RadNet, Inc.
Form 10-K
March 16, 2015

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, 2014

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 $217,067,155 on June 30, 2014 (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, 2014.

The number of shares of the registrant's common stock outstanding on March 10, 2015, was 43,654,575

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive proxy statement for the 2015 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, except to the extent required by law. Additionally, we do not undertake any responsibility to update you on the occurrence of 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.

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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, 2014, we operated directly or indirectly through joint ventures with hospitals, 259 centers located in California, Maryland, Florida, Delaware, New Jersey, Rhode Island and New York. 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 provides 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 taking 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 can make the RadNet imaging center operations more efficient and cost effective.

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, 2014, 2013 and 2012, we performed 4,828,488, 4,525,490, and 4,142,267

diagnostic imaging procedures and generated net revenue of $717.6 million, $703.0 million, and $647.2 million, respectively. Additional information concerning RadNet, Inc., including our consolidated subsidiaries, for each of the years ended December 31, 2014, 2013 and 2012 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 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.

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 30 employees, including a research and development team of 11 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 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. 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 projected 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 equipment. 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 can have either open or closed designs, routinely 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, 2014, we had 213 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, 2014, we had 125 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, 2014, we had 44 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, 2014, we had 44 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, 2014, we had 274 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, 2014, we had 392 ultrasound systems in operation.

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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, 2014, we had 226 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, 2014, we had 168 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 33% 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 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, 2014, we operated 259 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 multi-modality 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. As of December 31, 2014, we received approximately 56% of our payments from commercial insurance payors, 13% from managed care capitated payors, 21% 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, 2014.

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 management beneficially owns (either directly or indirectly) approximately 25% of our common stock.

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 intend 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 which we determine to be appropriate. 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 8 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 in California

Howard G. Berger, M.D. is our President and Chief Executive Officer, a member of our Board of Directors and is deemed to be the beneficial owner, directly and indirectly, of approximately 12.6% of our outstanding common stock as of December 31, 2014. Dr. Berger also owns, indirectly, 99% of the equity interests in BRMG. BRMG provides all of the professional medical services at the majority 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. BRMG is a partnership of ProNet Imaging Medical Group, Inc., Breastlink Medical Group, Inc. and Beverly Radiology Medical Group, Inc., each of which is 99% or 100% owned by Dr. Berger.

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, 2014, BRMG employed 94 full-time and 10 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, 2014, this percentage was 79%. 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, 2014, he owned 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 8 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.

John V Crues, III, M.D. is our Medical Director, a member of our Board of Directors and a 1% owner of BRMG. Dr. Crues owns a controlling interest in two medical groups ("Crues Entities") which provide professional medical services at some of our facilities in Manhattan and Brooklyn, New York while Dr. Berger owns a controlling interest in two medical groups ("NY Berger Entities") which provide professional medical services at one of our Manhattan, New York facilities. The Crues Entities and the NY Berger Entities are collectively hereinafter referred to as the "B&C Entities."

Non-BRMG and B&C Entity Locations

At the 8 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 New York, New York, 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, 2014	Year Ended December 31, 2013	Year Ended December 31, 2012
Commercial Insurance [1][2]	56%	55%	56%
Managed Care Capitated Payors	13%	13%	13%
Medicare& Medicaid	24%	25%	24%

[1] Includes Blue Cross/Blue Shield plans, which represented 20% of our net service fee revenue for the year ended December 31, 2014, 20% of our net service fee revenue for the year ended December 31, 2013 and 20% of our net service fee revenue for the year ended December 31, 2012.

[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. 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 129 fixed-site, freestanding outpatient diagnostic imaging facilities in California, 54 in Maryland, 24 in the Rochester and Hudson Valley areas of New York, 13 in New York City, 13 in Delaware, 5 in Rhode Island, 18 in New Jersey, as well as 3 individual facilities in Florida. 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, 2014:

	Year Ended December 31,				
	2010	2011	2012	2013	2014
Total facilities owned or managed (at beginning of the year)	180	201	233	246	250
Facilities added by:					
Acquisition	28	33	25	12	22
Internal development	8	2	–	–	–
Facilities closed or sold	-15	-3	-12	-8	-13
Total facilities owned (at year end)	201	233	246	250	259

Diagnostic Imaging Equipment

The following table indicates, as of December 31, 2014, 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	71	19	41	22	92	174	127	18	71	635
Florida	2	1	3	1	3	5	2	3	5	25
Delaware	8	–	6	–	5	19	15	2	4	59
New Jersey	19	1	16	3	19	21	23	2	15	119
New York	31	1	19	5	38	73	30	4	17	218
Maryland	53	4	37	13	66	97	73	15	56	414
Rhode Island	3	–	3	–	3	3	4	–	–	16
Total	187	26	125	44	226	392	274	44	168	1,486

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 Note 4 to our consolidated financial statements included in this annual report on Form 10-K.

Information Technology

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

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

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

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

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

Personnel

At December 31, 2014, we had a total of 4,506 full-time, 742 part-time and 1,113 per diem employees, including those employed by BRMG. These numbers include 118 full-time and 17 part-time physicians and 1,085 full-time, 432 part-time and 570 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, 2014, our California sales and marketing team consisted of one director of marketing and 41 customer service representatives, while our eastern marketing team consisted of one director of marketing and 88 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.

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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

We have a sports marketing program designed to increase our public profile. We provide X-ray equipment and a technician for all of the basketball games of the Lakers, Clippers and Sparks, as well as all Kings hockey games, all held at the Staples Center in Los Angeles, and University of Southern California football games held in the Los Angeles Coliseum. In exchange for this service, we receive game tickets and an advertisement in each team program throughout the season. 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, 2014, capital lease obligations, excluding interest, totaled approximately $11.8 million through 2017, including current installments totaling approximately $5.6 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. 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 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.

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

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

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

Liability Insurance

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

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

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

Regulation

General

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

Licensing and Certification Laws

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

Corporate Practice of Medicine

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

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

During the year ended December 31, 2014, approximately 21% 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.

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 121 of our 129 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.

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, 2014, we derived approximately 10.7% of our 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.

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 experience increased competition that limits our ability to expand our business. 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 12 acquisitions. These acquisitions have added 21 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 $1.4 million, $2.1 million, and $59.8 million for the years ended December 31, 2014, 2013, and 2012 respectively. As of December 31, 2014, our equity was $5.4 million. As a whole, results have shown improvement over the past three years. However, the net income for the year ended December 31, 2012 was driven by a benefit from income taxes of approximately $55.2 million. 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, 2014, our total indebtedness was $597.6 million, $567.8 million of which constituted guaranty indebtedness. Our substantial indebtedness could also:

- make it difficult for us to satisfy our 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.

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 failure to meet our capital expenditure requirements 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.

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.

There are inherent limitations on the effectiveness of our controls.

We do not expect that our disclosure controls or our internal control over financial reporting will prevent or detect all errors and all fraud. The design of any system of controls is based in part on certain assumptions, and there can be no assurance that any design will succeed in achieving its goals under all conditions. Failure to maintain an effective control environment could have a material adverse effect on our ability to accurately report our financial results, and the market price of our stock could decline.

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.

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

As of January 1, 2015, the SGR formula would result in a decrease to the physician Medicare fee schedule reimbursement by 24%. However, the Protecting Access to Medicare Act of 2014 delays the implementation of such cuts from taking effect until March 31, 2015. This short-term reprieve is the 17th time Congress has voted to delay implementation of the SGR formula, and is intended to give Congress additional time to finalize pending legislation that would permanently repeal the SGR formula.

While Congress has repeatedly intervened to mitigate the negative reimbursement impact associated with the SGR formula, there is no guarantee that Congress will continue to do so in the future. Moreover, the existing methodology may result in significant yearly fluctuations in the Medicare Physician Fee Schedule amounts, which may be unrelated to changes in the actual costs of providing physician services. Unless Congress enacts a change to the SGR methodology, the uncertainty regarding reimbursement rates and fluctuation will continue to exist. Moreover, if Congress does change the SGR methodology or substitute a new system for physician fee-for-service payments, it may require reductions in other Medicare programs including Medicare Advantage to offset such additional costs.

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. Other changes in reimbursement for services rendered by Medicare Advantage plans may reduce the revenues we receive for services rendered to Medicare Advantage enrollees.

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, 2014, approximately 25% of our net 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. 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. Credentialing of physicians is required by our payors prior to commencing payment.

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.

Newly enacted and future federal legislation could limit the prices we can charge for our services, which would reduce our revenue and adversely affect our operating results.

New legislation has introduced certain changes that may result in decreased revenue for the scans we perform. Among other things, the new legislation will adjust 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% starting January, 1, 2014. Other changes in reimbursement for services rendered by Medicare Advantage plans may reduce the revenues we receive for services rendered to Medicare Advantage enrollees.

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 believe that we maintain professional liability insurance coverage 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.

We may be subject to theft, loss or misuse of personal data about our employees, patients or other third parties, which could increase our expenses or result in legal proceedings.

The theft, loss or misuse of personal data collected, used, stored or transferred by us could result in increased security costs or costs related to defending legal proceedings. Privacy legislation and enforcement is constantly changing and creating a complex regulatory environment. Our failure to comply with privacy-related or data protection laws and regulations could result in proceedings against us by governmental entities or others.

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 the United States 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.

129 of our 259 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 129 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, 2013 through December 31, 2014, 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 and other space under leases nationwide, which expire at various dates through August 2020. As of December 31, 2014, total square footage under lease, including medical office, administrative and storage locations was approximately 1.8 million square feet.

We operate 129 fixed-site, freestanding outpatient diagnostic imaging facilities in California, 54 in Maryland, 24 in the Rochester and Hudson Valley areas of New York, 13 in New York City, 13 in Delaware, 5 in Rhode Island, 18 in New Jersey, as well as 3 individual facilities in Florida. 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.

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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, 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
December 31, 2013	$1.51	$2.68
September 30, 2013	2.35	3.35
June 30, 2013	2.26	2.90
March 31, 2013	2.50	3.22

The last low and high prices for our common stock on the NASDAQ Global Market for the period from January 1 to March 10, 2015 were $7.53 and $9.40, respectively.

Holders

As of March 10, 2015, 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 2015 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, 2014, 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 2009 to 2014 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, 2009 in our common stock and in each of the foregoing indices and the reinvestment of dividends through December 31, 2014. 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	12/31/10	12/30/11	12/31/12	12/31/13	12/31/14
RadNet, Inc.	38.24	-24.47	18.78	-33.99	411.38
S&P 500 Index	15.06	2.11	16.00	32.39	13.69
S&P Health Care Sector	2.90	12.73	17.89	41.46	25.34

INDEXED RETURNS

	Base Period	Years Ending				
Company / Index	**12/31/09**	**12/31/10**	**12/30/11**	**12/31/12**	**12/31/13**	**12/31/14**
RadNet, Inc.	**100**	138.24	104.41	124.02	81.86	418.63
S&P 500 Index	**100**	115.06	117.49	136.30	180.44	205.14
S&P Health Care Sector	**100**	102.90	116.00	136.75	193.45	242.46

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, 2014, 2013 and 2012, and the consolidated balance sheet data as of December 31, 2014 and 2013, 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, 2011 and 2010, and the consolidated balance sheet data set forth below as of December 31, 2012, 2011 and 2010, 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 Crues Entities, Dr. Crues and the Company, we are considered to have a controlling financial interest in BRMG and the Crues Entities (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 and Dr Crues' compensation, fees payable to us and amounts payable to third parties.

	Years Ended December 31,				
	2014	2013	2012	2011	2010
	(in thousands, except per share data)				
Statement of Operations Data:					
Net revenue	$717,569	$702,986	$647,153	$585,121	$518,657
Operating expenses:					
Cost of operations, excluding depreciation and amortization	602,652	598,655	542,993	477,828	420,973
Depreciation and amortization	59,258	58,890	57,740	57,481	53,997
Loss (gain) on sale and disposal of equipment, net	1,113	1,032	456	(2,240)	1,136
Gain on sale of imaging center and de-consolidation of jv	–	(2,108)	(2,777)	–	–
Meaningful use incentive	(2,034)	–	–	–	–

Loss on extinguishment of debt	15,927	–	–	–	9,871
Net income (loss) attributable to RadNet common stockholders	1,376	2,120	59,834	7,231	(12,852)
Basic income (loss) per share attributable to RadNet common stockholders	0.03	0.05	1.58	0.19	(0.35)
Diluted income (loss) per share attributable to RadNet common stockholders	0.03	0.05	1.52	0.19	(0.35)
Balance Sheet Data:					
Cash and cash equivalents	$307	$8,412	$362	$2,455	$627
Total assets	740,680	722,576	710,864	619,188	539,514
Total long-term liabilities	599,708	601,977	598,507	566,615	516,723
Total liabilities	732,982	720,366	717,548	688,995	621,987
Working capital	58,746	57,955	36,859	29,947	5,761
Equity (deficit)	7,698	2,210	(6,684)	(69,807)	(82,473)

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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, 2014, we operated directly or indirectly through joint ventures, 259 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, 2014, we had in operation 213 MRI systems, 125 CT systems, 44 PET or combination PET/CT systems, 44 nuclear medicine systems, 274 X-ray systems, 226 mammography systems, 392 ultrasound systems, and 168 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, 2014, 2013 and 2012, we performed 4,828,488, 4,525,490, and 4,142,267 diagnostic imaging procedures and generated net revenue of $717.6 million, $703.0 million, and $647.2 million, respectively. Additional information concerning RadNet, Inc., including our consolidated subsidiaries, for each of the years ended December 31, 2014, 2013 and 2012 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, 2014, we received approximately 69% of our payments from commercial insurance payors and from managed care capitated payors, 21% from Medicare and 3% from Medicaid, 4% from Workers Compensation programs and 2% from other sources. With the exception of Blue Cross/Blue Shield, which is approximately 20% and government payors amounting to approximately 24% of revenues respectively, no single payor accounted for more than 5% of our net revenue for the twelve months ended December 31, 2014.

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 2014 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 nine 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 also took advantage of continued low interest rates to refinance and expand our senior secured credit facility. In March, 2014 we amended our existing Credit and Guaranty Agreement to add an additional $30 million in first tier term loans at the effective rates under that agreement which are (a) the Adjusted Eurodollar Rate plus 3.25% or (b) the base rate plus 2.25% (as defined in the agreement). In addition, we entered into a Second Lien Credit and Guaranty Agreement pursuant to which we secured $180.0 million of new second lien term loans. We have the option of paying interest on the new term loans under the Second Lien Credit Agreement at either (a) the Adjusted Eurodollar Rate plus 7.0% or (b) the base rate plus 6.0% (as defined in the agreement). The Adjusted Eurodollar Rate has a minimum floor of 1.0% on both the first lien term loans and the second lien term loans. We used the proceeds from the new first lien term loans and second lien term loans in part to finance the retirement of $200.0 million in aggregate principal amount of 10 3/8% senior notes due 2018. At current Eurodollar rates, the refinance reduced our interest expenses on $200 million of 10 3/8% on the senior notes to $180 million of 8% guaranty debt, equating to annual savings of $5.1 million on interest expense.

The refinancing resulted in a $15.9 million expense in connection with the early retirement of the senior notes. After giving effect to that one-time charge, we generated net income of $1.2 million for 2014.

We finished the year with cash and cash equivalents of $307,000 and accounts receivable of $148.2 million. While cash was down, year over year, overall working capital was $58.7 million, virtually unchanged from the prior year. We continue to maintain our $101.3 million revolving credit facility. At December 31, 2014 we had a balance on this facility of $15.3 million and $85 million of additional borrowing capacity under this facility.

The consolidated financial statements in this annual report include the accounts of Radnet Management, BRMG and the B&C Entities. 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 Section 810-10-15-14 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

On October 6, 2014, we acquired a 49% equity interest in Garden State Radiology, LLC, consisting of two multi-modality imaging centers located in New Jersey for cash consideration of $2.2 million.

On September 1, 2014 we completed our acquisition 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 for a 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 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.

On July 1, 2014 we completed our acquisition of Moreno Valley Imaging consisting of a single multi-modality imaging center located in Moreno Valley, CA for cash consideration of $700,000. The facility provides MRI, CT, Ultrasound and X-ray services. We have made a fair value determination of the acquired assets and approximately $285,000 of fixed assets, $3,000 of other assets, $50,000 for a non compete covenant and $362,000 of goodwill were recorded with respect to this transaction.

On July 1, 2014 we completed our acquisition of Liberty Pacific Imaging Long Beach consisting of a single multi-modality imaging center located in Signal Hill, CA for cash consideration of $1.9 million and assumed capital lease debt of $65,000. The facility provides MRI, CT, Ultrasound and X-ray services. We have made a fair value determination of the acquired assets and assumed liabilities and $577,000 of fixed assets, $100,000 for a covenant not to compete and $1.3 million of goodwill were recorded with respect to this transaction.

On July 1, 2014 we completed our acquisition of Medical Imaging of Manhattan consisting of a single modality mammography center located in New York, New York for cash consideration of $2.4 million. We have made a fair value determination of the acquired assets and approximately $672,000 of fixed assets, $139,000 of other assets, a covenant not to compete of $150,000 and $1.4 million of goodwill were recorded with respect to this transaction.

On April 1, 2014, we acquired the diagnostic imaging practice of Sidney Friedman, M.D. located in Westchester, CA for $1.4 million. We have made a fair value determination of the assets acquired and have allocated $600,000 to imaging equipment, $470,000 to accounts receivable, a covenant not to compete of $100,000 and $231,000 to goodwill.

On January 2, 2014, we acquired the diagnostic imaging practice of Leslie A. Saint-Louis, M.D. located in New York, New York for $360,000. Upon acquisition, we relocated the practice to a nearby existing center in New York, New York. We have made a fair value determination of the assets acquired and have allocated $310,000 to goodwill and $50,000 to other intangible assets related to a covenant not to compete contract with Dr. Saint-Louis.

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.

RADNET, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS

(IN THOUSANDS EXCEPT SHARE DATA)

	Years Ended December 31,		
	2014	2013	2012
NET REVENUE			
Service fee revenue, net of contractual allowances and discounts	89.7%	91.0%	91.8%
Provision for bad debts	-4.0%	-3.8%	-3.8%
Net service fee revenue	85.7%	87.2%	88.0%
Revenue under capitation arrangements	10.3%	9.0%	8.2%
Total net revenue	96.0%	96.2%	96.2%
OPERATING EXPENSES			
Cost of operations, excluding depreciation and amortization	80.6%	81.9%	80.7%
Depreciation and amortization	7.9%	8.1%	8.6%
Loss on sale and disposal of equipment	0.1%	0.1%	0.1%
Severance costs	0.2%	0.1%	0.1%
Total operating expenses	88.9%	90.2%	89.4%
INCOME FROM OPERATIONS	7.1%	6.0%	6.7%
OTHER INCOME AND EXPENSES			
Interest expense	5.7%	6.3%	8.0%

Meaningful use incentive	-0.3%	0.0%	0.0%
Equity in earnings of joint ventures	-0.9%	-0.8%	-1.0%
Gain on sale of imaging centers	0.0%	-0.3%	0.0%
Gain on de-consolidation of joint venture	0.0%	0.0%	-0.4%
Loss on early extinguishment of Senior Notes	2.1%	0.0%	0.0%
Other (income) expenses	0.0%	0.0%	-0.5%
Total other expenses	6.6%	5.2%	6.1%
INCOME BEFORE INCOME TAXES	0.5%	0.8%	0.7%
(Provision For) Benefit From income taxes	-0.3%	-0.5%	8.2%
NET INCOME	0.2%	0.3%	8.9%
Net income attributable to noncontrolling interests	0.0%	0.0%	0.0%
NET INCOME ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS	0.2%	0.3%	8.9%

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 $4.6 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 $1.8 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 expenses, 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, an 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 (the “senior notes”). 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 to the Refinance Agreement and Second Lien Credit and Guaranty Agreement dated as of March 25,

2014. 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 amendment to the First Lien and Second Lien Credit and Guaranty 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 Amendment in April 2013.

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 11 to our consolidated financial statements contained herein for more details.

Year Ended December 31, 2013 Compared to the Year Ended December 31, 2012

Service Fee Revenue, net of contractual allowances and discounts

Service fee revenue, net of contractual allowances and discounts for the year ended December 31, 2013 was $665.3 million compared to $618.0 million for the year ended December 31, 2012, an increase of $47.3 million, or 7.7%.

Service fee revenue, net of contractual allowances and discounts, including only those centers which were in operation throughout the full fiscal years of both 2013 and 2012, decreased $39.6 million, or 6.6%. This 6.6% decrease is primarily the result of reduction in procedure volumes and corresponding collection rates. This comparison excludes revenue contributions from centers that were acquired subsequent to January 1, 2012. For the year ended December 31, 2013, service fee revenue, net of contractual allowances and discounts, from centers that were acquired subsequent to January 1, 2012 and excluded from the above comparison was $103.9 million. For the year ended December 31, 2012, net revenue from centers that were acquired subsequent to January 1, 2012 and excluded from the above comparison was $17.0 million.

Provision for Bad Debts

Provision for bad debts increased $2.0 million, or 7.7%, to $27.9 million, or 3.8% of net revenue, for the year ended December 31, 2013 compared to $25.9 million, or 3.8% of net revenue, for the year ended December 31, 2012. This increase is in line with the increase in service fee revenues.

Revenue Under Capitation Arrangements

Revenue under capitation arrangements for the year ended December 31, 2013 was $65.6 million compared to $55.1 million for the year ended December 31, 2012, an increase of $10.5 million, or 19.1%.

Revenue under capitation arrangements, including only those centers which were in operation throughout the full fiscal years of both 2013 and 2012, increased $7.7 million, or 15.0%. This 15.0% increase is due to additional capitation contracts entered into subsequent to the year 2012. This comparison excludes revenue contributions from centers that were acquired subsequent to January 1, 2012. For the year ended December 31, 2013, revenue under capitation arrangements from centers that were acquired subsequent to January 1, 2012 and excluded from the above comparison was $6.7 million. For the year ended December 31, 2012, net revenue from centers that were acquired subsequent to January 1, 2012 and excluded from the above comparison was $3.9 million.

Operating Expenses

Cost of operations for the year ended December 31, 2013 increased approximately $55.7 million, or 10.3%, from $543.0 million for the year ended December 31, 2012 to $598.7 million for the year ended December 31, 2013. The following table sets forth our operating expenses for the years ended December 31, 2013 and 2012 (in thousands):

	Years Ended December 31,	
	2013	2012
Salaries and professional reading fees, excluding stock-based compensation	$322,080	$298,409
Stock-based compensation	2,573	2,736
Building and equipment rental	64,998	60,624
Medical supplies	37,185	38,879
Other operating expenses *	171,819	142,345
Cost of operations	598,655	542,993
Depreciation and amortization	58,890	57,740
Loss on sale and disposal of equipment	1,032	456
Severance costs	806	736
Total operating expenses	$659,383	$601,925

***** 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 $23.7 million, or 7.9%, to $322.1 million for the year ended December 31, 2013, compared to $298.4 million for the year ended December 31, 2012.

Salaries and professional reading fees, including only those centers which were in operation throughout the full fiscal years of both 2013 and 2012, decreased $5.4 million, or 1.9%. This 1.9% 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, 2012. For the year ended December 31, 2013, salaries and professional reading fees from centers that were acquired subsequent to January 1, 2012 and excluded from the above comparison was $38.1 million. For the year ended December 31, 2012, salaries and professional reading fees from centers that were acquired subsequent to January 1, 2012, and excluded from the above comparison was $9.0 million.

·***Stock-based compensation***

Stock-based compensation decreased $163,000, or 6.0%, to $2.6 million for the year ended December 31, 2013 compared to $2.7 million for the year ended December 31, 2012. The decrease is due to fewer equity compensation instruments being issued in 2013 compared to the prior year.

· ***Building and equipment rental***

Building and equipment rental expenses increased $4.4 million, or 7.2%, to $65.0 million for the year ended December 31, 2013, compared to $60.6 million for the year ended December 31, 2012.

Building and equipment rental expenses, including only those centers which were in operation throughout the full fiscal years of both 2013 and 2012, decreased $3.2 million, or 5.4%. This 5.4% decrease is due to equipment lease buy-outs and the conversion of equipment operating leases to capital leases occurring over the third and fourth quarters of 2013. This comparison excludes contributions from centers that were acquired subsequent to January 1, 2012. For the year ended December 31, 2013, building and equipment rental expenses from centers that were acquired subsequent to January 1, 2012, and excluded from the above comparison, was $9.6 million. For the year ended December 31, 2012, building and equipment rental expenses from centers that were acquired subsequent to January 1, 2012, and excluded from the above comparison, was $2.0 million.

· ***Medical supplies***

Medical supplies expense decreased $1.7 million, or 4.4%, to $37.2 million for the year ended December 31, 2013, compared to $38.9 million for the year ended December 31, 2012.

Medical supplies expense, including only those centers which were in operation throughout the full fiscal years of both 2013 and 2012, decreased $5.3 million, or 14.0%. This 14.0% decrease is primarily due to an increase in rebates we received from certain vendors subsequent to January 1, 2013. This comparison excludes contributions from centers that were acquired or divested subsequent to January 1, 2012. For the year ended December 31, 2013, medical supplies expense from centers that were acquired subsequent to January 1, 2012, and excluded from the above comparison was $4.5 million. For the year ended December 31, 2012, medical supplies expense from centers that were acquired subsequent to January 1, 2012, and excluded from the above comparison was $856,000.

Other operating expenses

Other operating expenses increased $29.5 million, or 20.7%, to $171.8 million for the year ended December 31, 2013 compared to $142.3 million for the year ended December 31, 2012.

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Other operating expenses, including only those centers which were in operation throughout the full fiscal years of both 2013 and 2012, increased $43,000. This comparison excludes contributions from centers that were acquired or divested subsequent to January 1, 2012. 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 $33.9 million. For the year ended December 31, 2012, other operating expenses from centers that were acquired subsequent to January 1, 2012, and excluded from the above comparison were $4.5 million.

·***Depreciation and amortization expense***

Depreciation and amortization expense increased $1.2 million, or 2.0%, to $58.9 million for the year ended December 31, 2013 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 2013 and 2012, decreased $4.4 million or 7.8%. This 7.8% decrease is primarily due to several assets completing their depreciation schedules subsequent to January 1, 2012. This comparison excludes contributions from centers that were acquired or divested subsequent to January 1, 2012. For the year ended December 31, 2013, depreciation and amortization from centers that were acquired or divested subsequent to January 1, 2012 and excluded from the above comparison was $6.7 million. For the year ended December 31, 2012, depreciation and amortization from centers that were acquired subsequent to January 1, 2012, and excluded from the above comparison was $1.1 million.

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

Loss on sale of equipment was approximately $1.0 million for the year ended December 31, 2013 and primarily related to the difference between the net book value of certain equipment sold and proceeds we received from the sale. Loss on the sale of equipment was approximately $456,000 for the year ended December 31, 2012 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, 2013, we recorded severance costs of $806,000 compared to $736,000 recorded during the year ended December 31, 2012. 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 $8.0 million, or 14.9%, to $45.8 million for the year ended December 31, 2013 compared to $53.8 million for the year ended December 31, 2012. 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. Interest expense for the year ended December 31, 2012 included $3.6 million of amortization of deferred financing costs and discount on issuance of debt as well as $918,000 of amortization of Accumulated Other Comprehensive Loss associated with fair value adjustments to our interest rate swaps accumulated prior to April 6, 2010. Excluding these adjustments to interest expense for each period, interest expense decreased approximately $8.1 million for the year ended December 31, 2013 compared to the year ended December 31, 2012. This decrease was primarily due to the reduced interest rate on our credit facilities stemming from the amendment of April 10, 2013 and the ending of our interest rate swaps in November 2012. See “Liquidity and Capital Resources” below for more details on our credit facilities.

Gain on sale of Imaging Center

On April 1, 2013, we sold one of our wholly-owned multi-modality imaging centers located in Northfield, New Jersey for $3.9 million in cash. The net book value associated with the imaging center was $1.8 million on the date of sale and accordingly a gain of $2.1 million was recorded with respect to this transaction.

Other expenses / income

For the year ended December 31, 2013 we recorded approximately $228,000 of other expenses, primarily relating to costs associated with our Credit Agreement Amendment in 2013. For the year ended December 31, 2012, we recorded $3.7 million of other income primarily consisting of approximately $5.1 million of fair value adjustments on our interest rate swaps and an $810,000 bargain purchase gain related to our November 9, 2012 acquisition of Pueblo Radiology.

Income tax expense /benefit

For the year ended December 31, 2013, we recorded income tax expense of $3.5 million. For the year ended December 31, 2012 we recorded a benefit from income taxes of approximately $55.2 million primarily related to reversing the valuation allowance against our deferred tax assets (see Note 11 to our consolidated financial statements for more details).

Equity in earnings from unconsolidated joint ventures

Equity in earnings from our unconsolidated joint ventures decreased $282,000 or 4.4% to $6.2 million for the year ended December 31, 2013 compared to $6.5 million for the year ended December 31, 2012. This decrease is related in part to a decrease in procedure volumes at these joint venture imaging centers as well as an overall decrease in reimbursement rates throughout 2013.

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. We believe this information is useful to investors and other interested parties because we are highly leveraged and our non-GAAP metrics 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.

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 extraordinary and one-time events taken place during the period.

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, 2014, 2013, and 2012, respectively (in thousands):

	Years Ended December 31,		
	2014	2013	2012
Net income attributable to RadNet, Inc. common stockholders	$1,376	$2,120	$59,834
Plus provision for (benefit from) income taxes	1,967	3,510	(55,227)
Plus other expenses (income)	3	228	(3,679)
Plus loss on early extinguishment of Senior Notes	15,927	–	–
Plus interest expense	42,727	45,791	53,783
Plus severance costs	1,241	806	736
Plus loss (gain) on sale and disposal of equipment	1,113	1,032	456
Plus legal settlement	401	–	–
Less gain on sale of imaging center	–	(2,108)	–
Less gain on de-consolidation of joint venture	–	–	(2,777)
Plus depreciation and amortization	59,258	58,890	57,740
Plus non-cash employee stock-based compensation	2,500	2,574	2,736
Adjusted EBITDA	$126,513	$112,843	$113,602

Liquidity and Capital Resources

We had net income attributable to RadNet, Inc.'s common stockholders of $1.4 million, $2.1 million and $59.8 million, for the years ended December 31, 2014, 2013 and 2012, respectively. We had cash and cash equivalents of $307,000 and accounts receivable of $148.2 million at December 31, 2014, compared to cash of $8.4 million and accounts receivable of $133.6 million at December 31, 2013. We had a working capital balance of $58.7 million and $58.0 million at December 31, 2014 and 2013, respectively. We also had equity of $7.7 million and $2.2 million at December 31, 2014 and 2013, 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 and long-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 $61.0 million, $66.4 million, and $75.3 million for the years ended December 31, 2014, 2013 and 2012, respectively.

Cash used in investing activities was $53.6 million, $50.7 million, and $87.0 million for the years ended December 31, 2014, 2013 and 2012, respectively. For the year ended December 31, 2014, we purchased property and equipment for approximately $41.7 million, acquired the assets and businesses of additional imaging facilities for approximately $9.4 million (see Note 4 to the consolidated financial statements of this annual report), and purchased additional equity interests in non-consolidated joint ventures of $1.4 million and contributed $2.2 million to a new non-consolidated joint venture. Offsetting our cash used in investing activities was $1.1 million in proceeds from the sale of imaging equipment.

Cash used by financing activities was $15.4 million and $7.6 million for the years ended December 31, 2014 and December 31, 2013 respectively. For the year ended December 31, 2012, cash provided by financing activities was $9.6 million. The cash used by financing for the year ended December 31, 2014, was in part due to the contractual payments of equipment notes and capital leases of $23.9 million, incurrence of $6.7 million in deferred financing costs as part of the Refinance Agreement, as amended by the 2014 Amendment, offset by $15.3 million in borrowings on our revolving line of credit. See financing activity in 2014 below for more detail in regards to our 2014 amendment to Refinance Agreement.

At December 31, 2014, we had $399.8 million aggregate principal amount of first lien term loans and $180.0 million aggregate principal amount of second lien term loan debt outstanding and $15.3 million borrowed under the revolving credit facility. The revolving credit facility provides for a maximum borrowing limit of $101.25 million, subject to qualified borrowing base requirements.

As of December 31, 2014, we were in compliance with all covenants under the 2014 Amendment to the Refinance Agreement and Second Lien Credit and Guaranty Agreement.

Financing activity in 2014:

The following describes our 2014 financing activities:

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

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

2014 Amendment of the Refinance Agreement. Radnet Management amended that certain Credit and Guaranty Agreement dated October 10, 2012, by that certain first amendment dated April 3, 2013 (the “2013 Amendment”) (collectively, the “Refinance Agreement”), and subsequently by entering into a second amendment to the Refinance Agreement (the “2014 Amendment”) to provide for, among other things, the borrowing by Radnet Management of $30.0 million of additional first lien term loans (the “2014 First Lien Term Loans”).

Second Lien Credit and Guaranty Agreement. Radnet Management entered into a Second Lien Credit and Guaranty Agreement dated March 25, 2014 (the "Second Lien Credit Agreement") to provide for, among other things, the borrowing by Radnet Management 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 Refinance 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 Refinance Agreement, which address 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 Refinance Agreement. The revolver bears interest based on types of borrowings as follows: (i) unpaid principal at 6.5% 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 2014 Amendment provides 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 Refinance Agreement, as amended by the 2013 Amendment, which are (a) the Adjusted Eurodollar Rate (as defined in the Refinance Agreement) plus 3.25% or (b) the Base Rate (as defined in the Refinance Agreement) plus 2.25%. With respect to all of the term loans under the Refinance Agreement, as amended by the 2014 Amendment, the Adjusted Eurodollar Rate has a minimum floor of 1.0%. The Adjusted Eurodollar Rate at December 31, 2014 was 0.36%.

Payments. The scheduled amortization of the term loans under the Refinance Agreement, as amended by the 2014 Amendment, has been 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 by $16.8 million from pre-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.

Guarantees and Collateral. The obligations under the Refinance Agreement, as amended by the 2014 Amendment, 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 Refinance Agreement, as amended by the 2014 Amendment, 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 covenants, the Refinance Agreement, as amended by the 2014 Amendment, 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 Refinance Agreement, as amended by the 2014 Amendment contains financial covenants including a maximum total leverage ratio and a limit on annual capital expenditures.

Events of Default. In addition to certain events of default, events of default under the Refinance Agreement, as amended by the 2014 Amendment, 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 Refinance Agreement, as amended by the 2014 Amendment, 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 Refinance Agreement, as amended by the 2014 Amendment, to declare all amounts borrowed, together with accrued interest and fees, to be immediately due and payable and to exercise other default remedies.

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, 2014 was 0.36%. The rate paid on the Second Lien Credit Agreement at December 31, 2014 is 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) or events of default per section 8.01 as described below.

Restrictive Covenants. In addition to certain 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-leaseback transaction, 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 unsecured 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.

Prior financing activity to 2014:

The following describes our key financing activities prior to 2014:

2010 Credit Agreements

On April 6, 2010, we entered into a Credit and Guaranty Agreement with a syndicate of lenders (the "Credit Agreement"), whereby we obtained $385.0 million in senior secured first-lien bank financing, consisting of (i) a $285.0 million, six-year term loan facility and (ii) a $100.0 million, five-year revolving credit facility, including a swing line subfacility and a letter of credit subfacility (collectively, the "Credit Facilities").

2012 Refinancing

On October 10, 2012 we completed the refinancing of the Credit Facilities by entering into a new Credit and Guaranty Agreement with a syndicate of banks and other financial institutions (the "Refinance Agreement"). 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 Refinance Agreement were guaranteed by RadNet, Inc. and all of Radnet Management's current and future domestic subsidiaries and certain of our affiliates. The obligations under the Refinance Agreement, including the guarantees, were 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 to repay in full our 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.

2013 Amendment to the Refinance Agreement

On April 3, 2013, we entered into a first amendment to the Refinance Agreement. 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 Refinance Agreement; (ii) repay outstanding revolving loans; (iii) repay premium, fees and expenses incurred; and (iv) general corporate purposes.

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):

	2015	2016	2017	2018	2019	Thereafter	Total
Notes payable (1)	$55,143	$53,654	$51,570	$379,291	$14,600	$198,000	$752,258
Capital leases (2)	6,066	5,740	573	–	–	–	12,379
Operating leases (3)	59,980	53,969	46,223	35,350	26,327	81,976	303,825
Total	$121,189	$113,363	$98,366	$414,641	$40,927	$279,976	$1,068,462

(1) Includes variable rate debt for which the contractual obligation was estimated using the applicable rate at December 31, 2014.

(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 B&C Entity centers, this service fee revenue includes payments for both the professional medical interpretation revenue recognized by BRMG and the B&C Entities 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 B&C Entities. As it relates to non-BRMG and B&C Entity centers, 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.

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

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

	Years Ended December 31,		
	2014	2013	2012
Commercial insurance	$418,414	$415,408	$409,114
Medicare	157,923	156,066	122,971
Medicaid	24,248	24,017	20,101
Workers' compensation/personal injury	30,230	34,821	26,604
Other	39,321	34,995	39,192
Service fee revenue, net of contractual allowances and discounts	670,136	665,307	617,982
Provision for bad debts	(29,807)	(27,911)	(25,904)
Net service fee revenue	640,329	637,396	592,078

Revenue under capitation arrangements	77,240	65,590	55,075
Total net revenue	$717,569	$702,986	$647,153

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 each type of payer over an 18-month look-back period 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, 2014 and 2013 was $15.1 million and $12.7 million, respectively.

Accounts Receivable

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

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, 2014 totaled $200.3 million. Indefinite Lived Intangible Assets at December 31, 2014 totaled $7.5 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, 2014, noting no impairment, and have not identified any indicators of impairment through December 31, 2014.

We evaluate our long-lived assets (property and equipment) and intangibles, other than goodwill, for impairment whenever indicators of impairment exist. The accounting standards require 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, 2014.

Recent Accounting Standards

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 is effective for fiscal years (and interim reporting periods within fiscal years) beginning after December 15, 2016. We are currently evaluating the impact of the GAAP update on our consolidated financial position, results of operations and cash flows.

In July 2013, the FASB issued ASU No. 2013-11 ("ASU 2013-11"), *Presentation of an Unrecognized Tax Benefit When a Net Operating Loss Carryforward, a Similar Tax Loss, or a Tax Credit Carryforward Exists,* (Topic 740). ASU 2013-11 requires an unrecognized tax benefit, or a portion of an unrecognized tax benefit, to be presented in the financial statements as a reduction to a deferred tax asset for a net operating loss carryforward, a similar tax loss, or a tax credit carryforward, except as follows. To the extent a net operating loss carryforward, a similar tax loss, or a tax credit carryforward is not available at the reporting date, the unrecognized tax benefit should be presented in the financial statements as a liability and not combined with deferred tax assets. ASU 2013-11 became effective for annual and interim periods beginning after December 15, 2013, with early adoption permitted. The adoption of this standard did not have a material effect on our consolidated financial statements.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Foreign Currency Exchange Risk. We sell our services exclusively in the United States and 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. Fluctuations in foreign exchange rates could impact future operating results. A hypothetical 1% increase in the rate of exchange of foreign currencies against the dollar for 2014 would have resulted in an increase of approximately $15,000 in our operating expenses for the year.

Interest Rate Sensitivity. RadNet Inc. pays interest on various types of debt instruments to its suppliers, investors and lending institutions. The agreements entail either fixed or variable interest rates. Instruments which have fixed rates are mainly leases on radiology equipment. Variable rate interest obligations relate primarily to amounts borrowed under our outstanding credit facilities, which allows elections of either Adjusted Eurodollar or prime rates of interest. Under the 2014 Amendment to the Refinance Agreement and Second Lien Credit Agreement's election facilities', borrowed funds bear a 1.00% floor or 6 month Adjusted Eurodollar Rate plus an applicable margin of 3.25% for the 2014 First Lien Term Loans and 7% for the Second Lien Term Loans. At December 31, 2014, we had $399.8 million outstanding subject to an Adjusted Eurodollar election on the 2014 First Lien Term Loans and $180.0 million on the Second Lien Term Loans. As the Adjusted Eurodollar floor exceeds the current spot rate of 6 month Adjusted Eurodollar, the spot rate would have to increase more than 64 basis points before an additional interest expense would be accrued. An increase of 164 basis points would be necessary to realize a hypothetical 1% increase in the borrowing rate and an annual increase of $5.8 million of interest expense. At December 31, 2014, an additional $25.7 million was tied to the prime rate. A hypothetical 1% increase in the prime rate for 2013-2014 would have resulted in an annual increase in interest expense of approximately $257,000.

Item 8. Financial Statements and Supplementary Data

The Financial Statements are attached hereto and begin on page 53.

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, 2014 and 2013, 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, 2014. 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, 2014 and 2013, and the consolidated results of their operations and their cash flows for each of the three years in the period ended December 31, 2014, 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's internal control over financial reporting as of December 31, 2014, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated March 16, 2015, expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Los Angeles, California

March 16, 2015

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RADNET, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

(IN THOUSANDS EXCEPT SHARE AND PER SHARE DATA)

	As of December 31,	
	2014	2013
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$307	$8,412
Accounts receivable, net	148,235	133,599
Current portion of deferred tax assets	17,246	13,321
Due from affiliates	1,561	–
Prepaid expenses and other current assets	24,671	21,012
Total current assets	192,020	176,344
PROPERTY AND EQUIPMENT, NET	223,127	218,547
OTHER ASSETS		
Goodwill	200,304	196,395
Other intangible assets	47,624	50,042
Deferred financing costs, net of current portion	6,122	8,735
Investment in joint ventures	32,123	28,949
Deferred tax assets, net of current portion	35,334	39,914
Deposits and other	4,026	3,650
Total assets	$740,680	$722,576
LIABILITIES AND EQUITY (DEFICIT)		
CURRENT LIABILITIES		
Accounts payable, accrued expenses and other	$97,816	$106,316
Due to affiliates	6,289	2,655
Deferred revenue	1,964	1,344
Current portion of notes payable	19,468	3,103
Current portion of deferred rent	2,100	1,896
Current portion of obligations under capital leases	5,637	3,075
Total current liabilities	133,274	118,389
LONG-TERM LIABILITIES		
Deferred rent, net of current portion	20,965	18,989
Line of credit	15,300	–
Notes payable, net of current portion	551,059	572,669
Obligations under capital lease, net of current portion	6,143	2,779
Other non-current liabilities	6,241	7,540
Total liabilities	732,982	720,366
EQUITY		
RadNet, Inc. stockholders' equity (deficit):		
	4	4

Common stock - $.0001 par value, 200,000,000 shares authorized;42,825,676, and 40,089,196 shares issued and outstanding at December 31, 2014 and 2013, respectively		
Paid-in-capital	177,750	173,622
Accumulated other comprehensive loss	(112)	(50)
Accumulated deficit	(172,280)	(173,656)
Total RadNet, Inc.'s stockholders' equity (deficit)	5,362	(80)
Noncontrolling interests	2,336	2,290
Total equity	7,698	2,210
Total liabilities and equity	$740,680	$722,576

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,		
	2014	2013	2012
NET REVENUE			
Service fee revenue, net of contractual allowances and discounts	$670,136	$665,307	$617,982
Provision for bad debts	(29,807)	(27,911)	(25,904)
Net service fee revenue	640,329	637,396	592,078
Revenue under capitation arrangements	77,240	65,590	55,075
Total net revenue	717,569	702,986	647,153
OPERATING EXPENSES			
Cost of operations, excluding depreciation and amortization	602,652	598,655	542,993
Depreciation and amortization	59,258	58,890	57,740
Loss on sale and disposal of equipment	1,113	1,032	456
Severance costs	1,241	806	736
Total operating expenses	664,264	659,383	601,925
INCOME FROM OPERATIONS	53,305	43,603	45,228
OTHER INCOME AND EXPENSES			
Interest expense	42,727	45,791	53,783
Meaningful use incentive	(2,034)	–	–
Equity in earnings of joint ventures	(6,970)	(6,194)	(6,476)
Gain on sale of imaging centers	–	(2,108)	–
Gain on de-consolidation of joint venture	–	–	(2,777)
Loss on early extinguishment of Senior Notes	15,927	–	–
Other expenses (income)	3	228	(3,679)
Total other expenses	49,653	37,717	40,851
INCOME BEFORE INCOME TAXES	3,652	5,886	4,377
(Provision for) benefit from income taxes	(1,967)	(3,510)	55,227
NET INCOME	1,685	2,376	59,604
Net income (loss) attributable to noncontrolling interests	309	256	(230)
NET INCOME ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS	$1,376	$2,120	$59,834
BASIC NET INCOME PER SHARE ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS	$0.03	$0.05	$1.58
DILUTED NET INCOME PER SHARE ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS	$0.03	$0.05	$1.52
WEIGHTED AVERAGE SHARES OUTSTANDING			

Basic	41,070,077	39,140,480	37,751,170
Diluted	43,149,196	39,814,535	39,244,686

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,		
	2014	2013	2012
NET INCOME	$1,685	$2,376	$59,604
Foreign currency translation adjustments	(62)	(89)	67
Reclassification of net cash flow hedge losses included in net income during the period	–	–	918
COMPREHENSIVE INCOME	1,623	2,287	60,589
Less comprehensive income (loss) attributible to non-controlling interests	309	256	(230)
COMPREHENSIVE INCOME ATTRIBUTABLE TO RADNET, INC. COMMON STOCKHOLDERS	$1,314	$2,031	$60,819

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

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, 2012	37,426,460	$ 4	$165,796	$(235,610)	$ (946)	$(70,756)	$ 949	$(69,807)
Issuance of common stock upon exercise of options/warrants	74,022	–	–	–	–	–	–	–
Stock-based compensation	–	–	2,736	–	–	2,736	–	2,736
Purchase of non-controlling interests	–	–	(117)	–	–	(117)	–	(117)
De-consolidation of joint venture	–	–	–	–	–	–	(14)	(14)
Issuance of restricted stock	1,040,000	–	–	–	–	–	–	–
Dividends paid to noncontrolling interests	–	–	–	–	–	–	(71)	(71)
Change in cumulative foreign currency translation adjustment	–	–	–	–	67	67	–	67
Change in fair value of cash flow hedge from prior periods reclassified to earnings	–	–	–	–	918	918	–	918
Net income	–	–	–	59,834	–	59,834	(230)	59,604
BALANCE - DECEMBER 31, 2012	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	–	–	–	–	(89)	(89)	–	(89)

adjustment								
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
Dividends paid to noncontrolling interests	–	–	–	–	–	–	(148)	(148)
Change in cumulative foreign currency translation adjustment	–	–	–	–	(62)	(62)	–	(62)
Net income	–	–	–	1,376	–	1,376	309	1,685
BALANCE - DECEMBER 31, 2014	42,825,676	$ 4	$177,750	$(172,280)	$ (112)	$ 5,362	$ 2,336	$7,698

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,		
	2014	2013	2012
CASH FLOWS FROM OPERATING ACTIVITIES			
Net income	$1,685	$2,376	$59,604
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	59,258	58,890	57,740
Provision for bad debts	29,807	27,911	25,904
Equity in earnings of joint ventures	(6,970)	(6,194)	(6,476)
Distributions from joint ventures	7,358	7,204	6,477
Deferred rent amortization	2,180	3,871	3,608
Amortization and write off of deferred financing costs and loan discount	5,732	4,565	3,637
Loss on sale and disposal of equipment	1,113	1,032	456
Gain on bargain purchase	–	–	(810)
Loss on early extinguishment of Senior Notes	15,927	–	–
Gain on sale of imaging centers and de-consolidation of joint venture	–	(2,108)	(2,777)
Amortization of cash flow hedge	–	–	918
Stock-based compensation	2,500	2,574	2,736
Changes in operating assets and liabilities, net of assets acquired and liabilities assumed in purchase transactions:			
Accounts receivable	(43,973)	(31,531)	(17,350)
Other current assets	(5,514)	(2,243)	3,565
Other assets	(281)	260	(578)
Deferred taxes	655	2,907	(56,142)
Deferred revenue	620	71	197
Accounts payable , accrued expenses and other	(9,093)	(3,163)	(5,440)
Net cash provided by operating activities	61,004	66,422	75,269
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of imaging facilities	(9,428)	(7,223)	(45,493)
Purchase of property and equipment	(41,740)	(48,623)	(44,448)
Proceeds from sale of equipment	1,088	635	1,549
Proceeds from sale of imaging facilities	–	3,920	2,300
Proceeds from sale of joint venture interests	–	2,640	1,800
Equity contributions in existing and purchase of interest in joint ventures	(3,562)	(2,009)	(2,756)
Net cash used in investing activities	(53,642)	(50,660)	(87,048)
CASH FLOWS FROM FINANCING ACTIVITIES			
Principal payments on notes and leases payable	(23,913)	(9,764)	(22,223)
Proceeds from borrowings	210,000	35,122	344,485
Payments on Senior Notes	(211,344)	–	(277,875)
Deferred financing costs	(6,650)	(432)	(3,753)
Net proceeds (payments) on revolving credit facility	15,300	(33,000)	(25,000)

Payments on interest rate swaps, net of amounts received	–	–	(5,823)
Dividends paid to noncontrolling interests	(148)	(18)	(71)
Equity attributable to non-controlling interests	–	–	(117)
Purchase on non-controlling interests	(196)	–	–
Proceeds from issuance of common stock upon exercise of options/warrants	1,546	469	–
Net cash (used in) provided by financing activities	(15,405)	(7,623)	9,623
EFFECT OF EXCHANGE RATE CHANGES ON CASH	(62)	(89)	63
NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS	(8,105)	8,050	(2,093)
CASH AND CASH EQUIVALENTS, beginning of period	8,412	362	2,455
CASH AND CASH EQUIVALENTS, end of period	$307	$8,412	$362
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION			
Cash paid during the period for interest	$41,584	$41,841	$47,806
Cash paid during the period for income taxes	$1,070	$1,142	$918

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 $19.4 million, $16.7 million and $14.4 million during the years ended December 31, 2014, 2013 and 2012, respectively, that we had not paid for as of December 31, 2014, 2013 and 2012, 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, 2014, we added capital lease debt of approximately $12.6 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 provide diagnostic imaging services including magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), nuclear medicine, mammography, ultrasound, diagnostic radiology (X-ray), fluoroscopy and other related procedures. At December 31, 2014, we operated directly or indirectly through joint ventures, imaging centers located in California, Delaware, Florida, Maryland, New Jersey, New York, and Rhode Island. 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"). 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") Section 810-10-15-14 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 is deemed to be the beneficial owner, directly and indirectly, of approximately 12.6% of our outstanding common stock as of December 31, 2014. Dr. Berger also owns, indirectly, 99% of the equity interests in BRMG. BRMG provides all of the professional medical services at the majority 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. BRMG is a partnership of ProNet Imaging Medical Group, Inc., Breastlink Medical Group, Inc. and Beverly Radiology Medical Group, Inc., each of which is 99% or 100% owned by Dr. Berger.

John V Crues, III, M.D. is our Medical Director, a member of our Board of Directors and a 1% owner of BRMG. Dr. Crues owns a controlling interest in two medical groups ("Crues Entities") which provide professional medical services at some of our facilities in Manhattan and Brooklyn, New York while Dr. Berger owns a controlling interest in two medical groups ("NY Berger Entities") which provide professional medical services at one of our Manhattan, New York facilities. The Crues Entities and the NY Berger Entities are collectively hereinafter referred to as the "B&C Entities."

RadNet provides non-medical, technical and administrative services to BRMG and the B&C Entities for which it receives a management fee, pursuant to the related management agreements. Through the management agreement and our relationship with Dr. Berger and Dr. Crues, we have exclusive authority over all non-medical decision making related to the ongoing business operations of BRMG and the B&C Entities. Through our management agreement with BRMG and the B&C Entities, we determine the annual budget of BRMG and the B&C Entities and make all physician employment decisions. BRMG and the B&C Entities both have insignificant operating assets and liabilities, and de minimis equity. Through the management agreement with us, all cash flows of BRMG and the B&C Entities are transferred to us.

We have determined that BRMG and the B&C Entities 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 B&C Entities on a combined basis recognized $89.3 million, $76.7 million and $53.4 million of revenue, net of management service fees to RadNet, for the years ended December 31, 2014, 2013 and 2012, respectively, and $89.3 million, $76.7 million and $53.4 million of operating expenses for the years ended December 31, 2014, 2013 and 2012, respectively. RadNet recognized $287.4 million, $267.6 million and $208.7 million of net revenues for the years ended December 31, 2014, 2013 and 2012, respectively, for management services provided to BRMG and the B&C Entities relating primarily to the technical portion of total billed revenue. The cash flows of BRMG and the B&C Entities 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, 2014 and 2013, we have included approximately $79.7 million and $65.2 million, respectively, of accounts receivable and approximately $9.0 million and $11.9 million of accounts payable and accrued liabilities related to BRMG and the B&C Entities.

The creditors of BRMG and the B&C Entities 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 B&C Entities. However, both BRMG and the B&C Entities 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 B&C Entities 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/B&C Entity) 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, including 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 Cruse Entities 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.

RECLASSIFICATION – We have reclassified certain amounts in the 2013 and 2012 statements of cash flows to conform to the year end 2014 presentation.

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 B&C Entity centers, this service fee revenue includes payments for both the professional medical interpretation revenue recognized by BRMG and the B&C Entities 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 B&C Entities. As it relates to non-BRMG and B&C Entity centers, 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,		
	2014	2013	2012
Commercial insurance [1]	$418,414	$415,408	$409,114
Medicare	157,923	156,066	122,971
Medicaid	24,248	24,017	20,101
Workers' compensation/personal injury	30,230	34,821	26,604
Other	39,321	34,995	39,192
Service fee revenue, net of contractual allowances and discounts	670,136	665,307	617,982
Provision for bad debts	(29,807)	(27,911)	(25,904)
Net service fee revenue	640,329	637,396	592,078
Revenue under capitation arrangements	77,240	65,590	55,075
Total net revenue	$717,569	$702,986	$647,153

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[1] 20% of our net service fees revenue for each of the years ended December 31, 2014, 2013 and 2012 were earned from a single payor.

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 each type of payer over an 18-month look-back period 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 allowances for bad debts at December 31, 2014 and 2013 were $15.1 million and $12.7 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 $2.0 million during the twelve months ended December 31, 2014 relating to this incentive. This amount was earned under a Medicare program to promote the use of electronic health record technology. Our compliance with meaningful use criteria is subject to audit by the federal government.

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, 2014, 2013 and 2012, we recorded approximately $5.5 million, $4.9 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, 2014 we had a deferred revenue liability of approximately $1.9 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 expect to utilize this system beginning in the first quarter of 2015.

By following the accounting guidance under ASC 350-40, *Accounting for the Costs of Computer Software Developed for Internal Use,* the costs incurred by RMIS toward the development of this RIS system, which began on August 1, 2010 and continued until December 2014, were capitalized and will be amortized over its useful life which we determined to be 5 years. Total costs capitalized were approximately $6.4 million. Amortization of $107,000 per month will start in January 2015.

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

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

DEFERRED FINANCING COSTS - Costs of financing are deferred and amortized on a straight-line basis over the life of the associated loan, which approximates the effective interest rate method. Deferred financing costs, net of accumulated amortization, were $6.7 million and $10.0 million, for the years ended December 31, 2014 and 2013, respectively. 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.

GOODWILL AND INDEFINITE LIVED INTANGIBLES - Goodwill at December 31, 2014 totaled $200.3 million. Indefinite Lived Intangible Assets at December 31, 2014 totaled $7.5 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, 2014, noting no impairment, and have not identified any indicators of impairment through December 31, 2014.

LONG-LIVED ASSETS - We evaluate our long-lived assets (property and equipment) and intangibles, other than goodwill, for impairment whenever indicators of impairment exist. The accounting standards require 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, 2014.

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

UNINSURED RISKS – Prior to November 1, 2006 we maintained a self-insured workers' compensation insurance program for which our third party administrator over this program continues to make payments on behalf of the Company for claims incurred from November 1, 2004 through October 31, 2006. We are required to maintain a cash

collateral account with this administrator as guarantee of our submission of full reimbursement of claims paid on our behalf. We record this collateral deposit as restricted cash and include it as other assets in our consolidated balance sheet which amounted to approximately $529,000 as of both December 31, 2014 and 2013.

With respect to the above-mentioned claims incurred from November 1, 2004 through October 31, 2006, the estimated future cash obligation associated with the unpaid portion of those claims that remain open but have not yet been resolved is recorded to accrued expenses in our consolidated balance sheet. This current liability is determined by the administrator's estimate of loss development of open claims and was approximately $103,000 and $123,000 at December 31, 2014 and 2013, respectively.

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 an arrangement with a third party administrator to process claims under a new high-deductible workers' compensation insurance program. We have recorded liabilities as of December 31, 2014, and 2013 of $1.0 million and $280,000 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, 2014 and December 31, 2013 of approximately $88,000 and $95,000, 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, 2014, 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, 2014 and 2013 of $2.0 million and $2.8 million, respectively, for the estimated future cash obligations associated with the unpaid portion of the medical and dental claims incurred by our participants. Additionally, we entered into an agreement with Blue Shield for a stop loss policy that provides coverage for any claims that exceed $250,000 up to a maximum of $1.0 million in order for us to limit our exposure for unusual or catastrophic claims.

LOSS AND OTHER UNFAVORABLE CONTRACTS – We assess the profitability of our contracts to provide management services to our contracted physician groups and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future revenue is compared to anticipated costs. If the anticipated future cost exceeds the revenue, a loss contract accrual is recorded. In connection with the acquisition of Radiologix in November 2006, we acquired certain management service agreements for which forecasted costs exceeds forecasted revenue. As such, an $8.9 million loss contract accrual was established in purchase accounting, and is included in other non-current liabilities. The recorded loss contract accrual is being accreted into operations over the remaining term of the acquired management service agreements. As of December 31, 2014 and 2013, the remaining accrual balance is $6.1 million, and $6.4 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, 2014 and 2013, the remaining loss contract accrual for these leases is $218,000 and $328,000, 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, 2014 and 2013, the unfavorable contract liability on these leases is $1.2 million and $2.1 million, respectively.

EQUITY BASED COMPENSATION – We have one long-term incentive plan which we refer to as the 2006 Plan. As of December 31, 2014, we have reserved for issuance under the 2006 Plan 11,000,000 shares of common stock. Certain options granted under the 2006 Plan to employees are intended to qualify as incentive stock options under existing tax regulations. In addition, we may issue non-qualified stock options and warrants under the 2006 Plan from time to time to non-employees, in connection with acquisitions and for other purposes and we may also issue restricted stock under the 2006 Plan. 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.