are the primary beneficiary, and consequently, we consolidate the revenue and expenses, assets and liabilities of each. BRMG and the NY Groups on a combined basis recognized $113.1 million, $89.3 million and $76.7 million of revenue, net of management service fees to RadNet, for the years ended December 31, 2015, 2014 and 2013, respectively, and $113.1 million, $89.3 million and $76.7 million of operating expenses for the years ended December 31, 2015, 2014 and 2013, respectively. RadNet recognized $343.9 million, $287.4 million and $267.6 million of net revenues for the years ended December 31, 2015, 2014 and 2013, respectively, for management services provided to BRMG and the NY Groups relating primarily to the technical portion of total billed revenue. The cash flows of BRMG and the NY Groups are included in the accompanying consolidated statements of cash flows. All intercompany balances and transactions have been eliminated in consolidation. In our consolidated balance sheets at December 31, 2015 and 2014, we have included approximately $89.8 million and $79.7 million, respectively, of accounts receivable and approximately $8.5 million and $9.0 million of accounts payable and accrued liabilities related to BRMG and the NY Groups.

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

Aside from centers in California where we contract with BRMG for the provision of professional medical services and centers in New York, New York, where we contract with the NY Groups for the provision of professional medical services, at the remaining centers in California and at all of the centers which are located outside of California and New York, New York, we have entered into long-term contracts with independent radiology groups in the area to provide physician services at those facilities. These third party radiology practices provide professional services, including supervision and interpretation of diagnostic imaging procedures, in our diagnostic imaging centers. The radiology practices maintain full control over the provision of professional services. In these facilities we enter into long-term agreements with radiology practice groups (typically 40 years). Under these arrangements, in addition to obtaining technical fees for the use of our diagnostic imaging equipment and the provision of technical services, we provide management services and receive a fee based on the practice group’s professional revenue, including revenue derived outside of our diagnostic imaging centers. We own the diagnostic imaging equipment and, therefore, receive 100% of the technical reimbursements associated with imaging procedures. The radiology practice groups retain the professional reimbursements associated with imaging procedures after deducting management service fees paid to us. We have no financial controlling interest in the independent (non-BRMG or non-NY Groups) radiology practices; accordingly, we do not consolidate the financial statements of those practices in our consolidated financial statements.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

PRINCIPLES OF CONSOLIDATION - The operating activities of subsidiaries are included in the accompanying consolidated financial statements from the date of acquisition. Investments in companies in which the Company has the ability to exercise significant influence, but not control, are accounted for by the equity method. All intercompany

transactions and balances, with our consolidated entities and the unsettled amount of intercompany transactions with our equity method investees, have been eliminated in consolidation. As stated in Note 1 above, the BRMG and NY Groups are variable interest entities and we consolidate the operating activities and balance sheets of each.

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

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

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

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

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

	Years Ended December 31,		
	2015	2014	2013
Commercial insurance (1)	$486,489	$437,525	$430,735
Medicare	168,545	159,562	156,066
Medicaid	23,948	24,499	24,017
Workers' compensation/personal injury	32,728	30,543	34,821
Other (2)	35,046	18,007	19,668
Service fee revenue, net of contractual allowances and discounts	746,756	670,136	665,307
Provision for bad debts	(36,033)	(29,807)	(27,911)
Net service fee revenue	710,723	640,329	637,396
Revenue under capitation arrangements	98,905	77,240	65,590
Total net revenue	$809,628	$717,569	$702,986

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(1) 20% of our net service fees revenue for each of the years ended December 31, 2015, 2014 and 2013 were earned from a single payor.

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

PROVISION FOR BAD DEBTS - We provide for an allowance against accounts receivable that could become uncollectible to reduce the carrying value of such receivables to their estimated net realizable value. We estimate this allowance based on the aging of our accounts receivable by the historical payment pattern of each type of payor, write-off trends, and other relevant factors. A significant portion of our provision for bad debt relates to co-payments and deductibles owed to us from patients with insurance. Although we attempt to collect deductibles and co-payments due from patients with insurance at the time of service, this attempt to collect at the time of service is not an assessment of the patient’s ability to pay nor are revenues recognized based on an assessment of the patient’s ability to pay. There are various factors that can impact collection trends, such as changes in the economy, which in turn have an impact on the increased burden of co-payments and deductibles to be made by patients with insurance. These factors continuously change and can have an impact on collection trends and our estimation process. Our allowance for bad debts at December 31, 2015 and 2014 was $20.8 million and $15.1 million, respectively.

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

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

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

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

We recognize revenue for four units of accounting, hardware, software, installation (including manufacturing and configuration, training, implementation and project management) and post-contract support ("*PCS")*, as follows:

- **Hardware** – Revenue is recognized when the hardware is shipped. The hardware qualifies as a separate unit of accounting under ASC 605-25-25-5, as it meets the following criteria:
  - The hardware has standalone value as it is sold separately by other vendors and the customer could resell the hardware on a standalone basis; and
  - Delivery or performance of the undelivered items is probable and substantially within our control.
- **Software**– We sell essential software. This software revenue is recognized along with the related hardware revenue.
- **Installation** – Installation revenue related to essential software that is sold with hardware, is recognized when the installation is completed, as it qualifies as a separate unit of accounting once delivered as it can be provided by a third party.
- **Post-Contract Support** – Revenue is recognized over the term of the agreement, usually one year.

Our transactions do not generally contain refund provisions. We allocate the transaction price to each unit of accounting using relative selling price. We consider historical pricing, list price and market considerations in determining estimated selling price in the allocation.

For the years ended December 31, 2015, 2014 and 2013, we recorded approximately $6.1 million, $5.5 million and $4.9 million, respectively, in revenue related to our eRAD business which is included in net service fee revenue in our consolidated statement of operations. At December 31, 2015 we had a deferred revenue liability of approximately $1.5 million associated with eRAD sales which we expect to recognize into revenue over the next 12 months.

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

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

In accordance with ASC 350-40, *Accounting for the Costs of Computer Software Developed for Internal Use,* the costs incurred by RMIS toward the development of our RIS system, which began in August, 2010 and continued until December 2014, were capitalized and are being amortized over its useful life which we determined to be 5 years. Total costs capitalized were approximately $6.4 million. We began recording amortization of $107,000 per month for our use of this software in January 2015.

During the twelve months ended December 31, 2015, we entered into an agreement to license our RIS system to an outside customer. As of December 31, 2015, we received approximately $443,000 with respect to this licensing agreement. In accordance with ASC 350-40, we recorded the receipt of these funds against the capitalized software costs explained above. We intend to record any future proceeds in the same manner until the carrying value of our capitalized software costs are brought to zero. As of December 31, 2015, the net carrying value of our capitalized software costs was approximately $4.7 million.

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

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

DEFERRED FINANCING COSTS - Costs of financing are deferred and amortized on a straight-line basis over the life of the associated loan, which approximates the effective interest rate method. Deferred financing costs, net of accumulated amortization, were $4.9 million and $6.7 million, as of December 31, 2015 and 2014, respectively. In conjunction with our 2015 Incremental First Lien Supplemental term loan borrowing, approximately $531,000 was added to deferred financing costs. As part of our early extinguishment of senior notes during March and April of 2014, approximately $3.4 million of deferred financing costs were written off. See Note 8, Notes Payable, Line of Credit, and Capital Leases for more information.

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

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

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

GOODWILL AND INDEFINITE LIVED INTANGIBLES - Goodwill at December 31, 2015 totaled $239.4 million. Indefinite lived intangible assets at December 31, 2015 totaled $7.9 million and are associated with the value of certain trade name intangibles. Goodwill and trade name intangibles are recorded as a result of business combinations. Management evaluates goodwill and trade name intangibles, at a minimum, on an annual basis and whenever events and changes in circumstances suggest that the carrying amount may not be recoverable. Impairment of goodwill is tested at the reporting unit level by comparing the reporting unit’s carrying amount, including goodwill, to the fair value of the reporting unit. The fair value of a reporting unit is estimated using a combination of the income or

discounted cash flows approach and the market approach, which uses comparable market data. If the carrying amount of the reporting unit exceeds its fair value, goodwill is considered impaired and a second step is performed to measure the amount of impairment loss, if any. Impairment of trade name intangibles is tested at the subsidiary level by comparing the subsidiary's trade name carrying amount to its respective fair value. We tested both goodwill and trade name intangibles for impairment on October 1, 2015, noting no impairment, and have not identified any indicators of impairment through December 31, 2015.

LONG-LIVED ASSETS - We evaluate our long-lived assets (property and equipment) and intangibles, other than goodwill, for impairment whenever indicators of impairment exist. Generally accepted accounting principles (GAAP) requires that if the sum of the undiscounted expected future cash flows from a long-lived asset or definite-lived intangible is less than the carrying value of that asset, an asset impairment charge must be recognized. The amount of the impairment charge is calculated as the excess of the asset's carrying value over its fair value, which generally represents the discounted future cash flows from that asset or in the case of assets we expect to sell, at fair value less costs to sell. No indicators of impairment were identified with respect to our long-lived assets as of December 31, 2015.

INCOME TAXES - Income tax expense is computed using an asset and liability method and using expected annual effective tax rates. Under this method, deferred income tax assets and liabilities result from temporary differences in the financial reporting bases and the income tax reporting bases of assets and liabilities. The measurement of deferred tax assets is reduced, if necessary, by the amount of any tax benefit that, based on available evidence, is not expected to be realized. When it appears more likely than not that deferred taxes will not be realized, a valuation allowance is recorded to reduce the deferred tax asset to its estimated realizable value. For net deferred tax assets we consider estimates of future taxable income in determining whether our net deferred tax assets are more likely than not to be realized. Income taxes are further explained in Note 10.

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

On November 1, 2013 we entered into a high-deductible workers' compensation insurance policy. We have recorded liabilities as of December 31, 2015, and 2014 of $2.2 million and $1.0 million, respectively for the estimated future cash obligations associated with the unpaid portion of the workers compensation claims incurred.

We and our affiliated physicians carry an annual medical malpractice insurance policy that protects us for claims that are filed during the policy year and that fall within policy limits. The policy has a deductible for which we have recorded liabilities and included it in our consolidated balance sheets at December 31, 2015 and December 31, 2014 of approximately $24,000 and $88,000, respectively.

In December 2008, in order to eliminate the exposure for claims not reported during the regular malpractice policy period, we purchased a medical malpractice tail policy, which provides coverage for any claims reported in the event that our medical malpractice policy expires. As of December 31, 2015, this policy remains in effect.

We have entered into an arrangement with Blue Shield to administer and process claims under a self-insured plan that provides health insurance coverage for our employees and dependents. We have recorded liabilities as of December 31, 2015 and 2014 of $1.8 million and $2.0 million, respectively, for the estimated future cash obligations associated with the unpaid portion of the medical and dental claims incurred by our participants. Additionally, we entered into an agreement with Blue Shield for a stop loss policy that provides coverage for any claims that exceed $250,000 up to a maximum of $1.0 million in order for us to limit our exposure for unusual or catastrophic claims.

LOSS AND OTHER UNFAVORABLE CONTRACTS – We assess the profitability of our contracts to provide management services to our contracted physician groups and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future revenue is compared to anticipated costs. If the anticipated future cost exceeds the revenue, a loss contract accrual is recorded. In connection with the acquisition of Radiologix in November 2006, we acquired certain management service agreements for which forecasted costs exceeds forecasted revenue. As such, an $8.9 million loss contract accrual was established in purchase accounting, and is included in other non-current liabilities. The recorded loss contract accrual is being accreted into operations over the remaining term of the acquired management service agreements. As of December 31, 2015 and 2014, the remaining accrual balance is $5.7 million, and $6.1 million, respectively.

As part of our ongoing acquisition activities, we have certain operating lease commitments for facilities that are not in use. Accordingly, we have recorded a loss contract accrual related to the remaining payments under these lease

commitments. As of December 31, 2015 and 2014, the remaining loss contract accrual for these leases is $85,000 and $218,000, respectively.

In addition and related to acquisition activity, we have certain operating lease commitments for facilities where the fair market rent differs from the lease contract rate. We have recorded an unfavorable contract liability representing the difference between the total value of the fair market rent and the contract rent over the current term of the lease applicable from the date of acquisition. As of December 31, 2015 and 2014, the unfavorable contract liability on these leases is $581,000 and $1.2 million, respectively.

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

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

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

COMPREHENSIVE INCOME - ASC 220, *Comprehensive Income,* establishes rules for reporting and displaying comprehensive income and its components. Unrealized gains or losses on the change in fair value of the Company's cash flow hedging activities and foreign currency translation adjustments are included in comprehensive income. The components of comprehensive income for the three years in the period ended December 31, 2015 are included in the consolidated statements of comprehensive income.

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

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

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

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

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

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

	As of December 31, 2014		
		Level 2	Total

	Level 1	Level 3	Total Face Value
First Lien Term Loans	$–	$394,753	$–	$394,753	$399,750
Second Lien Term Loans	–	178,200	–	178,200	180,000

Our revolving credit facility had no aggregate principal amount outstanding as of December 31, 2015.

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

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

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

	Years Ended December 31,		
	2015	2014	2013
Net income attributable to RadNet, Inc. common stockholders	$7,709	$1,376	$2,120
BASIC NET INCOME PER SHARE ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS			
Weighted average number of common shares outstanding during the period	43,805,794	41,070,077	39,140,480
Basic net income per share attributable to RadNet, Inc. common stockholders	$0.18	$0.03	$0.05
DILUTED NET INCOME PER SHARE ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS			
Weighted average number of common shares outstanding during the period	43,805,794	41,070,077	39,140,480
Add nonvested restricted stock subject only to service vesting	865,326	994,610	316,905
Add additional shares issuable upon exercise of stock options and warrants	500,252	1,084,509	357,150
Weighted average number of common shares used in calculating diluted net income per share	45,171,372	43,149,196	39,814,535
Diluted net income per share attributable to RadNet, Inc. common stockholders	$0.17	$0.03	$0.05

For the years ended December 31, 2015, 2014 and 2013 we excluded 265,000, 245,000, and 4,663,750, respectively, outstanding options, in the calculation of diluted earnings per share because their effect would be antidilutive.

INVESTMENT IN JOINT VENTURES – We have ten unconsolidated joint ventures with ownership interests ranging from 35% to 50%. These joint ventures represent partnerships with hospitals, health systems or radiology practices and were formed for the purpose of owning and operating diagnostic imaging centers. Professional services at the joint venture diagnostic imaging centers are performed by contracted radiology practices or a radiology practice that participates in the joint venture. Our investment in these joint ventures is accounted for under the equity method. We evaluate our investment in joint ventures, including cost in excess of book value (equity method goodwill) for impairment whenever indicators of impairment exist. No indicators of impairment existed as of December 31, 2015. Activity in investment in joint ventures for the years ended December 31, 2014 and 2015, is provided below (in thousands):

Balance as of December 31, 2013	$28,949
Purchase of a 49% interest in a new joint venture	2,168
Equity contributions in existing joint ventures	1,394

Equity in earnings in these joint ventures	6,970
Distribution of earnings	(7,358)
Balance as of December 31, 2014	$32,123
Equity contributions in existing joint ventures	265
Equity in earnings in these joint ventures	8,927
Distribution of earnings	(7,731)
Balance as of December 31, 2015	$33,584

We received management service fees from the centers underlying these joint ventures of approximately $9.3 million per year for the years ended December 31, 2015, 2014 and 2013. We eliminate any unrealized portion of our management service fees with our equity in earnings of joint ventures.

The following table is a summary of key financial data for these joint ventures as of December 31, 2015 and 2014, respectively, and for the years ended December 31, 2015, 2014 and 2013, respectively, (in thousands):

	December 31,	
	2015	2014
Balance Sheet Data:		
Current assets	$28,186	$23,636
Noncurrent assets	91,660	49,347
Current liabilities	(15,258)	(9,534)
Noncurrent liabilities	(44,059)	(6,386)
Total net assets	$60,529	$57,063
Book value of RadNet joint venture interests	$28,397	$26,791
Cost in excess of book value of acquired joint venture interests	4,970	4,970
Elimination of intercompany profit remaining on Radnet's consolidated balance sheet	217	362
Total value of Radnet joint venture interests	$33,584	$32,123
Total book value of other joint venture partner interests	$32,132	$30,272

	2015	2014	2013
Net revenue	$125,544	$101,189	$93,134
Net income	$19,485	$14,854	$13,633

NOTE 3 – RECENT ACCOUNTING STANDARDS

In February 2016, the Financial Accounting Standards Board (the "FASB") issued Accounting Standards Update ("ASU") No. 2016-02 ("ASU 2016-02"), *Leases,* (Topic 842): Amendments to the FASB Accounting Standards Codification. ASU 2016-02 amends the existing accounting standards for lease accounting, including requiring lessees to recognize most leases on their balance sheets and making targeted changes to lessor accounting. The new standard requires a modified retrospective transition approach for all leases existing at, or entered into after, the date initial application, with an option to use certain transition relief. The amendments in this update are effective for fiscal years (and interim reporting periods within fiscal years) beginning after December 15, 2018. Early adoption of the amendments is permitted for all entities. We are currently evaluating the impact of the GAAP update on our results of operations and cash flows.

In November 2015, the FASB issued ASU No. 2015-17 ("ASU 2015-17), *Income Taxes* (Topic 740): Balance Sheet Classification of Deferred Taxes. ASU 2015-17 changes the classification of deferred taxes to be a noncurrent asset or liability regardless of the classification of the related asset or liability for financial reporting. The update is effective for fiscal years beginning after December 15, 2016. Early application is permitted at the beginning of an interim or annual reporting period. We are currently evaluating the impact of the GAAP update on our results of operations and cash flows.

In September 2015, the FASB issued ASU No. 2015-16 (“ASU 2015-16”), *Business Combinations,* (Topic 805): Simplifying the Accounting for Measurement-Period Adjustments. ASU 2015-16 eliminates the requirement to retrospectively apply adjustments made to provisional amounts recognized in a business combination. An entity will now recognize any adjustments in the reporting period in which the amounts are determined, calculated as if the accounting had been completed at the acquisition date. Disclosure is required for the portion of adjustments recorded in current-period earnings that would have been recorded in previous reporting periods had they been recognized as of the acquisition date. The update is effective for fiscal years (and interim reporting periods within fiscal years) beginning after December 15, 2015. Early adoption is permitted for financial statements that have not been previously issued. We are currently evaluating the impact of the GAAP update on our results of operations and cash flows.

In August 2015, the FASB issued ASU No. 2015-15 (“ASU 2015-15”), *Interest – Imputation of Interest*, (Subtopic 835-30): Presentation and Subsequent Measurement of Debt Issuance Costs Associated with Line-of-Credit Arrangements. ASU 2015-15 provides additional guidance to the presentation of debt issuance costs discussed originally in ASU No. 2015-03, which was issued in April 2015 and described below. ASU 2015-15 noted that ASU 2015-03 did not address the debt issue costs in regards to line-of-credit arrangements, which by their nature have fluctuating balances. ASU 2015-15 permits debt issuance costs specifically related to line-of-credit arrangements to be presented as an asset with subsequent amortization to interest expense ratably over the term of the line-of-credit arrangement, regardless of whether there are any outstanding borrowings on the arrangement. The update is effective for fiscal years (and interim reporting periods within fiscal years) beginning after December 15, 2015. Early adoption is permitted for financial statements that have not been previously issued. We are currently evaluating the impact of the GAAP update on our results of operations and cash flows.

In April 2015, the Financial Accounting Standards Board (the “FASB”) issued ASU No. 2015-03 (“ASU 2015-03”), *Interest – Imputation of Interest*, (Subtopic 835-30). ASU 2015-03 changes the accounting method for debt issuance costs from a deferred charge (i.e. an asset) to a contra liability in part because such costs provide no future economic benefit. Debt issue costs related to a recognized debt liability are to be presented in the balance sheet as a direct deduction from the carrying amount of the debt liability, consistent with the presentation of debt discounts. The update is effective for fiscal years (and interim reporting periods within fiscal years) beginning after December 15, 2015. Early adoption is permitted for financial statements that have not been previously issued. We are currently evaluating the impact of the GAAP update on our results of operations and cash flows.

In February 2015, the FASB issued ASU No. 2015-02 (“ASU 2015-02”), *Consolidation – Amendments to the Consolidation Analysis,* (Topic 810). ASU 2015-02 changes the analysis that a reporting entity must perform to determine whether it should consolidate certain types of legal entities. It is effective for annual reporting periods, and interim periods within those years, beginning after December 15, 2015. Early adoption is permitted, including adoption in an interim period. We are currently evaluating the impact of the GAAP update on our results of operations and cash flows.

In May 2014, the FASB issued ASU No. 2014-09 (“ASU 2014-09”), *Revenue from Contracts with Customers*, (Topic 606). ASU 2014-09 requires an entity to recognize revenue when it transfers promised goods or services to customers in an amount that reflects what it expects in exchange for the goods or services. It also requires more detailed disclosures to enable users of the financial statements to understand the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. The update was effective for fiscal years (and interim reporting periods within fiscal years) beginning after December 15, 2016, which has recently been extended to December 31, 2017. We are currently evaluating the impact of the GAAP update on our results of operations and cash flows.

NOTE 4 – FACILITY ACQUISITIONS AND DISPOSITIONS

Acquisitions

On October 1, 2015 we completed our acquisition of certain assets of Diagnostic Imaging Group, LLC (DIG), consisting of seventeen multi-modality imaging centers located in the boroughs of Brooklyn and Queens, New York, for the following: Cash consideration of $54.6 million ($49.6 million paid at execution, $5 million to be paid 18 months after acquisition or earlier if certain conditions are met), the assumption of $2.1 million in equipment debt, and issuance of 1.5 million RadNet common shares valued at $8.3 million on the acquisition date. The facilities provide a full range of radiology services including MRI, PET/CT, Mammography, Ultrasound, X-ray and other related services. The transaction also includes contingent consideration that is payable equal to five times the amount by which collections on the sellers' historical revenue exceeds a defined threshold. The estimated fair value of the liability on the acquisition date and as of December 31, 2015 is zero which is based on the probability of collections exceeding defined thresholds.

The total purchase price for the above business is as follows (in thousands):

Cash	$54,555
1.5 million shares of Radnet common stock	8,325
Total combined purchase price	$62,880

The determination of the net tangible and intangible assets acquired and liabilities assumed is based on the estimated fair values of the acquired assets and liabilities assumed as of the date of acquisition. The following table summarizes the preliminary fair value determination (in thousands):

Accounts receivable, net	$12,346
Prepaid expenses and other current assets	377
Property and equipment	17,959
Goodwill	40,035
Other intangibles	50
Accounts payable, accrued expenses and other	(4,939)
Obligations under capital lease	(2,948)
	$62,880

The final fair value determination is expected to be completed in the first quarter of 2016 upon receipt of a final valuation report from an external valuation firm.

The revenue and earnings of DIG included in our consolidated statement of operations from the acquisition date to December 31, 2015 are as follows (in thousands):

Net revenue	$17,498
Pretax income	1,880
Net income	1,166

The following unaudited pro-forma financial information for the years ended December 31, 2015 and 2014 represents the combined results of operations of RadNet and DIG as if DIG's acquisition had occurred on January 1, 2014. The unaudited pro-forma financial information does not necessarily reflect the results of operations that would have occurred had the entities comprising DIG constituted a single entity during such periods (in thousands, except per share data).

	(unaudited) Years ended December 31,	
	2015	2014
Net revenue	$882,478	$795,620
Net income	7,329	3,644
Pro-forma diluted net income per share	$0.16	$0.08

46,421 44,649

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

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

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

On June 1, 2015 we completed our acquisition of certain assets of Healthcare Radiology and Diagnostic systems, PLLC, consisting of a single multi-modality imaging center located in the Bronx, NY area for cash consideration of $425,000. The facility provides MRI, CT, Ultrasound and X-ray services. We have made a fair value determination of assets acquired and approximately $134,500 of fixed assets and $290,500 of leasehold improvements were recorded.

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

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

On September 1, 2014 we completed our acquisition of certain assets of Hematology Oncology Consultants located in Van Nuys, CA for cash consideration of $553,000. We have made a fair value determination of the acquired assets and approximately $15,000 of fixed assets, $164,000 of medical supplies inventory, $39,000 of other assets, $100,000 covenant not to compete intangible asset, and $235,000 of goodwill were recorded with respect to this transaction.

On September 1, 2014 we completed our acquisition of certain assets of Imaging Centers of Pasadena consisting of a single multi-modality imaging center located in Pasadena, CA for cash consideration of $1.8 million. The facility provides MRI, PET/CT, Ultrasound and X-ray services. We have made a fair value determination of the acquired assets and approximately $1.7 million of fixed assets and $105,000 of a covenant not to compete intangible asset were recorded with respect to this transaction.

On July 3, 2014 we completed our acquisition of certain imaging center equipment from Healthcare Partners for which we agreed to pay $2.1 million. We paid cash of $300,000 and signed a promissory note for the remainder of $1.8 million.