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**UNITED STATES
SECURITIES AND EXCHANGE COMMISSION**

Washington, D.C. 20549

Form 10-K

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

For the Fiscal Year Ended December 31, 2011

Commission file number: 000-50574

Symbion, Inc.

(Exact name of registrant as specified in its charter)

Delaware

(State or other jurisdiction of
incorporation or organization)

62-1625480

(I.R.S. Employer
Identification No.)

40 Burton Hills Boulevard, Suite 500

Nashville, Tennessee 37215

(Address of principal executive offices and zip code)

(615) 234-5900

(Registrant's telephone number, including area code)

Securities Registered Pursuant to Section 12(b) of the Act: **None**

Securities Registered Pursuant to Section 12(g) of the Act: **None**

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K 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

Non-accelerated filer

Accelerated filer

Smaller reporting company

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

None of the registrant's common stock is held by non-affiliates.

As of March 16, 2012, 1,000 shares of the registrant's common stock were outstanding.

Cautionary Note Regarding Forward-Looking Statements

This Annual Report on Form 10-K contains forward-looking statements based on our current expectations, estimates and assumptions about future events. All statements other than statements of current or historical fact contained in this report, including statements regarding our future financial position, business strategy, budgets, projected costs and plans and objectives of management for future operations, are forward-looking statements. The words “anticipate,” “believe,” “continue,” “estimate,” “expect,” “intend,” “may,” “plan,” “will” and similar expressions are generally intended to identify forward-looking statements.

These forward-looking statements involve various risks and uncertainties, some of which are beyond our control. Any or all of our forward-looking statements in this report may turn out to be wrong. We have based these forward-looking statements largely on our current expectations and projections about future events and financial trends that we believe may affect our financial condition, results of operations, business strategy and financial needs. They can be affected by inaccurate assumptions we might make or by known or unknown risks, uncertainties and assumptions, including the risks, uncertainties and assumptions described in Item 1A. “Risk Factors.”

In light of these risks, uncertainties and assumptions, the forward-looking events and circumstances discussed in this report may not occur and actual results could differ materially from those anticipated or implied in the forward-looking statements. When you consider these forward-looking statements, you should keep in mind these risk factors and other cautionary statements in this report.

Our forward-looking statements speak only as of the date made. Other than as required by law, we undertake no obligation to publicly update or revise any forward-looking statements, whether as a result of new information, future events or otherwise.

PART I

Item 1. *Business*

Overview

We own and operate a national network of short stay surgical facilities in 28 states. Our surgical facilities, which include ambulatory surgery centers (“ASCs”) and surgical hospitals, primarily provide non-emergency surgical procedures across many specialties, including, among others, orthopedics, pain management, gastroenterology and ophthalmology. Some of our surgical hospitals also provide acute care services such as diagnostic imaging, pharmacy, laboratory, obstetrics, physical therapy and wound care.

We own our surgical facilities in partnership with physicians and in some cases healthcare systems in the markets and communities we serve. We apply a market-based approach in structuring our partnerships with individual market dynamics driving the structure. We believe this approach aligns our interests with those of our partners.

As of December 31, 2011, we owned and operated 55 surgical facilities, including 49 ASCs and six surgical hospitals. We also managed eight additional ASCs. We owned a majority interest in 31 of the 55 surgical facilities and consolidated 49 facilities for financial reporting purposes. We are reporting two of the 55 surgical facilities as discontinued operations. In addition to our surgical facilities, we also manage one physician clinic in a market in which we operate an ASC and a surgical hospital.

We have benefited from both the growth in overall outpatient surgery cases as well as the migration of surgical procedures from the hospital to the surgical facility setting. Advancements in medical technology, such as lasers, arthroscopy and enhanced endoscopic techniques, have reduced the trauma of surgery and the amount of recovery time required by patients following a surgical procedure. Improvements in anesthesia also have shortened the recovery time for many patients and have reduced post-operative side effects such as pain, nausea and drowsiness. These medical advancements have enabled more patients to undergo surgery in a surgical facility setting.

On September 16, 2002, we reincorporated in Delaware after originally incorporating in Tennessee in January 1996. On August 23, 2007, we were acquired by Symbion Holdings Corporation (“Holdings”), which is owned by Crestview Partners, L.P. (“Crestview”) and certain affiliated funds managed by Crestview and co-investors, in a merger transaction (the “Merger”). As a result of the Merger, we no longer have publicly traded equity securities.

Industry Overview

The outpatient ambulatory surgery market in the United States has grown to a \$18.0 billion industry according to the Medicare Payment Advisory Commission. There are several factors leading to increased utilization of outpatient surgical facilities. We believe physicians often prefer to operate in surgical facilities, as compared to acute care hospitals, because of the efficiency and convenience surgical facilities afford. Procedures performed at surgical facilities are typically non-emergency, allowing physicians to schedule their time more efficiently and increase the number of procedures performed in a given period. Surgical facilities also provide physicians with more consistent nurse staffing and faster turnaround time between cases, as compared to acute care hospitals.

Many patients also prefer surgical facilities as a result of more convenient locations, shorter waiting times, and more convenient scheduling and registration than acute care hospitals. Additionally, Medicare beneficiaries generally experience lower coinsurance as a result

of lower Medicare payment rates. As patients increasingly have more input into the delivery of their healthcare, we believe these factors will be drivers of growth in ASC utilization.

Surgeries performed in ASC's are generally less expensive than those performed in acute care hospitals because of lower facility

development costs, more efficient staffing and work flow processes. We believe payors are attracted to the lower costs available at surgical facilities, as compared to acute care hospitals. With increased attention on controlling healthcare costs in the United States, we feel our facilities will benefit from their position as a low-cost alternative for delivering surgical procedures.

Advancements in medical technology such as lasers, arthroscopy, fiber optics and enhanced endoscopic techniques have reduced the trauma of surgery and the amount of recovery time required by patients following a surgical procedure. Improvements in anesthesia also have shortened the recovery time for many patients and have reduced certain post-operative side effects. These medical advancements have enabled more patients to undergo surgery not requiring an overnight stay and reduced the need for hospitalization following surgery.

Approximately 3,500 surgical procedures performed in ASCs are reimbursed by Medicare. As the Centers for Medicare and Medicaid Services ("CMS") continues to add surgical procedures to Medicare's list of approved ASC procedures, we believe this will have the effect of further expanding the market opportunity. There currently are approximately 5,300 Medicare certified ASCs operating in the United States according to the CMS. As the industry remains very fragmented, we believe there continues to be significant opportunities for consolidation.

Our Strategy

Our intent is to enhance the performance of our existing facilities by increasing revenues, profitability and return on our invested capital at all of our surgical facilities through operational focus, including recruitment and retention of surgeons and other physicians. We intend to expand our network of surgical facilities in attractive markets throughout the United States by selectively acquiring established facilities, developing new facilities, and expanding our presence in existing markets. We also intend to continue developing strategic relationships with healthcare systems, in both existing and new markets. When attractive opportunities arise, we may acquire or develop other types of facilities. The key components of our strategy are to:

- *Enhance the performance of our existing facilities through operational focus, including recruitment and retention of leading surgeons and other physicians for our surgical facilities.*

We have a dedicated operations team that is responsible for implementing best practices, cost controls and overall efficiencies at each of our surgical facilities. Our facilities benefit from our network of facilities by sharing best practices and participating in group purchasing agreements designed to reduce the cost of supplies and equipment. We also review and negotiate our managed care contracts to ensure that we are operating under the most favorable terms available to us.

We believe that establishing and maintaining strong relationships with surgeons and other physicians is a key factor to our success in acquiring, developing and operating surgical facilities. We identify and partner with surgeons and other physicians that we believe have established reputations for clinical excellence in their communities. We believe that we have had success in recruiting and retaining physicians because of the ownership structure of our surgical facilities and our staffing, scheduling and clinical systems that are designed to increase physician productivity, promote physicians' professional success and enhance the quality of patient care. We also believe that forming relationships with healthcare systems and other healthcare providers can enhance our ability to recruit physicians. We currently have strategic relationships with seven healthcare systems. We intend to continue to recruit additional physicians and expand the range of services offered at our surgical facilities to increase the number and types of surgeries performed in our facilities, including a focus on higher acuity cases. We are committed to enhancing programs and services for our physicians and patients by providing advanced technology, quality care, cost-effective service and convenience.

- *Capitalize on our experienced management team to expand our network of surgical facilities in attractive markets throughout the United States by selectively acquiring established facilities, developing new facilities, and expanding our presence in existing markets.*

We believe that the experience and capabilities of our senior management team provide a strategic advantage in improving the operations of our surgical facilities, attracting physicians and identifying new development and acquisition opportunities. Our senior management team has an average of over 30 years of experience in the healthcare industry having held senior management positions at public and private healthcare companies. Our management's broad industry experience has allowed us to establish strong relationships with participants throughout the healthcare industry. These relationships are helpful in forming leads for acquisitions and in making decisions about expanding into new markets and services. The experience and capabilities of our management team also enable us to pursue multiple growth strategies in the surgical facility market, including acquisitions of established surgical facilities, de novo developments in attractive markets, strategic relationships with healthcare systems and other healthcare providers and turnaround opportunities in connection with underperforming facilities. We have successfully executed each of these growth strategies, and intend to pursue each of them in the future.

Operations***Surgical Facility Operations***

As of December 31, 2011, we owned (with physician investors or healthcare systems) and operated 55 surgical facilities and managed eight additional surgical facilities. Six of our surgical facilities are licensed as hospitals. Our typical ASC is a freestanding facility with about 14,000 square feet of space and four fully equipped operating rooms, two treatment rooms and ancillary areas for preparation,

recovery, reception and administration. Our typical surgical hospital is larger than a typical ASC and includes inpatient hospital rooms and, in some cases, an emergency department.

Our surgical facilities primarily provide non-emergency surgical procedures across many specialties, including, among others, orthopedics, pain management, gastroenterology and ophthalmology. Some of our surgical hospitals also provide acute care services such as diagnostic imaging, pharmacy, laboratory, obstetrics, physical therapy and wound care. In certain markets where we believe it is appropriate, we operate surgical facilities that focus on a single specialty.

Our surgical facilities are generally located in close proximity to physicians' offices. Our staff at each surgical facility generally includes a facility administrator, a business manager, a medical director, registered nurses, operating room technicians and clerical workers. At each of our surgical facilities, we have arrangements with anesthesiologists to provide anesthesiology services. We also provide each of our surgical facilities with a full range of financial, marketing and operating services. For example, our regional managed care directors assist the local management team at each of our surgical facilities in developing relationships with managed care providers and negotiating managed care contracts.

All of our surgical facilities are Medicare certified. To ensure that a high level of care is provided, we implement quality assurance procedures at each of our surgical facilities. In addition, a majority of our surgical facilities are also independently accredited by either the Joint Commission or the Accreditation Association for Ambulatory Health Care. Each of our surgical facilities is available for use only by licensed physicians who have met professional credentialing requirements established by the facility's medical advisory committee. In addition, each surgical facility's medical director supervises and is responsible for the quality of medical care provided at the surgical facility.

Surgical Facility Ownership Structure

We own and operate our surgical facilities through partnerships or limited liability companies with physicians, physician groups, and in some cases healthcare systems. In some cases, a hospital system may own an interest in our surgical facility. One of our wholly owned subsidiaries typically serves as the general partner or managing member of our surgical facilities. We generally seek to own a majority interest in our surgical facilities, or otherwise have sufficient control over the facilities to be able to consolidate the financial results of operations of the facilities with ours. In some instances, we will acquire ownership in a surgical facility with the prior owners retaining ownership, and, in some cases, we offer new ownership to other physicians or hospital partners. We hold majority ownership in 31 of the 55 surgical facilities in which we own an interest. We typically provide a guarantee for our pro rata share of third-party debt of our non-consolidated surgical facilities. We provide intercompany debt for our consolidated facilities which often is secured by a pledge of assets of the partnership or limited liability company. We also have a management agreement with each of the surgical facilities, under which we provide day-to-day management services for a management fee, which is typically equal to a percentage of the revenues of the facility.

Each of the partnerships and limited liability companies through which we own and operate our surgical facilities is governed by a partnership or operating agreement. These partnership and operating agreements typically provide, among other things, for voting rights and limited transfer of ownership. The partnership and operating agreements also provide for the distribution of available cash to the owners. In addition, the agreements typically restrict the physician owners from owning an interest in a competing surgical facility during the period in which the physician owns an interest in our surgical facility and for one year after that period. The partnership and operating agreements for our surgical facilities typically provide that the facilities will purchase all of the physicians' ownership if certain adverse regulatory events occur, such as it becoming illegal for the physicians to own an interest in a surgical facility, refer patients to a surgical facility or receive cash distributions from a surgical facility. The purchase price that we would be required to pay for the ownership is based on pre-determined formulas, typically either a multiple of the surgical facility's EBITDA, as defined in our partnership and operating agreements, or the fair market value of the ownership as determined by an independent third-party appraisal. Some of these agreements require us to make a good faith effort to restructure our relationships with the physician investors in a manner that preserves the economic terms of the relationship prior to purchasing these interests. In certain circumstances, we have the right to purchase a physician's ownership, including upon a physician's breach of the restriction on ownership provisions of a partnership or operating agreement. In some cases, we have the right to require the physician owners to purchase our ownership in the event our management agreement with a surgical facility is terminated. In certain surgical facilities, the physician owners have the right to purchase our ownership upon a change in our control.

Surgical Facilities

The following table sets forth information regarding each of our surgical facilities as of December 31, 2011:

Surgical Facility	City	Number of Operating Rooms	Number of Treatment Rooms	Symbion Percentage Ownership
Alabama				
Birmingham Surgery Center	Birmingham	6	2	60% (1)
California				
Specialty Surgical Center of Beverly Hills / Brighton Way	Beverly Hills	3	2	32% (1)
Specialty Surgical Center of Beverly Hills / Wilshire Boulevard	Beverly Hills	4	2	32% (1)

Specialty Surgical Center of Encino	Encino	4	2	53% (1)
Specialty Surgical Center of Irvine	Irvine	4	1	51% (1)
Specialty Surgical Center of Westlake Village	Westlake Village	4	2	20%

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Surgical Facility	City	Number of Operating Rooms	Number of Treatment Rooms	Symbion Percentage Ownership
Colorado				
Minimally Invasive Spine Institute	Boulder	2	1	40% (1)
Animas Surgical Hospital	Durango	4	1	63% (1)(2)
			12 hospital rooms	
Florida				
West Bay Surgery Center	Largo	4	4	51% (1)
Jacksonville Beach Surgery Center	Jacksonville	4	1	78% (1)
Cape Coral Ambulatory Surgery Center	Cape Coral	5	6	65% (1)
Lee Island Coast Surgery Center	Fort Myers	5	3	49% (1)
Tampa Bay Regional Surgery Center	Largo	0	3	57% (1)
The Surgery Center of Ocala	Ocala	4	2	51% (1)
Blue Springs Surgery Center	Orange City	3	2	34% (1)
Georgia				
Premier Surgery Center	Brunswick	3	0	58% (1)
The Surgery Center	Columbus	4	2	63% (1)
Hawaii				
Honolulu Spine Center	Honolulu	2	0	61% (1)
Idaho				
Mountain View Hospital	Idaho Falls	10	3	49% (1)(2)
			43 hospital rooms	
Illinois				
Valley Ambulatory Surgery Center	St. Charles	6	1	40% (1)
Indiana				
New Albany Outpatient Surgery	New Albany	3	1	79% (1)
Kansas				
Cypress Surgery Center	Wichita	6	5	54% (1)
Kentucky				
DuPont Surgery Center	Louisville	5	0	61% (1)
Louisiana				
Greater New Orleans Surgery Center	Metairie	2	0	30% (1)
Physicians Medical Center	Houma	5	3	53% (1)(2)
			30 hospital rooms	
Massachusetts				
Worcester Surgery Center	Worcester	4	1	56% (1)
Michigan				
Novi Surgery Center	Novi	4	3	15%
Missouri				
Central Missouri Medical Park Surgical Center	Jefferson City	4	2	40% (1)
Timberlake Surgery Center	Chesterfield	4	1	56% (1)
St. Louis Spine and Orthopedic	Chesterfield	3	1	56% (1)
Mississippi				
DeSoto Surgery Center	DeSoto	2	1	—% (3)
Physicians Outpatient Center	Oxford	4	2	—% (3)

Montana

Great Falls Clinic Surgery Center	Great Falls	3	2	56% (1)
Great Falls Clinic Medical Center	Great Falls	3	20 hospital rooms	50% (2)(3)

<u>Surgical Facility</u>	<u>City</u>	<u>Number of Operating Rooms</u>	<u>Number of Treatment Rooms</u>	<u>Symbion Percentage Ownership</u>
New York				
South Shore Ambulatory Surgery Center	Lynbrook	4	1	40% (4)(1)
North Carolina				
Orthopaedic Surgery Center of Asheville	Asheville	3	0	57% (1)
Wilmington SurgCare	Wilmington	7	3	75% (1)
Ohio				
Physicians Ambulatory Surgery Center	Circleville	2	0	53% (1)
Valley Surgical Center	Steubenville	3	1	58% (1)
Oklahoma				
Lakeside Women's Hospital	Oklahoma City	3	3	42% (2)
			23 hospital rooms	
Oregon				
Gresham Station Surgery Center	Gresham	5	1	38%
Pennsylvania				
Village SurgiCenter	Erie	5	1	72% (1)
Surgery Center of Pennsylvania	Havertown	5	1	49% (1)
Rhode Island				
Bayside Endoscopy Center	Providence	0	6	75% (1)
East Greenwich Endoscopy Center	East Greenwich	0	4	45% (1)
East Bay Endoscopy Center	Portsmouth	0	1	75% (1)
South Carolina				
The Center for Specialty Surgery	Greenville	2	0	78% (1)
Tennessee				
Baptist Germantown Surgery Center	Memphis	6	1	—% (3)
Cool Springs Surgery Center	Franklin	5	1	36%
East Memphis Surgery Center	Memphis	6	2	—% (3)
Midtown Surgery Center	Memphis	4	0	—% (3)
Union City Surgery Center	Union City	3	1	—% (3)
UroCenter	Memphis	3	0	—% (3)
Premier Orthopaedic Surgery Center	Nashville	2	0	20%
Renaissance Surgery Center	Bristol	2	1	37% (1)
Texas				
Surgical Hospital of Austin	Austin	6	1	42% (1)(2)
			26 hospital rooms	
Central Park Surgery Center*	Austin	5	1	45% (1)
Clear Fork Surgery Center*	Fort Worth	4	1	34% (1)
Village Specialty Surgical Center	San Antonio	4	4	58% (1)
NorthStar Surgical Center	Lubbock	6	3	45% (1)
Texarkana Surgery Center	Texarkana	4	3	58% (1)
Washington				
Bellingham Surgery Center	Bellingham	4	0	84% (1)
Microsurgical Spine Center	Puyallup	1	1	50% (1)

(1) We consolidate this surgical facility for financial reporting purposes.

(2) This surgical facility is licensed as a hospital.

(3) We manage this surgical facility, but do not have ownership in the facility.

(4) Due to regulatory restrictions in the State of New York, we cannot directly hold ownership in the surgical facility. We hold 40% ownership in the limited liability company which provides administrative services to this surgical facility and consolidate the facility for financial reporting purposes. Additionally, we manage this facility.

* Facility reported as discontinued operations as of December 31, 2011.

Strategic Relationships

When attractive opportunities arise, we may develop, acquire or operate surgical facilities through strategic relationships with healthcare systems and other healthcare providers. We believe that forming a relationship with a healthcare system can enhance our ability to attract physicians and access managed care contracts for our surgical facilities in that market. We currently have relationships with seven healthcare systems relating to thirteen ASC's. These healthcare systems include:

- Lee Health Ventures, with which we own and operate a surgical facility in Ft. Myers, Florida;
- Wellmont Health Systems, with which we own and operate a surgical facility in Bristol, Tennessee;
- Berger Health Foundation, with which we own and operate a surgical facility in Circleville, Ohio;
- Vanderbilt Health Services, Inc., with which we own and operate a surgical facility in Franklin, Tennessee;
- Vanguard Health Systems, Inc., with which we own and operate a surgical facility in San Antonio, Texas;
- Baptist Memorial Health Services, Inc. ("Baptist Memorial"), for which we manage seven surgical facilities in Memphis, Tennessee and surrounding areas; and
- Adventist Health System, with which we own and operate a surgical facility in Orange City, Florida.

The strategic relationships through which we own and operate surgical facilities are governed by partnership and operating agreements that are generally comparable to the partnership and operating agreements of the other surgical facilities in which we own an interest. The primary difference between the structure of these strategic relationships and the other surgical facilities in which we hold ownership is that, in these strategic relationships, a healthcare system holds ownership in the surgical facility, in addition to physician investors. For a general description of the terms of our partnership and operating agreements, see "—Operations—Surgical Facility Ownership Structure." In each of these strategic relationships, we also have entered into a management agreement under which we provide day-to-day management services for a management fee equal to a percentage of the revenues of the surgical facility. The terms of those management agreements are comparable to the terms of our management agreements with other surgical facilities in which we own an interest.

We manage seven surgical facilities owned by Baptist Memorial under management agreements with Baptist Memorial in exchange for a management fee based on a percentage of the revenues of these surgical facilities. The management agreements terminate in 2014 and may be terminated earlier by either party for material breach after notice and an opportunity to cure.

Acquisitions and Developments

During 2011, our significant acquisitions were as follows:

- An incremental, controlling ownership interest in one of our Chesterfield, Missouri facilities in two separate transactions.
- An oncology practice, which is operated within our existing facility located in Idaho Falls, Idaho.
- A 56.0% ownership interest in a surgical facility located in Great Falls, Montana, which we consolidate for financial reporting purposes.
- A 50.0% ownership interest in a hospital located in Great Falls, Montana, which we account for as an equity method investment.
- Management rights in a physician clinic located in Great Falls, Montana.

We continuously evaluate opportunities to expand our presence in the surgical facility market by making strategic acquisitions of existing surgical facilities and by developing new surgical facilities in cooperation with local physician partners and, when appropriate, with healthcare systems and other strategic partners. We have the flexibility to structure our partnerships as two-way arrangements where either we are a majority owner partnered with physicians or we are a minority owner with buy-up rights. These buy-up rights give us the option to own a controlling interest at some point in the future. Alternatively, we may choose to pursue a three-way arrangement with physicians and a healthcare system partner.

Acquisition Program

We employ a dedicated acquisition team with experience in healthcare services. Our team seeks to acquire surgical facilities that meet our criteria, including prominence and quality of physician partners, specialty mix, opportunities for growth, level of competition in the local market, level of managed care penetration and our ability to access managed care organization contracts. Our team utilizes its extensive industry contacts, as well as referrals from current physician partners and other sources, to identify, contact and develop potential acquisition candidates.

We believe there are numerous acquisition opportunities that would pass our general screening criteria. We carefully evaluate each of our acquisition opportunities through an extensive due diligence process to determine which facilities have the greatest potential for growth and profitability improvements under our operating structure. In many cases, the acquisition team identifies specific opportunities to enhance a facility's productivity post-acquisition. For example, we may renovate or construct additional operating or treatment rooms in existing

facilities to meet anticipated demand for procedures based on an analysis of local market characteristics. Our team may also identify opportunities to attract additional physicians to increase the acquired facility's revenues and profitability. We have acquired 54 surgical facilities since January 1999.

Development Program

We develop surgical facilities in markets in which we identify substantial interest by physicians and payors. We have experience in developing both single and multi-specialty surgical facilities. When we develop a new surgical facility, we generally provide all of the services necessary to complete the project. We offer in-house capabilities for structuring partnerships and financing facilities and work with architects and construction firms in the design and development of surgical facilities. Before and during the development phase of a new surgical facility, we analyze the competitive environment in the local market, review market data to identify appropriate services to provide, prepare and analyze financial forecasts, evaluate regulatory and licensing issues and assist in designing the surgical facility and identifying appropriate equipment to purchase or lease. After the surgical facility is developed, we generally provide startup operational support, including information systems, equipment procurement and financing. We have developed 24 surgical facilities since January 1999.

Development of a typical ASC generally occurs over a 12 to 18 month period, depending on whether the facility is being constructed or available space improved. Total development costs typically amount to \$4.0 to \$6.0 million and include improvements to existing space, equipment and other furnishing costs and working capital. We typically fund about 80% of the development costs of a new surgical facility with a combination of corporate borrowings and cash from operations, and the remainder with equity contributed by us and the other owners of the facility. For our consolidated surgical facilities, the indebtedness typically consists of intercompany loans that we provide, and for our non-consolidated surgical facilities, the indebtedness typically consists of third-party debt for which we provide a guarantee for only our pro rata share.

Other Services

Although our business is primarily focused on owning and operating surgical facilities, we also manage a physician clinic in a market in which we operate an ASC and a surgical hospital.

Information Systems and Controls

Each of our surgical facilities uses a financial reporting system that provides information to our corporate office to track financial performance on a timely basis. In addition, each of our surgical facilities uses an operating system to manage its business that provides critical support in areas such as scheduling, billing and collection, accounts receivable management, purchasing and other essential operational functions. We have implemented systems to support all of our surgical facilities and to enable us to more easily access information about our surgical facilities on a timely basis.

We calculate net revenues through a combination of manual and system-generated processes. Our operating systems include insurance modules that allow us to establish profiles of insurance plans and their respective payment rates. The systems then match the charges with the insurance plan rates and compute a contractual adjustment estimate for each patient account. We then manually review the reasonableness of the systems' contractual adjustment estimate using the insurance profiles. This estimate is adjusted, if needed, when the insurance payment is received and posted to the account. Net revenues are computed and reported by the systems as a result of this activity.

It is our policy to collect co-payments and deductibles prior to providing services. It is also our policy to verify a patient's insurance 72 hours prior to the patient's procedure. Because our services are primarily non-emergency, our surgical facilities have the ability to control these processes. We do not track exceptions to these policies, but we believe that they occur infrequently and involve insignificant amounts. When exceptions do occur, we require patients whose insurance coverage is not verified to assume full responsibility for the fees prior to services being rendered, and we seek prompt payment of co-payments and deductibles and verification of insurance following the procedure.

We manually input each patient's account record and the associated billing codes. Our operating systems then calculate the amount of fees for that patient and the amount of the contractual adjustments. Claims are submitted electronically if the payor accepts electronic claims. We use clearinghouses for electronic claims, which then forward the claims to the respective payors. Payments are manually input to the respective patient accounts.

We have developed proprietary measurement tools to track key operating statistics at each of our surgical facilities by integrating data from our local operating systems and our financial reporting systems. Management uses these tools to measure operating results against target thresholds and to identify, monitor and adjust areas such as specialty mix, staffing, operating costs, employee expenses and accounts receivable management. Our corporate and facility-level management teams are compensated in part using performance-based incentives focused on revenue growth and improving operating income.

Marketing

We primarily direct our sales and marketing efforts at physicians who would use our surgical facilities. Marketing activities directed at physicians and other healthcare providers are coordinated locally by the individual surgical facility and are supplemented by dedicated corporate personnel. These activities generally emphasize the benefits offered by our surgical facilities compared to other facilities in the market, such as the proximity of our surgical facilities to physicians' offices, the ability to schedule consecutive cases without preemption by inpatient or emergency procedures, the efficient turnaround time between cases, our advanced surgical equipment and our simplified administrative procedures. Although the facility administrator is the primary point of contact, physicians who utilize our surgical

facilities are important sources of recommendations to other physicians regarding the benefits of using our surgical facilities. Each facility administrator develops a target list of physicians, and we continually review our progress in successfully recruiting additional local physicians.

We also market our surgical facilities directly to payors, such as health maintenance organizations, or HMOs, preferred provider organizations, or PPOs, and other managed care organizations and employers. Payor marketing activities conducted by our corporate office management and facility administrators emphasize the high quality of care, cost advantages and convenience of our surgical facilities, and are focused on making each surgical facility an approved provider under local managed care plans.

Competition

In each market in which we operate a surgical facility, we compete with hospitals and operators of other surgical facilities to attract physicians and patients. We believe that the competitive factors that affect our surgical facilities' ability to compete for physicians are convenience of location of the surgical facilities, access to capital and participation in managed care programs. In addition, we believe the national prominence, scale and reputation of our company are instrumental in attracting physicians. We believe that our surgical facilities attract patients based upon our quality of care, the specialties and reputations of the physicians who operate in our surgical facilities, participation in managed care programs, ease of access and convenient scheduling and registration procedures.

In developing or acquiring existing surgical facilities, we compete with other public and private surgical facility and hospital companies. Several large national companies own and/or manage surgical facilities, including HCA Holdings, Inc., Surgical Care Affiliates, Inc., AmSurg Corp. and United Surgical Partners International, Inc. We also face competition from local hospitals, physician groups and other providers who may compete with us in the ownership and operation of surgical facilities, as well as the trend of physicians choosing to perform procedures in an office-based setting rather than in a surgical facility.

Employees

At December 31, 2011, we had approximately 2,500 employees, of which about 1,600 were full-time employees. None of our employees are represented by a collective bargaining agreement. We believe that we have a good relationship with our employees.

Environmental

We are subject to various federal, state and local laws and regulations relating to the protection of the environment and human health and safety, including those governing the management and disposal of hazardous substances and wastes, the cleanup of contaminated sites and the maintenance of a safe workplace. Our operations include the use, generation and disposal of hazardous materials. We may, in the future, incur liability under environmental statutes and regulations with respect to contamination of sites we own or operate (including contamination caused by prior owners or operators of such sites, adjoining properties or other persons) and the off-site disposal of hazardous substances. We believe that we have been and are in substantial compliance with the terms of all applicable environmental laws and regulations and that we have no liabilities under environmental requirements that we would expect to have a material adverse effect on our business, results of operations or financial condition.

Insurance

We maintain liability insurance in amounts that we believe are appropriate for our operations. Currently, we maintain professional and general liability insurance that provides coverage on a claims-made basis of \$1.0 million per occurrence with a retention of \$50,000 per occurrence and \$3.0 million in annual aggregate coverage per surgical facility, including the facility and employed staff. We also maintain business interruption insurance and property damage insurance, as well as an additional umbrella liability insurance policy in the aggregate amount of \$25.0 million. Coverage under certain of these policies is contingent upon the policy being in effect when a claim is made regardless of when the events which caused the claim occurred. The cost and availability of such coverage has varied widely in recent years. In addition, physicians who provide professional services in our surgical facilities are required to maintain separate malpractice coverage with similar minimum coverage limits. While we believe that our insurance policies are adequate in amount and coverage for our anticipated operations, we cannot assure you that the insurance coverage is sufficient to cover all future claims or will continue to be available in adequate amounts or at a reasonable cost.

Sources of Revenue

Approximately 98% of our revenues in 2011 were obtained from facility fees related to healthcare services performed in our surgical facilities. The fee charged varies depending on the type of service provided, but usually includes all charges for usage of an operating room, a recovery room, special equipment, supplies, nursing staff and medications. Also, in a very limited number of surgical facilities, we charge for anesthesia services. Our fees do not include professional fees charged by the patient's surgeon, anesthesiologist or other attending physician, which are billed directly by such physicians to the patient or third-party payor. We recognize our facility fee on the date of service, net of estimated contractual adjustments and discounts for third-party payors, including Medicare and Medicaid. Any changes in estimated contractual adjustments and discounts are recorded in the period of change.

We are dependent upon private and government third-party sources of payment for the services we provide. The amounts that our surgical facilities receive in payment for their services may be adversely affected by market and cost factors as well as other factors over which we have no control, including Medicare, Medicaid, and state regulations and the cost containment and utilization decisions and reduced

reimbursement schedules of third-party payors. Approximately 26%, 25% and 24% of our revenues were from government sources, mostly Medicare, for the years ended December 31, 2011, 2010 and 2009, respectively.

The following table sets forth by type of payor the percentage of our patient service revenues generated in the periods indicated:

	Year Ended December 31,		
	2011	2010	2009
Private Insurance	67%	68%	71%
Government	26	25	24
Self-pay	3	4	4
Other	4	3	1
Total	100%	100%	100%

Medicare Reimbursement—Ambulatory Surgery Centers

Payments under the Medicare program to ASCs are made under a system whereby the Secretary of the Department of Health and Human Services (the “Secretary”) determines payment amounts prospectively for various categories of medical services performed in ASCs. Beginning in 2008, CMS transitioned Medicare payments to ASCs to a system based upon the hospital outpatient prospective payment system (“OPPS”). On November 1, 2011, CMS issued a final rule to update the Medicare program’s payment policies and rates for ASCs for calendar year (“CY”) 2012. The final rule applies a 1.6% increase to the ASC payment rate. CMS has also adopted a quality reporting program for ASCs for the first time. Beginning October 1, 2012, ASCs will be required to report five quality measures in order to be eligible for the full market basket update for the CY 2014 payment determination.

Medicare Reimbursement—Hospital Inpatient Services

Six of our surgical facilities are licensed as hospitals. Most inpatient services provided by hospitals are reimbursed by Medicare under the inpatient prospective payment system (“IPPS”). Under this prospective payment system, a hospital receives a fixed amount for inpatient hospital services based on each patient’s final assigned Medicare-severity diagnosis related group (“MS-DRG”). Each MS-DRG is assigned a payment rate that is prospectively set using national average resources used per case for treating a patient with a particular diagnosis. This MS-DRG assignment also affects the prospectively determined capital rate paid with each MS-DRG. MS-DRG and capital payments are adjusted by a predetermined geographic adjustment factor assigned to the geographic area in which the hospital is located. The index used to adjust the MS-DRG rates, known as the “hospital market basket index,” gives consideration to the inflation experienced by hospitals in purchasing goods and services.

On August 18, 2011, CMS issued the IPPS final rule for federal fiscal year (“FFY”) 2012, beginning on October 1, 2011. Under the final rule, hospitals that report quality data under the Inpatient Quality Reporting Program will receive a 1.0% payment rate increase for inpatient hospital stays paid under the IPPS and hospitals that do not report quality data will be subject to a 1.0% decrease in payment rates. Future realignments in the MS-DRG system could impact the margins we receive for certain services and additional adjustments will reduce IPPS payments to hospitals and could adversely impact our Medicare revenues.

Medicare Reimbursement—Hospital Outpatient Services

Most outpatient services provided by hospitals are reimbursed by Medicare under the OPPS whereby hospital outpatient services are classified into groups called ambulatory payment classifications (“APCs”). CMS establishes a payment rate for each APC by multiplying the scaled relative weight for the APC by a conversion factor. The payment rate is further adjusted to reflect geographic wage differences. APC classifications and payment rates are reviewed and adjusted on an annual basis. If CMS’ annual payment recalculations result in a decrease in APC payment rates for procedures performed in our hospitals, our revenues and profitability could be materially adversely affected.

On November 1, 2011, CMS issued the final OPPS rates for CY 2012. Under the final rule, the market basket update for CY 2012 for hospitals under the OPPS is a 1.9 % increase. Hospitals that submit quality data in accordance with the Hospital Outpatient Quality Data Reporting Program will receive the full 1.9% market basket update, while those that do not submit quality data will not receive the 1.9% market basket update and instead will be subject to a 0.1% decrease in reimbursement. As part of the final rule, CMS added three quality measures to the current list to be reported by hospital outpatient departments. There are now 26 measures that are to be reported for purposes of the CY 2014 payment determination.

Budget Control Act of 2011

On August 2, 2011, the Budget Control Act of 2011 (the “BCA”) was enacted. The BCA increased the nation’s debt ceiling, while taking steps to reduce the federal deficit. The BCA requires \$1.2 trillion in automatic across-the-board spending reductions for FFY 2013 through FFY 2021, split evenly between domestic and defense spending. While certain programs (including the Medicaid program) are protected from these automatic spending reductions, payments to Medicare providers may be subject to reductions of up to 2.0%.

Private Third-Party Payors

Most third-party payors pay pursuant to a written contract with our surgical facilities. These contracts generally require our hospitals and ASCs to offer discounts from their established charges. Some of our payments come from third-party payors with which our surgical facilities do not have written contracts. In those situations, commonly known as “out-of-network” services, we generally charge the patients the same co-payment or other patient responsibility amounts that we would have charged had our center had a contract with the third-

party payor. We also submit a claim for the services to the third-party payor along with full disclosure that our surgical facility has charged the patient an in-network patient responsibility amount.

Annual Cost Reports

Hospitals participating in the Medicare and some Medicaid programs, whether paid on a reasonable cost basis or under a prospective payment system, are required to meet certain financial reporting requirements. Federal and, where applicable, state regulations require submission of annual cost reports identifying medical costs and expenses associated with the services provided by each hospital to Medicare beneficiaries and Medicaid recipients.

Annual cost reports required under the Medicare and some Medicaid programs are subject to routine governmental audits. These audits may result in adjustments to the amounts ultimately determined to be payable to us under these reimbursement programs. Finalization of these audits often takes several years. Providers may appeal any final determination made in connection with an audit.

Governmental Regulation

General

The healthcare industry is highly regulated, and we cannot provide any assurance that the regulatory environment in which we operate will not significantly change in the future or that we will be able to successfully address any such changes.

Every state imposes licensing requirements on individual physicians and healthcare facilities. In addition, federal and state laws regulate HMOs and other managed care organizations. Many states require regulatory approval, including licensure, and in some cases certificates of need, before establishing certain types of healthcare facilities, including surgical hospitals and ASCs, offering certain services, including the services we offer, or making expenditures in excess of certain amounts for healthcare equipment, facilities or programs. Our ability to operate profitably will depend in part upon all of our surgical facilities obtaining and maintaining all necessary licenses, certificates of need and other approvals and operating in compliance with applicable healthcare regulations. Failure to do so could have a material adverse effect on our business.

The laws of many states prohibit physicians from splitting fees with non-physicians (i.e., sharing in a percentage of professional fees), prohibit non-physician entities (such as us) from practicing medicine and exercising control over or employing physicians and prohibit referrals to facilities in which physicians have a financial interest. We believe our activities do not violate these state laws. However, future interpretations of, or changes in, these laws might require structural and organizational modifications of our existing relationships with facilities and the physician network, and we cannot assure you that we would be able to appropriately modify such relationships. In addition, statutes in some states could restrict our expansion into those states.

Our surgical facilities are subject to federal, state and local laws dealing with issues such as occupational safety, employment, medical leave, insurance regulations, civil rights, discrimination, building codes and medical waste and other environmental issues. Federal, state and local governments are expanding the regulatory requirements on businesses. The imposition of these regulatory requirements may have the effect of increasing operating costs and reducing the profitability of our operations.

We believe that hospital, outpatient surgery and diagnostic services will continue to be subject to intense regulation at the federal and state levels. We are unable to predict what additional government regulations, if any, affecting our business may be enacted in the future or how existing or future laws and regulations might be interpreted. If we, or any of our surgical facilities, fail to comply with applicable laws, it might have a material adverse effect on our business.

Certificates of Need and Licensure

Capital expenditures for the construction of new healthcare facilities, the addition of beds or new healthcare services or the acquisition of existing healthcare facilities may be reviewable by state regulators under statutory schemes that are sometimes referred to as certificate of need laws. States with certificate of need laws place limits on the construction and acquisition of healthcare facilities and the expansion of existing facilities and services. In these states, approvals, generally known as certificates of need, are required for capital expenditures exceeding certain pre-set monetary thresholds for the development, acquisition and/or expansion of certain facilities or services, including surgical facilities. We have a concentration of surgical facilities in certificate of need states as we believe the regulations present a competitive advantage to existing operators.

Our healthcare facilities also are subject to state licensing requirements for medical providers. Our facilities have licenses to operate as ASCs in the states in which they operate, except for one facility in Colorado, one facility in Louisiana, one facility in Oklahoma, one facility in Texas, one facility in Idaho and one facility in Montana, each of which is licensed as a hospital. Our surgical facilities that are licensed as ASCs must meet all applicable requirements for ASCs. In addition, even though our surgical facilities that are licensed as hospitals primarily provide surgical services, they must meet all applicable requirements for general hospital licensure. To assure continued compliance with these regulations, governmental and other authorities periodically inspect our surgical facilities. The failure to comply with these regulations could result in the suspension or revocation of a facility's license. In addition, based on the specific operations of our

surgical facilities, some of these facilities maintain a pharmacy license, a controlled substance registration, a clinical laboratory certification waiver, and environmental protection permits for biohazards and/or radioactive materials, as required by applicable law.

Healthcare Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the “Healthcare Reform Acts”) were signed into law on March 23, 2010 and March 30, 2010, respectively, dramatically altering the U.S. healthcare system. The Healthcare Reform Acts are intended to provide coverage and access to substantially all Americans, to increase the quality of care provided, and to reduce the rate of growth in healthcare expenditures. The changes include, among other things, reducing payments to Medicare Advantage plans, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, bundling payments to hospitals and other providers, reducing Medicare and Medicaid payments, expanding Medicare and Medicaid eligibility, and expanding access to health insurance. As part of the effort to control or reduce healthcare spending, the Healthcare Reform Acts also contain a number of measures intended to reduce fraud and abuse in the Medicare and Medicaid programs, such as requiring the use of recovery audit contractors in the Medicaid program and limitations on the federal physician self-referral law (“Stark Law”) exception that allows physicians to have ownership interests in hospitals (the “Whole Hospital Exception”). Among other things, the Healthcare Reform Acts prohibit hospitals from increasing the percentages of the total value of the ownership interests held in the hospital by physicians after March 23, 2010, as well as places severe restrictions on the ability of a hospital subject to the Whole Hospital Exception to add operating rooms, procedure rooms and beds. The Healthcare Reform Acts provide for additional enforcement tools, cooperation between agencies, and funding for enforcement. In addition, the Healthcare Reform Acts mandate reductions in reimbursement, such as adjustments to the hospital inpatient and outpatient prospective payment system market basket updates and productivity adjustments to Medicare's annual inflation updates, which became effective in 2010 and 2011 or will be effective in 2012. However, a majority of the measures contained in the Healthcare Reform Acts do not take effect until 2013 or later. The United States Supreme Court is expected to rule on the constitutionality of the Healthcare Reform Acts in 2012. The Supreme Court will consider four issues: (1) whether the “individual mandate”—the requirement that all individuals purchase some form of health insurance—is constitutional; (2) if the individual mandate is found unconstitutional, whether it is severable from the remainder of the Healthcare Reform Acts; (3) whether the Healthcare Reform Act's requirement that states expand Medicaid eligibility or risk losing federal funds is constitutional; and (4) whether the individual mandate is a tax for purposes of the Anti-Injunction Act, meaning that plaintiffs seeking to challenge the requirement must wait until it takes effect in 2014. It is difficult to predict the impact the Healthcare Reform Acts will have on the Company's operations given the pending Supreme Court challenge, delay in implementing regulations, and possible amendment or repeal of elements of the Healthcare Reform Acts. The Healthcare Reform Acts could have a material adverse effect on our financial condition and results of operations.

Quality Improvement

Quality of care and value-based purchasing also have become significant trends and competitive factors in the healthcare industry. In 2005, CMS began making public performance data relating to ten quality measures that hospitals submit in connection with their Medicare reimbursement. Since that time, CMS has on several occasions increased the number of quality measures hospitals are required to report in order to receive the full IPPS and OPSP market basket updates. In addition, the Medicare program no longer reimburses hospitals for the cost of care relating to certain preventable adverse events, and many private healthcare payers have adopted similar policies. The Healthcare Reform Acts also contain a number of provisions that are intended to improve the quality of care that is provided to Medicare and Medicaid beneficiaries. For example, beginning July 1, 2011, the Healthcare Reform Acts prohibit Medicaid programs from using federal funds to reimburse providers for the costs of care needed to treat hospital acquired conditions (“HACs”). Beginning in FFY 2015, the Healthcare Reform Acts mandate a 1% reduction in Medicare payments for hospitals that were in the highest quartile of national risk-adjusted HAC rates for the previous FFY. Beginning in FFY 2013, the Healthcare Reform Acts require CMS to implement a value-based purchasing program for Medicare hospitals that would reduce IPPS payments by 1% in FFY 2013 (gradually increasing to 2% in FFY 2017) and to use those funds to provide additional payments to hospitals that meet certain clinical and patient experience of care quality measures. On May 6, 2011, CMS published a final rule on the value-based purchasing program, which describes which measurements will be taken into consideration and how the program will be administered. If the public performance data becomes a primary factor in where patients choose to receive care, and if competing hospitals have better results than our hospitals on those measures, we would expect that our patient volumes could decline. In addition, if our hospitals have high HAC rates or are unable to meet the required quality measures, the implementation of the value-based purchasing programs potentially could have a negative effect on our revenues.

Accountable Care Organizations

The Healthcare Reform Acts require HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of Accountable Care Organizations (“ACOs”). Beginning in 2012, Medicare will allow providers (including hospitals), physicians and other designated professionals and suppliers to form ACOs and voluntarily work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS will be eligible to share in a portion of the amounts saved by the Medicare program. HHS has significant discretion to determine key elements of the program, including what steps providers must take to be considered an ACO, how to decide if Medicare program savings have occurred, and what portion of such savings will be paid to ACOs. In addition, HHS will determine to what degree hospitals, physicians and other eligible participants will be able to form and operate an ACO without violating certain existing laws, including the Civil Monetary Penalty Law, the Anti-kickback Statute and the Stark Law. However, the Healthcare Reform Acts do not authorize HHS to waive other laws that may impact the ability of hospitals and other eligible participants to participate in ACOs, such as antitrust laws. The implementation of ACOs

could have a negative impact on our financial condition and results of operations if our facilities are unable to participate or if reimbursement is greatly reduced.

Medicare and Medicaid Participation

The majority of our revenues are expected to continue to be received through third-party reimbursement programs, including state and federal programs, such as Medicare and Medicaid, and private health insurance programs. To participate in the Medicare program and receive Medicare payment, our surgical facilities must comply with regulations promulgated by HHS. Among other things, these regulations, known as “conditions of coverage” or “conditions of participation,” impose numerous requirements on our facilities, their equipment, their personnel and their standards of medical care, as well as compliance with all applicable state and local laws and regulations. On April 26, 2007, CMS issued a policy memorandum that reaffirmed its prior interpretation of its conditions of participation that all hospitals (other than Critical Access Hospitals) participating in the Medicare program are required to provide basic emergency care interventions regardless of whether or not the hospital maintains an emergency department. Our six facilities licensed as hospitals are required to meet this requirement to maintain their participating provider status in the Medicare program. One of our hospitals, which does not have an emergency room, maintains a protocol for the transfer of patients requiring emergency treatment, which protocol may be interpreted as inconsistent with the 2007 CMS policy memorandum. Our surgical facilities must also satisfy the conditions of participation to be eligible to participate in the various state Medicaid programs. The requirements for certification under Medicare and Medicaid are subject to change and, in order to remain qualified for these programs, we may have to make changes from time to time in our facilities, equipment, personnel or services. Although we intend to continue to participate in these reimbursement programs, we cannot assure you that our surgical facilities will continue to qualify for participation.

The Healthcare Reform Acts require a hospital to provide written disclosure of physician ownership interests to the hospital's patients and on the hospital's website and in any advertising, along with annual reports to the government detailing such interests. Additionally, hospitals that do not have 24/7 physician coverage are required to inform patients of this fact and receive signed acknowledgment from the patients of the disclosure. A hospital's provider agreement may be terminated if it fails to provide the required notices. In 2010, CMS issued a “self-referral disclosure protocol” for hospitals and other providers that wish to self-disclose potential violations of the Stark Law to CMS and to attempt to resolve those potential violations and any related overpayment liabilities at levels below the maximum penalties and amounts set forth in the statute. The disclosure requirements set forth in the Healthcare Reform Acts and the self-referral disclosure protocol reflect a move towards increasing government scrutiny of the financial relationships between hospitals and referring physicians and increasing disclosure of potential violations of the Stark Law to the government by hospitals and other healthcare providers. We intend for all of our facilities to meet their disclosure obligations.

Survey and Accreditation

Hospitals are subject to periodic inspection by federal, state and local authorities to determine their compliance with applicable regulations and requirements necessary for licensing, certification and accreditation. Our hospitals currently are licensed under appropriate state laws and are qualified to participate in the Medicare and Medicaid programs.

Utilization Review

Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by quality improvement organizations, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of MS-DRG classifications and the appropriateness of cases of extraordinary length of stay or cost. Quality improvement organizations may deny payment for services provided or assess fines and also have the authority to recommend to HHS that a provider which is in substantial noncompliance with the standards of the quality improvement organization be excluded from participation in the Medicare program. Utilization review is also a requirement of most non-governmental managed care organizations.

Federal Anti-Kickback Statute and Medicare Fraud and Abuse Laws

The Social Security Act includes provisions addressing false statements, illegal remuneration and other instances of fraud and abuse in the Medicare program. These provisions are commonly referred to as the Medicare fraud and abuse laws, and include the statute commonly known as the federal anti-kickback statute (the “Anti-kickback Statute”). The Anti-kickback Statute prohibits providers and others from, among other things, soliciting, receiving, offering or paying, directly or indirectly, any remuneration in return for either making a referral for, or ordering or arranging for, or recommending the order of, any item or service covered by a federal healthcare program, including, but not limited to, the Medicare program. Violations of the Anti-kickback Statute are criminal offenses punishable by imprisonment and fines of up to \$25,000 for each violation. Civil violations are punishable by fines of up to \$50,000 for each violation, as well as damages of up to three times the total amount of remuneration received from the government for healthcare claims.

In addition, the Medicare Patient and Program Protection Act of 1987, as amended by the Health Insurance Portability and Accountability Act of 1996, (“HIPAA”), and the Balanced Budget Act of 1997, impose civil monetary penalties and exclusion from state and federal healthcare programs on providers who commit violations of the Medicare fraud and abuse laws. Pursuant to the enactment of HIPAA, as of June 1, 1997, the Secretary may, and in some cases must, exclude individuals and entities that the Secretary determines have “committed an act” in violation of the Medicare fraud and abuse laws or improperly filed claims in violation of the Medicare fraud and abuse laws from

participating in any federal healthcare program. HIPAA also expanded the Secretary's authority to exclude a person involved in fraudulent activity from participating in a program providing health benefits, whether directly or indirectly, in whole or in part, by the U.S. government. Additionally, under HIPAA, individuals who hold a direct or indirect ownership or controlling interest in an entity that is found to violate the Medicare fraud and abuse laws may also be excluded from Medicare and Medicaid and other federal and state healthcare programs if the individual knew or should have known, or acted with deliberate ignorance or reckless disregard of, the truth or falsity of the

information of the activity leading to the conviction or exclusion of the entity, or where the individual is an officer or managing employee of such entity. This standard does not require that specific intent to defraud be proven by the Office of the Inspector General of the U.S. Department of Health and Human Services (the "OIG"). Under HIPAA it is also a crime to defraud any commercial healthcare benefit program.

Because physician-investors in our surgical facilities are in a position to generate referrals to the facilities, the distribution of available cash to those investors could come under scrutiny under the Anti-Kickback Statute. The U.S. Third Circuit Court of Appeals has held that the Anti-kickback Statute is violated if one purpose (as opposed to a primary or sole purpose) of a payment to a provider is to induce referrals. Other federal circuit courts have followed this decision. Further, Section 6402(f)(2) of the Affordable ARE Act amends the Anti-kickback Statute by adding a provision to clarify that a person need not have actual knowledge of such section or specific intent to commit a violation of the Anti-kickback Statute. Because none of these cases involved a joint venture such as those owning and operating our surgical facilities, it is not clear how a court would apply these holdings to our activities. It is clear, however, that a physician's investment income from a surgical facility may not vary with the number of his or her referrals to the surgical facility, and we comply with this prohibition.

Under regulations issued by the OIG, certain categories of activities are deemed not to violate the Anti-kickback Statute (commonly referred to as the safe harbors). According to the preamble to these safe harbor regulations, the failure of a particular business arrangement to comply with the regulations does not determine whether the arrangement violates the Anti-kickback Statute. The safe harbor regulations do not make conduct illegal, but instead outline standards that, if complied with, protect conduct that might otherwise be deemed in violation of the Anti-kickback Statute. Failure to meet a safe harbor does not indicate that the arrangement violates the Anti-kickback Statute.

We believe the ownership and operations of our surgery centers and hospitals will not fit wholly within safe harbors, but we attempt to incorporate elements of a safe harbor in all of our facilities. Our ASCs, for example, are structured to fit as closely as possible within the safe harbor designed to protect distributions to physician-investors in ambulatory surgery centers who directly refer patients to the ambulatory surgery center and personally perform the procedures at the center as an extension of their practice (the "ASC Safe Harbor"). The ASC Safe Harbor protects four categories of investors, including facilities owned by (1) general surgeons, (2) single-specialty physicians, (3) multi-specialty physicians and (4) hospital/physician ventures, provided that certain requirements are satisfied. These requirements include the following:

1. The ASC must be an ASC certified to participate in the Medicare program, and its operating and recovery room space must be dedicated exclusively to the ambulatory surgery center and not a part of a hospital (although such space may be leased from a hospital if such lease meets the requirements of the safe harbor for space rental);
2. Each investor must be either (a) a physician who derived at least one-third of his or her medical practice income for the previous fiscal year or 12-month period from performing procedures on the list of Medicare-covered procedures for ambulatory surgery centers, (b) a hospital, or (c) a person or entity not in a position to make or influence referrals to the center, nor to provide items or services to the ambulatory surgery center, nor employed by the ASC or any investor;
3. Unless all physician-investors are members of a single specialty, each physician-investor must perform at least one-third of his or her procedures at the ASC each year (this requirement is in addition to the requirement that the physician-investor has derived at least one-third of his or her medical practice income for the past year from performing procedures);
4. Physician-investors must have fully informed their referred patients of the physician's investment;
5. The terms on which an investment interest is offered to an investor are not related to the previous or expected volume of referrals, services furnished or the amount of business otherwise generated from that investor to the entity;
6. Neither the ASC nor any other investor nor any person acting on their behalf may loan funds to or guarantee a loan for an investor if the investor uses any part of such loan to obtain the investment interest;
7. The amount of payment to an investor in return for the investment interest is directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor;
8. All physician-investors, any hospital-investor and the center agree to treat patients receiving benefits or assistance under a federal healthcare program in a non-discriminatory manner;
9. All ancillary services performed at the ASC for beneficiaries of federal healthcare programs must be directly and integrally related to primary procedures performed at the ASC and may not be billed separately;
10. No hospital-investor may include on its cost report or any claim for payment from a federal healthcare program any costs associated with the ASC;

11. The ASC may not use equipment owned by or services provided by a hospital-investor unless such equipment is leased in accordance with a lease that complies with the Anti-Kickback statute equipment rental safe harbor and such services are provided in accordance with a contract that complies with the Anti-Kickback Statute personal services and management contract safe harbor; and
12. No hospital-investor may be in a position to make or influence referrals directly or indirectly to any other investor or the ASC.

We believe that the ownership and operations of our surgical facilities will not satisfy this ASC Safe Harbor for investment interests in ASCs because, among other things, we or one of our subsidiaries will generally be an investor in and provide management services to each ambulatory surgery center. We cannot assure you that the OIG would view our activities favorably even though we strive to achieve compliance with the remaining elements of this safe harbor.

In addition, although we expect each physician-investor to utilize the ASC as an extension of his or her practice, we cannot assure you that all physician-investors will derive at least one-third of their medical practice income from performing Medicare-covered ASC procedures, perform one-third of their procedures at the ASC or inform their referred patients of their investment interests. Interests in our ASC joint ventures are purchased at fair market value. Investors who purchase at a later time generally pay more for a given percentage interest than founding investors. The result is that while all investors are paid distributions in accordance with their ownership interests, for ASCs where there are later purchases we cannot meet the safe harbor requirement that return on investment is directly proportional to the amount of capital investment. The OIG has on several occasions reviewed investments relating to ASCs, and in Advisory Opinion No. 07-05, raised concerns that (a) purchases of interests from physicians might yield gains on investment rather than capital infusion to the ASCs, (b) such purchases could be meant to reward or influence the selling physicians' referrals to the ASC or the hospital, and (c) such returns might not be directly proportional to the amount of capital invested. Nonetheless, we believe our fair market value purchase requirements and distribution policies comply with the Anti-kickback Statute.

We hold ownership in one ambulatory surgery center in which a physician group that includes primary care physicians who do not use the ambulatory surgery center also holds ownership. In OIG Advisory Opinion No. 03-5 (February 6, 2003), the OIG declined to grant a favorable opinion to a proposed ambulatory surgery center structure that would have been jointly owned by a hospital and a multi-specialty group practice that was composed of a substantial number of primary care physicians who would not personally use the ambulatory surgery center. We believe that the ownership of our ambulatory surgery center complies with the Anti-kickback Statute because we understand that the physician group that owns an interest in our ambulatory surgery center is structured to fit within the definition of a unified group practice under the federal law prohibiting physician self-referrals, commonly known as the Stark Law, and the income distributions of the group practice comply with the Stark Law's acceptable methods of income distribution. Although these provisions directly apply only to liability under the Stark Law, we believe that the same principles are relevant to an analysis under the Anti-kickback Statute. We believe that no physician in the group practice receives an income distribution that is based directly on his or her referrals to the ASC, and we believe that the group's ownership of the ASC is no different than its ownership of other ancillary services common in physician practices. Nevertheless, there can be no assurance that the proposed arrangement will not be determined to be in violation of the law.

In OIG Advisory Opinion No. 09-09 (July 29, 2009), the OIG concluded that an arrangement involving an ASC joint venture between a hospital and physicians involving the combination of their two ASCs into a single, larger ASC presented minimal risk of fraud or abuse, despite the fact that it did not fit within any applicable anti-kickback safe harbors. Additionally, the OIG stated that fair market value should be determined based only on the tangible assets of each ASC since the physician investors are referral sources for the ASC. The OIG stated that a cash flow-based valuation of the business contributed by the physician investors potentially would include the value of the physician investors' referrals over the time that their ASC was in existence prior to the merger with the hospital's ASC. The OIG went on to note that a valuation involving intangible assets would not necessarily result in a violation of the Anti-kickback Statute, but would require a review of all the facts and circumstances. It is not clear whether the OIG is concerned about using a cash flow-based valuation in most healthcare transactions involving referral sources, or just transactions, like this one, where the parties' contributions would be valued differently for contributing the same assets if only one party's contribution is valued as a going concern based on cash flow. Also, the OIG appears to be focused on historical cash flow rather than a projected, discounted cash flow, which is a commonly used valuation methodology. What is clear is that for the first time, the OIG addressed valuation methodologies, which could lead to increased scrutiny of all transactions involving physicians.

Our hospitals comply as closely as possible with the safe harbor for investments in small entities. Our hospital investments do not fit wholly within the safe harbor because more than 40% of the investment interests are held by investors who are either in a position to refer to the hospital or who provide services to the hospital and more than 40% of the hospital's gross revenues last year were derived from referrals generated by investors. However, we believe we comply with the remaining elements of the safe harbor.

In addition to the physician ownership in our surgical facilities, other financial relationships of ours with potential referral sources could potentially be scrutinized under the Anti-kickback Statute. We have entered into management agreements to manage many of our surgical facilities, as well as our physician network. Most of these agreements call for our subsidiary to be paid a percentage-based management fee. Although there is a safe harbor for personal services and management contracts (the "Personal Services and Management Safe Harbor"), the Personal Services and Management Safe Harbor requires, among other things, that the amount of the aggregate compensation paid to the manager over the term of the agreement be set in advance. Because our management fees are generally based on a percentage of revenues, our management agreements do not typically meet this requirement. We do, however, believe that our management arrangements satisfy the other requirements of the Personal Services and Management Safe Harbor for personal services and management contracts. The OIG has taken the position in several advisory opinions that percentage-based management agreements are not protected by a safe harbor, and consequently, may violate the Anti-kickback Statute. We have implemented formal compliance programs designed to safeguard against overbilling and believe that our management agreements comply with the requirements of the Anti-kickback Statute. However, we cannot assure you that the OIG would find our compliance programs to be adequate or that our management agreements would

be found to comply with the Anti-kickback Statute.

We also typically guarantee a surgical facility's third-party debt financing and certain lease obligations as part of our obligations under a management agreement. Physician investors are generally not required to enter into similar guarantees. The OIG might take the

position that the failure of the physician investors to enter into similar guarantees represents a special benefit to the physician investors given to induce patient referrals and that such failure constitutes a violation of the Anti-Kickback Statute. We believe that the management fees (and in some cases guarantee fees) are adequate compensation to us for the credit risk associated with the guarantees and that the failure of the physician investors to enter into similar guarantees does not create a material risk of violating the Anti-kickback Statute. However, the OIG has not issued any guidance in this regard.

The OIG is authorized to issue advisory opinions regarding the interpretation and applicability of the Anti-kickback Statute, including whether an activity constitutes grounds for the imposition of civil or criminal sanctions. We have not, however, sought such an opinion regarding any of our arrangements. If it were determined that our activities, or those of our surgical facilities, violate the Anti-kickback Statute, we, our subsidiaries, our officers, our directors and each surgical facility investor could be subject, individually, to substantial monetary liability, prison sentences and/or exclusion from participation in any healthcare program funded in whole or in part by the U.S. government, including Medicare, TRICARE or state healthcare programs.

Evolving interpretations of current, or the adoption of new, federal or state laws or regulations could affect many of our arrangements. Law enforcement authorities, including the OIG, the courts and Congress, are increasing their scrutiny of arrangements between healthcare providers and potential referral sources to ensure that the arrangements are not designed as a mechanism to exchange remuneration for patient care referrals or opportunities. Investigators have also demonstrated a willingness to look behind the formalities of a business transaction to determine the underlying purposes of payments between healthcare providers and potential referral sources.

Federal Physician Self-Referral Law

Congress has enacted the federal physician self-referral law, or Stark Law, that prohibits certain self-referrals for healthcare services. As currently enacted, the Stark Law prohibits a practitioner, including a physician, dentist or podiatrist, from referring patients to an entity with which the practitioner or a member of his or her immediate family has a "financial relationship" for the provision of certain "designated health services" that are paid for in whole or in part by Medicare or Medicaid unless an exception applies. The term "financial relationship" is broadly defined and includes most types of ownership and compensation relationships. The Stark Law also prohibits the entity from seeking payment from Medicare or Medicaid for services that are rendered through a prohibited referral. If an entity is paid for services provided through a prohibited referral, it may be required to refund the payments. Violations of the Stark Law may also result in the imposition of damages equal to three times the amount improperly claimed and civil monetary penalties of up to \$15,000 per prohibited claim and \$100,000 per prohibited circumvention scheme and exclusion from participation in the Medicare and Medicaid programs. For the purposes of the Stark Law, the term "designated health services" is defined to include:

- clinical laboratory services;
- physical therapy services;
- occupational therapy services;
- radiology services, including magnetic resonance imaging, computerized axial tomography scan and ultrasound services;
- radiation therapy services and supplies;
- durable medical equipment and supplies;
- parenteral and enteral nutrients, equipment and supplies;
- prosthetics, orthotics and prosthetic devices and supplies;
- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

The list of designated health services does not, however, include surgical services that are provided in an ASC. Furthermore, in final Stark Law regulations published by HHS on January 4, 2001, the term "designated health services" was specifically defined to not include services that are reimbursed by Medicare as part of a composite rate, such as services that are provided in an ASC. However, if designated health services are provided by an ASC and separately billed, referrals to the ASC by a physician-investor would be prohibited by the Stark Law. Because our facilities that are licensed as ASCs do not have independent laboratories and do not provide designated health services apart from surgical services, we do not believe referrals to these facilities by physician-investors are prohibited. If legislation or regulations are implemented that prohibit physicians from referring patients to surgical facilities in which the physician has a beneficial interest, our business and financial results would be materially adversely affected.

Six of our facilities are licensed as hospitals. The Stark Law currently includes the Whole Hospital Exception, which applies to physician ownership of a hospital, provided such ownership is in the whole hospital and the physician is authorized to perform services at the hospital. Physician investment in our facilities licensed as hospitals meet this requirement. However, changes to the Whole Hospital Exception have been the subject of recent regulatory action and legislation. Changes in the Healthcare Reform Acts include:

- a prohibition on hospitals from having any physician ownership unless the hospital already had physician ownership and a Medicare provider agreement in effect as of December 31, 2010;

- a limitation on the percentage of total physician ownership or investment interests in the hospital or entity whose assets include the hospital to the percentage of physician ownership or investment as of March 23, 2010;
- a prohibition from expanding the number of beds, operating rooms, and procedure rooms for which it is licensed after March 23, 2010, unless the hospital obtains an exception from the Secretary of the Department of Health and Human Services;
- a requirement that return on investment be proportionate to the investment by each investor;
- restrictions on preferential treatment of physician versus nonphysician investors;

- a requirement for written disclosures of physician ownership interests to the hospital's patients and on the hospital's website and in any advertising, along with annual reports to the government detailing such interests;
- a prohibition on the hospital or other investors from providing financing to physician investors;
- a requirement that any hospital that does not have 24/7 physician coverage inform patients of this fact and receive signed acknowledgement from the patients of the disclosure; and
- a prohibition on "grandfathered" status for any physician owned hospital that converted from an ambulatory surgery center to a hospital on or after March 23, 2010.

We cannot predict whether other proposed amendments to the Whole Hospital Exception will be included in any future legislation or if Congress will adopt any similar provisions that would prohibit or otherwise restrict physicians from holding ownership interests in hospitals. The Healthcare Reform Acts could have an adverse effect on our financial condition and results of operations.

In addition to the physician ownership in our surgical facilities, we have other financial relationships with potential referral sources that potentially could be scrutinized under the Stark Law. We have entered into personal service agreements, such as medical director agreements, with physicians at our hospitals. We believe that our agreements with referral sources satisfy the requirements of the personal service arrangements exception to the Stark Law and have implemented formal compliance programs designed to safeguard against overbilling. However, we cannot assure you that the OIG would find our compliance programs to be adequate or that our agreements with referral sources would be found to comply with the Stark Law.

Additionally, the physician network we manage must comply with the "in-office ancillary services exception" of the Stark Law. We believe that this physician network operates in compliance with the applicable language of statutory exceptions to the Stark Law, including the exceptions for services provided by physicians within a group practice or in-office ancillary services. There have been extensive discussions and proposed changes to these exceptions. We cannot provide assurances that CMS may not propose and later adopt changes to the in-office ancillary services exception or whether if adopted any such changes would not adversely affect the physician practices that we manage, and thus that portion of our business. If future revisions modify the provisions of the Stark Law regulations that are applicable to our business, our revenues and profitability could be materially adversely affected and could require us to modify our relationships with our physician and healthcare system partners.

False and Other Improper Claims

The U.S. government is authorized to impose criminal, civil and administrative penalties on any person or entity that files a false claim for payment from the Medicare or Medicaid programs or other federal and state healthcare programs. Claims filed with private insurers can also lead to criminal and civil penalties, including, but not limited to, penalties relating to violations of federal mail and wire fraud statutes, as well as penalties under the anti-fraud provisions of HIPAA. While the criminal statutes are generally reserved for instances of fraudulent intent, the U.S. government is applying its criminal, civil and administrative penalty statutes in an ever-expanding range of circumstances. For example, the U.S. government has taken the position that a pattern of claiming reimbursement for unnecessary services violates these statutes if the claimant merely should have known the services were unnecessary, even if the government cannot demonstrate actual knowledge. The U.S. government has also taken the position that claiming payment for low-quality services is a violation of these statutes if the claimant should have known that the care being provided was substandard.

Over the past several years, the U.S. government has accused an increasing number of healthcare providers of violating the federal Act. The False Claims Act prohibits a person from knowingly presenting, or causing to be presented, a false or fraudulent claim to the U.S. government. The statute defines "knowingly" to include not only actual knowledge of a claim's falsity, but also reckless disregard for or intentional ignorance of the truth or falsity of a claim. The Fraud Enforcement and Recovery Act of 2009 further expanded the scope of the False Claims Act by, among other things, creating liability for knowingly and improperly avoiding or decreasing an obligation to pay money to the federal government. The Healthcare Reform Acts also created federal False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later. The Healthcare Reform Acts also provide that claims submitted in connection with patient referrals that result from violations of the Anti-kickback Statute constitute false claims for the purposes of the federal False Claims Act, and some courts have held that a violation of the Stark Law can result in False Claims Act liability, as well. Because our surgical facilities perform hundreds of similar procedures a year for which they are paid by Medicare, and there is a relatively long statute of limitations, a billing error or cost reporting error could result in significant civil or criminal penalties.

Under the qui tam, or whistleblower, provisions of the False Claims Act, private parties may bring actions on behalf of the U.S. government. These private parties, often referred to as relators, are entitled to share in any amounts recovered by the government through trial or settlement. Both whistleblower lawsuits and direct enforcement activity by the government have increased significantly in recent years and have increased the risk that a healthcare company, like us, will have to defend a false claims action, pay fines or be excluded from the Medicare and Medicaid programs and other federal and state healthcare programs as a result of an investigation resulting from a whistleblower case. Although we believe that our operations materially comply with both federal and state laws, they may nevertheless be the subject of a whistleblower lawsuit or may otherwise be challenged or scrutinized by governmental authorities. Providers found liable for False Claims Act violations are subject to damages of up to three times the actual damage sustained by the government plus mandatory civil monetary penalties between \$5,500 and \$11,000 for each separate false claim. A determination that we have violated these laws could have a

material adverse effect on us.

Privacy and Security Requirements

We are subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information

Technology for Economic and Clinical Health Act (“HITECH Act”), which was enacted as part of the American Recovery and Reinvestment Act of 2009. The HITECH Act strengthened the requirements and significantly increased the penalties for violations of the HIPAA privacy and security regulations. The HITECH Act also requires us to notify patients of any unauthorized access, acquisition, or disclosure of their unsecured protected health information that poses significant risk of financial, reputational or other harm to a patient.

The HIPAA privacy standards apply to individually identifiable information held or disclosed by a covered entity in any form, whether communicated electronically, on paper or orally. These standards impose extensive administrative requirements on us. These standards require our compliance with rules governing the use and disclosure of this health information. They create rights for patients in their health information, such as the right to amend their health information, and they require us to impose these rules, by contract, on any business associate to whom we disclose such information in order to perform functions on our behalf.

The HIPAA security standards require us to establish and maintain reasonable and appropriate administrative, technical and physical safeguards to ensure the integrity, confidentiality and the availability of electronic health and related financial information. The security standards were designed to protect electronic information against reasonably anticipated threats or hazards to the security or integrity of the information and to protect the information against unauthorized use or disclosure. Although the security standards do not reference or advocate a specific technology, and covered healthcare providers, plans and clearinghouses have the flexibility to choose their own technical solutions, the security standards have required us to implement significant new systems, business procedures and training programs. We believe that we are in material compliance with the privacy and security requirements of HIPAA.

Violations of the HIPAA privacy and security regulations may result in civil and criminal penalties. The HITECH Act strengthened the requirements of the HIPAA privacy and security regulations and significantly increased the penalties for violations by introducing a tiered penalty system, with penalties of up to \$50,000 per violation with a maximum civil penalty of \$1.5 million in a calendar year for violations of the same requirement. Under the HITECH Act, HHS is required to conduct periodic compliance audits of covered entities and their business associates. The HITECH Act also extends the application of certain provisions of the security and privacy regulations to business associates and subjects business associates to civil and criminal penalties for violation of the regulations.

The HITECH Act authorizes State Attorneys General to bring civil actions seeking either an injunction or damages in response to violations of HIPAA privacy and security regulations or the new data breach law that affects the privacy of their state residents. We expect vigorous enforcement of the HITECH Act's requirements by HHS and State Attorneys General. Final rules relating to the HITECH Act, HIPAA enforcement and breach notification are expected to be published in the near future. Additionally, HHS announced a pilot audit program that will run until December 2012 in the first phase of HHS' implementation of the HITECH Act's requirements of periodic audits of covered entities and business associates to ensure their compliance with the HIPAA privacy and security regulations. We cannot predict whether our surgical facilities will be able to comply with the final rules and the financial impact to our surgical facilities in implementing the requirements under the final rules when they take effect, or whether our hospitals will be selected for an audit, or the results of such an audit.

Our facilities also remain subject to any state laws that relate to privacy or the reporting of data breaches that are more restrictive than the regulations issued under HIPAA and the requirements of the HITECH Act. For example, various state laws and regulations may require us to notify affected individuals in the event of a data breach involving certain personal information, such as social security numbers, dates of birth and credit card information.

Adoption of Electronic Health Records

The HITECH Act also includes provisions designed to increase the use of Electronic Health Records (“EHR”) by both physicians and hospitals. Beginning with FFY 2011 and extending through FFY 2016, eligible hospitals may receive reimbursement incentives based upon successfully demonstrating “meaningful use” of its certified EHR technology. Beginning in FFY 2015, those hospitals that do not successfully demonstrate meaningful use of EHR technology are subject to reductions in reimbursements. On July 13, 2010, HHS released final meaningful use regulations. We are currently planning the implementation of EHR at some of our facilities and intend to comply with the EHR meaningful use requirements, but we may not comply in time to qualify for the maximum available incentive payments in FFY 2012. Implementation of EHR and compliance with the HITECH Act will result in significant costs. We do not currently know the cost that will be associated with implementation and the amount of reimbursement incentives we will receive.

HIPAA Administrative Simplification Requirements

The HIPAA transaction regulations were issued to encourage electronic commerce in the healthcare industry. These regulations include standards that healthcare providers must follow when electronically transmitting certain healthcare transactions, such as healthcare claims. We believe that we are in compliance with these regulations.

State Regulation

Many of the states in which our surgical facilities operate have adopted statutes and/or regulations that prohibit the payment of kickbacks or any type of remuneration in exchange for patient referrals and that prohibit healthcare providers from, in certain circumstances, referring a patient to a healthcare facility in which the provider has an ownership or investment interest. While these statutes generally mirror

the federal Anti-Kickback Statute and Stark Law, they vary widely in their scope and application. Some are specifically limited to healthcare services that are paid for in whole or in part by the Medicaid program; others apply to all healthcare services regardless of payor; and others apply only to state-defined designated services, which may differ from the designated health services under the Stark Law. In addition, many states have adopted statutes that mirror the False Claims Act and that prohibit the filing of a false or fraudulent claim with a state governmental agency. We intend to comply with all applicable state healthcare laws, rules and regulations. However, these laws, rules and

regulations have typically been the subject of limited judicial and regulatory interpretation. As a result, we cannot assure you that our surgical facilities will not be investigated or scrutinized by the governmental authorities empowered to do so or, if challenged, that their activities would be found to be lawful. A determination of non-compliance with the applicable state healthcare laws, rules, and regulations could subject our surgical facilities to civil and criminal penalties and could have a material adverse effect on our operations.

Many states in which our surgical facilities are located or may be located in the future, do not permit business corporations to practice medicine, exercise control over or employ physicians, or engage in various business practices, such as fee-splitting with physicians (i.e. the sharing in a percentage of professional fees). The existence, interpretation and enforcement of these laws vary significantly from state to state. A determination of non-compliance with these laws could result in fines and or require us to restructure some of our existing relationships with our physicians. We are also subject to various state insurance statutes and regulations that prohibit us from submitting inaccurate, incorrect or misleading claims. Many state insurance laws and regulations are broadly worded and could be implicated, for example, if our surgical facilities were to waive an out-of-network co-payment or other patient responsibility amounts without fully disclosing the waiver on the claim submitted to the payor. While some of our surgical facilities waive the out-of-network portion of patient co-payment amounts when providing services to patients whose health insurance is covered by a payor with which the surgical facilities are not contracted, our surgical facilities fully disclose waivers in the claims submitted to the payors. We believe that our surgical facilities are in compliance with all applicable state insurance laws and regulations regarding the submission of claims. We cannot assure you, however, that none of our surgical facilities' insurance claims will ever be challenged. If we were found to be in violation of a state's insurance laws or regulations, we could be forced to discontinue the violative practice, which could have an adverse effect on our financial position and results of operations, and we could be subject to fines and criminal penalties.

Recovery Audit Contractors and Medicaid Integrity Contractors

CMS has expanded the pilot recovery audit contractor ("RAC") program to a permanent nationwide program. RACs are private contractors contracting with CMS to identify overpayment and underpayments for services through post-payment reviews of Medicare providers and suppliers. The Healthcare Reform Acts expands the RAC program's scope to include managed Medicare and to include Medicaid claims by requiring all states to establish programs to contract with RACs. All states were required to implement Medicaid RAC programs by January 1, 2012. In addition, CMS employs Medicaid Integrity Contractors ("MICs") to perform post-payment audits of Medicaid claims and identify overpayments. The Healthcare Reform Acts increases federal funding for the MIC program for federal fiscal year 2011 and later years. In addition to RACs and MICs, the state Medicaid agencies and other contractors have increased their review activities. MICs are assigned to five geographic regions and have commenced audits in states assigned to those regions. We cannot quantify the financial impact of potential RAC or MIC audits, but could incur expenses associated with responding to and challenging any audit, as well as costs of repayment of alleged overpayments.

Regulations Affecting Our New York Operations

We own an interest in a limited liability company which provides administrative services to a surgery center located in New York. Laws in the State of New York require that corporations have natural persons as stockholders to be approved by the New York Department of Health as a licensed healthcare facility. Accordingly, we are not able to own interests in a limited partnership or limited liability company that owns an interest in a healthcare facility located in New York. Laws in the State of New York also prohibit the delegation of certain management functions by a licensed healthcare facility, including but not limited to the authority to appoint and discharge senior management, independently control the books and records of the facility, dispose of assets of the facility outside of day-to-day operations and adopt policies affecting the delivery of healthcare services. The law does permit a licensed facility to lease premises and obtain various services from non-licensed entities. However, it is not clear what types of delegation constitute a violation. Although we believe that our operations and relationships in New York are in compliance with these laws, if New York regulatory authorities or a third-party asserts a contrary position, we may be unable to continue or expand our operations in New York.

Emergency Medical Treatment and Active Labor Act

Our hospitals are subject to the Emergency Medical Treatment and Active Labor Act ("EMTALA"). This federal law requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency department for treatment and, if the patient is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the patient to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions or transfer exists regardless of a patient's ability to pay for treatment. Off-campus facilities such as surgery centers that lack emergency departments or otherwise do not treat emergency medical conditions generally are not subject to EMTALA. They must, however, have policies in place that explain how the location should proceed in an emergency situation, such as transferring the patient to the closest hospital with an emergency department. There are severe penalties under EMTALA if a hospital fails to screen or appropriately stabilize or transfer a patient or if the hospital delays appropriate treatment in order to first inquire about the patient's ability to pay, including civil monetary penalties and exclusion from participation in the Medicare program. In addition, an injured patient, the patient's family or a medical facility that suffers a financial loss as a direct result of another hospital's violation of the law can bring a civil suit against that other hospital. CMS has actively enforced EMTALA and has indicated that it will continue to do so in the future. Although we believe that our hospitals comply with EMTALA, we cannot predict whether CMS will implement new requirements in the future and, if so, whether our

hospitals will comply with any new requirements.

Regulatory Compliance Program

It is our policy to conduct our business with integrity and in compliance with the law. We have in place and continue to enhance a company-wide compliance program that focuses on all areas of regulatory compliance including billing, reimbursement, cost reporting

practices and contractual arrangements with referral sources.

This regulatory compliance program is intended to help ensure that high standards of conduct are maintained in the operation of our business and that policies and procedures are implemented so that employees act in full compliance with all applicable laws, regulations and company policies. Under the regulatory compliance program, every employee and certain contractors involved in patient care, and coding and billing, receive initial and periodic legal compliance and ethics training. In addition, we regularly monitor our ongoing compliance efforts and develop and implement policies and procedures designed to foster compliance with the law. The program also includes a mechanism for employees to report, without fear of retaliation, any suspected legal or ethical violations to their supervisors, designated compliance officers in our facilities, our compliance hotline or directly to our corporate compliance office. We believe our compliance program is consistent with standard industry practices. However, we cannot provide any assurances that our compliance program will detect all violations of law or protect against qui tam suits or government enforcement actions.

Available Information

Our website is www.symbion.com. We make available free of charge on this website under "Investors — SEC Filings" links to our periodic and other reports and amendments to those reports filed with or furnished to the Securities and Exchange Commission ("SEC") as soon as reasonably practicable after we electronically file or furnish such materials.

Item 1A. Risk Factors

The following are some of the risks and uncertainties that could cause our actual financial condition, results of operations, business and prospects to differ materially from those contemplated by the forward-looking statements contained in this report or our other filings with the SEC. If any of the following risks actually occurred, our business, financial condition and operating results could suffer.

Risks Related to Our Business and Industry

Our substantial leverage could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, expose us to interest rate risk to the extent of our variable rate debt and prevent us from meeting our obligations under our outstanding indebtedness.

As of December 31, 2011, we had (a) total indebtedness of approximately \$558.3 million and (b) \$50.0 million of undrawn availability under our \$50.0 million senior secured super-priority revolving credit facility (the "New Credit Facility"). In addition, subject to the restrictions in our New Credit Facility and the indentures governing our outstanding notes, we may incur significant additional indebtedness, which may be secured, from time to time.

The level of our indebtedness could have important consequences, including:

- making it more difficult for us to make payments on our outstanding debt obligations;
- limiting cash flow available for general corporate purposes, including capital expenditures and acquisitions, because a substantial portion of our cash flow from operations must be dedicated to servicing our debt;
- limiting our ability to obtain additional debt financing in the future for working capital, capital expenditures or acquisitions;
- limiting our flexibility in reacting to competitive and other changes in our industry and economic conditions generally; and
- exposing us to risks inherent in interest rate fluctuations because some of our borrowings will be at variable rates of interest, which could result in higher interest expense in the event of increases in interest rates.

Our ability to pay or to refinance our indebtedness will depend upon our future operating performance, which will be affected by general economic, financial, competitive, legislative, regulatory, business and other factors beyond our control.

Restrictive covenants in our debt instruments may adversely affect us.

The indentures governing our 11.00%/11.75% senior PIK toggle notes due 2015 (the "Toggle Notes"), our \$341.0 million aggregate outstanding principal amount of 8.00% senior secured notes due 2016 (the "Senior Secured Notes"), and our 8.00% senior PIK exchangeable notes due 2017 (the "PIK Exchangeable Notes") contain various covenants that limit, among other things, our ability and the ability of our restricted subsidiaries to:

- incur additional indebtedness;
- make certain distributions, investments and other restricted payments;

- dispose of our assets;
- grant liens on our assets;
- engage in transactions with affiliates;

- merge, consolidate or transfer substantially all of our assets; and
- make payments to us (in the case of our restricted subsidiaries).

In addition, our New Credit Facility contains other and more restrictive covenants, including covenants requiring us to maintain specified financial ratios and to satisfy other financial condition tests. Our ability to meet those financial ratios and tests can be affected by events beyond our control, and we cannot assure you that we will continue to meet those tests. A breach of any of these covenants could result in a default under our New Credit Facility. Upon the occurrence of an event of default under our New Credit Facility, the lenders could elect to declare all amounts outstanding under our New Credit Facility to be immediately due and payable and terminate all commitments to extend further credit. If we were unable to repay those amounts, the lenders could proceed against the collateral granted to them to secure that indebtedness. We have pledged substantially all of our assets, other than assets of our non-guarantor subsidiaries, as security under our New Credit Facility. If the lenders under our New Credit Facility accelerate the repayment of borrowings, we cannot assure you that we will have sufficient assets to repay our New Credit Facility and our other indebtedness.

We cannot assure you that our business will generate sufficient cash flow from operations, that currently anticipated revenue growth and operating improvements will be realized or that future borrowings will be available to us under our New Credit Facility in amounts sufficient to enable us to pay our indebtedness, or to fund our other liquidity needs. If we are unable to meet our debt service obligations or fund our other liquidity needs, we could attempt to restructure or refinance our indebtedness or seek additional equity capital. We cannot assure you that we will be able to accomplish those actions on satisfactory terms, if at all.

The current state of the economy and future economic conditions may adversely impact our business.

The U.S. economy continues to experience difficult conditions. Burdened by economic constraints, patients have delayed or canceled non-emergency surgical procedures. It is difficult to predict the degree to which our business will continue to be impacted by such conditions or the course of the economy in the future.

We depend on payments from third-party payors, including government healthcare programs and managed care organizations. If these payments are reduced or eliminated, our revenues and profitability could be adversely affected.

We are dependent upon private and governmental third-party sources of payment for the services provided to patients in our surgical facilities. The amounts that our surgical facilities receive in payment for their services may be adversely affected by market and cost factors as well as other factors over which we have no control, including Medicare, Medicaid and state regulations and the cost containment and utilization decisions and reduced reimbursement schedules of third-party payors, Congressional changes and refinements to the Medicare ASC payment system and CMS refinements to Medicare's reimbursement policies.

If we are unable to negotiate contracts or maintain satisfactory relationships with private third-party payors, our revenues and operating income will decrease.

Payments from private third-party payors (including state workers' compensation programs) represented about 67% and 68% of our patient service revenues for the years ended December 31, 2011 and 2010, respectively. Most of these payments came from third-party payors with which our facilities have contracts. Managed care companies such as health maintenance organizations, or HMOs, preferred provider organizations, or PPOs, which offer prepaid and discounted medical service packages, represent a growing segment of private third-party payors. If we fail to enter into favorable contracts and to maintain satisfactory relationships with managed care organizations, our revenues may decrease. Cost containment measures, such as fixed fee schedules, capitation payment arrangements, reductions in reimbursement schedules by third-party payors and closed provider networks, could also cause a reduction of our revenues in the future.

Some of our payments from third-party payors come from third-party payors with which our surgical facilities do not have a contract. In those cases, commonly known as "out-of-network" services, we generally charge the patients the same co-payment or other patient responsibility amounts that we would have charged had our center had a contract with the payor. We also submit a claim for the services to the payor along with full disclosure that our surgical facility has charged the patient an in-network patient responsibility amount. Historically, those third-party payors who do not have contracts with our surgical facilities typically have paid our claims at higher than comparable contracted rates. However, there is a growing trend for third-party payors to adopt out-of-network fee schedules that are more comparable to our contracted rates or to take other steps to discourage their enrollees from seeking treatment at out-of-network surgical facilities. In these cases, we seek to enter into contracts with the payors. In certain situations, we have seen an increase in the volume of cases in those instances where we transition from out-of-network to in-network billing, although we may experience an overall decrease in revenues to the surgical facility. We can provide no assurance that we will see a sufficient increase in volume of cases to compensate for the decrease in per case revenues where we transition from out-of-network to in-network billing.

Payments from workers' compensation payors represented approximately 11% of our patient service revenues for both years ended December 31, 2010 and 2011. Several states have recently considered or implemented workers' compensation provider fee schedules. In

some cases, the fee schedule rates contain lower rates than the rates our surgical facilities have historically been paid for the same services. If the trend of states adopting lower workers' compensation fee schedules continues, it could have a material adverse effect on our financial condition and results of operations.

Our growth strategy depends in part on our ability to acquire and develop additional surgical facilities on favorable terms. If we are unable to do so, our future growth could be limited and our operating results could be adversely affected.

Our strategy is to increase our revenues and earnings by continuing to focus on existing surgical facilities and continuing to acquire and develop additional surgical facilities. Between January 1999 and December 31, 2011, we acquired 54 surgical facilities and developed 24 surgical facilities, including 23 surgical facilities that we subsequently divested. We may be unable to identify suitable acquisition and development opportunities and to negotiate and complete acquisitions and new projects on favorable terms. In addition, our acquisition and development program requires substantial capital resources, and we may need to obtain additional capital or financing, from time to time, to fund these activities. As a result, we may take actions that could have a materially adverse effect on our financial condition and results of operations, including incurring substantial debt. Sufficient financing may not be available to us on satisfactory terms, if at all.

We may encounter numerous business risks in acquiring and developing additional surgical facilities, and may have difficulty operating and integrating those surgical facilities.

If we acquire or develop additional surgical facilities, we may be unable to successfully operate the surgical facilities, and we may experience difficulty in integrating their operations and personnel. For example, in some acquisitions, we have experienced delays in implementing standard operating procedures and systems and improving existing managed care agreements and the mix of specialties offered at the surgical facilities. Following the acquisition of a surgical facility, key physicians may cease to use the facility or we may be unable to retain key management personnel. If we acquire the assets of a surgical facility rather than ownership in the entity that owns the surgical facility, we may be unable to assume the surgical facility's existing managed care contracts and may have to renegotiate, or risk losing, one or more of the surgical facility's managed care contracts. We may also be unable to collect the accounts receivable of an acquired surgical facility. We may also experience negative effects on our reported results of operations because of acquisition-related charges and potential impairment of goodwill and other intangibles.

In addition, we may acquire surgical facilities with unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations. Although we maintain professional and general liability insurance, we do not maintain insurance specifically covering any unknown or contingent liabilities that may have occurred prior to the acquisition of companies and surgical facilities. In some cases, our right to indemnification for these liabilities may be subject to negotiated limits.

In developing new surgical facilities, we may be unable to attract physicians to use our facilities or contract with third-party payors. In addition, our newly developed surgical facilities typically incur net losses during the initial periods of operation and, unless and until their case loads grow, they generally experience lower total revenues and operating margins than established surgical facilities. Integrating a new surgical facility could be expensive and time consuming and could disrupt our ongoing business and distract our management and other key personnel. If we are unable to timely and efficiently integrate an acquired or newly developed facility, our business could suffer.

Efforts to regulate the construction, acquisition or expansion of healthcare facilities could prevent us from acquiring additional surgical facilities, renovating our existing facilities or expanding the breadth of services we offer.

Some states require prior approval for the construction, acquisition or expansion of healthcare facilities or expansion of the services the facilities offer. In giving approval, these states consider the need for additional or expanded healthcare facilities or services, as well as the financial resources and operational experience of the potential new owners of existing healthcare facilities. In many of the states in which we currently operate, certificates of need must be obtained for capital expenditures exceeding a prescribed amount, changes in capacity or services offered and various other matters. The remaining states in which we now or may in the future operate may adopt similar legislation. Our costs of obtaining a certificate of need could be significant, and we cannot assure you that we will be able to obtain the certificates of need or other required approvals for additional or expanded surgical facilities or services in the future. In addition, at the time we acquire a surgical facility, we may agree to replace or expand the acquired facility. If we are unable to obtain required approvals, we may not be able to acquire additional surgical facilities, expand healthcare services we provide at these facilities or replace or expand acquired facilities.

If we fail to maintain good relationships with the physicians who use our surgical facilities, our revenues and profitability could be adversely affected.

Our business depends upon the efforts and success of the physicians who provide medical services at our surgical facilities and the strength of our relationships with these physicians. These physicians are not employees of our surgical facilities and are not contractually required to use our facilities. We generally do not enter into contracts with physicians who use our surgical facilities, other than partnership and operating agreements with physicians who own interests in our surgical facilities, provider agreements with anesthesiology groups that provide anesthesiology services in our surgical facilities, medical director agreements and pain clinic agreements. Physicians who use our surgical facilities also use other facilities or hospitals and may choose to perform procedures in an office-based setting that might otherwise be performed at our surgical facilities. In recent years, pain management and gastrointestinal procedures have been performed increasingly in an office-based setting. Although physicians who own interests in our surgical facilities are subject to agreements restricting ownership of competing facilities, these agreements may not restrict procedures performed in a physician office or in other unrelated facilities. Also, these

agreements restricting ownership of competing facilities are difficult to enforce, and we may be unsuccessful in preventing physicians who own interests in our surgical facilities from acquiring interests in competing facilities.

In addition, the physicians who use our surgical facilities may choose not to accept patients who pay for services through certain third-party payors, which could reduce our revenues. From time to time, we may have disputes with physicians who use our surgical

facilities and/or own interests in our surgical facilities or our company. Our revenues and profitability could be significantly reduced if we lost our relationship with one or more key physicians or groups of physicians, or if such physicians or groups reduce their use of our surgical facilities. In addition, any damage to the reputation of a key physician or group of physicians or the failure of these physicians to provide quality medical care or adhere to professional guidelines at our surgical facilities could damage our reputation, subject us to liability and significantly reduce our revenues.

We cannot predict the effect that healthcare reform and other changes in government programs may have on our business, financial condition or results of operations.

The Healthcare Reform Acts dramatically alter the United States healthcare system and are intended to decrease the number of uninsured Americans and reduce overall healthcare costs. The Healthcare Reform Acts attempt to achieve these goals by, among other things, requiring most Americans to obtain health insurance, expanding Medicare and Medicaid eligibility, reducing Medicare and Medicaid payments, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, and bundling payments to hospitals and other providers. The Healthcare Reform Acts also contain a number of measures that are intended to reduce fraud and abuse in the Medicare and Medicaid programs, such as requiring the use of recovery audit contractors in the Medicaid program expanding the scope of the federal False Claims Act and generally prohibiting physician-owned hospitals from adding new physician owners or increasing the number of beds and operating rooms for which they are licensed. The Healthcare Reform Acts provide for additional enforcement tools, cooperation between agencies, and funding for enforcement. The United States Supreme Court is expected to rule on the constitutionality of the Healthcare Reform Acts in 2012. The Supreme Court will consider four issues: (1) whether the "individual mandate" - the requirement that all individuals purchase some form of health insurance - is constitutional; (2) if the individual mandate is found unconstitutional, whether it is severable from the remainder of the Healthcare Reform Acts; (3) whether the Healthcare Reform Act's requirement that states expand Medicaid eligibility or risk losing federal funds is constitutional; and (4) whether the individual mandate is a tax for purposes of the Anti-Injunction Act, meaning the plaintiffs seeking to challenge the requirement must wait until it takes effect in 2014. It is difficult to predict the impact the Healthcare Reform Acts will have on our operations given the delay in implementing regulations, pending court challenges, and possible amendment or repeal of elements of the Healthcare Reform Acts. However, depending on how they are ultimately interpreted, amended and implemented, the Healthcare Reform Acts could have an adverse effect on our business, financial condition and results of operations.

If we fail to comply with legislative and regulatory rules relating to privacy and security of patient health information and standards for electronic transactions, we may experience delays in payment of claims and increased costs and be subject to substantial fines.

HIPAA mandates the adoption of privacy, security and integrity standards related to patient information. HIPAA also standardizes the method for identifying providers, employers, health plans and patients. We believe that we are in compliance with the HIPAA regulations. However, if we fail to comply with the requirements of HIPAA, we could be subject to significant penalties under a tiered penalty system with penalties of up to \$50,000 per violation with a maximum civil penalty of \$1.5 million in a calendar year for violations of the same requirement.

If we fail to comply with laws and regulations relating to the operation of our surgical facilities, we could suffer penalties or be required to make significant changes to our operations.

We are subject to many laws and regulations at the federal, state and local government levels in which we operate. These laws and regulations require that our surgical facilities meet various licensing, certification and other requirements.

If we fail or have failed to comply with applicable laws and regulations, we could suffer civil or criminal penalties, including becoming the subject of cease and desist orders, the loss of our licenses to operate and disqualification from Medicare, Medicaid and other government-sponsored healthcare programs.

In pursuing our growth strategy, we may seek to expand our presence into new geographic markets. In new geographic markets, we may encounter laws and regulations that differ from those applicable to our current operations. If we are unable to comply with these legal requirements in a cost-effective manner, we may be unable to expand geographically.

Our revenues will decline if federal or state programs reduce our Medicare or Medicaid payments or if managed care companies reduce reimbursement amounts. In addition, the financial condition of payors and healthcare cost containment initiatives may limit our revenues and profitability.

During 2011, we derived 26% of our revenues from government payors, including 25% from the Medicare and Medicaid programs. During 2010, we derived 25% of our revenues from government payors, including 24% from the Medicare and Medicaid programs. The Medicare and Medicaid programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations concerning patient eligibility requirements, funding levels and the method of calculating payments or reimbursements, among other things; requirements for utilization review; and federal and state funding restrictions, all of which could materially increase or decrease payments

from these government programs in the future, as well as affect the timing of payments to our facilities. Additionally, the Budget Control Act of 2011 requires \$1.2 trillion in automatic across-the-board spending reductions for FFY 2013 through FFY 2021, split evenly between domestic and defense spending. While certain programs (including the Medicaid program) are protected from these automatic spending reductions, Medicare reimbursement rates may be reduced by up to 2%.

We are unable to predict the effect of future government healthcare funding policy changes on our operations. If the rates paid by governmental payers are reduced, if the scope of services covered by governmental payers is limited or if we, or one or more of our surgical facilities, are excluded from participation in the Medicare, Medicaid or other government-sponsored healthcare programs, there could be a material adverse effect on our business, financial condition, results of operations or cash flows.

During the past several years, healthcare payors, such as federal and state governments, insurance companies and employers, have undertaken initiatives to revise payment methodologies and monitor healthcare costs. As part of their efforts to contain healthcare costs, payors increasingly are demanding discounted fee structures or the assumption by healthcare providers of all or a portion of the financial risk relating to paying for care provided, often in exchange for exclusive or preferred participation in their benefit plans. We expect efforts to impose greater discounts and more stringent cost controls by government and other payors to continue, thereby reducing the payments we receive for our services. In addition, these payors have instituted policies and procedures to substantially reduce or limit the use of inpatient services.

The amount of our provision for doubtful accounts is based on our assessments of historical collection trends, business and economic conditions, trends in federal and state governmental and private employer health coverage and other collection indicators. A continuation in trends that results in increasing the proportion of accounts receivable being comprised of uninsured accounts and deterioration in the collectability of these accounts could adversely affect our collections of accounts receivable, results of operations and cash flows. As enacted, the Healthcare Reform Acts seek to decrease, over time, the number of uninsured individuals. Among other things, the Healthcare Reform Acts will, beginning in 2014, expand Medicaid and incentivize employers to offer, and require individuals to carry, health insurance or be subject to penalties. However, it is difficult to predict the full impact of the Healthcare Reform Acts due to the pending Supreme Court challenge, their complexity, lack of implementing regulations and interpretive guidance, gradual and potentially delayed implementation, pending court challenges, and possible repeal and/or amendment, as well as our inability to foresee how individuals and businesses will respond to the choices afforded them by the Healthcare Reform Acts.

Our surgical facilities do not satisfy all of the requirements for any of the safe harbors under the federal Anti-kickback Statute. If we fail to comply with the federal Anti-kickback Statute, we could be subject to criminal and civil penalties, loss of licenses and exclusion from the Medicare and Medicaid programs, which may result in a substantial loss of revenues.

The Anti-kickback Statute prohibits the offer, payment, solicitation or receipt of any form of remuneration in return for referring, ordering, leasing, furnishing, purchasing or arranging for or recommending or inducing the ordering, purchasing or leasing of items or services payable by Medicare, Medicaid, or any other federally funded healthcare program. The Anti-kickback Statute is very broad in scope, and many of its provisions have not been uniformly or definitively interpreted by existing case law or regulations. Violations of the Anti-kickback Statute may result in substantial civil or criminal penalties, including criminal fines of up to \$25,000 and civil penalties of up to \$50,000 for each violation, plus three times the remuneration involved or the amount claimed and exclusion from participation in the Medicare and Medicaid programs. The exclusion, if applied to our surgical facilities, could result in significant reductions in our revenues and could have a material adverse effect on our financial condition and results of operations. In addition, many of the states in which we operate have also adopted laws, similar to the Anti-kickback Statute, that prohibit payments to physicians in exchange for referrals, some of which apply regardless of the source of payment for care. These statutes typically impose criminal and civil penalties as well as loss of licenses. No state or federal regulatory actions have been taken against our surgical facilities under anti-kickback statutes during the time we have owned or operated the facilities. Management is not aware of any such actions prior to our acquisition or management of these surgical facilities.

Regulations implement various "safe harbors" to the Anti-kickback Statute. Business arrangements that meet the requirements of the safe harbors are deemed to be in compliance with the Anti-kickback Statute. Business arrangements that do not meet the safe harbor requirements do not necessarily violate the Anti-kickback Statute, but may be subject to scrutiny by the federal government to determine compliance. However, the structure of the partnerships and limited liability companies operating our surgical facilities, as well as our business arrangement involving a physician network, do not satisfy all of the requirements of the safe harbor and, therefore, are not immune from government review or prosecution.

If we fail to comply with physician self-referral laws as they are currently interpreted or may be interpreted in the future, or if other legislative restrictions are issued, we could incur a significant loss of reimbursement revenues.

The federal physician self-referral law, commonly referred to as the Stark Law, prohibits a physician from making a Medicare or Medicaid reimbursed referral for a "designated health service" to an entity if the physician or a member of the physician's immediate family has a "financial relationship" with the entity. The list of "designated health services" under the Stark Law does not include ambulatory surgery services, but it does include services such as clinical laboratory services, and certain imaging services that may be provided by an ASC. Under the current Stark Law and related regulations, services provided at an ASC are not covered by the statute, even if those services include imaging, laboratory services or other Stark designated health services, provided that (i) the ASC does not bill for these services separately, or (ii) if the center is permitted to bill separately for these services, they are specifically exempted from Stark Law prohibitions. These are generally radiology and other imaging services integral to performance of surgical procedures that meet certain requirements and

certain outpatient prescription drugs. Services provided at our facilities licensed as hospitals are covered by the Stark Law, but referrals for such services are exempt from the Stark Law under its “whole hospital exception.” Certain services provided by our managed physician network are covered by the Stark Law, but referrals for those services are exempt from the Stark Law under its “in-office ancillary services exception,” among others.

The Stark Law and similar state statutes are subject to different interpretations with respect to many important provisions. Violations of these self-referral laws may result in substantial civil or criminal penalties, including treble damages for amounts improperly claimed, civil monetary penalties of up to \$15,000 per prohibited service billed, up to \$100,000 per prohibited circumvention scheme and exclusion from participation in the Medicare and Medicaid and other federal and state healthcare programs. Exclusion of our ASCs or hospitals from these programs through future judicial or agency interpretation of existing laws or additional legislative restrictions on physician ownership or investments in healthcare entities could result in a significant loss of reimbursement revenues. We cannot provide assurances that CMS will not undertake other rulemaking to address additional revisions to the Stark Law regulations. If future rules modify the provisions of the Stark Law regulations that are applicable to our business, our revenues and profitability could be materially adversely affected and could require us to modify our relationships with our physician and healthcare system partners.

Healthcare reform has limited our ability to own and operate our hospitals.

Six of our owned surgical facilities are licensed as hospitals. As discussed herein, the Stark Law currently includes an exception relating to physician ownership of a hospital, provided that the physician's ownership interest is in the whole hospital and the physician is authorized to perform services at the hospital known as the Whole Hospital Exception. Physician investment in our facilities licensed as hospitals currently meets this requirement. The Whole Hospital Exception was addressed in the Healthcare Reform Acts, which provide, among other things: (i) a prohibition on hospitals from having any physician ownership unless the hospital already had physician ownership as of March 23, 2010 and a Medicare provider agreement in effect on December 31, 2010; (ii) a limitation on the percentage of the total value of the physician ownership in the hospital to such percentage as of March 23, 2010; (iii) a requirement for written disclosures of physician ownership interests, along with an annual report to the government detailing such ownership; and (iv) severe restrictions on the ability of a hospital subject to the whole hospital exception to add operating rooms, procedure rooms and beds. While our hospitals were grandfathered at the dates of enactment of the Healthcare Reform Acts, they are subject to the above restrictions, which could have an adverse effect on our financial condition and results of operations. If future legislation prohibiting physician referrals to hospitals in which the physicians own an interest were enacted by the U.S. Congress, our financial condition and results of operations could be materially adversely affected.

We may be subject to actions for false and other improper claims.

Federal and state government agencies, as well as private payors, have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of the cost reporting and billing practices of healthcare organizations and their quality of care and financial relationships with referral sources. In addition, the OIG and the U.S. Department of Justice have, from time to time, undertaken national enforcement initiatives that focus on specific billing practices or other suspected areas of abuse.

The U.S. government is authorized to impose criminal, civil and administrative penalties on any person or entity that files a false claim for payment from the Medicare or Medicaid programs and other federal and state healthcare programs. Claims filed with private insurers can also lead to criminal and civil penalties, including, but not limited to, penalties relating to violations of federal mail and wire fraud statutes, as well as penalties under the anti-fraud provisions of HIPAA. While the criminal statutes are generally reserved for instances of fraudulent intent, the U.S. government is applying its criminal, civil and administrative penalty statutes in an ever-expanding range of circumstances. For example, the government has taken the position that a pattern of claiming reimbursement for unnecessary services violates these statutes if the claimant merely should have known the services were unnecessary, even if the government cannot demonstrate actual knowledge. The government has also taken the position that claiming payment for low-quality services is a violation of these statutes if the claimant should have known that the care was substandard. The Fraud Enforcement and Recovery Act of 2009 further expanded the scope of the False Claims Act to create liability for knowingly and improperly avoiding or decreasing an obligation to pay money to the federal government and the Healthcare Reform Acts created federal False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later.

We are also subject to various state insurance statutes and regulations that prohibit us from submitting inaccurate, incorrect or misleading claims. Although we believe that our operations comply with both federal and state laws, they may nevertheless be the subject of a whistleblower lawsuit or may otherwise be challenged or scrutinized by governmental authorities. A determination that we have violated these laws could have a material adverse effect on our financial condition or results of operations.

We are subject to increasingly stringent governmental regulation, and may be subjected to allegations that we have failed to comply with governmental regulations which could result in sanctions and even greater scrutiny that reduce our revenues and profitability.

All participants in the healthcare industry are required to comply with many laws and regulations at the federal, state and local government levels. These laws and regulations require that our facilities meet various requirements, including those relating to our relationships with physicians and other referral sources, the adequacy and quality of medical care, equipment, personnel, operating policies and procedures, billing and cost reports, payment for services and supplies, maintenance of adequate records, privacy, compliance with building codes and environmental protection, among other matters. Many of the laws and regulations applicable to the healthcare are complex, and, in public statements, governmental authorities have taken positions on issues for which little official interpretation was previously

available. Some of these positions appear to be inconsistent with common practices within the industry but have not previously been challenged. Moreover, some government investigations that have in the past been conducted under the civil provisions of federal law are now being conducted as criminal investigations under the Medicare fraud and abuse laws.

The healthcare industry has seen a number of ongoing investigations related to patient referrals, physician recruiting practices, cost reporting and billing practices, laboratory and home healthcare services, physician ownership of hospitals and other healthcare providers, and joint ventures involving hospitals and physicians. The Healthcare Reform Acts provide for additional enforcement tools, cooperation between agencies, and funding for enforcement. Federal and state government agencies have announced heightened and coordinated civil and criminal enforcement efforts. In addition, the OIG (which is responsible for investigating fraud and abuse activities in government programs) and the U.S. Department of Justice periodically establish targeted enforcement initiatives that focus on specific billing practices or other areas that are highly susceptible to fraud and abuse. The OIG reported savings and expected recoveries for federal healthcare programs of more than \$29.6 billion for FFY 2011 as a result of its enforcement activities.

Hospitals continue to be one of the primary focal areas of the OIG and other governmental fraud and abuse programs. In January 2005, the OIG issued Supplemental Compliance Program Guidance for Hospitals that focuses on hospital compliance risk areas. Some of the risk areas highlighted by the OIG include correct outpatient procedure coding, revising admission and discharge policies to reflect current CMS rules, submitting appropriate claims for supplemental payments such as pass-through costs and outlier payments and a general discussion of the fraud and abuse risks related to financial relationships with referral sources. Each federal fiscal year, the OIG also publishes a General Work Plan that provides a brief description of the activities that the OIG plans to initiate or continue with respect to the programs and operations of HHS and details the areas that the OIG believes are prone to fraud and abuse. In addition, the claims review strategies used by Recovery Audit Contractors, or RACs, generally include a review of high dollar claims, including inpatient hospital claims. As a result, during the three year RAC demonstration program, a large majority of the total amounts recovered by RACs came from hospitals.

The laws and regulations with which we must comply are complex and subject to change. In the future, different interpretations or enforcement of these laws and regulations could subject our practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. If we fail to comply with applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate our hospitals and our ability to participate in the Medicare, Medicaid and other federal and state healthcare programs.

If a federal or state agency asserts a different position or enacts new laws or regulations regarding illegal remuneration under the Medicare, Medicaid or other governmental programs, we may be subject to civil and criminal penalties, experience a significant reduction in our revenues or be excluded from participation in the Medicare, Medicaid or other government-sponsored healthcare programs.

Any change in interpretations or enforcement of existing or new laws and regulations could subject our current practices to allegations of impropriety or illegality, or could require us to make changes in our surgical facilities, equipment, personnel, services, pricing, capital expenditure programs and operating expenses, which could have a material adverse effect on our financial condition and results of operations.

Additionally, new federal or state laws may be enacted that would cause our relationships with physician investors to become illegal or result in the imposition of penalties against us or our surgical facilities. If any of our business arrangements with physician investors were deemed to violate the Anti-kickback Statute, the Stark Law or similar laws, or if new federal or state laws were enacted rendering these arrangements illegal, our financial condition and results of operations would be materially adversely affected.

If laws governing the corporate practice of medicine or fee-splitting change, we may be required to restructure some of our relationships, which may result in a significant loss of revenues and divert other resources.

The laws of various states in which we operate or may operate in the future do not permit business corporations to practice medicine, to exercise control over or employ physicians who practice medicine or to engage in various business practices, such as fee-splitting with physicians (i.e., sharing in a percentage of professional fees). The interpretation and enforcement of these laws vary significantly from state to state. We provide management services to a physician network. If our arrangements with this network were deemed to violate state corporate practice of medicine, fee-splitting or similar laws, or if new laws are enacted rendering our arrangements illegal, we may be required to restructure these arrangements, which may result in a significant loss of revenues and divert other resources.

The loss of certain physicians can have a disproportionate impact on certain of our facilities.

Generally, the top referring physicians within each of our facilities represent a large share of our revenues and admissions. The loss of one or more of these physicians, even if temporary, could cause a material reduction in our revenues, which could take significant time to replace given the difficulty and cost associated with recruiting and retaining physicians.

We make significant loans to, and are generally liable for debts and other obligations of, the partnerships and limited liability companies that own and operate some of our surgical facilities.

We own and operate our surgical facilities through 17 limited partnerships and 38 limited liability companies. Local physicians, physician groups and healthcare systems also own an interest in all but one of these partnerships and limited liability companies. In the

partnerships in which we are the general partner, we are liable for 100% of the debts and other obligations of the partnership, even if we do not own all of the partnership interests. For the majority of our surgical facilities, indebtedness at the partnership level is funded through intercompany loans that we provide. Through many of these loans, which totaled approximately \$47.9 million as of December 31, 2011, we have a security interest in the partnership's or limited liability company's assets. However, our financial condition and results of operations

would be materially adversely affected if our surgical facilities are unable to repay these intercompany loans.

Our New Credit Facility and the indentures governing our outstanding notes allow us to borrow funds that we can lend to the partnerships and limited liability companies in which we own an interest. Although most of our intercompany loans are secured by the assets of the partnership or limited liability company, the physicians and physician groups that own an interest in these partnerships and limited liability companies generally do not guarantee a pro rata amount of this debt or the other obligations of these partnerships and limited liability companies.

We also guarantee the third-party debts and other obligations of many of the non-consolidated partnerships and limited liability companies in which we own an interest. As of December 31, 2011, we had approximately \$643,000 of off-balance sheet guarantees of non-consolidated third-party debt in connection with these surgical facilities. In most instances, the physicians and/or physician groups have also guaranteed their pro-rata share of the indebtedness to secure the financing.

If our operations in New York are found not to be in compliance with New York law, we may be unable to continue or expand our operations in New York.

We own an interest in a limited liability company which provides administrative services to an ASC located in New York. Laws in the State of New York require that corporations have natural persons as stockholders to be approved by the New York Department of Health as a licensed healthcare facility. Accordingly, we are not able to own interests in a limited partnership or limited liability company that owns an interest in a healthcare facility located in New York. Laws in the State of New York also prohibit the delegation of certain management functions by a licensed healthcare facility. The law does permit a licensed facility to lease premises and obtain various services from non-licensed entities. However, it is not clear what types of delegation constitute a violation. Although we believe that our operations and relationships in New York are in compliance with applicable laws, if New York regulatory authorities or a third-party asserts a contrary position, we may be unable to continue or expand our operations in New York.

If regulations change, we may be obligated to purchase some or all of the ownership of our physician partners or renegotiate some of our partnership and operating agreements with our physician partners and management agreements with surgical facilities.

Upon the occurrence of various fundamental regulatory changes or changes in the interpretation of existing regulations, we may be obligated to purchase all of the ownership of the physician investors in most of the partnerships or limited liability companies that own and operate our surgical facilities. The purchase price that we would be required to pay for the ownership is typically based on either a multiple of the surgical facility's EBITDA, as defined in our partnership and operating agreements with these surgical facilities, or the fair market value of the ownership as determined by a third-party appraisal. The physician investors in some of our surgical facilities can require us to purchase their interests in exchange for cash or shares of our common stock if these regulatory changes occur. In addition, some of our partnership agreements with our physician partners and management agreements with surgical facilities require us to attempt to renegotiate the agreements upon the occurrence of various fundamental regulatory changes or changes in the interpretation of existing regulations and provide for termination of the agreements if renegotiations are not successful.

Regulatory changes that could create purchase or renegotiation obligations include changes that:

- make illegal the referral of Medicare or other patients to our surgical facilities by physician investors;
- create a substantial likelihood that cash distributions to physician investors from the partnerships or limited liability companies through which we operate our surgical facilities would be illegal;
- make illegal the ownership by the physician investors of interests in the partnerships or limited liability companies through which we own and operate our surgical facilities; or
- require us to reduce the aggregate percentage of physician investor ownership in our hospitals.

We do not control whether or when any of these regulatory events might occur. In the event we are required to purchase all of the physicians' ownership, our existing capital resources would not be sufficient for us to meet this obligation. These obligations and the possible termination of our partnership and management agreements would have a material adverse effect on our financial condition and results of operations.

If we become subject to large malpractice and related legal claims, we could be required to pay significant damages, which may not be covered by insurance.

In recent years, physicians, hospitals and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability or related legal theories. Many of these actions involve large monetary claims and significant defense costs. We maintain liability insurance in amounts that we believe are appropriate for our operations. Currently, we maintain professional and

general liability insurance that provides coverage on a claims-made basis of \$1.0 million per occurrence with a retention of \$50,000 per occurrence and \$3.0 million in annual aggregate coverage per surgical facility. In addition, physicians who provide professional services in our surgical facilities are required to maintain separate malpractice coverage with similar minimum coverage limits. We also maintain business interruption insurance and property damage insurance, as well as an additional umbrella liability insurance policy in the aggregate

amount of \$25.0 million. However, this insurance coverage may not cover all claims against us. Insurance coverage may not continue to be available at a cost allowing us to maintain adequate levels of insurance. If one or more successful claims against us were not covered by or exceeded the coverage of our insurance, our financial condition and results of operations could be adversely affected.

We face intense competition for physicians, nurses, strategic relationships, acquisitions and managed care contracts, which may result in a decline in our revenues, profitability and market share.

The healthcare business is highly competitive. We compete with other healthcare providers, primarily hospitals and other surgical facilities, in attracting physicians to utilize our surgical facilities, nurses and medical staff to support our surgical facilities, and in contracting with managed care payors in each of our markets. There are unaffiliated hospitals in each market in which we operate. These hospitals have established relationships with physicians and payors. In addition, other companies either currently are in the same or similar business of developing, acquiring and operating surgical facilities or may decide to enter our business. Many of these companies have greater resources than we do, including financial, marketing, staff and capital resources. We also may compete with some of these companies for entry into strategic relationships with healthcare systems and healthcare professionals. In addition, many physician groups develop surgical facilities without a corporate partner, utilizing consultants who perform services for a fee and do not take an equity interest in the ongoing operations of the facility. In recent years, more physicians are choosing to perform procedures, including pain management and gastrointestinal procedures, in an office-based setting rather than in a surgical facility. If we are unable to compete effectively with any of these entities or groups, we may be unable to implement our business strategies successfully and our financial position and results of operations could be adversely affected.

Our surgical facilities are sensitive to regulatory, economic and other conditions of the states where they are located. In addition, three of our surgical facilities account for a significant portion of our patient service revenues.

Our revenues are particularly sensitive to regulatory, economic and other conditions in the states of Texas and Florida. As of December 31, 2011, we owned and operated six surgical facilities in Texas and seven surgical facilities in Florida. The Texas facilities represented about 10% of our patient service revenues during 2011 and 12% during 2010, and the surgical facilities in Florida represented about 9% of our patient service revenues during both 2011 and 2010.

In addition, our facilities in Idaho Falls, Idaho, Houma, Louisiana and Durango, Colorado each generated approximately 24%, 5% and 5% of our patient service revenues during 2011, and 15%, 5% and 6%, respectively, of our patient service revenues during 2010. We acquired our facility in Idaho Falls, Idaho during 2010. If these facilities are adversely affected by regulatory, economic and other conditions, or if these facilities do not perform effectively, our financial condition and results of operations will be adversely affected.

We depend on our senior management, and we may be adversely affected if we lose any member of our senior management.

We are highly dependent on our senior management, including Richard E. Francis, Jr., our chairman of the board and chief executive officer, and Clifford G. Adlerz, our president and chief operating officer. Our employment agreements with Messrs. Francis and Adlerz have three-year terms which automatically extend until terminated. We may terminate each employment agreement for cause. In addition, either party may terminate the employment agreement at any time by giving prior written notice to the other party. We do not maintain "key man" life insurance policies on any of our officers. Because our senior management has contributed greatly to our growth since inception, the loss of key management personnel or our inability to attract, retain and motivate sufficient numbers of qualified management personnel could have a material adverse effect on our financial condition and results of operations.

If we are unable to integrate and operate our information systems effectively, our operations could be disrupted.

Our operations significantly depend on effective information systems. Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs. Moreover, our acquisition activity requires frequent transitions from, and the integration of, various information systems. If we experience difficulties with the transition from information systems or are unable to properly maintain or expand our information systems, we could suffer, among other things, operational disruptions and increases in administrative expenses.

Risks Related to Our Corporate Structure

We may have a special legal responsibility to the holders of ownership interests in the entities through which we own our surgical facilities, which may conflict with the interests of our noteholders and prevent us from acting solely in our own best interests or the interests of our noteholders.

We generally hold our ownership interests in surgical facilities through limited partnerships or limited liability companies in which we maintain ownership along with physicians or physician practice groups. As general partner or manager of these entities, we may have a special responsibility, known as a fiduciary duty, to manage these entities in the best interests of the other interest holders. As a result, we may

encounter conflicts between our responsibility to the other interest holders and our responsibility to enhance the value of our company. For example, we have entered into management agreements to provide management services to our surgical facilities in exchange for a fee. Disputes may arise as to the nature of the services to be provided or the amount of the fee to be paid. In these cases, we are obligated to exercise reasonable, good faith judgment to resolve the disputes and may not be free to act solely in our own best interests or the interests of the noteholders. Disputes may also arise between us and our physician investors with respect to a particular business decision or regarding

the interpretation of the provisions of the applicable limited partnership agreement or operating agreement. We seek to avoid these disputes but have not implemented any measures to resolve these conflicts if they arise. If we are unable to resolve a dispute on terms favorable or satisfactory to us, our financial condition and results of operations may be adversely affected.

We are a holding company with no operations of our own.

We are a holding company, and our ability to service our debt is dependent upon the earnings from the business conducted by our subsidiaries that operate the surgical facilities. The effect of this structure is that we depend on the earnings of our subsidiaries, and the distribution or payment to us of a portion of these earnings to meet our obligations, including those under our New Credit Facility and outstanding notes and any of our other debt obligations. The distributions of those earnings or advances or other distributions of funds by these entities to us, all of which are contingent upon our subsidiaries' earnings, are subject to various business considerations. In addition, distributions by our subsidiaries could be subject to statutory restrictions, including state laws requiring that such subsidiaries be solvent, or contractual restrictions. Some of our subsidiaries may become subject to agreements that restrict the sale of assets and significantly restrict or prohibit the payment of dividends or the making of distributions, loans or other payments to stockholders, partners or members.

We do not have exclusive control over the distribution of cash from our operating entities and may be unable to cause all or a portion of the cash of these entities to be distributed.

All of the surgical facilities in which we have ownership are held through partnerships or limited liability companies. We typically own, directly or indirectly, the general partnership or majority member interests in these entities. The partnership and operating agreements for these entities provide for distribution of available cash, in some cases on a quarterly basis subject in certain cases to requirements that we obtain approval of other equity holders. Many of these agreements also impose limits on the ability of these entities to make loans or transfer assets to us. If we are unable to cause sufficient cash to be distributed from one or more of these entities, our relationships with the physicians who also own an interest in these entities may be damaged and we could be adversely affected, as could our ability to make debt service payments. We may not be able to resolve favorably any dispute regarding cash distribution or other matters with a healthcare system with which we share control of the distributions made by these entities. Further, the failure to resolve a dispute with these healthcare systems could cause an entity in which we own an interest to be dissolved.

We are controlled by principal stockholders whose interests may differ from your interests.

Circumstances may occur in which the interests of our principal stockholders could be in conflict with the interests of the holders of our notes. In addition, these stockholders may have an interest in pursuing transactions that, in their judgment, enhance the value of their equity investment in our company, even though those transactions may involve risks to other interest holders.

A majority of the outstanding shares of common stock of our parent company are held by Crestview and certain related investors (the "Crestview Funds"). As a result of their stock ownership, the Crestview Funds control us and have the power to elect a majority of our directors, appoint new management and approve any action requiring the approval of the holders of common stock, including adopting amendments to our certificate of incorporation and approving acquisitions or sales of all or substantially all of our assets. The directors elected by the Crestview Funds have the ability to control decisions affecting our capital structure, including the issuance of additional capital stock, the implementation of stock repurchase programs and the declaration of dividends.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our corporate headquarters are located in Nashville, Tennessee in approximately 44,000 square feet of leased office space, under a ten-year lease that commenced on November 1, 2002. Upon expiration of the initial ten-year term, the lease may be renewed for two additional five-year periods. To exercise the renewal option, we must give notice at least nine months prior to the expiration of the lease term in question. Effective January 27, 2012, we amended our lease agreement to extend our lease term to December 31, 2017.

Our surgical facilities typically are located on real estate leased by the partnership or limited liability company that operates the facility. These leases generally have initial terms of ten years, but range from two to 15 years. Most of the leases contain options to extend the lease period for up to ten additional years. The surgical facilities are generally responsible for property taxes, property and casualty insurance and routine maintenance expenses. Two of our surgical facilities are located on real estate owned by the limited partnership or limited liability company that owns the surgical facility. We generally guarantee the lease obligations of the partnerships and limited liability companies that own our surgical facilities.

Additional information about our surgical facilities and our other properties can be found in Item 1 of this report under the caption, "Business—Operations."

Item 3. *Legal Proceedings*

We are, from time to time, subject to claims and suits arising in the ordinary course of business, including claims for damages for personal injuries, breach of management contracts and employment related claims. In certain of these actions, plaintiffs request payment for

damages, including punitive damages, that may not be covered by insurance.

Item 4. *Mine Safety Disclosure* —Not applicable.

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

We are wholly owned by Symbion Holdings Corporation which is owned by Crestview and certain affiliated funds managed by Crestview and co-investors. There is no public trading market for our equity securities or those of Holdings. As of March 16, 2012, there were 10 holders of Holdings common stock.

Item 6. *Selected Financial Data*

The following selected consolidated financial and other data should be read in conjunction with "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Item 7 and our audited consolidated financial statements and the related notes included elsewhere in this report. The selected consolidated statement of operations data set forth below for the years ended December 31, 2011, 2010 and 2009, and the selected consolidated balance sheet data set forth below at December 31, 2011 and 2010, are derived from our audited consolidated financial statements that are included elsewhere in this report. The selected consolidated statement of operations data set forth below for the years ended December 31, 2008 and 2007, and the selected consolidated balance sheet data set forth below at December 31, 2009, 2008 and 2007, are derived from our audited consolidated financial statements that are not included in this report.

The historical results presented below are not necessarily indicative of the results to be expected for any future period.

	Year Ended December 31,				
	2011	2010	2009	2008	2007
	(in thousands)				
Consolidated Statement of Operations Data:					
Revenues	\$ 444,653	\$ 394,555	\$ 323,667	\$ 306,437	\$ 276,971
Cost of revenues	316,978	280,346	229,063	205,487	185,914
General and administrative expense	22,723	22,465	21,448	23,923	31,872
Depreciation and amortization	20,263	18,354	16,008	14,107	11,608
Provision for doubtful accounts	6,963	6,596	2,730	3,455	3,982
Income on equity investments	(1,876)	(2,901)	(2,318)	(1,504)	(16)
Impairment and loss (gain) on disposal of long-lived assets, net	4,822	(907)	2,813	898	(706)
Loss on debt extinguishment	4,751	—	—	—	—
Litigation settlements, net	(391)	(35)	—	893	—
Business combination remeasurement gains	—	(3,169)	—	—	—
Merger transaction expenses	—	—	—	—	7,522
Total operating expenses	374,233	320,749	269,744	247,259	240,176
Operating income	70,420	73,806	53,923	59,178	36,795
Interest expense, net	(54,321)	(48,020)	(44,936)	(43,433)	(20,055)
Income before income taxes and discontinued operations	16,099	25,786	8,987	15,745	16,740
Provision for income taxes	9,372	7,725	7,685	13,081	3,178
Income from continuing operations	6,727	18,061	1,302	2,664	13,562
Income (loss) from discontinued operations, net of taxes	207	(190)	(4,754)	(1,296)	2,550
Net income (loss)	6,934	17,871	(3,452)	1,368	16,112
Less: Net income attributable to noncontrolling interests	(33,521)	(26,611)	(19,002)	(22,166)	(21,514)
Net loss attributable to Symbion, Inc.	\$ (26,587)	\$ (8,740)	\$ (22,454)	\$ (20,798)	\$ (5,402)
Cash Flow Data — continuing operations:					
Net cash provided by operating activities	\$ 67,489	\$ 66,928	\$ 57,335	\$ 57,121	\$ 49,101
Net cash used in investing activities	(18,103)	(53,009)	(11,193)	(32,719)	(50,909)
Net cash (used in) provided by financing activities	(53,912)	10,251	(41,417)	(30,586)	16,698
Other Data:					
EBITDA(1)	\$ 68,088	\$ 62,809	\$ 55,039	\$ 54,131	\$ 44,451
EBITDA as a % of revenues	15.3%	15.9%	17.0%	17.7%	16.0%
Number of surgical facilities operated as of end of period(2)	63	62	67	68	61

As of December 31,

	2011	2010	2009	2008	2007
	(in thousands)				
Consolidated Balance Sheet Data:					
Working capital	\$ 89,021	\$ 77,301	\$ 40,782	\$ 52,271	\$ 70,619
Total assets	978,094	970,397	790,727	783,563	768,814
Total long-term debt, less current maturities	544,694	507,228	444,487	439,917	428,870
Total Symbion, Inc. stockholders' equity	158,129	185,426	193,413	211,206	233,286

(1) When we use the term "EBITDA," we are referring to net income (loss) plus (a) (loss) income from discontinued operations, net of taxes (b) income tax expense, (c) interest expense, net, (d) depreciation and amortization, (e) non-cash (gains) losses, net of noncontrolling interests, and (f) non-cash stock option compensation, and less (g) net income attributable to noncontrolling interests. Noncontrolling interest represents the interest of third parties, such as physicians, and in some cases, healthcare systems that own an interest in surgical facilities that we consolidate for financial reporting purposes. Our operating strategy is to apply a market-based approach in structuring our partnerships with individual market dynamics driving the structure. We believe that it is helpful to investors to present EBITDA as defined above because it excludes the portion of net income attributable to these third-party interests and clarifies for investors our portion of EBITDA generated by our surgical facilities and other operations.

(2) Includes surgical facilities that we manage but in which we do not have an ownership interest.

We use EBITDA as a measure of liquidity. We have included it because we believe that it provides investors with additional information about our ability to incur and service debt and make capital expenditures. We also use EBITDA, with some variation in the calculation, to determine compliance with some of the covenants under the New Credit Facility, as well as to determine the interest rate and commitment fee payable under the senior secured credit facility. See "Management's Discussion and Analysis of Financial Condition and Results of Operations - EBITDA and Consolidated Adjusted EBITDA".

EBITDA is not a measurement of financial performance or liquidity under GAAP. It should not be considered in isolation or as a substitute for net income, operating income, cash flows from operating, investing or financing activities, or any other measure calculated in accordance with generally accepted accounting principles. The items excluded from EBITDA are significant components in understanding and evaluating financial performance and liquidity. Our calculation of EBITDA may not be comparable to similarly titled measures reported by other companies.

The following table reconciles EBITDA to net cash provided by operating activities—continuing operations:

	Year Ended December 31,				
	2011	2010	2009	2008	2007
	(in thousands)				
EBITDA	\$ 68,088	\$ 62,809	\$ 55,039	\$ 54,131	\$ 44,451
Depreciation and amortization	(20,263)	(18,354)	(16,008)	(14,107)	(11,608)
Non-cash (losses) gains, net of noncontrolling interests	(9,573)	4,076	(2,813)	(898)	706
Non-cash stock option compensation expense	(1,353)	(1,336)	(1,297)	(2,114)	(10,746)
Interest expense, net	(54,321)	(48,020)	(44,936)	(43,433)	(20,055)
Provision for income taxes	(9,372)	(7,725)	(7,685)	(13,081)	(3,178)
Net income attributable to noncontrolling interests	33,521	26,611	19,002	22,166	21,514
Merger transaction expenses	—	—	—	—	(7,522)
Income (loss) from discontinued operations, net of taxes	207	(190)	(4,754)	(1,296)	2,550
Net income (loss)	6,934	17,871	(3,452)	1,368	16,112
(Income) loss from discontinued operations	(207)	190	4,754	1,296	(2,550)
Depreciation and amortization	20,263	18,354	16,008	14,107	11,609
Amortization of deferred financing costs	2,886	2,004	2,004	4,477	2,194
Non-cash payment-in-kind interest option	22,368	26,079	23,263	17,616	—
Non-cash recognition of other comprehensive loss into earnings	665	2,731	2,853	—	—
Non-cash credit risk adjustment of financial instruments	—	189	1,629	—	—
Non-cash stock option compensation expense	1,353	1,336	1,297	2,114	10,746
Non-cash losses (gains)	4,822	(4,076)	2,813	898	(706)
Loss on debt extinguishment	4,751	—	—	—	—
Deferred income tax provision (benefit)	8,971	10,979	8,682	13,718	15,854
Equity in earnings of unconsolidated affiliates, net of distributions received	106	50	(207)	333	(16)
Provision for doubtful accounts	6,963	6,596	2,730	3,455	3,982
Changes in operating assets and liabilities, net of effects of acquisitions and dispositions:					
Accounts receivable	(11,261)	(15,018)	(4,442)	(3,089)	739
Other assets and liabilities	(1,125)	(358)	(597)	828	(8,863)
Net cash provided by operating activities—continuing operations	\$ 67,489	\$ 66,927	\$ 57,335	\$ 57,121	\$ 49,101

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

The following discussion and analysis of our financial condition and results of operations should be read in conjunction with Item 6. "Selected Financial Data" and our audited consolidated financial statements and related notes included elsewhere in this report. This discussion contains forward-looking statements that involve risks and uncertainties. For additional information regarding some of the risks and uncertainties that affect our business and the industry in which we operate, please read Item 1A. "Risk Factors" found elsewhere in this report. Our actual results may differ materially from those estimated or projected in any of these forward-looking statements.

Executive Overview

We own and operate a national network of short stay surgical facilities in 28 states. Our surgical facilities, which include ASCs and surgical hospitals, primarily provide non-emergency surgical procedures across many specialties, including, among others, orthopedics, pain management, gastroenterology and ophthalmology. Some of our surgical hospitals also provide acute care services, such as diagnostic imaging, pharmacy, laboratory, obstetrics, physical therapy and wound care. We own our surgical facilities in partnership with physicians and in some cases healthcare systems in the markets and communities we serve. We apply a market-based approach in structuring our partnerships with individual market dynamics driving the structure. We believe this approach aligns our interests with those of our partners. As of March 16, 2012, we owned and operated 55 surgical facilities, including 49 ASC's and six surgical hospitals. We also managed eight additional ASCs. We owned a majority interest in 31 of the 55 surgical facilities and consolidated 49 of these facilities for financial reporting

purposes. We are reporting two of the 55 surgical facilities as discontinued operations. In addition to our surgical facilities, we also manage one physician clinic in a market in which we operate an ASC and a surgical hospital.

We have benefited from both the growth in overall outpatient surgery cases as well as the migration of surgical procedures from the hospital to the surgical facility setting. Advancements in medical technology, such as lasers, arthroscopy and enhanced endoscopic techniques, have reduced the trauma of surgery and the amount of recovery time required by patients following a surgical procedure.

Improvements in anesthesia also have shortened the recovery time for many patients and have reduced post-operative side effects such as pain, nausea and drowsiness. These medical advancements have enabled more patients to undergo surgery in a surgical facility setting.

On June 14, 2011, we issued \$350.0 million aggregate principal amount of 8.00% Senior Secured Notes due 2016 at a price of 98.492% (the "Offering"). We used the net proceeds from the sale of the Senior Secured Notes, together with cash on our balance sheet, to repay in full, all outstanding borrowings under our \$350.0 million existing senior secured credit facilities and to repurchase \$70.8 million aggregate principal amount of our Toggle Notes, at par plus accrued and unpaid interest, from certain holders of Toggle Notes. Simultaneous with the closing of the Offering, we entered into a new \$50.0 million senior secured super-priority revolving credit facility and issued \$88.5 million aggregate principal amount of 8.00% senior PIK Exchangeable Notes due 2017 to affiliates of Crestview and certain other holders of Toggle Notes in exchange for \$85.4 million aggregate principal amount of our existing Toggle Notes, at par plus accrued and unpaid interest. Effective September 9, 2011, we cancelled \$9.0 million aggregate principal amount of our Senior Secured Notes held by certain holders of such notes, plus accrued and unpaid interest, in exchange for our issuance to such parties of an additional \$9.2 million aggregate principal amount of our PIK Exchangeable Notes.

We continue to focus on improving the performance of our same store facilities, selectively acquiring established facilities and developing new facilities. Effective October 1, 2011, we acquired an oncology practice, which is operated within our existing facility located in Idaho Falls, Idaho. The purchase price of the acquisition was \$3.8 million, consisting of \$2.7 million of cash and approximately \$1.1 million in the form of equity ownership in our facility located in Idaho Falls, Idaho. This transaction was financed with cash borrowings under an available facility level line of credit.

Effective August 1, 2011 we acquired a 56.0% ownership interest in an ASC and a 50.0% ownership interest in a 20-bed surgical hospital located in Great Falls, Montana. We consolidate the ASC for financial reporting purposes and account for the surgical hospital as an equity method investment for financial reporting purposes. In addition, we acquired the rights to manage a medical clinic in Great Falls, Montana consisting of multi-specialty physicians who are partners in the surgical facilities acquired. The aggregate purchase price was \$5.2 million plus the assumption of debt of approximately \$232,000. This acquisition was financed with cash from operations.

Effective January 7, 2011, we acquired an incremental ownership interest of 3.5% at one of our surgical facilities located in Chesterfield, Missouri for a purchase price of \$1.8 million. Additionally, on July 1, 2011, we acquired an additional incremental ownership interest of 2.0% in this facility for a purchase price of \$1.0 million. Both transactions were financed with cash from operations. Subsequent to this acquisition, we owned a 55.5% ownership interest in this facility.

Effective September 30, 2011, we completed a scheduled termination of our physician network agreements which included a surgical facility we operated. We received aggregate proceeds of \$481,000 and recorded a loss of \$251,000.

Revenues

Our revenues consist of patient service revenues, physician service revenues and other service revenues. Our patient service revenues relate to fees charged for surgical or diagnostic procedures performed at surgical facilities that we consolidate for financial reporting purposes. Physician service revenues are revenues from our recently divested physician network consisting of reimbursed expenses, plus participation in the excess of revenues over expenses of the physician networks, as provided for in our service agreements with our physician networks. Other service revenues consist of management and administrative service fees derived from the non-consolidated facilities that we account for under the equity method, management of surgical facilities in which we do not own an interest, and management services we provide to physician clinics for which we are not required to provide capital or additional assets.

The following tables summarize our revenues by service type as a percentage of total revenues for the periods indicated:

	Year Ended December 31,		
	2011	2010	2009
Patient service revenues	98%	97%	96%
Physician service revenues	1	1	2
Other service revenues	1	2	2
Total	100%	100%	100%

Payor Mix

The following table sets forth by type of payor the percentage of our patient service revenues generated in the periods indicated:

	Year Ended December 31,		
	2011	2010	2009
Private Insurance	67%	68%	71%
Government	26	25	24
Self-pay	3	4	4
Other	4	3	1
Total	100%	100%	100%

Case Mix

We primarily operate multi-specialty facilities where physicians perform a variety of procedures in specialties, including orthopedics, pain management, gastroenterology and ophthalmology, among others. We believe this diversification provides us protection from any adverse pricing and utilization trends in any individual procedure type and results in greater consistency in our case volume.

The following table sets forth the percentage of cases in each specialty performed at surgical facilities which we consolidate for financial reporting purposes for the periods indicated:

	Year Ended December 31,		
	2011	2010	2009
Ear, nose and throat	5.9%	5.8%	5.7%
Gastrointestinal	30.1	30.2	29.5
General surgery	3.8	3.9	4.0
Obstetrics/gynecology	2.9	2.8	2.9
Ophthalmology	15.8	16.2	17.2
Orthopedic	16.9	17.0	15.9
Pain management	13.9	13.6	13.7
Plastic surgery	2.7	2.8	2.7
Other	8.0	7.7	8.4
Total	100%	100%	100%

Case Growth*Same Store Information*

We define same store facilities as those facilities that were operating throughout the respective years ended December 31, 2011 and 2010. The following same store facility table includes both consolidated surgical facilities included in continuing operations that are included in our revenue and non-consolidated surgical facilities that are not reported in our revenue, as we account for these surgical facilities using the equity method. This same store facilities table is presented to allow comparability to other companies in our industry for the periods indicated:

	Three Months Ended December 31,		Year Ended December 31,	
	2011	2010	2011	2010
Cases	62,459	63,482	230,050	237,043
Case growth	(1.6)%	N/A	(3.0)%	N/A
Net patient service revenue per case	\$ 2,052	\$ 1,870	\$ 1,517	\$ 1,509
Net patient service revenue per case growth	9.7 %	N/A	0.6 %	N/A
Number of same store surgical facilities	49	N/A	47	N/A

Our same store revenue increased by 8.1% for the three months ended December 31, 2011 compared to the 2010 period with a decrease in cases of 1.6% offset by a 9.7% increase in net revenue per case, primarily driven by higher acuity cases at our surgical hospitals.

Our same store results for the quarter include two of our surgical hospitals which were excluded from our year over year same store results because they were acquired subsequent to January 1, 2010.

Our same store revenue decreased by 2.4% for the year ended December 31, 2011 compared to 2010 with a decrease in cases of 3.0% offset by a 0.6% increase in net revenue per case. The decrease in cases resulted from a combination of volume weakness experienced throughout the year combined with a scheduled termination of an agreement with a health plan to utilize one of our facilities for a specified period of time.

Consolidated Information

The following table sets forth information for all surgical facilities included in continuing operations that we consolidate for financial reporting purposes for the periods indicated. Accordingly, the table includes surgical facilities that we have acquired or developed since January 1, 2010:

	Three Months Ended December 31,		Year Ended December 31,	
	2011	2010	2011	2010
Cases	60,127	59,526	232,075	230,829
Case growth	1.0%	N/A	0.5%	N/A
Net patient service revenue per case	\$ 1,990	\$ 1,815	\$ 1,871	\$ 1,656
Net patient service revenue per case growth	9.7%	N/A	13.0%	N/A
Number of surgical facilities operated as of end of the period(1)	61	60	61	60
Number of consolidated surgical facilities	47	47	47	47

(1) Includes surgical facilities that we manage but do not own.

Operating Trends

Our operating income margin, excluding non-cash gains and losses, for the year ended December 31, 2011, increased to 18.0% from 17.7% during the year ended December 31, 2010. This increase is attributable to growth at our surgical hospitals, including an increase in net patient revenue per case due to an increase in higher acuity cases performed at these facilities. However, we continue to experience volume weakness across our system, primarily in our ASCs. Consistent with the overall volume decrease experienced by our industry, our comparable same store cases reflect a decline of 3.0% for 2011 compared to 2010. Our case volume was impacted by a scheduled termination of an agreement with a health plan to utilize one of our facilities for a specified period of time. Our operating income margins remain sensitive to volume changes due to certain fixed costs such as facility rent expense and minimum staffing requirements, in addition to month to month volatility.

Acquisitions and Developments*2011 Activities*

Effective October 1, 2011, we acquired an oncology practice, which is operated within our existing facility located in Idaho Falls, Idaho. The purchase price of the acquisition was \$3.8 million, consisting of \$2.7 million of cash and approximately \$1.1 million in the form of equity ownership in our facility located in Idaho Falls, Idaho. This transaction was financed with cash borrowings under an available facility level line of credit.

Effective August 1, 2011, we acquired a 56.0% ownership interest in an ambulatory surgery center and a 50.0% ownership interest in a 20-bed surgical hospital located in Great Falls, Montana. We consolidate the ambulatory surgery center for financial reporting purposes and account for the surgical hospital as an equity method investment for financial reporting purposes. In addition, we acquired the rights to manage a medical clinic in Great Falls, Montana consisting of multi-specialty physicians who are partners in the surgical facilities acquired. The aggregate purchase price was \$5.2 million plus the assumption of debt of approximately \$232,000. The acquisition was financed with cash from operations.

Effective January 7, 2011, we acquired an incremental ownership interest of 3.5% at our surgical facility located in Chesterfield, Missouri for a purchase price of \$1.8 million. Additionally, on July 1, 2011, we acquired an additional incremental ownership interest of 2.0% in this facility for a purchase price of \$1.0 million. Both transactions were financed with cash from operations. As of March 16, 2012, we owned a 55.5% ownership interest in this facility.

2010 Activities

Effective July 1, 2010, we acquired an incremental, controlling ownership interest of 37.0% in one of our surgical facilities located in Chesterfield, Missouri for \$18.8 million. Subsequent to the acquisition, we held a 50.0% ownership interest in the facility. As part of the acquisition, we consolidated \$4.8 million of third-party facility debt on our balance sheet. We subsequently restructured this debt using borrowings from our \$100.0 million revolving, swingline and letter of credit facility (the "Revolving Facility"). As a result of this acquisition, we hold a controlling interest in this facility. The acquisition was treated as a business combination, and we began consolidating the facility for financial reporting purposes in the third quarter of 2010. We financed the aggregate purchase price with proceeds from our Revolving Facility.

Effective April 9, 2010, we acquired an ownership of 54.5% in a surgical hospital located in Idaho Falls, Idaho for approximately \$31.9 million plus the assumption of approximately \$6.1 million of debt and other obligations of \$48.0 million, which we consolidate on our balance sheet. The other obligations include a financing obligation of \$48.0 million payable to the hospital facility lessor for the land, buildings and improvements of the facility. We financed the acquisition with borrowings from our Revolving Facility. We consolidate this

facility for financial reporting purposes.

2009 Activities

Effective February 28, 2009, we acquired an incremental ownership of 18.0% in our surgical facility located in Westlake Village, California, for a purchase price of \$416,000, financed with cash from operations. We account for this investment under the equity method. Prior to the acquisition, we owned 1.0% of this facility.

Effective May 1, 2009, we acquired a 91.8% ownership interest in a surgical hospital in Austin, Texas for \$350,000 plus the assumption of \$2.6 million of debt. Subsequently, we reduced our ownership in this facility to 47.0%. The purchase price was financed with cash from operations. We consolidate this surgical facility for financial reporting purposes. We also entered into a management agreement with this facility.

Effective September 1, 2009, we acquired an ownership of 28.8% in a surgical facility located in Gresham, Oregon for \$525,000. The purchase price was financed with cash from operations. We account for this investment under the equity method. We also entered into a management agreement with this facility.

Also during the first quarter of 2009, we opened one surgical facility that was under development as of December 31, 2008. We consolidate this surgical facility for financial reporting purposes.

Discontinued Operations and Divestitures

From time to time, we evaluate our portfolio of surgical facilities to ensure the facilities are performing as we expect. During the fourth quarter of 2011, we committed to a plan to divest our interest in two facilities that we consolidated for financial reporting purposes. During 2010, we disposed of four surgical facilities which are classified as discontinued operations. In connection with one of our disposed facilities, we recorded an accrual of \$1.7 million for future contractual obligations under a facility operating lease. As of December 31, 2011, the lease liability was \$923,000. There were no future contractual obligations in connection with the divestiture of the other three facilities. The assets, liabilities, revenues, expenses and cash flows of the four facilities have been classified as discontinued operations for all periods presented.

Revenues, income from operations before taxes, income tax provision (benefit), loss on sale, net of taxes and income (loss) from discontinued operations, net of taxes, for the following periods indicated, were as follows (in thousands):

	Year Ended December 31,		
	2011	2010	2009
Revenues	\$ 11,630	\$ 20,191	\$ 27,825
Income from operations before income taxes	882	(501)	1,203
Income tax provision (benefit)	257	67	117
Loss on sale, net of taxes	(418)	378	(5,840)
Income (loss) from discontinued operations, net of taxes	\$ 207	\$ (190)	\$ (4,754)

Critical Accounting Policies

Our significant accounting policies and practices are described in Note 3 of our consolidated financial statements included elsewhere in this report. In preparing our consolidated financial statements in conformity with accounting principles generally accepted in the United States, our management must make estimates and assumptions that affect the reported amounts of assets and liabilities and related disclosures at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Certain accounting estimates are particularly sensitive because of their complexity and the possibility that future events affecting them may differ materially from our current judgments and estimates. Our actual results could differ from those estimates. We believe that the following critical accounting policies are important to the portrayal of our financial condition and results of operations and require our management's subjective or complex judgment because of the sensitivity of the methods, assumptions and estimates used. This listing of critical accounting policies is not intended to be a comprehensive list of all of our accounting policies. In many cases, the accounting treatment of a particular transaction is specifically dictated by generally accepted accounting principles in the United States, with no need for management's judgment regarding accounting policy.

Consolidation and Control

Our consolidated financial statements include our accounts and those of our wholly owned subsidiaries, as well as our interests in surgical facilities that we control through our ownership of a majority voting interest or other rights granted to us by contract as the sole general partner or manager to manage and control the business. The rights of the limited partners or minority members in these surgical

facilities are generally limited to those that protect their ownership, including the right to approve of the issuance of new ownership interests, and those that protect their financial interests, including the right to approve the acquisition or divestiture of significant assets or the incurrence of debt that physician limited partners or members are required to guarantee on a pro rata basis based upon their respective ownership, or that exceeds 20.0% of the fair market value of the surgical facility's assets. All significant intercompany balances and transactions, including management fees from consolidated surgical facilities, are eliminated in consolidation.

We also hold non-controlling interests in some surgical facilities over which we exercise significant influence. Significant influence includes financial interests, duties, rights and responsibilities for the day-to-day management of the surgical facility. These non-controlling interests are accounted for under the equity method.

We also consider the relevant sections of the Financial Accounting Standards Board's *Accounting Standards Codification*, Topic 810, *Consolidation*, to determine if we have the power to direct the activities and are the primary beneficiary of (and therefore should consolidate) any entity whose operations we do not control with voting rights. At December 31, 2011, we consolidate two entities because we are the primary beneficiary.

Revenue Recognition

Our revenues are comprised of patient service revenues, physician service revenues and other service revenues. Our patient service revenues relate to fees charged for surgical or diagnostic procedures performed at surgical facilities that we consolidate for financial reporting purposes. These fees are billed either to the patient or a third-party payor. Our fees vary depending on the procedure, but usually include all charges for usage of an operating room, a recovery room, special equipment, supplies, nursing staff and medications. Also, in a very limited number of our surgical facilities, we charge for anesthesia services. Our fees normally do not include professional fees charged by the patient's surgeon, anesthesiologist or other attending physician, which are billed directly by the physicians to the patient or third-party payor. We recognize patient service revenues on the date of service, net of estimated contractual adjustments and discounts for third-party payors, including Medicare and Medicaid. Changes in estimated contractual adjustments and discounts are recorded in the period of change.

Physician service revenues are revenues from a physician network, consisting of reimbursed expenses, plus participation in the excess of revenues over expenses of the physician networks, as provided for in our service agreements with our physician networks. Reimbursed expenses include the costs of personnel, supplies and other expenses incurred to provide the management services to the physician networks. We recognize physician service revenues in the period in which reimbursable expenses are incurred and in the period in which we have the right to receive a percentage of the amount by which a physician network's revenues exceed its expenses. Physician service revenues are based on net billings with any changes in estimated contractual adjustments reflected in service revenues in the subsequent period. Effective September 30, 2011, the Company completed a scheduled termination of its physician network agreements.

Our other service revenues consist of management and administrative service fees derived from non-consolidated surgical facilities that we account for under the equity method, management of surgical facilities in which we do not own an interest and management services we provide to physician networks for which we are not required to provide capital or additional assets. The fees we derive from these management arrangements are based on a pre-determined percentage of the revenues of each surgical facility and physician network. We recognize other service revenues in the period in which services are rendered.

Allowance for Contractual Adjustments and Doubtful Accounts

Our patient service revenues and receivables from third-party payors are recorded net of estimated contractual adjustments and allowances from third-party payors, which we estimate based on the historical trend of our surgical facilities' cash collections and contractual write-offs, accounts receivable agings, established fee schedules, relationships with payors and procedure statistics. While changes in estimated reimbursement from third-party payors remain a possibility, we expect that any such changes would be minimal and, therefore, would not have a material effect on our financial condition or results of operations.

We estimate our allowances for bad debts using similar information and analysis. While we believe that our allowances for contractual adjustments and bad debts are adequate, if the actual write-offs are significantly different from our estimates, it could have a material adverse effect on our financial condition and results of operations. Because in most cases, we have the ability to verify a patient's insurance coverage before services are rendered and because we have entered into contracts with third-party payors which account for a majority of our total revenues, the out-of-period contractual adjustments have been minimal. Our net accounts receivable reflected allowances for doubtful accounts of \$10.2 million, \$10.0 million and \$8.9 million, at December 31, 2011, 2010 and 2009, respectively.

The following table summarizes our days sales outstanding for the periods indicated:

	Year Ended December 31,		
	2011	2010	2009
Days sales outstanding	51	48	38

The increase in days sales outstanding from 2009 to 2010 is primarily attributable to the acquisition of the incremental, controlling ownership interest in one of our surgical facilities located in Chesterfield, Missouri. This surgical facility has a high concentration of cases associated with legal proceedings which routinely have an extended collection cycle.

Our collection policies and procedures are based on the type of payor, size of claim and estimated collection percentage for each patient account. The operating systems used to manage our patient accounts provide for an aging schedule in 30-day increments, by payor, physician and patient. Each surgical facility is responsible for analyzing accounts receivable to ensure the proper collection and aged

category. The operating systems generate reports that assist in the collection efforts by prioritizing patient accounts. Collection efforts include direct contact with insurance carriers or patients, written correspondence and the use of legal or collection agency assistance, as required.

At a consolidated level, we review the standard aging schedule, by facility, to determine the appropriate provision for doubtful

accounts by monitoring changes in our consolidated accounts receivable by aged schedule, day's sales outstanding and bad debt expense as a percentage of revenues. At a consolidated level, we do not review a consolidated aging by payor. Regional and local employees review each surgical facility's aged accounts receivable by payor schedule. These employees have a closer relationship with the payors and have a more thorough understanding of the collection process for that particular surgical facility. Furthermore, this review is supported by an analysis of the actual net revenues, contractual adjustments and cash collections received. If our internal collection efforts are unsuccessful, we further review patient accounts with balances of \$25 or more. We then classify the accounts based on any external collection efforts we deem appropriate. An account is written-off only after we have pursued collection with legal or collection agency assistance or otherwise deemed an account to be uncollectible. Typically, accounts will be outstanding a minimum of 120 days before being written-off.

The following table summarizes our accounts receivable aging, net of contractual adjustments but before our allowance for doubtful accounts and certain other allowances, for consolidated surgical facilities as of the periods indicated (in thousands):

	Year Ended December 31,			
	2011		2010	
	Amount	% of Total	Amount	% of Total
Current	\$ 34,060	40%	\$ 31,110	41%
31 to 60 days	14,091	17	12,882	17
61 to 90 days	7,174	9	6,907	9
91 to 120 days	3,907	5	4,795	6
121 to 150 days	3,787	4	3,641	5
Over 150 days	21,062	25	17,319	22
Total	<u>\$ 84,081</u>	<u>100%</u>	<u>\$ 76,654</u>	<u>100%</u>

We recognize that final reimbursement of outstanding accounts receivable is subject to final approval by each third-party payor. However, because we have contracts with our third-party payors and we verify the insurance coverage of the patient before services are rendered, the amounts that are pending approval from third-party payors are minimal. Amounts are classified outside of self-pay if we have an agreement with the third-party payor or we have verified a patient's coverage prior to services rendered. It is our policy to collect co-payments and deductibles prior to providing services. It is also our policy to verify a patient's insurance 72 hours prior to the patient's procedure. Because our services are primarily non-emergency, our surgical facilities have the ability to control these procedures. Our patient service revenues from self-pay as a percentage of total revenues were approximately 3% for the year ended December 31, 2011 and approximately 4% for December 31, 2010.

Income Taxes

We use the asset and liability method to account for income taxes. Under this method, deferred income tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. If a net operating loss carryforward exists, we make a determination as to whether that net operating loss carryforward will be utilized in the future. A valuation allowance will be established for certain net operating loss carryforwards where their recoverability is deemed to be uncertain. The carrying value of the net deferred tax assets assumes that we will be able to generate sufficient future taxable income in certain tax jurisdictions, based on estimates and assumptions. If these estimates and related assumptions change in the future, we will be required to adjust our deferred tax valuation allowances.

Long-Lived Assets, Goodwill and Intangible Assets

Long-lived assets, including property, plant and equipment, comprise a significant portion of our total assets. We evaluate the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist. When events, circumstances or operating results indicate that the carrying values of certain long-lived assets and the related identifiable intangible assets might be impaired, we assess whether the carrying value of the assets will be recovered through undiscounted future cash flows expected to be generated from the use of the assets and their eventual disposition. If the assessment indicates that the recorded carrying value will not be recoverable, that cost will be reduced to estimated fair value. Estimated fair value will be determined based on a discounted future cash flow analysis.

Goodwill represents our single largest asset, and is a significant portion of our total assets. We review goodwill and indefinite lived intangible assets annually, as of December 31, or more frequently if certain indicators arise. We review goodwill at the reporting unit level, which we have determined to be the consolidated results of Symbion, Inc. We compare the carrying value of the net assets of the reporting unit to the net present value of the estimated discounted future cash flows of the reporting unit. If the carrying value exceeds the net present value of the estimated discounted future cash flows, an impairment indicator exists and an estimate of the impairment loss is calculated. The

fair value calculation includes multiple assumptions and estimates, including the projected cash flows and discount rates applied. Changes in these assumptions and estimates could result in goodwill impairment that could materially adversely impact our financial position and results of operations.

As previously discussed, the Company was acquired in a leveraged buy-out transaction on August 23, 2007. We accounted for the Merger using the purchase method of accounting. As a result, we recorded goodwill of \$509.8 million.