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HEALTH FACILITIES & SERVICES REVIEW BOARD

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name	Advocate Condell Ambulatory Surgery Center
Street Address:	825 S. Milwaukee Avenue
City and Zip Code:	Libertyville, IL 60048
County: Lake	Health Service Area 8 Health Planning Area: A-09

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Advocate Condell Ambulatory Surgery Center, LLC
Address:	825 S. Milwaukee Avenue, Libertyville, IL 60048
Name of Registered Agent:	The Corporation Trust Company
Name of President:	Robert Harmon
CEO Address;	520 Lake Cook Road, Suite 250, Deerfield, IL 60015
Telephone Number	(855) 472-7135

Type of Ownership of Applicant/Co-Applicant

- ☐ Non-profit Corporation
- ☐ For-profit Corporation
- ☒ Limited Liability Company
- ☐ Partnership
- ☐ Governmental
- ☐ Sole Proprietorship
- ☐ Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact

[Person to receive ALL correspondence or inquiries)

Name:	Robert Harmon
Title:	Vice President of Operations
Company Name:	Surgical Care Affiliates
Address:	520 Lake Cook Road, Suite 250, Deerfield, IL 60015
Telephone Number:	(847) 267-9820
E-mail Address:	robbie.harmon@scasurgery.com
Fax Number:	(855) 472-7135

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name:	Myndee Balkan
Title:	Manager, Planning
Company Name:	Advocate Condell Medical Center
Address:	801 S. Milwaukee Avenue, Libertyville, IL 60048
Telephone Number:	(847) 990-5521
E-mail Address:	myndee.balkan@advocatehealth.com
Fax Number:	(847) 362-1721

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name:	Sonja Reece, FACHE
Title:	Director, Health Facilities Planning
Company Name:	Advocate Health Care
Address:	1304 Franklin Avenue, Normal, IL 61761
Telephone Number:	(309) 268-5482
E-mail Address:	sonja.reece@advocatehealth.com
Fax Number:	(309) 888-0961

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name:	Joe Ourth
Title:	Attorney
Company Name:	Arnstein & Lehr, LLP
Address:	120 S. Riverside Plaza, Suite 1200, Chicago, IL 60606-3910
Telephone Number	(312) 876-7815
E-mail Address:	jourth@arnstein.com
Fax Number:	(312) 876-6215

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Applicant /Co-Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Advocate Condell Medical Center
Address: 801 S. Milwaukee Avenue, Libertyville, IL 60048
Name of Registered Agent: Gail D. Hasbrouck
Name of President: Dominica M. Tallarico, President, Advocate Condell Medical Center
CEO Address: 801 S. Milwaukee Avenue, Libertyville, IL 60048
Telephone Number: (847) 990-5202

Type of Ownership of Applicant/Co-Applicant

- ☒ Non-profit Corporation
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County: Lake	Health Service Area 8 Health Planning Area: A-09

Applicant /Co-Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Advocate Health and Hospitals Corporation, as the sole shareholder of Advocate Condell Medical Center
Address: 3075 Highland Parkway, Suite 600, Downers Grove, IL 60515
Name of Registered Agent: Gail D. Hasbrouck
Name of Chief Executive Officer: James H. Skogsbergh
CEO Address: 3075 Highland Parkway, Suite 600, Downers Grove, IL 60515
Telephone Number: (630) 572-9393

Type of Ownership of Applicant/Co-Applicant

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Applicant /Co-Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	Advocate Health Care Network
Address:	3075 Highland Parkway, Suite 600, Downers Grove, IL 60515
Name of Registered Agent: Gail D. Hasbrouck	
Name of Chief Executive Officer: James H. Skogsbergh	
CEO Address: 3075 Highland Parkway, Suite 600, Downers Grove, IL 60515	
Telephone Number: (630) 572-9393	

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County: Lake	Health Service Area 8 Health Planning Area: A-09

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Evangelical Services Corporation
Address of Registered Agent 3075 Highland Parkway, Suite 600, Downers Grove, IL 60515
Name of Registered Agent: Gail D. Hasbrouck
Name of Chief Executive Officer: James R. Dan, MD
CEO Address: 3075 Highland Parkway, Suite 600, Downers Grove, IL 60515
Telephone Number: (630) 572-9393

Type of Ownership of Applicant/Co-Applicant

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Applicant /Co-Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Surgical Care Affiliates, Inc.
Address 520 Lake Cook Road, Suite 250, Deerfield, IL 60015
Name of Registered Agent: The Corporation Trust Company
Name of Corporate Officer: Andrew P. Hayek, President and CEO
Officer Address: 520 Lake Cook Road, Suite 250, Deerfield, IL 60015
Telephone Number: 847-236-0921

Type of Ownership of Applicant/Co-Applicant

☐ Non-profit Corporation ☐ Partnership
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Applicant /Co-Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Surgical Care Affiliates, LLC.
Address: 569 Brookwood Village, Suite 901, Birmingham, AL 35209
Name of Registered Agent: The Corporation Trust Company
Name of Corporate Officer: Andrew P. Hayek, President and CEO
Officer Address: 520 Lake Cook Road, Suite 250, Deerfield, IL 60015
Telephone Number: 847-236-0921

Type of Ownership of Applicant/Co-Applicant

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Applicant /Co-Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: SCA Surgery Holdings, LLC.
Address: 569 Brookwood Village, Suite 901, Birmingham, AL 35209
Name of Registered Agent: The Corporation Trust Company
Name of Corporate Officer: Andrew P. Hayek, President and CEO
Officer Address: 520 Lake Cook Road, Suite 250, Deerfield, IL 60015
Telephone Number: 847-236-0921

Type of Ownership of Applicant/Co-Applicant

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[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: SCA-Illinois, LLC
Address: 569 Brookwood Village, Suite 901, Birmingham, AL 35209
Name of Registered Agent: The Corporation Trust Company
Name of Corporate Officer: Richard L. Sharff, Jr., Vice President
Officer Address: 569 Brookwood Village, Suite 901, Birmingham, AL 35209
Telephone Number: 205-545-2572

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Exact Legal Name: Advocate-SCA Partners, LLC
Address: 569 Brookwood Village, Suite 901, Birmingham, AL 35209
Name of Registered Agent: The Corporation Trust Company
Name of President: Ajay Chokshi
CEO Address 520 Lake Cook Road, Suite 250, Deerfield, IL 60015
Telephone Number: (847) 236-0921

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- ☐ Other

- o Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact

[Person to receive ALL correspondence or inquiries)

Name:	Robert Harmon
Title:	Vice President of Operations
Company Name:	Surgical Care Affiliates
Address:	520 Lake Cook Road, Suite 250, Deerfield, IL 60015
Telephone Number:	(847) 267-9820
E-mail Address:	robbie.harmon@scasurgery.com
Fax Number:	(855) 472-7135

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name:	Myndee Balkan
Title:	Manager, Planning
Company Name:	Advocate Condell Medical Center
Address:	801 S. Milwaukee Avenue, Libertyville, IL 60048
Telephone Number:	(847) 990-5521
E-mail Address:	myndee.balkan@advocatehealth.com
Fax Number:	(847) 362-1721

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name:	Sonja Reece, FACHE
Title:	Director, Health Facilities Planning
Company Name:	Advocate Health Care
Address:	1304 Franklin Avenue, Normal, IL 61761
Telephone Number:	(309) 268-5482
E-mail Address:	sonja.reece@advocatehealth.com
Fax Number:	(309) 888-0961

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name:	Joe Ourth
Title:	Attorney
Company Name:	Arnstein & Lehr, LLP
Address:	120 S. Riverside Plaza, Suite 1200, Chicago, IL 60606-3910
Telephone Number	(312) 876-7815
E-mail Address:	jourth@arnstein.com
Fax Number:	(312) 876-6215

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**

Name:	Robert Harmon
Title:	Vice President of Operations
Company Name:	Surgical Care Affiliates
Address:	520 Lake Cook Road, Suite 250, Deerfield, IL 60015
Telephone Number:	(847) 267-9820
E-mail Address:	robbie.harmon@scasurgery.com
Fax Number:	(855) 472-7135

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Advocate Condell Medical Center

Address of Site Owner: 801 S. Milwaukee Ave., Libertyville, IL 60048

Street Address or Legal Description of Site: 825 S. Milwaukee Avenue, Libertyville, IL 60048

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.

APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility, and insert after this page.]

Exact Legal Name: Advocate Condell Ambulatory Surgery Center, LLC

Address: 825 S. Milwaukee Avenue, Libertyville, IL 60048

☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☒	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 **(http://www.hfsrb.illinois.gov)**.

APPEND DOCUMENTATION AS ATTACHMENT -5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT-6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

☒ Substantive

☐ Non-substantive

2. Narrative Description

Provide in the space below, a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms, NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

Advocate Condell Ambulatory Surgery Center, LLC, is proposing to establish a multi-specialty ambulatory surgery treatment center. Co-applicants are Advocate Condell Medical Center (Condell, Hospital); Advocate Health and Hospitals Corporation, as the sole shareholder of Advocate Condell Medical Center; Advocate Health Care Network; Evangelical Services Corporation; Surgical Care Affiliates, Inc.; Surgical Care Affiliates, LLC, SCA Surgery Holdings, LLC, SCA-Illinois, LLC; and Advocate-SCA Partners, LLC. The proposed ASTC will be located on the campus of Advocate Condell Medical Center, with an address of 825 S. Milwaukee, Libertyville, Illinois, 60048.

Advocate-SCA Partners, LLC will hold 51% interest in the Advocate Condell Ambulatory Surgery Center, LLC. The physician members of the Advocate Condell Ambulatory Surgery Center, LLC will have a combined interest of 49%, and none of them will hold 5% ownership. Advocate-SCA Partners, LLC is comprised of SCA-Illinois, LLC with 51% interest and Advocate's for-profit corporation, Evangelical Services Corporation, with the other 49% interest.

The proposed new ASTC will develop and implement a charity care policy to mirror the charity care policy of Advocate Condell Medical Center. This includes seeing Medicare, Medicaid and charity care patients.

The physicians have considered their surgical cases at Condell that are appropriate for care at the ASTC and have committed to refer 1,361 outpatient surgical cases, or 2,559 hours to the proposed ASTC. That volume of hours supports two operating rooms, which are planned in the ASTC.

In addition to the two surgical operating rooms, the proposed ASTC will provide five pre-operative stations, eight recovery stations, and appropriate support space. The ASTC will also include non-clinical areas such as administration, visitor/staff support, medical records, and storage.

In accordance with Code 1110-1540 g) 4), this Project qualifies as a cooperative venture by Advocate Condell Medical Center (the "existing Hospital"), Surgical Care Affiliates, and twenty surgeons on the Condell medical staff. The Hospital provides outpatient services to the population of the Geographic Service Area defined as within a 45 minute drive time. The Hospital has sufficient utilization to support its existing 12 operating rooms and add 2 operating rooms in the proposed Project. The Hospital has committed to not seek to add additional operating rooms until the ASTC is at target utilization rate for 12 consecutive months. The proposed charges for comparable procedures at the ASTC will be lower than those of the Hospital. Because this only involves cases from Condell, there will be no impact on any other hospitals or ASTCs.

The Project is expected to cost $10,039,720 with 10,979 square feet of new construction. The building is designed for efficiency and flexibility in delivery of patient care. It is also designed for energy efficiency and long-term durability of infrastructure. The anticipated completion date is March 31, 2017.

The Project is classified substantive as it proposes a new facility.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

PROJECT COSTS AND SOURCES OF FUNDS

USE OF FUNDS	CLINICAL	NON-CLINICAL	TOTAL
Preplanning Costs	34,461	21,039	55,500
Site Survey and Soil Investigation	3,105	1,895	5,000
Site Preparation	203,707	124,369	328,076
Off Site Work	-	-	-
New Construction Contracts	3,414,814	2,084,855	5,499,669
Modernization Contracts	-	-	-
Contingencies	308,142	188,131	496,272
Architectural/Engineering Fees	355,489	217,038	572,527
Consulting and Other Fees	205,415	125,413	330,828
Movable or Other Equipment (not in construction contracts)	1,654,286	772,789	2,427,075
Bond Issuance Expense (project related)	-	-	-
Net Interest Expense During Construction (project related)	-	-	-
Fair Market Value, Leased Space, Equipment	-	-	-
Other Costs To Be Capitalized	167,390	102,197	269,587
Acquisition of Building or Other Property (excluding land)	34,266	20,921	55,187
TOTAL USES OF FUNDS	**$ 6,381,074**	**$ 3,658,646**	**$ 10,039,720**
SOURCE OF FUNDS	**CLINICAL**	**NON-CLINICAL**	**TOTAL**
Cash and Securities	3,757,196	2,056,684	5,813,879
Pledges	-	-	-
Gifts and Bequests	-	-	-
Bond Issues (project related)	-	-	-
Mortgages	-	-	-
Leases (fair market value)	2,623,878	1,601,963	4,225,841
Governmental Appropriations	-	-	-
TOTAL SOURCES OF FUNDS	**$ 6,381,074**	**$ 3,658,646**	**$ 10,039,720**

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

The project involves the establishment of a new facility or a new category of service
☒ Yes ☐ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is $713,218

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☐ Preliminary
☒ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): March 31, 2017

Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed. ☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies
☒ Project obligation will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals for Advocate Condell Medical Center

Are the following submittals up to date as applicable:

☒ **Cancer Registry**
☒ **APORS**
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Provide in the following format, the department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical-Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert following this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which the data are available. Include observation days in the patient day totals for each bed service.** Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: Advocate Condell Medical Center		**CITY: Libertyville, IL**			
REPORTING PERIOD DATES: From: January 1, 2013 to: December 31, 2013					
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	214	11,739	58,883	--	214
Obstetrics	26	2,395	5,916	--	26
Pediatrics	16	516	1,446	--	16
Intensive Care	17	1,284	4,431	--	17
Comprehensive Physical Rehabilitation	0	0	0	--	0
Acute/Chronic Mental Illness	0	0	0	--	0
Neonatal Intensive Care	0	0	0	--	0
General Long Term Care	0	0	0	--	0
Specialized Long Term Care	0	0	0	--	0
Long Term Acute Care	0	0	0	--	0
Other (identify)	0	0	0	--	0
TOTALS:	273	15,934	71,314	--	273

Also have 12 Dedicated Observation rooms.

Source: HFSRB Hospital Profile, 2013

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Advocate Condell Ambulatory Surgery Center, LLC in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

3/5/15	3/5/15
SIGNATURE	SIGNATURE
Robert Harmon	Matthew L. Primack
PRINTED NAME	PRINTED NAME
President	Vice President
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 5 day of March 2015	Notarization: Subscribed and sworn to before me this 5 day of March 2015
Angela M. Sutherland	Angela M. Sutherland
Signature of Notary	Signature of Notary
Seal: OFFICIAL SEAL ANGELA M SUTHERLAND Notary Public - State of Illinois My Commission Expires Apr 16, 2016	Seal: OFFICIAL SEAL ANGELA M SUTHERLAND Notary Public - State of Illinois My Commission Expires Apr 16, 2016

*Insert EXACT legal name of the applicant

Certificate

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- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Advocate Condell Medical Center, in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

Dominica Tallarico
SIGNATURE

Dominica M. Tallarico
PRINTED NAME

President, Advocate Condell Medical Center
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 19th day of February 2015

Cristin G. Foster
Signature of Notary

Seal

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/04/15

William P. Santulli
SIGNATURE

William P. Santulli
PRINTED NAME

Executive Vice President/COO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 19th day of February 2015

Cristin G. Foster
Signature of Notary

Seal

OFFICIAL SEAL
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NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/04/15

*Insert EXACT legal name of the applicant

Certificate

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- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Advocate Health and Hospitals Corporation, as the sole shareholder of Advocate Condell Medical Center, in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

James H. Skogsbergh
PRINTED NAME

President and CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 19th day of February 2015

Signature of Notary

Seal

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/04/15

SIGNATURE

William P. Santulli
PRINTED NAME

Executive Vice President/COO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 19th day of February 2015

Signature of Notary

Seal

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/04/15

*Insert EXACT legal name of the applicant

Certificate

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Advocate Health Care Network in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

James H. Skogsbergh
PRINTED NAME

President and CEO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 19th day of February 2015

Signature of Notary

Seal

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/04/15

SIGNATURE

William P. Santulli
PRINTED NAME

Executive Vice President/COO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me this 19th day of February 2015

Signature of Notary

Seal

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/04/15

*Insert EXACT legal name of the applicant

Certificate

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- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Evangelical Services Corporation in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

James R. Dan, MD
PRINTED NAME

President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 19th day of February 2015

Cristin G. Foster
Signature of Notary

Seal

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/04/15

SIGNATURE

Eric Tower
PRINTED NAME

Assistant Secretary
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 19th day of February 2015

Cristin G. Foster
Signature of Notary

Seal

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/04/15

*Insert EXACT legal name of the applicant

CERTIFICATION

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- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Surgical Care Affiliates, Inc.
***in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.**

SIGNATURE

Richard L. Sharff, Jr.
PRINTED NAME

Executive Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2nd day of March, 2015

Signature of Notary

Seal

KINESHIA RONAY COLLINS
My Commission Expires
September 22, 2018

SIGNATURE

Jennifer Kimbrough
PRINTED NAME

Compliance Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2nd day of March, 2015

Signature of Notary

Seal

KINESHIA RONAY COLLINS
My Commission Expires
September 22, 2018

*Insert EXACT legal name of the applicant

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
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- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Surgical Care Affiliates, LLC *in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Richard L. Sharff, Jr.
PRINTED NAME

EVP
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2nd day of March

Signature of Notary

Seal

KINESHIA RONAY COLLINS
My Commission Expires
September 22, 2018

SIGNATURE

Pete Clemens
PRINTED NAME

CFO
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 2nd day of March

Signature of Notary

Seal

KINESHIA RONAY COLLINS
My Commission Expires
September 22, 2018

*Insert EXACT legal name of the applicant

CERTIFICATION

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- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of SCA Surgery Holdings, LLC *in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE	SIGNATURE
Richard L. Sharff, Jr.	Pete Clemens
PRINTED NAME	PRINTED NAME
VP	CFO
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this 2nd day of March	Notarization: Subscribed and sworn to before me this 2nd day of March
Signature of Notary	Signature of Notary
Seal	Seal
KINESHIA RONAY COLLINS My Commission Expires September 22, 2018	KINESHIA RONAY COLLINS My Commission Expires September 22, 2018

*Insert EXACT legal name of the applicant

Certificate

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of SCA-Illinois, LLC in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Richard L. Sharff, Jr.
PRINTED NAME

Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 20th day of February, 2015

Signature of Notary

Seal

KINESHIA RONAY COLLINS
My Commission Expires
September 22, 2018

SIGNATURE

Joseph T. Clark
PRINTED NAME

Vice President
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 20th day of February, 2015

Signature of Notary

Seal

KINESHIA RONAY COLLINS
My Commission Expires
September 22, 2018

*Insert EXACT legal name of the applicant

Certificate

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- in the case of a corporation, any two of its officers or members of its Board of Directors;
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- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Advocate-SCA Partners, LLC in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

SIGNATURE

Scott Powder
PRINTED NAME

Board Member
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 20th day of February 2015

Cristin G. Foster
Signature of Notary

Seal

OFFICIAL SEAL
CRISTIN G FOSTER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/04/15

SIGNATURE

Michael Rucker
PRINTED NAME

Board Member
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 19th day of February 2015

Theresa K. Knar
Signature of Notary

Seal

OFFICIAL SEAL
THERESA K KNAR
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/18/16

Lake County

*Insert EXACT legal name of the applicant

SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.

2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.

3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded if any. For facility projects, include statements of age and condition and regulatory citations if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Report.

APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

1) Identify **ALL** of the alternatives to the proposed project:

   Alternative options **must** include:

   A) Proposing a project of greater or lesser scope and cost;

   B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

   C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

   D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT-13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following::

   a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

   b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

   c. The project involves the conversion of existing space that results in excess square footage.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

APPEND DOCUMENTATION AS ATTACHMENT-14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT-15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage of the proposed shell space;

2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function;

3. Evidence that the shell space is being constructed due to
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data are available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.

2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and

3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT-17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII - SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing establishment, expansion or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion and modernization). After identifying the applicable review criteria for each category of service involved , read the criteria and provide the required information, AS APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

H. Non-Hospital Based Ambulatory Surgery

This section is applicable to all projects proposing to establish or modernize a non-hospital based ambulatory surgical treatment center or to the addition of surgical specialties.

1. Criterion 1110.1540(a), Scope of Services Provided

Read the criterion and complete the following:

a. Indicate which of the following types of surgery are being proposed:

_____Cardiovascular	_____Obstetrics/Gynecology	_____Pain Management
_____Dermatology	_____Ophthalmology	_____Podiatry
_____Gastroenterology	_____Oral/Maxillofacial	_____Thoracic
_____General/Other	_____Orthopedic	_____Otolaryngology
_____Neurology	_____Plastic	_____Urology

b. Indicate if the project will result in a _____ limited or _____ a multi-specialty ASTC.

2. Criterion 1110.1540(b), Target Population

Read the criterion and provide the following:

a. On a map (8 ½" x 11"), outline the intended geographic services area (GSA).

b. Indicate the population within the GSA and how this number was obtained.

c. Provide the travel time in all directions from the proposed location to the GSA borders and indicate how this travel time was determined.

3. Criterion 1110.1540(c), Projected Patient Volume

Read the criterion and provide signed letters from physicians that contain the following:

a. The number of referrals anticipated annually for each specialty.

b. For the past 12 months, the name and address of health care facilities to which patients were referred, including the number of patients referred for each surgical specialty by facility.

c. A statement that the projected patient volume will come from within the proposed GSA.

d. A statement that the information in the referral letter is true and correct to the best of his or her belief.

4. Criterion 1110.1540(d), Treatment Room Need Assessment

Read the criterion and provide:

a. The number of procedure rooms proposed.

b. The estimated time per procedure including clean-up and set-up time and the methodology used in arriving at this figure.

5. Criterion 1110.1540(e), Impact on Other Facilities

Read the criterion and provide:

a. A copy of the letter sent to area surgical facilities regarding the proposed project's impact on their workload. NOTE: This letter must contain: a description of the project including its size, cost, and projected workload; the location of the proposed project; and a request that the facility administrator indicate what the impact of the proposed project will be on the existing facility.

b. A list of the facilities contacted. **NOTE**: Facilities must be contacted by a service that provides documentation of receipt such as the US. Postal Service, FedEx or UPS. The documentation must be included in the application for permit.

6. Criterion 1110.1540(f), Establishment of New Facilities

Read the criterion and provide:

a. A list of services that the proposed facility will provide that are not currently available in the GSA; or

b. Documentation that the existing facilities in the GSA have restrictive admission policies; or

c. For co-operative ventures,

a. Patient origin data that documents the existing hospital is providing outpatient surgery services to the target population of the GSA, and

b. The hospital's surgical utilization data for the latest 12 months, and

c. Certification that the existing hospital will not increase its operating room capacity until such a time as the proposed project's operating rooms are operating at or above the target utilization rate for a period of twelve full months; and

d. Certification that the proposed charges for comparable procedures at the ASTC will be lower than those of the existing hospital.

7. Criterion 1110.1540(g), Charge Commitment

Read the criterion and provide:

a. A complete list of the procedures to be performed at the proposed facility with the proposed charge shown for each procedure.

b. A letter from the owner and operator of the proposed facility committing to maintain the above charges for the first two years of operation.

8. Criterion 1110.1540(h), Change in Scope of Service

Read the criterion and, if applicable, document that existing programs do not currently provide the service proposed or are not accessible to the general population of the geographic area in which the facility is located.

APPEND DOCUMENTATION AS ATTACHMENT-27, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The following Sections DO NOT need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18 month period prior to the submittal of the application):

- **Section 1120.120 Availability of Funds – Review Criteria**
- **Section 1120.130 Financial Viability – Review Criteria**
- **Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)**

VIII. 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: **Indicate the dollar amount to be provided from the following sources:**

_____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
		TOTAL FUNDS AVAILABLE

APPEND DOCUMENTATION AS ATTACHMENT-36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

IX. 1120.130 - Financial Viability

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. **"A" Bond rating or better**
2. **All of the projects capital expenditures are completely funded through internal sources**
3. **The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent**
4. **The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.**

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

Provide Data for Projects Classified as:	**Category A or Category B (last three years)**			**Category B (Projected)**
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 1120.140 - Economic Feasibility

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or

2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:

A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or

B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. **Reasonableness of Project and Related Costs**

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT-39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 43.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			

Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT-40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. (20 ILCS 3960/3) Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT-41, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

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Appendix 1: Physicians Referrals, Appendix 2: Financials

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Type of Ownership of Applicant/Co-Applicant

☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☒	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**

Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

See Attachment 1, Exhibit 1, for the Advocate Condell Ambulatory Surgery Center certificate of good standing.

File Number 0508782-1

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

ADVOCATE CONDELL AMBULATORY SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON FEBRUARY 13, 2015, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

Authentication #: 1505002082
Authenticate at: http://www.cyberdriveillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 19TH *day of* FEBRUARY *A.D.* 2015 .

Jesse White

SECRETARY OF STATE

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Type of Ownership of Applicant/Co-Applicant

☒	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company	☐	Sole Proprietorship	☐	Other

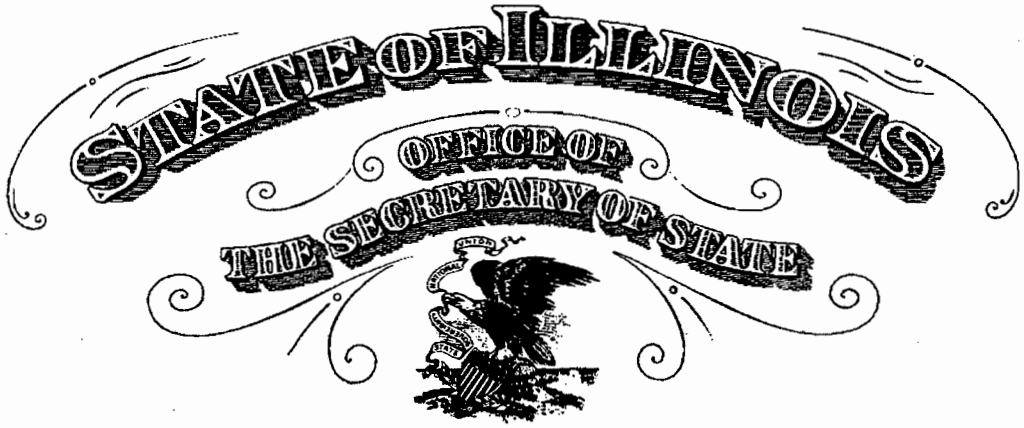
- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**

Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

See Attachment 1, Exhibits 2 to 4.

File Number 6610-658-6



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

ADVOCATE CONDELL MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON APRIL 29, 2008, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 1504902958
Authenticate at: http://www.cyberdriveillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 18TH *day of* FEBRUARY *A.D.* 2015 .

Jesse White

SECRETARY OF STATE

File Number 1004-695-5

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

ADVOCATE HEALTH AND HOSPITALS CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 12, 1906, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 1504902934
Authenticate at: http://www.cyberdriveillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 18TH *day of* FEBRUARY *A.D.* 2015 .

Jesse White

SECRETARY OF STATE

C

File Number 1707-692-2

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

ADVOCATE HEALTH CARE NETWORK, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JUNE 14, 1923, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 1504902894

Authenticate at: http://www.cyberdriveillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 18TH *day of* FEBRUARY *A.D.* 2015 .

Jesse White

SECRETARY OF STATE

Type of Ownership of Applicant/Co-Applicant

☐	Non-profit Corporation	☐	Partnership		
☒	For-profit Corporation	☐	Governmental		
☐	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**

Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

Evangelical Service Corporation is shown as Exhibit 5

Surgical Care Affiliates, Inc., is registered in the State of Delaware. It conducts no business in Illinois other than to serve as a holding entity and is not required by the Illinois Secretary of State to register to do business in Illinois. Its certificate of good standing from Delaware is included as Exhibit 6.

File Number 5291-138-9

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

EVANGELICAL SERVICES CORPORATION, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON NOVEMBER 24, 1982, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE BUSINESS CORPORATION ACT OF THIS STATE RELATING TO THE PAYMENT OF FRANCHISE TAXES, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

Authentication #: 1504903006
Authenticate at: http://www.cyberdrivelllinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 18TH *day of* FEBRUARY *A.D.* 2015 .

Jesse White

SECRETARY OF STATE

Delaware

PAGE 1

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "SURGICAL CARE AFFILIATES, INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE SECOND DAY OF MARCH, A.D. 2015.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

Jeffrey W. Bullock, Secretary of State

4322814 8300

150302601

AUTHENTICATION: 2163085

DATE: 03-02-15

You may verify this certificate online at corp.delaware.gov/authver.shtml

Type of Ownership of Applicant/Co-Applicant

☐	Non-profit Corporation	☐	Partnership		
☐	For-profit Corporation	☐	Governmental		
☒	Limited Liability Company	☐	Sole Proprietorship	☐	Other

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**

Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

Surgical Care Affiliates, LLC, SCA Surgery Holdings, LLC, and SCA-Illinois, LLC, are registered in the State of Delaware. They conduct no business in Illinois other than to serve as holding entities and are not required by the Illinois Secretary of State to register to do business in Illinois. Their certificates of good standing from Delaware are included as Exhibit 7, 8 and 9.

Advocate-SCA Partners, LLC, certificate of good standing is included as Exhibit 10.

Delaware

PAGE 1

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "SURGICAL CARE AFFILIATES, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE THIRD DAY OF MARCH, A.D. 2015.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN PAID TO DATE.

Jeffrey W. Bullock, Secretary of State

4289130 8300

150303338

AUTHENTICATION: 2163693

DATE: 03-03-15

You may verify this certificate online at corp.delaware.gov/authver.shtml

Delaware

PAGE 1

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "SCA SURGERY HOLDINGS, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE THIRD DAY OF MARCH, A.D. 2015.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN PAID TO DATE.

Jeffrey W. Bullock, Secretary of State

4545056 8300

150303341

AUTHENTICATION: 2163694

DATE: 03-03-15

You may verify this certificate online at corp.delaware.gov/authver.shtml

Delaware

PAGE 1

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF FORMATION OF "SCA-ILLINOIS, LLC", FILED IN THIS OFFICE ON THE THIRTEENTH DAY OF JANUARY, A.D. 2015, AT 5:41 O'CLOCK P.M.

Jeffrey W. Bullock, Secretary of State

5673924 8100

150046568

You may verify this certificate online at corp.delaware.gov/authver.shtml

AUTHENTICATION: 2038556

DATE: 01-14-15

State of Delaware
Secretary of State
Division of Corporations
Delivered 05:46 PM 01/13/2015
FILED 05:41 PM 01/13/2015
SRV 150046568 - 5673924 FILE

CERTIFICATE OF FORMATION

OF

SCA-ILLINOIS, LLC

1. The name of the limited liability company is SCA-Illinois, LLC.

2. The address of its registered office in the State of Delaware is: Corporation Trust Center, 1209 Orange Street, in the City of Wilmington, Delaware 19801. The name of its registered agent at such address is The Corporation Trust Company.

IN WITNESS WHEREOF, the undersigned have executed this Certificate of Formation of SCA-Illinois, LLC this 13th day of January, 2015.

By: RLS

Printed Name: Richard L. Sharff, Jr.

Title: Authorized Person

File Number 0509172-1

STATE OF ILLINOIS
OFFICE OF
THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

ADVOCATE-SCA PARTNERS, LLC, A DELAWARE LIMITED LIABILITY COMPANY HAVING OBTAINED ADMISSION TO TRANSACT BUSINESS IN ILLINOIS ON FEBRUARY 25, 2015, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A FOREIGN LIMITED LIABILITY COMPANY ADMITTED TO TRANSACT BUSINESS IN THE STATE OF ILLINOIS.

SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818

Authentication #: 1505800784
Authenticate at: http://www.cyberdriveillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 27TH *day of* FEBRUARY *A.D.* 2015 .

Jesse White

SECRETARY OF STATE

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: Advocate Condell Medical Center
Address of Site Owner 801 S. Milwaukee, Libertyville, IL
Street Address or Legal Description of Site: 825 S Milwaukee Avenue, Libertyville, IL 60048-3199 **Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.**
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Proof of site ownership is shown as Attachment 2, Exhibit 1.

Advocate Condell Medical Center
801 South Milwaukee Avenue || Libertyville, IL 60048 || T 847.362.2900 || advocatehealth.com

March 2, 2015

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, Second Floor
Springfield, IL 62761

RE: Advocate Condell Ambulatory Surgery Center

Dear Ms. Avery:

This attestation letter is submitted to indicate that Advocate Condell Medical Center owns the proposed Advocate Condell Ambulatory Surgery Center site, at 825 S. Milwaukee Avenue, in Libertyville, Illinois.

We trust this attestation complies with the State Agency Proof of Ownership requirement indicated in the Permit application – July 2013 edition.

Respectfully,

Dominica M. Tallarico
President
Advocate Condell Medical Center

Notarization:

Subscribed and sworn to before me
This 2nd day of March, 2015.

OFFICIAL SEAL
(Seal) THERESA KUNAR
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/18/16
LAKE County

Signature of Notary Theresa K. Kunz

A faith-based health system serving individuals, families and communities

Operating Identity/Licensee

[Provide this information for each applicable facility, and insert after this page.]

Exact Legal Name: Advocate Condell Ambulatory Surgery Center, LLC

Address: 825 S. Milwaukee Avenue, Libertyville, IL 60048-3199

☐	Non-profit Corporation	☐	Partnership	
☐	For-profit Corporation	☐	Governmental	
☒	Limited Liability Company	☐	Sole Proprietorship	☐
	Other			

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.**

APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Certificate of Good Standing for Advocate Condell Ambulatory Surgery Center, LLC is appended as Attachment 3, Exhibits 1.

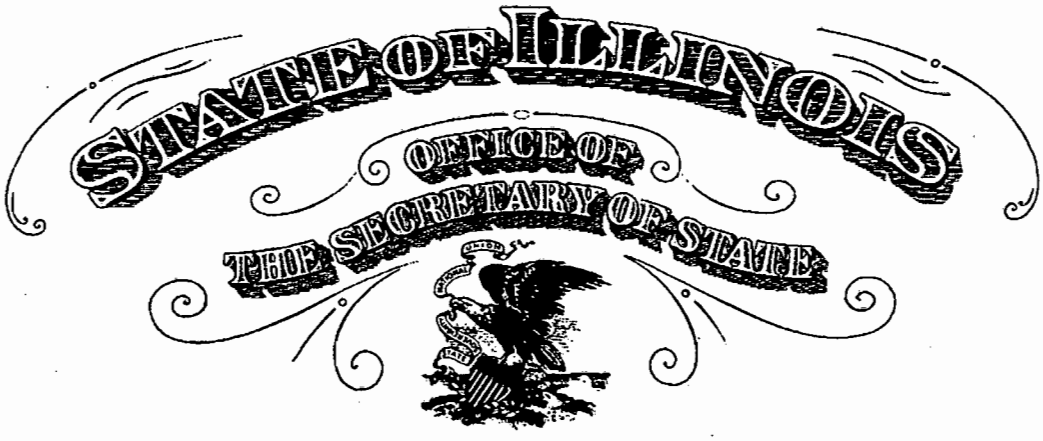
The October 17, 2014 Letter of Intent with the physicians is shown as Attachment 3, Exhibit 2. At the time the Letter of Intent was written, the joint venture company was referred to as "SCA-ESC Holdco". The joint venture has since been formed with the name Advocate-SCA Partners, LLC.

SCA-Illinois, LLC will hold 51% interest in Advocate-SCA Partners, LLC. Advocate's for-profit corporation, Evangelical Services Corporation, will hold the other 49% of Advocate-SCA Partners, LLC.

Advocate-SCA Partners, LLC will hold 51% interest in the Advocate Condell Ambulatory Surgery Center, LLC. The physician members of the Advocate Condell Ambulatory Surgery Center, LLC will have a combined interest of 49%, and none of them will hold 5% ownership.

The physician members and their individual interests are shown as Exhibit 2.

File Number 0508782-1



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that

ADVOCATE CONDELL AMBULATORY SURGERY CENTER, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON FEBRUARY 13, 2015, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.

Authentication #: 1505002082
Authenticate at: http://www.cyberdriveillinois.com

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 19TH *day of* FEBRUARY *A.D.* 2015 .

Jesse White

SECRETARY OF STATE

October 17, 2014

RE: De Novo Ambulatory Surgery Project

Ladies and Gentlemen:

On behalf of Surgical Care Affiliates, LLC ("SCA") and Evangelical Services Corporation ("ESC"), I would like to thank you for the opportunity to engage in further negotiations with each of you (each a "Physician", and collectively the "Physicians") regarding the development and operation of a new ambulatory surgery center (the "Center") anticipated to be developed with three (3) operating rooms located on or near the Advocate Condell Medical Center in Libertyville, Illinois. The proposed terms contained in this letter (the "Letter of Intent") are based upon information provided to SCA and ESC without independent verification and are as follows:

1. Formation and Capitalization of the Company. A limited liability company (the "SCA-ESC Holdco") will be formed by SCA and ESC to own a fifty-one percent (51%) interest in a newly formed limited liability company (the "Company") with the Physicians owning in the aggregate a forty-nine percent (49%) interest of the Company; provided that it is anticipated that each Physician, individually or through an investment entity or trust, will own up to a two percent (2%) interest in the Company. Within thirty (30) days of execution of this Letter of Intent, each Physician, SCA and ESC shall contribute his or her pro rata share of a Fifty Thousand Dollar ($50,000) equity contribution to the Company based on his or her desired post-formation ownership percentage (e.g. a two percent (2%) investment would require a One Thousand Dollar ($1,000) initial contribution). This equity contribution is nonrefundable and shall be used to pay for initial costs and fees of the certificate of need ("CON") application process with the Illinois Health Facilities Services Review Board and other legal fees and expenses. Upon CON approval, each Physician, SCA and ESC shall contribute to the Company an amount equal to its, his or her pro rata share of the Company's remaining development fees including but not limited to CON costs and expenses. SCA and ESC anticipate that the total capital contribution required from each Physician will be equal to an amount between Twenty-Five Thousand Dollars ($25,000) and One Hundred Twenty-Five Thousand Dollars ($125,000) depending on each Physician's desired post-formation ownership percentage.

2. Operating Agreement. The SCA-ESC Holdco and the Physicians will enter into an operating agreement (the "Operating Agreement") for the Company that will contain governance rights and covenants, including but not limited to, the following:

a. a Board of Managers, comprised of three (3) representatives appointed by the Physicians with a total of three (3) votes and four (4) representatives appointed by SCA-ESC Holdco with a total of four (4) votes, to conduct the business and affairs of the Company;

b. a restrictive covenant that will prohibit the Physicians from participating in an ambulatory surgery center, hospital or any business competitive with the Center within a certain mutually agreeable geographic range; provided that such covenant shall not prohibit the Physicians from owning interests in competing businesses and ventures as of the effective date of the Operating Agreement;

c. the addition of rights to repurchase ownership units upon certain "buy/sell" events, including, without limitation, disability, death, incompetence, retirement, relocation, failure to remain a qualified physician investor with active medical

61040422_3

staff privileges at the Center, or failure to satisfy extension of practice requirements, transfers in violation of the Operating Agreement, material breach of the Operating Agreement, failure to maintain malpractice insurance, loss of medical license or controlled substances registration, gross misconduct or conviction of a felony or crime of moral turpitude; a change in law that makes the ownership in the Company and/or referrals by the physician partners illegal.

3. Upon execution of this Letter of Intent, the SCA-ESC Holdco and the Physicians shall have thirty (30) days to enter into a development services agreement (the "Development Services Agreement") under the terms of which SCA will provide certain development services with regard to the Center, including but not limited to assisting with architectural development, surgical clinic licensure, Medicare certification and/or accreditation, certificate of need application, general project coordination and budgeting.

4. Upon execution of the Operating Agreement, the SCA-ESC Holdco and the Company shall enter into a management agreement (the "Management Agreement") that will commence as of the date the Center begins operations under the terms of which SCA will become the manager of the Center and provide day- to-day management services including but not limited to managed care contracting services on behalf of the Center. The aggregate fee for providing these services will be five percent (5%) of net patient revenue plus reimbursement of direct expenses incurred by the SCA-ESC Holdco (or SCA as subcontractors) on behalf of the Center including, but not limited to, insurance premiums, the cost of employing the Center employees, legal fees, and tax return preparation.

5. Upon execution of this Letter of Intent by SCA, ESC and the Physicians, SCA and ESC will direct their legal counsels to begin preparation of the Operating Agreement, Development Services Agreement and the Management Agreement (the "Formation Documents") for review by the Physicians and their respective counsel. The Formation Documents shall contain provisions in accordance with the foregoing together with such further appropriate terms and conditions as are customary in such joint venture arrangements and mutually acceptable to the parties.

6. Conditions to Execution of Formation Documents. The obligations of the parties to proceed under the Formation Documents will be contingent upon the final satisfaction or waiver by each party of the following conditions (as applicable):

a. Due Diligence. Satisfaction by SCA and ESC of the results of its due diligence review of the Physicians and feasibility of the Center.

b. No Conflict. No court or governmental or regulatory authority shall have enacted or issued any statute, rule, regulation, judgment, injunction or other order which prohibits the consummation of, or materially adversely affects the anticipated benefits from, the transactions contemplated by the Formation Documents.

c. Senior Management Approval. The Formation Documents shall have been duly authorized and approved by senior management of SCA and ESC.

d. Joint Venture Partner. SCA and ESC shall have entered into the definitive documents with regard to the formation and capitalization of the SCA-ESC Holdco.

BINDING PROVISIONS. Paragraphs 1-6 of this Letter of Intent are non-binding and do not create an obligation by any party to enter into a binding agreement with respect to the development of the Center (provided that the agreement on nonrefundability of the initial contribution shall be binding). No person shall bring any claim against any person based upon this Letter of Intent as the result of a failure to agree on or enter into the Formation Documents or the transactions contemplated herein or otherwise, except for obligations arising out of the following paragraphs of this Letter of Intent, which are legally binding and enforceable agreements of each of the parties hereto.

7. Exclusivity.

   a. SCA and ESC contemplate the expenditure of substantial sums of time and money in connection with legal, accounting, financial and due diligence work to be performed in connection with transactions contemplated by this Letter of Intent (the "Transaction"). The Physicians agree to negotiate exclusively and in good faith with SCA and ESC during the Exclusivity Period (defined below) with respect to the development of the Center.

   b. For purposes of inducing SCA and ESC to execute this Letter of Intent, neither Practice nor any Selling Physician shall, directly or indirectly, without SCA's and ESC's prior written consent, initiate or hold discussions with any person or entity concerning the development or purchase of any ambulatory surgical center or similar surgical center during the period following the date that this Letter of Intent is executed until April 30, 2015 (the "Exclusivity Period"). Should a Physician be approached by a third party during the Exclusivity Period with respect to the development or purchase of any ambulatory surgical center or similar surgical center, the Physician agrees to fully disclose to SCA and ESC such communication.

   c. The parties consider the provisions herein, including without limitation, the provisions of this paragraph to be fair, reasonable and integral to the protection of each party. Each party agrees that the breach or threatened breach of this Letter of Intent by any party would cause serious and irreparable injury to the non-breaching party, and therefore each party agrees that the other party may not have an adequate remedy at law in connection with any violation of this Letter of Intent, and, in addition to all other remedies available at law or in equity, each party shall be entitled to injunctive or similar relief for any breach of this Letter of Intent.

8. Confidentiality.

   a. Upon execution of this Letter of Intent, SCA, ESC, the Physicians and their respective representatives and affiliates agree to promptly share information regarding the development of the Center and such other nonpublic information as is reasonably requested in order to facilitate the matters addressed within this Letter of Intent (the "Confidential Information"). The Confidential Information shall be used for the sole purpose of evaluating the Transaction. Moreover, each party further agrees to transmit the Confidential Information only to those of its representatives who need to know such information for the purpose of evaluating the Transaction.

b. Each party who receives Confidential Information shall advise its representatives of the terms and conditions of this paragraph of this Letter of Intent and shall obtain the verbal agreement of its representatives to keep all of the Confidential Information confidential and to be bound by the provisions of the agreement as if each was a party hereto. Notwithstanding anything in this Letter of Intent to the contrary, aparty may disclose the terms and conditions of this Letter of Intent to any of its accounting, legal or financial advisor so long as such persons are advised of the duties of confidentiality hereunder. Each party shall remain responsible for any breaches of such duties by its representatives or advisors, without regard to whether such representative/advisor in fact agreed to be bound by this Letter of Intent.

c. Neither party nor its representatives shall disclose to any person (other than as may be required to obtain any consents, license or permit necessary to consummate the Transaction) (a) that discussions are taking place with respect to the Transaction, (b) the substance of any such discussions, or (c) that Confidential Information has been made available to a party or its representatives.

d. Each party agrees to consult the other party regarding the contents of any public statements regarding their relationship prior to making such public statements other than statements required to obtain any consents, license or permit necessary to consummate the Transaction.

e. No obligation of confidentiality shall exist as to (i) information or materials that are in the public domain at the time of the disclosure or thereafter become part of the public domain through no act or omission of the disclosing party, (ii) information that was lawfully disclosed after the date hereof by a third party, or (iii) information of a general nature concerning the business of the Center.

9. Expenses and Legal Fees. Each party hereto agrees that it shall pay its own expenses and those of its respective agents, advisors, attorneys and accountants with respect to carrying out of the due diligence, negotiation of this Letter of Intent and the Formation Documents.

10. Governing Law. This Letter of Intent shall be governed by the laws of the State of Illinois without regard to its choice of law provisions.

11. Prior Agreements. This Letter of Intent supersedes any prior agreement regarding the subject matter of this Letter of Intent. Any such prior agreement shall not be effective for any purpose.

12. Risk; Accredited Investor. Each party also acknowledges that it, he or she is either:

a. an accredited investor, i.e., he or she individually earns more than $200,000 per year or $300,000 jointly with a spouse for the preceding two (2) years or has a net worth, inclusive of principal residence and any other asset, in excess of $1,000,000; or

b. is financially capable of assessing and bearing the risk of loss inherent in the investment but has notified SCA that he or she does not meet accredited investor.

13. Termination of Letter of Intent. This Letter of Intent will be of no force and effect with respect to an individual Physician if such Physician has not signed and returned the same to SCA by 5:00 p.m. central daylight savings time on or before October 31, 2014. Additionally, with respect to SCA, ESC and all timely signing Physicians, this Letter of Intent will terminate upon the earlier to occur of (i) entry into the Formation Documents; or (ii) May 1, 2015; or (iii) the mutual agreement of a majority of the signing Physicians, SCA and ESC.

14. Conflict of Interest. While McGuireWoods LLP will develop the Formation Documents, each party should understand that McGuireWoods LLP acts as general counsel to SCA and that the other parties are encouraged to obtain independent counsel in connection herewith and in connection with the Formation Documents.

If the foregoing describes our preliminary understanding with respect to development of the Center and the execution and delivery of the Formation Documents, please sign below so that we may commence due diligence and the preparation of the Formation Documents.

Execution of this Letter of Intent is intended to confirm our understanding in principle and is subject to negotiation of the Formation Documents between the applicable parties.

Please direct all communications regarding this proposal to Walker Badham at (205) 253-8135 or at Walker.Badham@scasurgery.com. We appreciate the opportunity to discuss this matter and look forward to working with you.

Very Truly Yours,

Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

Surgical Care Affiliates, LLC

By: _____
Name: Richard L. Sharff, Jr.
Title: EVP

Evangelical Services Corporation

By: _____
Name: Denise Keefe
Title: President, Advocate At Home

Physicians:

Signature: _____
Printed Name: _____
Desired Percentage (max 2%): _____

Signature: _____
Printed Name: _____
Desired Percentage (max 2%): _____

13. Termination of Letter of Intent. This Letter of Intent will be of no force and effect with respect to an individual Physician if such Physician has not signed and returned the same to SCA by 5:00 p.m. central daylight savings time on or before October 31, 2014. Additionally, with respect to SCA, ESC and all timely signing Physicians, this Letter of Intent will terminate upon the earlier to occur of (i) entry into the Formation Documents; or (ii) May 1, 2015; or (iii) the mutual agreement of a majority of the signing Physicians, SCA and ESC.

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If the foregoing describes our preliminary understanding with respect to development of the Center and the execution and delivery of the Formation Documents, please sign below so that we may commence due diligence and the preparation of the Formation Documents.

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Please direct all communications regarding this proposal to Walker Badham at (205) 253-8135 or at Walker.Badham@scasurgery.com. We appreciate the opportunity to discuss this matter and look forward to working with you.

Very Truly Yours,

_____
Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

Surgical Care Affiliates, LLC	*Evangelical Services Corporation*
By:_____	By:_____
Name:_____	Name:_____
Title:_____	Title:_____

Physicians:

Signature:_____	Signature:_____
Printed Name: Daniel Nielsen MD	Printed Name:_____
Desired Percentage (max 2%): 2%	Desired Percentage (max 2%):_____

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Very Truly Yours,

_____

Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

Surgical Care Affiliates, LLC

By:_____
Name:_____
Title:_____

Evangelical Services Corporation

By:_____
Name:_____
Title:_____

Physicians:

Signature: [signature]
Printed Name: [illegible]
Desired Percentage (max 2%): [illegible]

Signature:_____
Printed Name:_____
Desired Percentage (max 2%):_____

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Very Truly Yours,

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Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

Surgical Care Affiliates, LLC	*Evangelical Services Corporation*
By:_____	By:_____
Name:_____	Name:_____
Title:_____	Title:_____

Physicians:

Signature: Michael Scher	Signature:_____
Printed Name: Scherr	Printed Name:_____
Desired Percentage (max 2%): 2%	Desired Percentage (max 2%):_____

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Very Truly Yours,

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Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

Surgical Care Affiliates, LLC	*Evangelical Services Corporation*
By:_____	By:_____
Name:_____	Name:_____
Title:_____	Title:_____

***Physicians*:**

Signature: 10/30/14	Signature:_____
Printed Name: AARON SUGG	Printed Name:_____
Desired Percentage (max ~~2~~%): 2% 25K	Desired Percentage (max 2%):_____

Signature:
Printed Name: L. GIBSON
Desired Percentage (max 2%): 1%

Signature:
Printed Name:
Desired Percentage (max 2%):

Signature:
Printed Name:
Desired Percentage (max 2%):

Signature:
Printed Name:
Desired Percentage (max 2%):

Signature:
Printed Name:
Desired Percentage (max 2%):

Signature:
Printed Name:
Desired Percentage (max 2%):

Signature:
Printed Name:
Desired Percentage (max 2%):

Signature:
Printed Name:
Desired Percentage (max 2%):

Signature:
Printed Name:
Desired Percentage (max 2%):

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Very Truly Yours,

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Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

Surgical Care Affiliates, LLC

By:_____
Name:_____
Title:_____

Evangelical Services Corporation

By:_____
Name:_____
Title:_____

Physicians:

Signature: [signature]
Printed Name: Paul Strohmayer
Desired Percentage (max 2%): 1

Signature:_____
Printed Name:_____
Desired Percentage (max 2%):_____

5

61040422_3

13. Termination of Letter of Intent. This Letter of Intent will be of no force and effect with respect to an individual Physician if such Physician has not signed and returned the same to SCA by 5:00 p.m. central daylight savings time on or before October 31, 2014. Additionally, with respect to SCA, ESC and all timely signing Physicians, this Letter of Intent will terminate upon the earlier to occur of (i) entry into the Formation Documents; or (ii) May 1, 2015; or (iii) the mutual agreement of a majority of the signing Physicians, SCA and ESC.

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Very Truly Yours,

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Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

Surgical Care Affiliates, LLC

By:_____
Name:_____
Title:_____

Evangelical Services Corporation

By:_____
Name:_____
Title:_____

Physicians:

Signature:_____
Printed Name: Ronald Kim
Desired Percentage (max 2%): 2 %

Signature:_____
Printed Name:_____
Desired Percentage (max 2%):_____

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Very Truly Yours,

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Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

Surgical Care Affiliates, LLC

By:_____
Name:_____
Title:_____

Evangelical Services Corporation

By:_____
Name:_____
Title:_____

Physicians:

Signature:_____
Printed Name:_____
Desired Percentage (max 2%):_____

Signature:_____
Printed Name:_____
Desired Percentage (max 2%):_____

5

61040422_3

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Very Truly Yours,

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Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

Surgical Care Affiliates, LLC	***Evangelical Services Corporation***
By:_____	By:_____
Name:_____	Name:_____
Title:_____	Title:_____

Physicians:

Signature:_____	Signature:_____
Printed Name: Robert Socco	Printed Name:_____
Desired Percentage (max 2%): 2%	Desired Percentage (max 2%):_____

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Very Truly Yours,

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Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

Surgical Care Affiliates, LLC

By:_____
Name:_____
Title:_____

Evangelical Services Corporation

By:_____
Name:_____
Title:_____

Physicians:

Signature: Raza M Khan
Printed Name: RAZA M. KHAN
Desired Percentage (max 2%): 2%

Signature:_____
Printed Name:_____
Desired Percentage (max 2%):_____

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Surgical Care Affiliates, LLC

By:_____
Name:_____
Title:_____

Evangelical Services Corporation

By:_____
Name:_____
Title:_____

Physicians:

Signature: Ben Johnson
Printed Name: Ben Johnson
Desired Percentage (max 2%): 2%

Signature:_____
Printed Name:_____
Desired Percentage (max 2%):_____

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Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

Surgical Care Affiliates, LLC

By:_____
Name:_____
Title:_____

Evangelical Services Corporation

By:_____
Name:_____
Title:_____

Physicians:

10-30-2014
Signature: C Jarvik MD
Printed Name: Charles E. Jarvik
Desired Percentage (max 2%): 2%

Signature:_____
Printed Name:_____
Desired Percentage (max 2%):_____

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Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

Surgical Care Affiliates, LLC

By:_____
Name:_____
Title:_____

Evangelical Services Corporation

By:_____
Name:_____
Title:_____

Physicians:

Signature: [signature]
Printed Name: Gregory G. Carolis
Desired Percentage (max 2%): 2%

Signature:_____
Printed Name:_____
Desired Percentage (max 2%):_____

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Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

Surgical Care Affiliates, LLC

By:_____
Name:_____
Title:_____

Evangelical Services Corporation

By:_____
Name:_____
Title:_____

Physicians:

Signature:_____
Printed Name: Jonathan Citino MD
Desired Percentage (max 2%): 2%

Signature:_____
Printed Name: Juan Alzate MD
Desired Percentage (max 2%): 2%

Signature: [signature]
Printed Name: Robert K. Erickson MD
Desired Percentage (max 2%): 2%

Signature:
Printed Name:
Desired Percentage (max 2%):

Signature:
Printed Name:
Desired Percentage (max 2%):

Signature:
Printed Name:
Desired Percentage (max 2%):

Signature:
Printed Name:
Desired Percentage (max 2%):

Signature:
Printed Name:
Desired Percentage (max 2%):

Signature:
Printed Name:
Desired Percentage (max 2%):

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Printed Name:
Desired Percentage (max 2%):

Signature:
Printed Name:
Desired Percentage (max 2%):

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Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

Surgical Care Affiliates, LLC	***Evangelical Services Corporation***
By:_____	By:_____
Name:_____	Name:_____
Title:_____	Title:_____

Physicians:

Signature:_____	Signature:_____
Printed Name: Roger B Collins	Printed Name:_____
Desired Percentage (max 2%): 2 %	Desired Percentage (max 2%):_____

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Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

Surgical Care Affiliates, LLC

By:_____
Name:_____
Title:_____

Evangelical Services Corporation

By:_____
Name:_____
Title:_____

Physicians:

Signature:_____
Printed Name: [illegible]
Desired Percentage (max 2%): 1.0% (one percent)

Signature:_____
Printed Name:_____
Desired Percentage (max 2%):_____

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Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

Surgical Care Affiliates, LLC

By:_____
Name:_____
Title:_____

Evangelical Services Corporation

By:_____
Name:_____
Title:_____

Physicians:

Signature: [signature]
Printed Name: MATT MEYER
Desired Percentage (max 2%): 2%

Signature:_____
Printed Name:_____
Desired Percentage (max 2%):_____

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Joe Clark, on behalf of Surgical Care Affiliates

ACKNOWLEDGED AND AGREED:

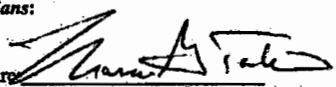
Surgical Care Affiliates, LLC

By:_____
Name:_____
Title:_____

Evangelical Services Corporation

By:_____
Name:_____
Title:_____

Physicians:

Signature: 
Printed Name: MARCUS G. TALERICO
Desired Percentage (max 2%): 2%

Signature:_____
Printed Name:_____
Desired Percentage (max 2%):_____

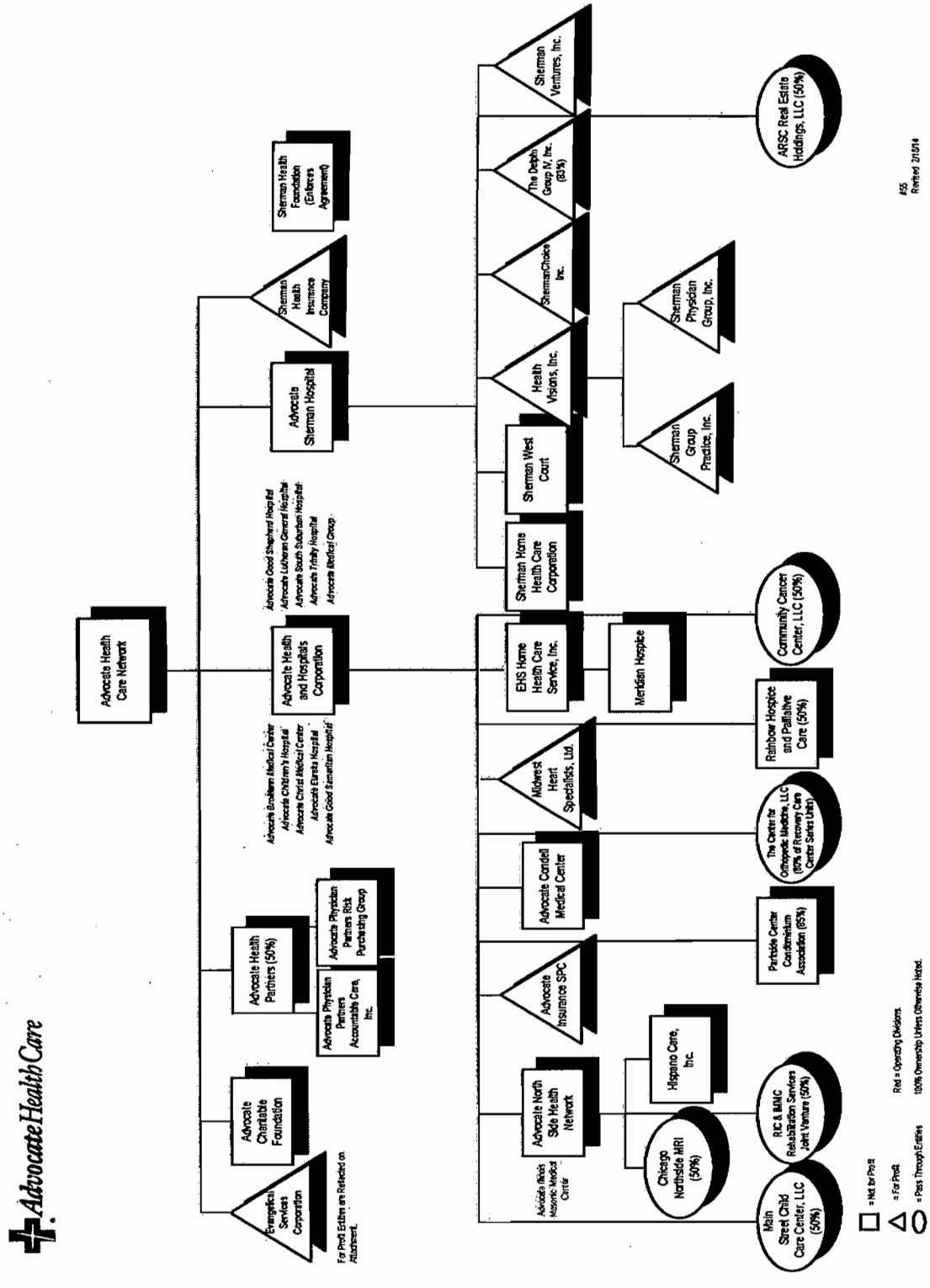
Organizational Relationships

Provide (for each co-applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.
APPEND DOCUMENTATION AS ATTACHMENT-4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

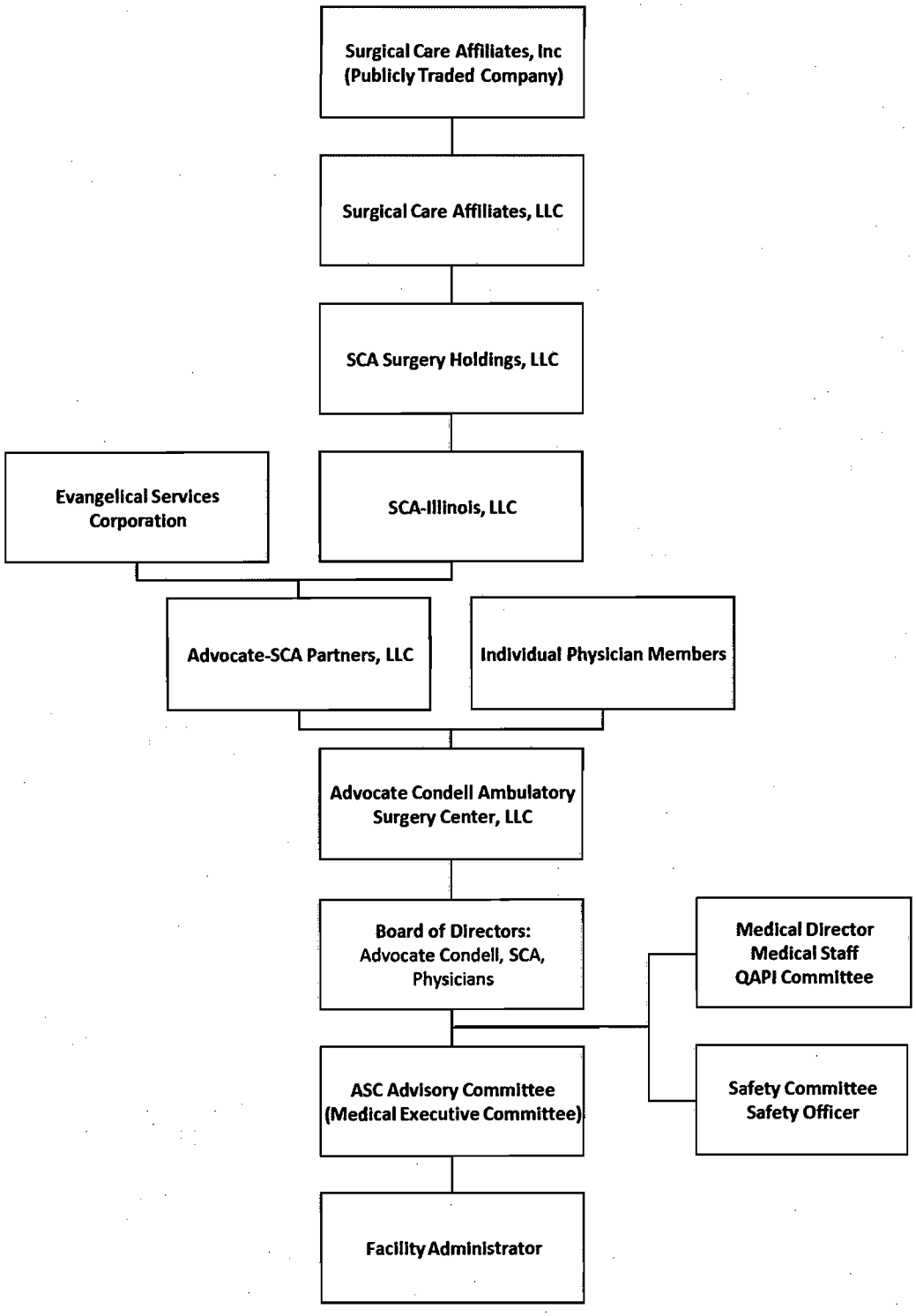
Attachment 4, Exhibit 1, is an organization chart that shows all of the relevant Advocate organizations including Advocate Health Care Network, Advocate Health and Hospitals Corporation, Evangelical Services Corporation, and Advocate Condell Medical Center.

Attachment 4, Exhibit 2 is an organization chart that shows a continuation from Evangelical Services Corporation to Advocate Condell Ambulatory Surgery Center, LLC. It also shows the structure and progression of Surgical Care Affiliates to Advocate Condell Ambulatory Surgery Center, LLC

Advocate-SCA Partners, LLC will own 51% of the Advocate Condell Ambulatory Surgery Center, LLC. The physicians will own 49%. See the Letter of Intent shown as Attachment 3, Exhibit 2 for the type of financial contribution.


Advocate Health Care
Advocate Health Care Network
Advocate Health and Hospitals Corporation
Advocate Sherman Hospital
Sherman Health Insurance Company
Sherman Health Foundation (Enforces Agreement)
Evangelical Services Corporation
Advocate Charitable Foundation
Advocate Health Partners (50%)
Advocate Physician Partners Accountable Care, Inc.
Advocate Physician Partners Risk Purchasing Group
Advocate Illinois Masonic Medical Center
Advocate North Side Health Network
Chicago Northside MRI (50%)
Hispano Care, Inc.
Advocate Insurance SPC
Advocate Condell Medical Center
Midwest Heart Specialists, Ltd.
Main Street Child Care Center, LLC (50%)
RC & MMC Rehabilitation Services Joint Venture (50%)
Parkside Center Condominium Association (85%)
The Center for Orthopedic Medicine, LLC (50% of Recovery Care Center Series Units)
Rainbow Hospice and Palliative Care (50%)
Community Cancer Center, LLC (50%)
EHS Home Health Care Service, Inc.
Meridian Hospice
Sherman Home Health Care Corporation
Sherman West Court
Health Visions, Inc.
Sherman Group Practice, Inc.
Sherman Physician Group, Inc.
ShermanChoice Inc.
The Delphi Group IV, Inc. (83%)
Sherman Ventures, Inc.
ARSC Real Estate Holdings, LLC (50%)
Advocate Good Shepherd Hospital
Advocate Lutheran General Hospital
Advocate South Suburban Hospital
Advocate Trinity Hospital
Advocate Medical Group
Advocate Bethany Hospital
Advocate Brotherhood Medical Center
Advocate Children's Hospital
Advocate Christ Medical Center
Advocate Eureka Hospital
Advocate Good Samaritan Hospital
Advocate Health Care
For Profit Entities are Reflected on Attachment
= Not for Profit
= For Profit
= Pass Through Entities
Red = Operating Divisions
100% Ownership Unless Otherwise Noted
#25
Revised 2/15/14

Advocate Condell Ambulatory Surgery Center Organizational Chart



Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at **www.FEMA.gov** or **www.illinoisfloodmaps.org**. **This map must be in a readable format**. In addition please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5 **(http://www.hfsrb.illinois.gov)**.

APPEND DOCUMENTATION AS ATTACHMENT -5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

See Attachment 5, Exhibits 1 & 2.

Advocate Condell Medical Center
801 South Milwaukee Avenue || Libertyville, IL 60048 || T 847.362.2900 || advocatehealth.com

March 2, 2015

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, Second Floor
Springfield, IL 62761

RE: Advocate Condell Ambulatory Surgery Center

Dear Ms. Avery:

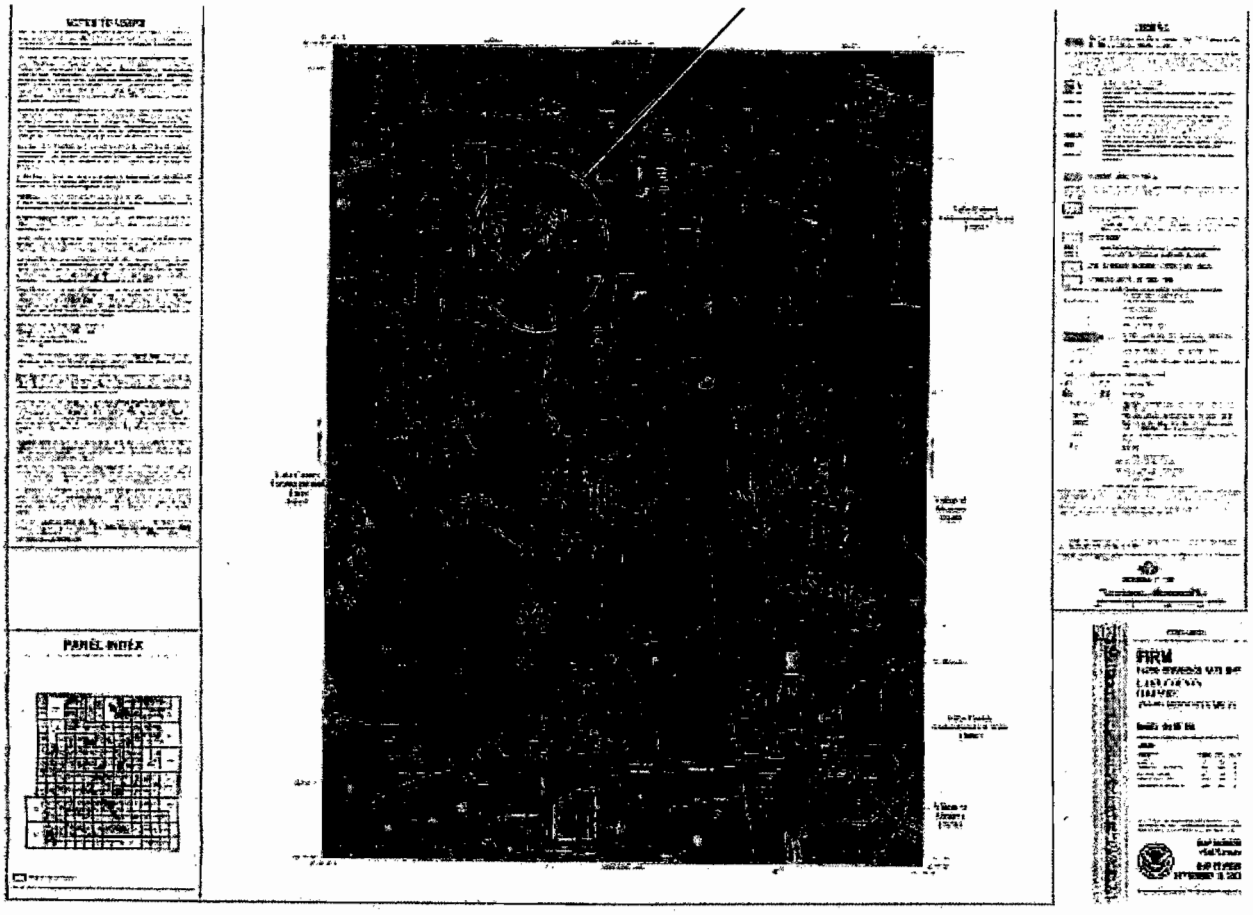
This attestation letter is submitted to indicate that the location of the proposed Advocate Condell Ambulatory Surgery Center, at 825 S. Milwaukee Ave, Libertyville, IL, which is on the campus of Advocate Condell Medical Center, is not in a flood plain. See FEMA map that indicates where the property is located. The location is outlined in red.

We trust this attestation complies with the State Agency Flood Plain Rule under Illinois Executive Order #2005-5 requirement indicated in the Permit application – July 2013 edition.

Respectfully,

Dominica M. Tallarico
President
Advocate Condell Medical Center

Advocate Condell Ambulatory Surgery Center will be
on campus of Advocate Condell Medical Center
South Milwaukee Ave. and Condell Drive, Libertyville, IL



Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.
APPEND DOCUMENTATION AS ATTACHMENT-6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Attachment 6, Exhibit 1, is a letter from the Illinois Historic Preservation Agency which documents that no historic, architectural, or archaeological sites exist within the Project area.

ILLINOIS HISTORIC Preservation AGENCY

FAX 217/524-7525

Lake County
Libertyville
801 South Milwaukee Avenue
IHFSRB
New construction, Advocate Condell Medical Center

PLEASE REFER TO: IHPA LOG #003012615

February 13, 2015

Janet M. Hood
Advocate Health Care
3075 Highland Parkway, Suite 600
Downers Grove, IL 60515

Dear Ms. Hood:

The Illinois Historic Preservation Agency is required by the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420, as amended, 17 IAC 4180) to review all state funded, permitted or licensed undertakings for their effect on cultural resources. Pursuant to this, we have received information regarding the referenced project for our comment.

Our staff has reviewed the specifications under the state law and assessed the impact of the project as submitted by your office. We have determined, based on the available information, that no significant historic, architectural or archaeological resources are located within the proposed project area.

According to the information you have provided concerning your proposed project, apparently there is no federal involvement in your project. However, please note that the state law is less restrictive than the federal cultural resource laws concerning archaeology. If your project will use federal loans or grants, need federal agency permits, use federal property, or involve assistance from a federal agency, then your project must be reviewed under the National Historic Preservation Act of 1966, as amended. Please notify us immediately if such is the case.

This clearance remains in effect for two (2) years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the IL Human Skeletal Remains Protection Act (20 ILCS 3440).

Please retain this letter in your files as evidence of compliance with the Illinois State Agency Historic Resources Preservation Act.

Sincerely,

Rachel Leibowitz, Ph.D.
Deputy State Historic
Preservation Officer

1 Old State Capitol Plaza
Springfield IL 62701

ILLINOISHISTORY.GOV

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

PROJECT COSTS AND SOURCES OF FUNDS			
USE OF FUNDS	**CLINICAL**	**NON-CLINICAL**	**TOTAL**
Preplanning Costs	34,461	21,039	55,500
Site Survey and Soil Investigation	3,105	1,895	5,000
Site Preparation	203,707	124,369	328,076
Off Site Work	-	-	-
New Construction Contracts	3,414,814	2,084,855	5,499,669
Modernization Contracts	-	-	-
Contingencies	308,142	188,131	496,272
Architectural/Engineering Fees	355,489	217,038	572,527
Consulting and Other Fees	205,415	125,413	330,828
Movable or Other Equipment (not in construction contracts)	1,654,286	772,789	2,427,075
Bond Issuance Expense (project related)	-	-	-
Net Interest Expense During Construction (project related)	-	-	-
Fair Market Value, Leased Space, Equipment	-	-	-
Other Costs To Be Capitalized	167,390	102,197	269,587
Acquisition of Building or Other Property (excluding land)	34,266	20,921	55,187
TOTAL USES OF FUNDS	**$ 6,381,074**	**$ 3,658,646**	**$ 10,039,720**
SOURCE OF FUNDS	**CLINICAL**	**NON-CLINICAL**	**TOTAL**
Cash and Securities	3,757,196	2,056,684	5,813,879
Pledges	-	-	-
Gifts and Bequests	-	-	-
Bond Issues (project related)	-	-	-
Mortgages	-	-	-
Leases (fair market value)	2,623,878	1,601,963	4,225,841
Governmental Appropriations	-	-	-
TOTAL SOURCES OF FUNDS	**$ 6,381,074**	**$ 3,658,646**	**$ 10,039,720**

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

COST ITEMIZATIONS		
1	**Preplanning Costs**	
	Con Prep - Architectural services	$ 5,000
	CON Prep - PM services	$ 5,500
	Legal	$ 23,000
	CON application fee	$ 22,000
	Total	**$ 55,500**
2	**Site Survey and Soil Investigation**	
	Total	**$ 5,000**
3	**Site Preparation**	
	Total	**$ 328,076**
4	**Off Site Work**	
	Total	**$ -**
5	**New Construction Contracts**	
	Base construction contract clinical buildout	$ 1,986,530
	Base construction contract non-clinical buildout	$ 1,234,200
	MOB ASC infrastructure	$ 171,190
	Base construction contract shell & core	$ 2,036,865
	Interior signs	$ 6,235
	Exterior signs	$ 20,000
	Construction phase testing per code	$ 6,000
	Permit fees	$ 38,649
	Total	**$ 5,499,669**
6	**Modernization Contracts**	
	Total	**$ -**
7	**Contingencies**	
	Construction Contracts -Buildout	$ 292,586
	Construction Contracts - Shell and Core	$ 203,687
	Total	**$ 496,272**
8	**Architectural and Engineering Fees (basic)**	
	Basic Architectural and Engineering - Buildout	$ 241,976
	Civil Engineering	$ 65,000
	Landscape Architect	$ 15,000
	Reimbursable expenses	$ 14,145
	Basic Architectural and Engineering - Shell and Core	$ 236,405
	Total	**$ 572,527**
9	**Consulting and Other Fees**	
	State & Local Plans review fees	$ 7,356
	Commissioning Services	$ 28,291
	Materials testing	$ 7,073
	Test and Balance	$ 14,145

	Medical Equipment Planning	$ 48,541
	Program management	$ 117,702
	Consulting and Other Fees - Shell and Core	$ 107,720
	Total	**$ 330,828**
10	**Moveable or Other Equipment**	
	Major medical equipment (See separate list)	$ 1,654,286
	Copiers, office equipment and appliances	$ 15,250
	Furniture	$ 100,600
	Security	$ 30,000
	Shelving	$ 37,863
	Support carts	$ 796
	Med Records	$ 9,257
	Estimated Taxes	$ 129,364
	Medical Equipment Contingency	$ 184,805
	Artwork	$ 5,500
	Non-clinical Freight and Handling	$ 55,442
	IT network/voice installation	$ 40,000
	IT network hardware	$ 77,423
	IT Desktop hardware	$ 43,490
	IT Miscellaneous hardware	$ 5,500
	IT software, move in, PC setup, training, support	$ 37,500
	Total	**$ 2,427,075**
11	**Bond issuance expense**	
	Total	**$ -**
12	**Net Interest Expense (project related)**	
	Total	**$ -**
13	**Fair Market Value of Leased Space & Equipment**	
	Total	**$ -**
14	**Other Costs to be Capitalized**	
	Total For shell and core	**$ 269,587**
15	**Acquisition of Building or other Property**	
	Permits for shell and core	$ 55,187
	Total	**$ 55,187**
	Grand Total	**$ 10,039,720**

Medical Equipment List (does not include non-medical)	
DESCRIPTION	**QTY**
ANESTHESIA MACHINES W/ VITAL SIGN MONITOR	**2**
APPLIANCES (LOT) INCLUDES 1 EA ADA DISHWASHER, 2 EA FULL SIZE FRIDGE, MICROWAVE, & 1 EA FULL SIZE FRIDGE NOURISHMENT, 1 EA LOCKABLE MEDS FRIDGE, 1 EA CT ICEMAKER WITH FILTER.	**As listed**
BLANKET WARMER	**2**
C-ARM (S)	**1**
CARTS: ANES CARTS 2 EA, AIRWAY 1 EA, CAST 1 EA, CODE 1 EA, & MH CART 1 EA	
DEFIB UNIT	**1**
EKG & STAND	**1**
ENT SHAVER	**1**
ESU W/ STAND & FOOT SWITCH	**2**
GLIDE-O-SCOPE FOR DIFFICULT INTUBATION	**1**
INSTRUMENT CONTAINERS FOR STERILIZATION	**1**
INSTRUMENTS	**1**
INSTRUMENTS (LAPAROSCOPES)	**1**
INSTRUMENTS (ARTHROSCOPES)	**1**
MICROSCOPE ENT (REFURB)	**1**
MICROSCOPE SURGICAL (REFURB).	**1**
MISCELLANEOUS (HOUSE KEEPING CARTS, LARYNGOSCOPE BLADES & HANDLES, O2 FLOW METERS, NARCOTIC CABINET, SHARPS, SUCTION REGULATORS, SUPPLY MOVING EQUIPMENT, OTO / OPHTHALMOSCOPE SETS, WASTE CONTAINERS & WHEELCHAIRS)	**As listed**
OR TABLE ACCESSORIES (HAND TABLE, LEG HOLDER, UROLOGY ATTACHMENT, YELLOW FIN (PR), WILSON FRAME)	**As listed**
OR TABLES	**2**
PATIENT STRETCHERS	**8**
PATIENT RECLINERS	**3**
POWER EQUIPMENT	**2**
S/S FURNITURE FACILITY	**1**
S/S FURNITURE OR'S	**2**
STERIS V PRO 60	**1**
TOURNIQUET SYS	**1**
VIDEO TOWERS (OR'S) HD	**2**
VITAL SIGN MONITORS (STEPDOWN)	**3**
VITAL SIGN MONITORS (PRE-OP)	**2**

VITAL SIGN MONITORS (PACU)	6
MOVEABLE SUB TOTAL:	**$1,335,657**
FIXED MEDICAL SUB TOTAL:	**$318,629**
OVER ALL SUB TOTAL:	**$1,654,286**

As part of Advocate's population health strategy, the Advocate Condell Ambulatory Surgery Center will focus on providing a lower cost setting for patients to receive the same high quality care they have become accustomed to receiving from Advocate hospitals. Because the objective is to provide access to this setting to as many patients and physicians as possible, the ASTC will be investing in **equipment to serve a wide variety of patient and physician needs**.

Though this increases the initial capital investment required, it will allow the ASTC to deliver efficient, high quality, and more affordable care to patients seeking care from **five different physician specialties.** This is not currently available to patients and physicians within the Advocate network in and around Advocate Condell Medical Center.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.
Indicate the stage of the project's architectural drawings: ☐ None or not applicable ☐ Preliminary ☒ Schematics ☐ Final Working
Anticipated project completion date (refer to Part 1130.140): March 31, 2017 .
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140): ☐ Purchase orders, leases or contracts pertaining to the project have been executed. ☐ Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies ☒ Project obligation will occur after permit issuance.
APPEND DOCUMENTATION AS ATTACHMENT-8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

There is no documentation required for this section as the Project obligation has not occurred.

Cost Space Requirements

Provide in the following format, the department/area **DGSF** or the building/area **BGSF** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Cost Space Requirement

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	Cost	Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Surgery and Recovery	$3,278,445	0	3,487	3,487	0	0	0
Clinical Support	$3,102,629	0	3,300	3,300	0	0	0
Total Clinical	$6,381,074		6,787	6,787			
NON REVIEWABLE							
Non-clinical	$3,658,646	0	4,162	4,162	0	0	0
TOTAL	$10,039,720	0	10,949	10,949	0	0	0

SECTION III – BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT-11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

1. The listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.

Attachment 11, Exhibit 1 is the listing of all the hospital facilities owned by Advocate Health Care Network.

Exhibit 2 contains the list of all the Illinois ambulatory surgery treatment centers managed by Surgical Care Affiliates. The licensing and certification is shown for all.

Exhibit 3 is the current state hospital license for Advocate Condell Medical Center.

Exhibit 4 is the most recent DNV accreditation certificate for Condell.

2. Certified Listing of Any Adverse Action Against Any Facility Owned or Operated by the Applicant

By the signatures on the Certification pages, the applicants attest there have been no adverse actions against any facility owned and/or operated by Advocate Health Care Network, Advocate Health and Hospitals Corporation, or Surgical Care Affiliates as demonstrated by compliance with the CMS Conditions of Participation with Medicare and Medicaid, during the three years prior to the filing of this application.

3. Authorization Permitting IHFPB and DPH to Access Necessary Documentation

By the signatures on the Certification pages, the applicants hereby authorize the Illinois Health Facilities and Services Review Board and the Illinois Department of Public Health to access information in order to verify any documentation or information submitted in response to the requirements of this subsection, or to obtain any documentation or information which the State Board or Department of Public Health find pertinent to this subsection.

4. Exception for Filing Multiple Certificates of Need in One Year

Not applicable. This is the first certificate of need application filed by the co-applicants in 2015.

Advocate Health Care Facilities

Facility	Location	License No.	Joint Commission Accreditation No.	DNV Accreditation No.
Advocate Condell Medical Center	801 S. Milwaukee Ave., Libertyville, IL	0005579	Not applicable	147414-2013-AHC-USA-NIAHO

Additional hospitals owned and operated as a part of Advocate Health Care Network:

Facility	Location	License No.	Joint Commission Accreditation No.	DNV Accreditation No.
Advocate BroMenn Medical Center	1304 Franklin Ave. Normal, IL	0005645	Not applicable	127532-2012-AHC-USA-NIAHO
Advocate Christ Medical Center	4440 W. 95th St. Oak Lawn, IL	0000315	Not applicable	135696-2013-AHC-USA-NIAHO
Advocate Eureka Hospital	101 S. Major Eureka, IL	0005652	Not applicable	127988-2012-AHC-USA-NIAHO
Advocate Good Shepherd Hospital	450 W. Highway, #22 Barrington, IL	0003475	Not applicable	114892-2012-AHC-USA-NIAHO
Advocate Illinois Masonic Medical Center	836 W. Wellington Chicago, IL	0005165	4068	Not yet surveyed
Advocate Lutheran General Hospital	1775 Dempster Park Ridge, IL	004796	Not applicable	117368-2012-AHC-USA-NIAHO
Advocate Good Samaritan Hospital	3815 Highland Ave. Downers Grove, IL	0003384	Not applicable	115804-2012-AHC-USA-NIAHO
Advocate South Suburban Hospital	17800 S. Kedzie Ave Hazel Crest, IL	0004697	Not applicable	127995-2012-AHC-USA-NIAHO
Advocate Sherman Hospital	1425 N. Randall Rd Elgin, IL	0005884	Not applicable	165481-2014-AHC-USA-NIAHO
Advocate Trinity Hospital	2320 E. 93rd St. Chicago, IL	0004176	Not applicable	120735-2012-AHC-USA-NIAHO

Surgical Care Affiliates Facilities in Illinois

Facility	Location	License No.	Joint Commission Accreditation No.	Other Accreditation No.
Hawthorn Surgery Center	240 Center Dr. Vernon Hills, IL 60061	7003188	452470	N/A
Loyola Ambulatory Surgery Center	One South 224 Summit Ave. #201 Oak Brook Terrace, IL 60181	2138771	452472	N/A
Amsurg Surgery Center	998 129th Infantry Dr. Joliet, IL 60435	7003160	452473	N/A
Northwest Surgicare	1100 W. Central Road, Lower Basement L4 Arlington Heights, IL 60005	7000920	Not applicable	AAAHC #1007
Belleville Surgical Center	28 North 64th St. Belleville, IL 62223	7001175	Not applicable	AAAHC #74
Physician's Surgical Center	311 West Lincoln St. S. 300 Belleville, IL 62220	7003191	Not applicable	*recently purchased and will roll up under Belleville's AAAHC # 74

DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 11/30/2015

Lic Number 0005579

Date Printed 10/31/2014

Advocate Condell Medical Center

801 South Milwaukee Avenue
Libertyville, IL 60048

FEE RECEIPT NO.

Illinois Department of PUBLIC HEALTH

HF1063968

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

Issued under the authority of the Illinois Department of Public Health

LaMar Hasbrouck, MD, MPH
Acting Director

EXPIRATION DATE	CATEGORY	I.D. NUMBER
11/30/2015		0005579

General Hospital

Effective 12/01/2014

Advocate Condell Medical Center
801 South Milwaukee Avenue
Libertyville, IL 60048

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. #4012320 10M 3/12

DNV HEALTHCARE INC.

CERTIFICATE OF ACCREDITATION

Certificate No. 147414-2013-AHC-USA-NIAHO

This is to certify that

Advocate Condell Medical Center

801 S. Milwaukee Avenue, Libertyville, IL 60048

Complies with the requirements of the:

NIAHO® Hospital Accreditation Program

Pursuant to the authority granted to Det Norske Veritas Healthcare, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, this organization is deemed in compliance with the Medicare Conditions of Participation for Hospitals (42 C.F.R. §482). This certificate is valid for a period of three (3) years from the Effective Date of Accreditation.

Effective Date of Accreditation:

December 12, 2013

for the Accreditation Body:

DET NORSKE VERITAS HEALTHCARE, INC.

HOUSTON, TEXAS

Patrick Horine
Chief Executive Officer

Yehuda Dror
President

Lack of continual fulfillment of the conditions set out in the Certification/Accreditation Agreement may render this Certificate invalid.

ACCREDITED UNIT: DNV HEALTHCARE INC., 400 TECHNECENTER DRIVE, SUITE 100 MILFORD, OHIO 45150,OH, UNITED STATES ,TEL: 513-947-8343
WWW.DNVACCREDITATION.COM

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]
4. Cite the sources of the information provided as documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded if any. For facility projects, include statements of age and condition and regulatory citations if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Report. APPEND DOCUMENTATION AS ATTACHMENT-12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

1. Document that the Project will provide health services that improve the health care or well-being of the market area population to be served.

The purpose of the proposed Project is to meet the community needs for access to high quality, cost efficient, easily accessible outpatient surgical care. The applicants propose to establish a modern, state-of-the-art ambulatory surgery treatment center (ASTC) on the campus of Advocate Condell Medical Center (Condell). The 20 physicians who have committed to performing outpatient surgery at the proposed ASTC are all on the staff at Condell. Referrals to the ASTC will be patients that are currently receiving outpatient surgical procedures at Condell. The physicians and Condell are proposing a facility that will allow procedures that are appropriate for an ASTC to be performed in a setting that has been demonstrated to be less costly, more efficient, and more convenient for patients and their families.

In April 2014, Daniel R. Levinson, Inspector General of the Department of Health and Human Services, released a study of Ambulatory Surgical Centers (ASC). It said, in part: "We recognize that not all procedures can be performed in an ASC because a procedure might pose a significant safety risk to the patient. To account for this, we obtained (in the study) patient-risk statistics from the Agency for Healthcare Research and Quality. The risk statistics showed that 33 percent of hospital patients 65 and older were considered to have no-risk medical profiles and an additional 35 percent were considered to be at low risk for procedures performed at an ASC. In total, 68 percent of patients had either low- or no-risk medical profiles."

New research by Elizabeth Munnich and Stephen Parenta, published in Health Affairs Vol. 33, Issue 5, May, 2014, concludes that ASTCs "deliver better care at lower cost than hospitals for appropriate patients". On average, the study found patients spend 25.5% less time in ASTCs than hospitals, mostly due to improved processes in pre-op and recovery. Even higher risk patients were found to have significantly fewer readmissions when treated in an ASTC versus a hospital (2.5% fewer). The findings indicate that the highest risk Medicare patients were less likely that other high risk Medicare patients to visit an emergency department or be admitted to a hospital following an outpatient surgery when they were treated in an ASTC, even among similar patients.

Additional research outlines the benefits of an ASTC: provide high quality surgical care, excellent outcomes and high levels of patient satisfaction at a lower cost than hospital based outpatient departments for appropriate patients. Surgical procedures performed at an ASTC are charged at lower rates and result in lower out-of-pocket expenses for patients.

Patient satisfaction is increased due to easier access to parking, shorter wait times and an expedited process to get in and out of the operating rooms. In a survey by Press Ganey, a noted healthcare consulting company, they found an average 92% patient satisfaction for care and service at Ambulatory Surgery Centers. (Press Ganey Associates, "Outpatient Pulse Report," 2008.)

Surgeons are more efficient due to faster turnover of rooms and designated surgical times without delay from urgent and trauma cases pushing these patients to a later time.

The Project is designed with a configuration for optimal patient flow, quality equipment equal to the hospital, appropriate storage for large equipment, waiting space for families and consultation rooms for patients and families to meet with physicians in privacy.

2. Define the planning area or market area, or other, per the applicant's definition.

The applicants expect the service area of the proposed ambulatory surgery treatment center to replicate that of Advocate Condell Medical Center. Advocate Condell Medical Center is a major provider of health care to the residents of Lake County, serving the residents of Libertyville and Lake County since 1928. The hospital has continued to adapt to changing health care needs, identifying the need to provide the continuum of outpatient services to families that live in the hospital's defined service area. A map of Health Service Area 8 is included as Attachment 12, Exhibit 1 and the Condell service area is included as Attachment 12, Exhibit 2.

The population in Condell's service area is expected to continue gradual growth as outlined below:

	2010	2014	Projected 2019
Primary Service Area	388,095	388,395	388,676
Secondary Service Area	170,780	171,216	171,609
Total Service Area	558,875	559,611	560,285

Thoughtful expansion of health care services has occurred as the population has grown. However, the most significant impact has been from the increasing demand for quality health care options. The history of ambulatory surgical treatment centers has been fueled by the desire for alternatives to the traditional hospital based services.

In Section 1110.1540 the Geographic Service Area for Ambulatory Surgery Treatment Centers is defined as the communities that are within 45 minutes driving time. A listing of the zip codes and the communities they represent, along with the 20 physicians' Condell patients from that 45 minute drive time, is provided in Attachment 27, Exhibit 1. It is followed by a listing of all their outpatient surgeries. It will show that 98% of those patients come from the Geographic Service Area and 95% are from Illinois.

3. Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project. [See 1110.230(b) for examples of documentation.]

As the only Level I Trauma Center in Lake County, Advocate Condell Medical Center's scheduled outpatient procedures are not always performed as anticipated due to emergency or trauma patients taking higher priority for surgical time. Over the past few years, physicians have found patients report leaving the hospital's primary service area to seek outpatient care in a more efficient and lower cost setting. With only one surgical department on campus for both inpatients and outpatients, efficiency and throughput is not as desirable as in an ambulatory setting.

While Advocate Health Care continues to strengthen its population health strategy, it is important to identify opportunities to meet the demands and expectations of the population in the service area. With increasing out-of-pocket expenses, high deductible plans, and increasing co-payments, patients are becoming more cost sensitive which is impacting patients' willingness to get procedures done in a timely manner.

4. Cite the sources of the information provided as documentation.

- Illinois Department of Public Health Hospital Licensing Code
- Illinois Health Facilities and Services Review Board (HFSRB) Administrative Rules
- Illinois Hospital Association
- State of Illinois Trauma Center Feasibility Study, 1/2/15, from the IL Department of Public Health
- Daniel R. Levinson, Inspector General of the Department of Health and Human Services, Study of Ambulatory Surgical Centers (ASC). April 2014.
- *Health Affairs* Vol. 33, Issue 5, May, 2014
- IHA COMPdata
- AIA/FGI Guidelines for Design and Construction of Health Care Facilities
- Advocate Condell Medical Center Admission Data
- Claritas and the US Census Bureau
- HFSRB Hospital Profiles
- HFSRB Inventories and Data
- Health care literature regarding current trends re patient needs
- Advocate Condell Medical Center Public Relations archives
- Lake County and Libertyville building codes

5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.

The primary purpose the Project addresses is to **provide the "right care, at the right time, in the right place".** One step to do this is to provide ambulatory surgical service options, on a dependable schedule, to appropriate patients in Advocate Condell Medical Center's service area. The proposed Project is to provide these patients with a cost efficient, high quality ASTC setting that offers a broad list of surgical specialties. The advantages an ASTC provides combines improved patient

access, increased patient satisfaction, higher physician and staff efficiency, and decreased costs for surgical care.

Advocate Health Care is transforming many services to meet community needs. The array of services is expanding to provide alternatives to traditional inpatient care. This Project is another step to address unnecessary hospitalizations and manage care for improved outcomes.

This ASTC is not intended to replace the important surgical capacity that is provided at Advocate Condell Medical Center. As noted by the Illinois Hospital Association, in its Feb 2, 2015 letter to the Crain's Chicago Business Editor, "Hospitals need flexibility to ramp up their surgical capacity beyond day-to-day needs. Such capacity was critical in saving lives in the Boston Marathon bombing. Consider flu, Ebola, tornadoes, mass shootings, car accidents, terrorist attacks. We need our hospitals to be available and ready." The proposed Project will support Condell's vital surgical capacity, and continue to fulfill its role as a Level I Trauma Center.

One of the applicants, SCA-Illinois, brings experience from its parent, Surgical Care Affiliates, Inc. (SCA) which manages 185 facilities across 34 states. SCA-Illinois will lead the development of the ASTC program to streamline patient care flow. With that guidance, the Project will be designed to optimize access through efficiency and flexibility. The design and functional layout of the center will address throughput and ease of use, improving patient and physician satisfaction. SCA-Illinois offers strong surveillance and quality controls, as well as administrative and consulting services. The knowledge gained from SCA's national experience, will help to ensure that the ASTC excels in the quality of care it provides.

The Accountable Care Act has prompted a major shift in health care delivery. Advocate Health Care embraced that change and developed an accountable care organization (ACO) that is recognized at the national level as a model of delivery and ranked the largest in the nation. Known as AdvocateCare, the commercial plan was developed in conjunction with Blue Cross Blue Shield. Advocate now offers a Medicare ACO model and a Medicaid ACO.

Advocate Health Care's Population Health initiative will continue to require all its health care entities to develop cost effective, high quality delivery models. This proposed Project will follow the trend for ambulatory surgery centers to have an economic partnership between physicians, a hospital and an experienced ambulatory surgical operator with mutual goals to serve the population's health status and well-being.

The proposed new ASTC will develop and implement a charity care policy to mirror the charity care policy of Advocate Condell Medical Center. This includes seeing Medicare, Medicaid and charity care patients. It is noted that the ASTC will not have emergency or urgent care so the volume of charity care may vary from the experience at Condell.

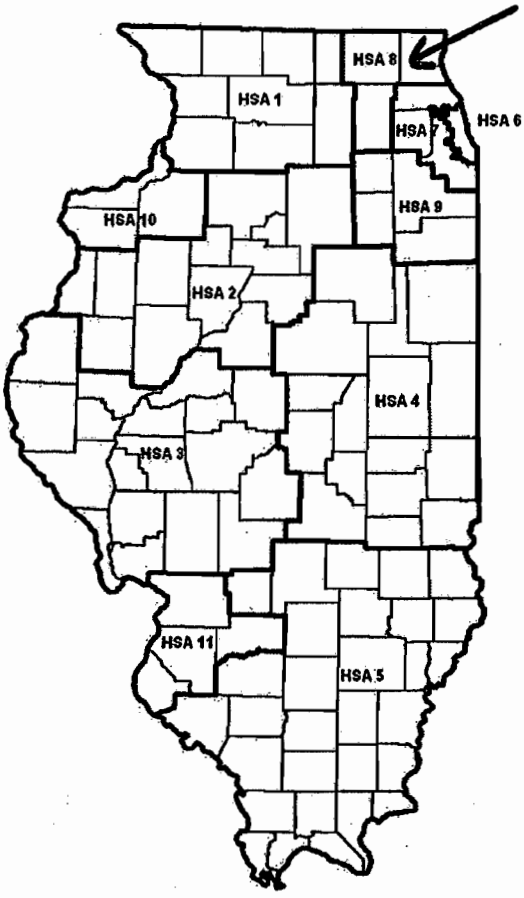
After the establishment of the proposed Project, the physicians who will practice in the ASTC will also continue to perform at Condell those inpatient and ambulatory procedures that are more appropriately performed in the hospital setting. Those include patients who present in the Emergency Department or compromised patients with multiple conditions needing a more complex range of services.

6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.

- The first goal is to erect the shell and core of the Project by October, 2015
- The next goal is to frame the interior rooms by February, 2016.
- The third goal is to complete the interior build-out by August, 2016
- Various Village and State inspections are expected to be completed by October, 2016
- Occupancy of the new facility will be completed by March 31, 2017.

Map Marked with Arrow to Identify Health Service Area 8, the HSA for the Proposed ASTC

Planning Process for Non-Hospital Based Ambulatory Surgery Category of Service

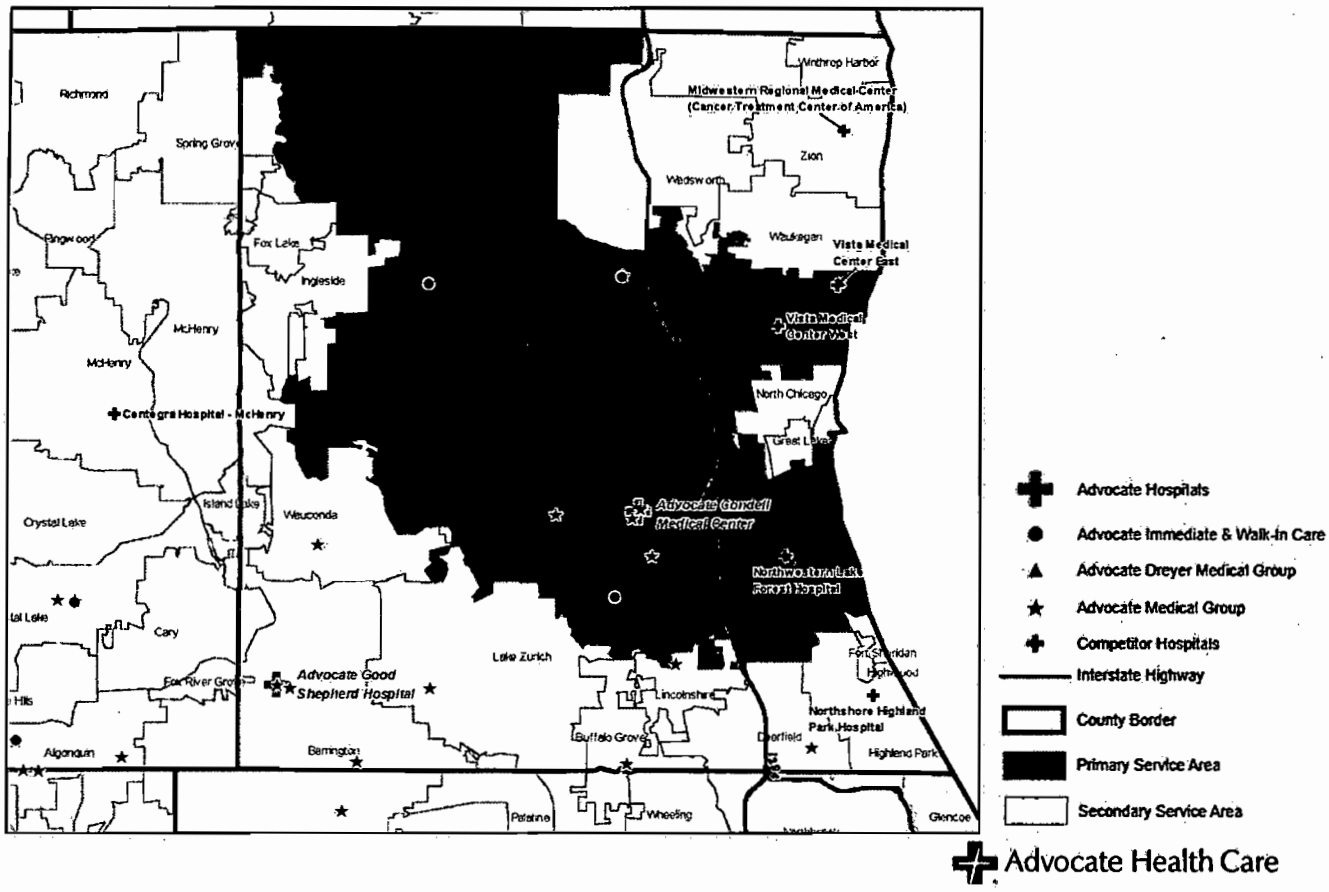


For the Non-Hospital Based Ambulatory Surgery category of service:

1. The planning areas are the designated Health Service Areas
2. No utilization standard has been established.

Source: IHFSRB

Advocate Condell Medical Center — Service Area Map



Source: Hospital records

Advocate Condell Medical Center
Patient Origin Report - Based on Inpatient Discharges 01/01/2013 - 12/31/2013
Includes Observation Patients (Excludes Normal Newborns)

Zip Code	City Name	PO Name	Patient Volume	% of Total Patient Volume
		PRIMARY SERVICE AREA		
60073	**Round Lake**	Round Lake	3,347	15.5%
60060	**Mundelein**	Mundelein	2,092	9.7%
60030	**Grayslake**	Grayslake	1,920	8.9%
60085	**Waukegan**	Waukegan	1,716	7.9%
60048	**Libertyville**	Libertyville	1,573	7.3%
60031	**Gurnee**	Gurnee	1,444	6.7%
60061	**Vernon Hills**	Vernon Hills	1,395	6.4%
60046	**Lake Villa**	Lake Villa	1,337	6.2%
60002	**Antioch**	Antioch	934	4.3%
60044	**Lake Bluff**	Lake Bluff	80	0.4%
60045	**Lake Forest**	Lake Forest	59	0.3%
Primary Service Area Total			**15,897**	**73.4%**
		SECONDARY SERVICE AREA		
60087	**Waukegan**	Waukegan	582	2.7%
60099	**Zion**	Zion	532	2.5%
60041	**Ingleside**	Ingleside	395	1.8%
60084	**Wauconda**	Wauconda	390	1.8%
60064	**North Chicago**	North Chicago	369	1.7%
60020	**Fox Lake**	Fox Lake	350	1.6%
60089	**Buffalo Grove**	Buffalo Grove	295	1.4%
60069	**Lincolnshire**	Lincolnshire	243	1.1%
60083	**Wadsworth**	Wadsworth	200	0.9%
Secondary Service Area Total			**3,356**	**15.5%**
		OUTSIDE OF SERVICE AREA (OTHER)		
Other Total			**2,398**	**11.1%**
Patient Volume Total			**21,651**	**100.0%**

Source: CompData

Criterion 1110.230 – Background, Purpose of the Project, and Alternatives

READ THE REVIEW CRITERION and provide the following required information:

ALTERNATIVES

1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

A) Proposing a project of greater or lesser scope and cost;

B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;

C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and

D) Provide the reasons why the chosen alternative was selected.

2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short term (within one to three years after project completion) and long term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT-13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The following alternatives were considered when this Project was in planning:

1. **Modernize the existing hospital surgery suite to add a dedicated area for outpatient procedures:** The need for separate, dedicated operating rooms to address the need for better outpatient processing was considered. Because of the location of the current surgery, the process of creating a separate suite would involve significant relocations of other departments or an addition to the hospital. That option proved to be quite costly. While that would provide separate ORs, the ease of access and the opportunity to enhance patient and physician satisfaction compared to a stand-alone facility would not be achieved. This alternative was rejected due to increased capital costs, inefficiencies in care delivery and patient dissatisfaction.

Cost: $15,000,000

2. **Create a dedicated area for outpatient procedures within the current hospital surgery suite complement of rooms:** Careful consideration was given to designating two operating rooms exclusively for outpatient use. The peak utilization pattern would preclude that as a reasonable solution. The need for restricted special purpose rooms, such as open heart and trauma, would further limit the flexibility to use the remaining rooms. Creating an ambulatory

setting in the midst of an acute care suite would not provide the advantages of today's dedicated ambulatory surgery treatment center regarding ease of access, efficient throughput, and lower cost would not be achieved. This alternative was rejected due to inefficiencies in care delivery and would not address needed capacity.

Cost $7,000,000

3. **Acquire or joint venture with an existing ambulatory surgery treatment center:** Acquiring or creating a joint venture with an existing surgery center would expedite the timing to offer this service. However, there are no surgery centers in the Advocate Condell Medical Center immediate service area that have expressed an interest in being acquired or seeking a joint venture. Furthermore, an ASTC in another location would not have the same efficiencies as one on the hospital campus. For example, an ASTC on the Advocate Condell campus allows patients to utilize needed hospital services without duplicating high cost ancillaries. This alternative was rejected due to lack of availability in the hospital's geographic service area and inefficiencies.

Cost: Without any existing facilities expressing interest, the cost to acquire or joint venture with another facility is not known.

4. **Utilizing other healthcare resources to serve the population:** As a leader in population health, Advocate Condell patients and their physicians would need to look for the highest quality, cost appropriate setting for their outpatient procedures. This would leave the hospital and the physicians without the ability to control quality and cost. Without this option on the Advocate Condell campus, patients would be forced to leave the area for this type of care and not maintain their current physician relationship.

Cost: Unable to estimate the cost impact on patients and physicians

5. **Build a dedicated ambulatory surgery treatment center on the Advocate Condell Medical Center campus:** The proposed project is superior to the alternatives listed above. Key reasons are highlighted below:
    A. Capital cost is lower to build an ambulatory surgery treatment center than expanding the hospital surgery suite.
    B. The option of an ambulatory surgery treatment center on campus provides patients and physicians with the most efficient model of care.
    C. Patient access and satisfaction will be enhanced in this ambulatory setting.
    D. Financial benefit will be provided for both patients and payers due to the lower cost for these outpatient surgical procedures. This has become increasingly important with population health initiatives.
    E. Capacity will be created in the current hospital ORs. Current surgery capacity is optimized for inpatients, complex outpatient procedures and trauma cases. As the only hospital with a Level 1 Trauma Center in Lake County, physicians are often challenged to add on procedures.
    F. Patients will have access to a high quality, appropriate setting while maintaining current health care relationships in their service area. By developing this ASTC in partnership with Advocate Health Care, the applicants will provide the efficiencies that are part of the Accountable Care Organization by lowering health care cost, enhancing quality of

care and improving health care outcomes. The proposed Project is supported by the integration of systems that focus on managing population based health status for patients living in the service area.

G. Collaboration with the hospital, physicians and the partnership with Surgical Care Affiliates, brings expertise in this model of ambulatory care and will provide an integrated delivery system for surgical care.

Cost: $10,039,720

	Description	Patient Access	Quality	Cost	Financial Benefit, Short Range	Financial Benefit, Long Range	Conclusion
1.	Modernize existing hospital surgery suite to add a dedicated area for outpatient procedures	Would be somewhat improved for outpatients but not as good as a stand-alone ASTC	Quality of surgery will remain the same as current	$15,000,000	None. Would be disruptive to the hospital operation to build-an addition.	None, due to the higher cost	Rejected
2.	Create a dedicated area for outpatient procedures within the current hospital surgery complement of rooms	Overall patient access would not improve as it would reduce the flexibility on room use.	The quality of care could be reduced due to variable access to the designated ORs.	$7,000,000	Lower cost but loss of 2 ORs would limit the ability to accept patients for surgery	The loss of flexibility of the two ORs could also affect the ancillary revenue	Rejected
3	Acquire or joint venture with an existing ambulatory surgery treatment center.	Would not provide access to Advocate ancillaries that could be achieved on the hospital campus.	The quality of care could be appropriate, with careful management of a joint venture	Unable to estimate	The option to acquire or JV has not been offered so it is difficult to comment on the financial benefit	The physical separation of an acquired ASTC lowers efficiencies and any financial benefit over time	Rejected
4.	Utilize other healthcare resources to serve the population	Patients who prefer Advocate Condell would not have access to the hospital of their choice	The quality of care would not be controlled	Unable to estimate.	No construction costs would be incurred.	The referral of patients to other area facilities would not allow for the continuity of patient care and potentially duplicate ancillary testing and other services.	Rejected
5.	Build a dedicated ambulatory surgery treatment center on the Advocate Condell Medical Center campus	Patients would have easy access to a facility designed for outpatients, with reduced wait times, quick turnaround, high quality services and appropriate cost	Would continue to provide overall high quality health care services.	$10,039,720	Financial benefit to patients and providers	The up-front expenditure will strengthen the long term use of the hospital by patients who prefer Advocate Condell. This supports the population health model by using appropriate outpatient services.	✓ **Accepted**

Quality of Care

The research done over the past 20+ years measures the quality of care that is realized in a carefully managed ambulatory surgery treatment center. Surgical Care Affiliates, the parent of SCA-Illinois which is one of the applicants, has extensive experience in quality assessment. This company operates 185 surgical facilities in 34 states across the nation. Their skill in measuring and improving quality is paramount to their operation. In the future, outcome data that demonstrates quality of care related to this Project can be found in multiple reports, including patient satisfaction results, physician satisfaction results, infection control, and medication errors statistics. Advocate Condell and physician leadership will monitor all of these reports.

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following::

   a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

   b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

   c. The project involves the conversion of existing space that results in excess square footage.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

APPEND DOCUMENTATION AS ATTACHMENT-14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Document that the amount of physical space for the proposed Project is necessary and not excessive.

The clinical area consists of five pre-operative bays, two operating rooms, eight recovery stations, an exam room, clean and soiled processing rooms, two nursing stations, locker rooms, patient toilets, a nourishment station, a wheelchair bay, and wide internal corridors. The non-clinical areas include a vestibule, reception office, patient waiting area, business office, vending room, public toilets, medical records, administrative office, nursing office, conference room, data equipment room, bulk storage, house-keeping closets, mechanical and pump rooms, equipment storage, scheduling office, all served by internal corridors.

The size of the operating rooms and recovery area as shown in the table below demonstrates the proposed Project has met the State standards for clinical space.

SIZE OF PROJECT				
Department/Service	Proposed DGSF	State Standard	Difference	Met Standard
ASTC Operating Rooms and Recovery	3,487 dgsf/2 ORs = 1,743/OR	1,660-2,200 dgsf/treatment room	-457	Yes

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

	UTILIZATION				
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT-15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B.

Twenty physicians have committed to referrals resulting in 2,559 hours of outpatient surgery to the proposed ASTC in year one, which are sufficient to justify the two surgical operating rooms. See attachment #15, Exhibit 1

2,559 hours ÷ 1,500 hours per OR = 1.7 ORs, rounded to 2 ORs.

Additional growth assumptions for this new facility were based on the previous years for all of Condell's outpatient surgical hours. The outpatient surgical hours for the past three years projects the expected utilization for outpatient surgery will continue to increase by 5.75% per year.

All OP Surgery Hours at Condell	Base yr. 2012	2013	2014	% change 2012-2014	Annual Change Projected*	2015	2016
OP Surgical Hours	9,517	9,968	10,643	11.8%	5.75%	11,255	11,902

*Based on Compound Annual Growth Rate formula

Projecting this increase of 5.75% per year for the outpatient procedures referred to the ASTC, indicates that the facility will be at 95% capacity in two years.

2,559 ASTC hours x 1.0575 = 2,706 hours by the end of the first year

2,706 ASTC hours x 1.0575 = 2,862 hours by end of the second year.

2,862/3,000 hours = 95%

	DEPT./ SERVICE	HISTORICAL UTILIZATION Surgical Hours.	PROJECTED UTILIZATION in Hours**	STATE STANDARD	MET STANDARD?
YEAR 1	ASTC	2,559 hours	2,706	1,500-3,000	Yes
YEAR 2	ASTC		2,862	1,500-3,000	Yes

**Hours based on total time patient was in the operating room, plus the set up and clean up.

Physician Referrals to ASTC

Physician	Cases Referred to ASTC	Specialty	Avg OR Hours/Case with set up-clean up*	Hours needed
JOHNSON-MD, BENJAMIN C	80	Otolaryngology	1.63	130
GIBSON-MD, LAURENCE F	44	General Surgery	1.73	76
LIESEN-MD, DANIEL A	47	General Surgery	1.73	81
PARIKH-DO, AMIT	49	General Surgery	1.73	85
SCHEER-MD, MICHAEL F	48	General Surgery	1.73	83
SIEGEL-MD, AARON M	44	General Surgery	1.73	76
STROHMAYER-MD, PAUL N	88	General Surgery	1.73	152
CARONIS-MD, GREGORY G	48	Orthopedic	2.12	102
COLLINS-MD, ROGER B	74	Orthopedic	2.12	157
FRANK-MD, CHARLES E	96	Orthopedic	2.12	204
MEIS-MD, JOSEPH A	45	Orthopedic	2.12	95
NEAULT-MD, MARK A	114	Orthopedic	2.12	242
TALERICO-MD, MARCUS	109	Orthopedic	2.12	231
ALZATE-MD, JUAN	65	Neurosurgery	2.06	134
CITOW-MD, JONATHAN S	145	Neurosurgery	2.06	299
ERICKSON-MD, ROBERT K	30	Neurosurgery	2.06	62
COHEN-MD, JUSTIN	13	Urology	1.49	19
KHAN-MD, RAZA M	82	Urology	1.49	122
KIM-MD, RONALD J	41	Urology	1.49	61
SAFFRIN-MD, ROBERT S	99	Urology	1.49	148
Grand Total	1,361			2,559

* The hours per case (total time the patient is in the OR including set up and clean up time) are based on the experience of each specialty in 2013 at Advocate Condell Medical Center

ASSURANCES:

1) The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the end of the second year of operation after the project completion, the applicant will meet or exceed the utilization standards specified in Appendix B.

APPEND DOCUMENTATION AS ATTACHMENT-17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

See Attachment 17, Exhibit 1, for the assurance letter.

SCA
Surgical Care Affiliates

February 19, 2015

Ms. Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, Second Floor
Springfield, IL 62761

Re: Advocate Condell Ambulatory Surgery Center

Dear Ms. Olson:

This letter is to provide the Illinois Health Facilities and Services Review Board the assurance required with the Certificate of Need application for an ambulatory surgery treatment center.

Based on the information available at this time, it is my understanding that by the second year of operations after project completion, Advocate Condell Ambulatory Surgery Center reasonably expects to achieve and maintain the utilization standards for ambulatory surgery treatment centers, as specified in 77 Ill. Administrative Code 1100.640.

Sincerely,

Robert Harmon
Vice President Operations
Surgical Care Affiliates

520 Lake Cook Road, Suite 250 | Deerfield, IL 60015 | 205.545.2572 | 800.768.0094 | www.scasurgery.com

SECTION VII - SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing establishment, expansion or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion and modernization). After identifying the applicable review criteria for each category of service involved , read the criteria and provide the required information, AS APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

H. Non-Hospital Based Ambulatory Surgery

This section is applicable to all projects proposing to establish or modernize a non-hospital based ambulatory surgical treatment center or to the addition of surgical specialties.

1. Criterion 1110.1540(a), Scope of Services Provided

Read the criterion and complete the following:

a. Indicate which of the following types of surgery are being proposed:

_____Cardiovascular	___ ___Obstetrics/Gynecology	_____Pain Management
_____ Dermatology	_____Ophthalmology	_____Podiatry
___ ___Gastroenterology	_____Oral/Maxillofacial	_____Thoracic
__X___ General/Other	__X__ Orthopedic	__X__ Otolaryngology
__X___ Neurology	_____Plastic	__X___ Urology

b. Indicate if the project will result in a _____ limited or __X____ a multi-specialty ASTC.

Note: The format of the information supplied follows the NEW Code as Amended at 38 Ill. Reg. 8861, effective April 15, 2014.

~~**2. Criterion 1110.1540(b), Target Population**~~

~~Read the criterion and provide the following:~~

~~a. On a map (8 ½" x 11"), outline the intended geographic services area (GSA). Not required in April 15, 2014 update of the Code.~~

~~b. Indicate the population within the GSA and how this number was obtained.~~

~~c. Provide the travel time in all directions from the proposed location to the GSA borders and indicate how this travel time was determined.~~

~~**3. Criterion 1110.1540(c), Projected Patient Volume**~~

~~Read the criterion and provide signed letters from physicians that contain the following:~~

~~a. The number of referrals anticipated annually for each specialty.~~

~~b. For the past 12 months, the name and address of health care facilities to which patients were referred, including the number of patients referred for each surgical specialty by facility.~~

~~c. A statement that the projected patient volume will come from within the proposed GSA.~~

d. A statement that the information in the referral letter is true and correct to the best of his or her belief.

4. Criterion 1110.1540(d), Treatment Room Need Assessment

Read the criterion and provide:

a. The number of procedure rooms proposed.

b. The estimated time per procedure including clean-up and set-up time and the methodology used in arriving at this figure.

5. Criterion 1110.1540(e), Impact on Other Facilities

Read the criterion and provide:

a. A copy of the letter sent to area surgical facilities regarding the proposed project's impact on their workload. NOTE: This letter must contain: a description of the project including its size, cost, and projected workload; the location of the proposed project; and a request that the facility administrator indicate what the impact of the proposed project will be on the existing facility.

b. A list of the facilities contacted. **NOTE**: Facilities must be contacted by a service that provides documentation of receipt such as the US. Postal Service, FedEx or UPS. The documentation must be included in the application for permit.

6. Criterion 1110.1540(f), Establishment of New Facilities

Read the criterion and provide:

a. A list of services that the proposed facility will provide that are not currently available in the GSA; or

b. Documentation that the existing facilities in the GSA have restrictive admission policies; or

c. For co-operative ventures,

a. Patient origin data that documents the existing hospital is providing outpatient surgery services to the target population of the GSA, and

b. The hospital's surgical utilization data for the latest 12 months, and

c. Certification that the existing hospital will not increase its operating room capacity until such a time as the proposed project's operating rooms are operating at or above the target utilization rate for a period of twelve full months; and

d. Certification that the proposed charges for comparable procedures at the ASTC will be lower than those of the existing hospital.

7. Criterion 1110.1540(g), Charge Commitment

Read the criterion and provide:

a. A complete list of the procedures to be performed at the proposed facility with the proposed charge shown for each procedure.

b. A letter from the owner and operator of the proposed facility committing to maintain the above charges for the first two years of operation.

8. Criterion 1110.1540(h), Change in Scope of Service

Read the criterion and, if applicable, document that existing programs do not currently provide the service proposed or are not accessible to the general population of the geographic area in which the facility is located.

APPEND DOCUMENTATION AS ATTACHMENT-27, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

1110.1540 Non-Hospital Based Ambulatory Surgical Treatment Center Services

(a)(5)(A) & (B) Introduction, Identification of ASTC Service and # of Surgical Treatment Rooms

The proposed Project is for the establishment of a new non-hospital based ambulatory surgical treatment center (ASTC). The ASTC will be constructed on the campus of the Advocate Condell Medical Center, at the south-west corner of South Milwaukee Ave. and Condell Drive in Libertyville, IL.

The Project is a cooperative venture operated by Advocate Condell Medical Center, Surgical Care Affiliates, and twenty physicians on the Condell medical staff. The patient base will come solely from Advocate Condell, which has sufficient historical workload to justify the Project.

Five surgical services are proposed: Orthopedics, General Surgery, Neurosurgery, Urology, and Otolaryngology. The ASTC will have two surgical treatment rooms (operating rooms) that will be shared by each of these specialties.

1110.1540 Non-Hospital Based Ambulatory Surgical Treatment Center Services

(b)(1) through (4) Background of the Applicant

The information requirements contained in this Section are applicable to all projects except projects that are solely for discontinuation. An applicant shall document the *qualifications, background, character and financial resources to adequately provide a proper service for the community* and also demonstrate that the project promotes the *orderly and economic development of health care facilities in the State of Illinois that avoids unnecessary duplication of facilities* or service. [20 ILCS 3960/2]

All details are found in Attachment 11

1110.1540 Non-Hospital Based Ambulatory Surgical Treatment Center Services

(c)(2)(A) & (B) Service to Geographic Service Area

Service to Geographic Service Area Residents
The applicant shall document that the primary purpose of the project will be to provide necessary health care to the residents of the geographic service area (GSA) in which the proposed project will be physically located.

A) The applicant shall provide a list of zip code areas (in total or in part) that comprise the GSA. The GSA is the area consisting of all zip code areas that are located within 45 minutes multi-directional travel time (under normal driving conditions) of the project's site.

B) The applicant shall provide patient origin information by zip code for all admissions for the last 12-month period, verifying that at least 50% of admissions were residents of the GSA. Patient origin information shall be based upon the patient's legal residence (other than a health care facility) for the last six months immediately prior to admission.

A review was conducted of all zip codes that are within a 45 minute drive time of the Project to comprise the ASTC Geographic Service Area (GSA). This geographic area includes a population of 6,548,257 in 275 zip code areas. Attachment 27, Exhibit 1 provides the list of zip codes and town names.

Twenty physicians have committed to bring their appropriate outpatients to the proposed Project from their current patients, those that they presently take to Advocate Condell Medical Center.

The patient zip codes for their current outpatient surgical cases at Advocate Condell are provided in Attachment 27 Exhibit 1. As shown, 2,230 or 98% of their total patients (2,269) were patients that live in the zip codes within a 45 minute drive time and are located in the geographic service area (GSA).

Attachment 27, Exhibit 2 shows ALL of the outpatient surgical cases (2,269) performed by these physicians at Condell, including those outside the Geographic Service Area. It reveals the patients who live in Wisconsin but are within 45 minutes of the proposed ASTC site. This shows 75 patients or 3% lived within the 45 minute drive time, but were from outside of Illinois.

In total, 95% of the patients live in the Illinois Geographic Service Area, demonstrating that significantly more that 50% of the admissions of the intended Ambulatory Surgery Treatment Center's service area are residents of the GSA.

Zip Codes within 45 Minute Travel Time, and Outpatient Surgery Cases from those Zip Codes by ASTC Physician in Past 12 Months

Zip Codes within 45 minute drive time of Advocate Condell Medical Center and Project Site
Outpatient Surgery Volumes for ASTC Surgeons by Zip Code

		Physicians Listed By Initial																			
Zip	City	JA	GC	JC	Jco	RC	RE	CF	LG	BJ	RK	Rki	DL	JM	MN	AP	RS	MS	AS	PS	MT	Grand Total
53104	Bristol	-	-	-	-	-	-	2	-	-	-	-	-	-	-	1	1	-	-	2	-	6
53105	Burlington	1	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	1	-	1	-	4
53108	Caledonia	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
53126	Franksville	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
53128	Genoa City	-	1	3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	5
53132	Franklin	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
53139	Kansasville	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
53140	Kenosha	1	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	2	
53142	Kenosha	3	1	-	-	-	-	1	-	-	1	-	-	-	-	-	1	-	-	-	1	8
53143	Kenosha	-	1	-	-	-	-	-	-	-	-	-	-	-	2	-	-	-	-	-	1	4
53144	Kenosha	1	-	2	-	3	2	-	1	-	-	-	-	-	-	-	1	-	-	-	-	10
53154	Oak Creek	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
53158	Pleasant Prairie	1	1	1	-	2	1	1	1	-	2	-	1	1	-	-	1	1	-	-	-	14
53168	Salem	1	-	1	-	2	-	-	-	1	-	-	1	-	-	-	1	-	-	-	-	7
53170	Silver Lake	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1
53177	Sturtevant	1	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2
53179	Trevor	-	-	1	-	-	-	1	-	-	-	-	-	-	2	1	-	-	-	-	-	5
53181	Twin Lakes	1	-	-	-	-	1	-	1	1	-	-	-	-	-	-	-	-	-	-	-	4
53182	Union Grove	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
53403	Racine	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	1
53404	Racine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
53405	Racine	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
53406	Racine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60002	Antioch	4	7	10	1	7	2	4	5	1	10	5	3	1	6	5	12	2	3	11	7	106
60004	Arlington Heights	-	-	-	-	1	-	3	-	-	-	-	-	2	3	-	-	-	-	-	3	12
60005	Arlington Heights	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60006	Arlington Heights	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60007	Elk Grove Village	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
60008	Rolling Meadows	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60009	Elk Grove Village	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60010	Barrington	-	-	4	-	-	-	2	-	-	-	-	-	-	-	-	-	-	3	-	1	10
60011	Barrington	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60012	Crystal Lake	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Zip Codes within 45 Minute Travel Time, and Outpatient Surgery Cases from those Zip Codes by ASTC Physician in Past 12 Months

Zip	City	JA	GC	JC	Jco	RC	RE	CF	LG	BJ	RK	Rki	DL	JM	MN	AP	RS	MS	AS	PS	MT	Grand Total
60013	Cary	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60014	Crystal Lake	2	-	3	-	-	1	-	-	1	-	-	-	-	-	-	-	-	-	-	3	10
60015	Deerfield	1	-	6	-	-	-	2	-	-	1	-	-	6	7	1	-	-	-	-	-	24
60016	Des Plaines	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
60017	Des Plaines	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60018	Des Plaines	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60019	Des Plaines	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60020	Fox Lake	1	-	1	1	-	-	-	1	2	4	-	1	2	-	-	1	-	1	1	3	19
60021	Fox River Grove	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60022	Glencoe	-	-	2	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	3
60025	Glenview	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60026	Glenview	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	1
60029	Golf	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60030	Grayslake	5	6	12	5	16	4	10	11	12	6	15	6	2	19	5	10	4	3	11	13	175
60031	Gurnee	7	7	12	2	14	3	5	6	8	8	1	6	4	8	8	10	7	6	14	5	141
60034	Hebron	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1
60035	Highland Park	2	-	4	-	-	-	3	-	1	-	1	-	-	3	-	-	-	-	2	-	16
60037	Fort Sheridan	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60038	Palatine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60039	Crystal Lake	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60040	Highwood	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3	1	4
60041	Ingleside	-	1	5	-	2	1	2	2	1	4	1	3	-	3	2	3	1	1	7	1	40
60042	Island Lake	-	-	1	-	-	-	-	2	-	-	-	1	-	1	-	-	-	1	-	-	6
60043	Kenilworth	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60044	Lake Bluff	-	-	2	-	1	1	1	-	-	-	1	-	-	2	-	2	-	-	-	-	10
60045	Lake Forest	1	1	3	1	1	1	1	-	3	2	-	2	2	8	-	2	1	-	-	1	30
60046	Lake Villa	4	4	15	-	9	6	8	3	13	13	7	5	2	13	4	11	6	4	5	14	146
60047	Lake Zurich	2	-	5	-	3	-	8	-	-	2	-	-	6	10	-	3	1	1	3	3	47
60048	Libertyville	2	4	11	1	11	2	19	4	19	11	8	6	7	18	6	9	12	2	11	12	175
60050	McHenry	1	1	3	-	-	-	-	1	-	1	-	-	1	1	-	1	-	-	-	-	10
60051	McHenry	4	2	4	-	2	3	2	1	-	-	-	1	1	3	1	2	-	1	2	3	32
60053	Morton Grove	-	-	2	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	3
60055	Palatine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60056	Mount Prospect	-	-	1	-	-	-	-	-	-	1	-	-	-	1	-	-	-	-	-	-	3
60060	Mundelein	9	16	14	4	13	2	25	6	14	10	8	2	14	17	7	16	4	2	11	14	208
60061	Vernon Hills	6	4	7	-	2	2	6	1	5	7	5	4	6	8	5	1	7	1	5	10	92
60062	Northbrook	-	-	4	-	-	1	3	-	2	-	-	-	1	-	-	-	-	-	-	-	11

Zip Codes within 45 Minute Travel Time, and Outpatient Surgery Cases from those Zip Codes by ASTC Physician in Past 12 Months

Zip	City	JA	GC	JC	Jco	RC	RE	CF	LG	BJ	RK	Rki	DL	JM	MN	AP	RS	MS	AS	PS	MT	Grand Total
60064	North Chicago	1	2	-	-	1	1	-	3	-	4	1	3	-	-	3	2	-	1	5	3	30
60065	Northbrook	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60067	Palatine	-	-	-	-	-	-	1	-	-	-	-	-	2	-	-	-	-	-	-	1	4
60068	Park Ridge	-	-	1	-	-	-	-	-	-	-	-	-	-	2	-	-	-	-	-	-	3
60069	Lincolnshire	-	-	4	-	1	-	3	-	-	-	-	-	1	3	-	-	-	-	-	-	12
60070	Prospect Heights	1	-	1	-	-	-	3	-	-	-	-	-	-	1	-	-	-	-	-	-	6
60071	Richmond	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	1
60072	Ringwood	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60073	Round Lake	7	9	16	1	16	5	8	10	16	16	7	5	4	9	13	26	6	13	15	25	227
60074	Palatine	1	-	1	-	-	1	3	-	-	2	-	-	-	-	-	-	-	-	-	-	8
60075	Russell	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60076	Skokie	-	-	1	-	-	-	1	-	-	-	-	-	-	2	-	-	-	-	-	-	4
60077	Skokie	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
60078	Palatine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60079	Waukegan	-	-	-	-	-	-	-	1	-	1	-	-	-	-	-	-	1	-	-	-	3
60081	Spring Grove	1	1	3	-	1	-	1	-	2	-	-	1	-	1	-	-	1	-	-	3	15
60082	Techny	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60083	Wasdworth	1	2	1	1	-	1	-	-	4	4	1	1	-	-	1	-	3	1	-	4	25
60084	Wauconda	1	1	4	1	1	-	3	1	1	1	-	-	2	4	1	-	-	1	2	1	25
60085	Waukegan	9	4	5	2	8	1	2	6	9	11	1	10	-	-	8	18	15	19	14	15	157
60086	North Chicago	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60087	Waukegan	5	-	3	1	4	1	1	2	6	3	2	3	-	-	4	10	2	2	4	4	57
60088	Great Lakes	2	-	-	1	-	-	-	-	1	-	-	-	-	1	-	2	-	-	-	3	10
60089	Buffalo Grove	1	3	10	-	1	1	14	1	1	1	1	-	8	11	1	2	1	-	-	4	61
60090	Wheeling	-	-	2	-	1	-	4	1	-	-	-	1	1	2	-	1	1	-	-	1	15
60091	Wilmette	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60093	Winnetka	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60094	Palatine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60095	Palatine	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60096	Winthrop Harbor	1	-	1	-	1	1	1	-	2	-	-	1	-	-	1	1	-	-	-	1	11
60097	Wonder Lake	-	-	2	-	-	-	1	-	1	-	-	-	-	-	-	1	-	-	-	1	6
60098	Woodstock	-	-	3	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	4
60099	Zion	4	3	6	-	2	2	3	2	4	3	1	7	-	1	1	12	-	4	11	9	75
60101	Addison	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
60102	Algonquin	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	2
60103	Bartlett	-	-	1	-	-	-	-	-	-	-	-	-	-	2	-	-	-	-	-	-	3

Zip Codes within 45 Minute Travel Time, and Outpatient Surgery Cases from those Zip Codes by ASTC Physician in Past 12 Months

Zip	City	JA	GC	JC	Jco	RC	RE	CF	LG	BJ	RK	Rki	DL	JM	MN	AP	RS	MS	AS	PS	MT	Grand Total
60104	Bellwood	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60105	Bensenville	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60106	Bensenville	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60107	Streamwood	-	-	-	-	-	-	1	-	-	-	-	-	-	-	1	-	-	-	-	-	2
60108	Bloomingdale	-	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2
60110	Carpentersville	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
60116	Carol Stream	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60117	Bloomingdale	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60118	Dundee	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	2
60120	Elgin	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60121	Elgin	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60122	Carol Stream	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60123	Elgin	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1
60124	Elgin	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60126	Elmhurst	-	-	1	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	2
60128	Carol Stream	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60130	Forest Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60131	Franklin Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60132	Carol Stream	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60133	Hanover Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60136	Gilberts	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60137	Glen Ellyn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60138	Glen Ellyn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60139	Glendale Heights	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60140	Hampshire	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60141	Hines	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60142	Huntley	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	1
60143	Itasca	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
60148	Lombard	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60152	Marengo	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60153	Maywood	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60154	Westchester	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
60155	Broadview	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60156	Lake in the Hills	-	-	2	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-	-	4
60157	Medinah	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60159	Schaumburg	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60160	Melrose Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Zip Codes within 45 Minute Travel Time, and Outpatient Surgery Cases from those Zip Codes by ASTC Physician in Past 12 Months

Zip	City	JA	GC	JC	Jco	RC	RE	CF	LG	BJ	RK	Rki	DL	JM	MN	AP	RS	MS	AS	PS	MT	Grand Total
60161	Melrose Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60162	Hillside	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60163	Berkeley	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60164	Melrose Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1
60165	Stone Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60168	Schaumburg	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60169	Hoffman Estates	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60170	Elgin	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60171	River Grove	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60172	Roselle	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60173	Schaumburg	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
60174	Saint Charles	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
60176	Schiller Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	1
60177	South Elgin	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60179	Hoffman Estates	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60180	Union	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60181	Villa Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60184	Wayne	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60185	West Chicago	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60186	West Chicago	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60187	Wheaton	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
60188	Carol Stream	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60189	Wheaton	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60190	Winfield	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60191	Wood Dale	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60192	Hoffman Estates	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1
60193	Schaumburg	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60194	Schaumburg	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60195	Schaumburg	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60196	Schaumburg	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60197	Carol Stream	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60199	Carol Stream	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60201	Evanston	-	-	-	-	-	-	-	-	-	-	-	-	-	2	-	-	-	-	-	1	3
60202	Evanston	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60203	Evanston	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60204	Evanston	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60208	Evanston	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Zip Codes within 45 Minute Travel Time, and Outpatient Surgery Cases from those Zip Codes by ASTC Physician in Past 12 Months

Zip	City	JA	GC	JC	Jco	RC	RE	CF	LG	BJ	RK	Rki	DL	JM	MN	AP	RS	MS	AS	PS	MT	Grand Total
60209	Evanston	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60301	Oak Park	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	1
60302	Oak Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60303	Oak Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60304	Oak Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60305	River Forest	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60399	Wood Dale	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60402	Berwyn	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
60415	Chicago Ridge	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60453	Oak Lawn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60455	Bridgeview	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60458	Justice	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60459	Burbank	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60465	Palos Hills	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60480	Willow Springs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60482	Worth	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60501	Summit Argo	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60513	Brookfield	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60514	Clarendon Hills	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60515	Downers Grove	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60516	Downers Grove	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60517	Woodridge	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	1
60521	Hinsdale	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60523	Oak Brook	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60525	La Grange	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60526	La Grange Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60527	Willowbrook	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60532	Lisle	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
60534	Lyons	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60540	Naperville	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60546	Riverside	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60558	Western Springs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60559	Westmont	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60561	Darien	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60563	Naperville	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60599	Fox Valley	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60601	Chicago	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Zip Codes within 45 Minute Travel Time, and Outpatient Surgery Cases from those Zip Codes by ASTC Physician in Past 12 Months

Zip	City	JA	GC	JC	Jco	RC	RE	CF	LG	BJ	RK	Rki	DL	JM	MN	AP	RS	MS	AS	PS	MT	Grand Total
60602	Chicago	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60603	Loop	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60604	Chicago	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60605	Chicago	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60606	Wacker Drive	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60607	Chicago	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1
60608	Pilsen	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60609	New City	-	-	1	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	2
60610	Fort Dearborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60611	Ontario Street	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1
60612	Midwest	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60613	Lakeview	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60614	Lincoln Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60616	Twenty Second Str	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60618	Avondale/N Center	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	1
60619	Grand Crossing	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60620	Auburn Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60622	Wicker Park	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	1
60623	Hawthorne	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60624	Garfield Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60625	Ravenswood	-	-	1	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	2
60626	Rogers Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60630	Jefferson Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60631	Norwood Park	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	1
60632	Elsdon	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60634	Chicago	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60637	Jackson Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60638	Clearing	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60639	Belmont Cragin	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
60640	Uptown	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60641	Chicago	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60642	Evergreen Park II	-	-	1	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	2
60644	Austin	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60645	Avalon Park	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
60646	Lincolnwood	-	-	1	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	2
60647	Logan Square	-	-	-	-	-	-	1	-	-	-	-	-	-	1	-	-	-	-	1	-	3
60649	South Shore	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60651	Division Street	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60653	Hyde Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60654	Merchandise Mart	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60656	Harwood Heights	-	-	1	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	2
60657	Lakeview	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60659	West Ridge	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60660	Rogers Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60661	Haymarket	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60666	Amf Ohare	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60706	Harwood Heights	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	1
60707	Elmwood Park	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60712	Lincolnwood	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
60714	Niles	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
60804	Cicero	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		99	83	223	22	130	48	162	74	132	130	66	77	78	186	81	165	80	71	143	180	2,230

List of ALL Advocate Condell Outpatient Surgical Cases by ASTC Physician by Zip Code in Past 12 Months

Zip Code	JA	GC	JC	Jco	RC	RE	CF	LG	BJ	RK	RKi	DL	JM	MN	AP	RS	MS	AS	PS	MT	Grand Total
25143																1					1
29418														1							1
33160			1																		1
34145			1																		1
34229			1																		1
46375						1															1
48331										2											2
49006							1														1
51448			1																		1
53104							2								1	1			2		6
53105	1											1					1		1		4
53121			1																		1
53128		1	3																	1	5
53140	1											1									2
53142	3	1					1			1						1				1	8
53143		1												2						1	4
53144	1		2		3	2		1								1					10
53147	1																		1		2
53158	1	1	1		2	1	1	1		2		1	1			1	1				14
53168	1		1		2				1			1				1					7
53170																	1				1
53177	1				1																2
53179			1				1							2	1						5
53181	1					1		1	1												4
53182			1																		1
53191	1																				1
53403													1								1
53405			1																		1
54165												1									1
56258														1							1
60002	4	7	10	1	7	2	4	5	1	10	5	3	1	6	5	12	2	3	11	7	106
60004					1		3						2	3						3	12
60007			1																		1
60010			4				2											3		1	10
60014	2		3			1			1											3	10
60015	1		6				2			1			6	7	1						24
60016							1														1
60020	1		1	1				1	2	4		1	2			1		1	1	3	19
60022			2											1							3
60026										1											1

List of ALL Advocate Condell Outpatient Surgical Cases by ASTC Physician by Zip Code in Past 12 Months

60030	5	6	12	5	16	4	10	11	12	6	15	6	2	19	5	10	4	3	11	13	175
60031	7	7	12	2	14	3	5	6	8	8	1	6	4	8	8	10	7	6	14	5	141
60034																				1	1
60035	2		4				3		1		1			3					2		16
60040																			3	1	4
60041		1	5		2	1	2	2	1	4	1	3		3	2	3	1	1	7	1	40
60042			1					2				1		1				1			6
60044			2		1	1	1				1			2		2					10
60045	1	1	3	1	1	1	1		3	2		2	2	8		2	1			1	30
60046	4	4	15		9	6	8	3	13	13	7	5	2	13	4	11	6	4	5	14	146
60047	2		5		3		8			2			6	10		3	1	1	3	3	47
60048	2	4	11	1	11	2	19	4	19	11	8	6	7	18	6	9	12	2	11	12	175
60050	1	1	3					1		1			1	1		1					10
60051	4	2	4		2	3	2	1				1	1	3	1	2		1	2	3	32
60053			2				1														3
60056			1							1				1							3
60060	9	16	14	4	13	2	25	6	14	10	8	2	14	17	7	16	4	2	11	14	208
60061	6	4	7		2	2	6	1	5	7	5	4	6	8	5	1	7	1	5	10	92
60062			4			1	3		2				1								11
60064	1	2			1	1		3		4	1	3			3	2		1	5	3	30
60067							1						2							1	4
60068			1											2							3
60069			4		1		3						1	3							12
60070	1		1				3							1							6
60071																		1			1
60073	7	9	16	1	16	5	8	10	16	16	7	5	4	9	13	26	6	13	15	25	227
60074	1		1			1	3			2											8
60076			1				1							2							4
60077	1																				1
60079								1		1							1				3
60081	1	1	3		1		1		2			1		1			1			3	15
60083	1	2	1	1		1			4	4	1	1			1		3	1		4	25
60084	1	1	4	1	1		3	1	1	1			2	4	1			1	2	1	25
60085	9	4	5	2	8	1	2	6	9	11	1	10			8	18	15	19	14	15	157
60087	5		3	1	4	1	1	2	6	3	2	3			4	10	2	2	4	4	57
60088	2			1					1					1		2				3	10
60089	1	3	10		1	1	14	1	1	1	1		8	11	1	2	1			4	61
60090			2		1		4	1				1	1	2		1	1			1	15
60096	1		1		1	1	1		2			1			1	1				1	11
60097			2				1		1							1				1	6
60098			3														1				4

List of ALL Advocate Condell Outpatient Surgical Cases by ASTC Physician by Zip Code in Past 12 Months

60099	4	3	6		2	2	3	2	4	3	1	7		1	1	12		4	11	9	75
60101			1																		1
60102			1													1					2
60103			1											2							3
60107							1								1						2
60108		1	1																		2
60110			1																		1
60115						1															1
60118																				2	2
60123																				1	1
60126			1					1													2
60142																			1		1
60143			1																		1
60154	1																				1
60156			2											1	1						4
60164																				1	1
60173	1																				1
60174			1																		1
60176																			1		1
60187					1																1
60192																				1	1
60201														2						1	3
60301														1							1
60402						1															1
60450												1									1
60457			1																		1
60490																				1	1
60504			1																		1
60506	1		1											1							3
60517																1					1
60532					1																1
60538							1														1
60607																				1	1
60609			1										1								2
60611																	1				1
60618														1							1
60622														1							1
60625			1									1									2
60631														1							1
60639					1																1
60642			1											1							2

List of ALL Advocate Condell Outpatient Surgical Cases by ASTC Physician by Zip Code in Past 12 Months

60643																		1		1
60645			1																	1
60646			1											1						2
60647							1							1				1		3
60656			1											1						2
60706									1											1
60714			1																	1
61038																			1	1
61062			1																	1
61107													1							1
61115																		1		1
61242														1						1
61704		2																		2
61705																			1	1
61938			1																	1
92562															1					1
95124										1										1
96003			1																	1
99712		1																		1
Grand Total	**102**	**86**	**234**	**22**	**130**	**50**	**164**	**74**	**132**	**133**	**66**	**79**	**79**	**190**	**82**	**166**	**80**	**71**	**146**	**183**	**2269**

Within 45 Min Drive Time	**99**	**83**	**223**	**22**	**130**	**48**	**162**	**74**	**132**	**130**	**66**	**77**	**78**	**186**	**81**	**165**	**80**	**71**	**143**	**180**	**2,230**

Out of 45 Minute Service Area	**3**	**3**	**11**	**0**	**0**	**2**	**2**	**0**	**0**	**3**	**0**	**2**	**1**	**4**	**1**	**1**	**0**	**0**	**3**	**3**	**39**

Percentage within 45 Minute Geographic Service Area: 2,230 / 2,269 = 98%

Note that 75 cases within the 45 Minute Geographic Service Area are from Wisconsin: 75 / 2,230 = 3%

This data verifies more than 50% of the admissions were residents of the Geographic Service Area.

1110.1540 Non-Hospital Based Ambulatory Surgical Treatment Center Services

(d)(1)$ (2) or (3) Service Demand

The applicant shall provide physician referral letters that attest to the physician's total number of treatments (for each ASTC service that has been referred to existing IDPH-licensed ASTCs or hospitals located in the GSA during the 12-month period prior to submission of the application. The documentation of physician referrals shall include the following information:

A) patient origin by zip code of residence;

B) name and specialty of referring physician;

C) name and location of the recipient hospital or ASTC; and

D) number of referrals to other facilities for each proposed ASTC service for each of the latest two years.

2) Projected Service Demand
The applicant shall provide the following documentation:

A) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing IDPH-licensed ASTCs or hospitals located in the GSA during the 12-month period prior to submission of the application;

B) Documentation demonstrating that the projected patient volume, as evidenced by the physician referral letters, is from within the GSA defined under subsection (c)(2);

C) An estimated number of treatments the physician will refer annually to the applicant facility within a 24-month period after project completion. The anticipated number of referrals cannot exceed the physician's experienced caseload. The percentage of projected referrals used to justify the proposed establishment cannot exceed the historical percentage of applicant market share within a 24-month period after project completion;

D) Referrals to health care providers other than IDPH-licensed ASTCs or hospitals will not be included in determining projected patient volume;

E) Each physician referral letter shall contain the notarized signature, the typed or printed name, the office address, and the specialty of the physician; and

F) Verification by the physician that the patient referrals have not been used to support another pending or approved CON application for the subject services.

Referral letters from 20 physicians are found in the Appendix of this application. They demonstrate the physicians' commitment to send to the proposed ASTC cases from their volume they have done at Advocate Condell Medical Center. The cases total 1,361 surgeries, which represent 2,559 hours of operating room time including set up and clean up. The time was based on the experience of each specialty in 2013 at Advocate Condell Medical Center.

1110.1540 Non-Hospital Based Ambulatory Surgical Treatment Center Services

(f)(1) & (2) Treatment Room Need Assessment

1) **The applicant shall document that the proposed number of surgical/treatment rooms for each ASTC service is necessary to service the projected patient volume. The number of rooms shall be justified based upon an annual minimum utilization of 1,500 hours of use per room, as established in 77 Ill. Adm. Code 1100.**

2) **For each ASTC service, the applicant shall provide the number of patient treatments/sessions, the average time (including setup and cleanup time) per patient treatment/session, and the methodology used to establish the average time per patient treatment/session (e.g., experienced historical caseload data, industry norms or special studies).**

Twenty physicians have committed to performing 2,559 hours of outpatient surgery in the proposed ASTC in year one which is sufficient to justify the two surgical operating rooms. See attachment #15, Exhibit 1

2,559 hours ÷ 1,500 hours per OR = 1.7 ORs, rounded to 2 ORs.

To assess additional growth for this new facility, the past pattern of Condell's outpatient surgical hours was analyzed. The pattern of outpatient surgical hours over the past three years revealed the expected utilization will increase by 5.8% per year.

All OP Surgery Hours at Condell	Base yr. 2012	2013	2014	% change 2012-2014	Annual Change Projected*	2015	2016
OP Surgical Hours	9,517	9,968	10,643	11.8%	5.75%	11,255	11,902

*Based on Compound Annual Growth Rate formula

Using this calculation indicates the facility will be at 95% capacity in two years:

2,559 ASTC hours x 1.0575 = 2,706 hours by the end of the first year
2,706 ASTC hours x 1.0575 = 2,862 hours by end of the second year.
2,862/3,000 hours = 95%

	DEPT./ SERVICE	HISTORICAL UTILIZATION Surgical Hours.	PROJECTED UTILIZATION in Hours**	STATE STANDARD	MET STANDARD?
YEAR 1	ASTC	2,559 hours	2,706	1,500-3,000	Yes
YEAR 2	ASTC		2,862	1,500-3,000	Yes

**Hours based on total time patient was in the operating room, plus set up and clean up.

Physician Referrals to ASTC

Physician	Cases Referred to ASTC	Specialty	Avg OR Hours/Case with set up-clean up*	Hours needed
JOHNSON-MD, BENJAMIN C	80	Otolaryngology	1.63	130
GIBSON-MD, LAURENCE F	44	General Surgery	1.73	76
LIESEN-MD, DANIEL A	47	General Surgery	1.73	81
PARIKH-DO, AMIT	49	General Surgery	1.73	85
SCHEER-MD, MICHAEL F	48	General Surgery	1.73	83
SIEGEL-MD, AARON M	44	General Surgery	1.73	76
STROHMAYER-MD, PAUL N	88	General Surgery	1.73	152
CARONIS-MD, GREGORY G	48	Orthopedic	2.12	102
COLLINS-MD, ROGER B	74	Orthopedic	2.12	157
FRANK-MD, CHARLES E	96	Orthopedic	2.12	204
MEIS-MD, JOSEPH A	45	Orthopedic	2.12	95
NEAULT-MD, MARK A	114	Orthopedic	2.12	242
TALERICO-MD, MARCUS	109	Orthopedic	2.12	231
ALZATE-MD, JUAN	65	Neurosurgery	2.06	134
CITOW-MD, JONATHAN S	145	Neurosurgery	2.06	299
ERICKSON-MD, ROBERT K	30	Neurosurgery	2.06	62
COHEN-MD, JUSTIN	13	Urology	1.49	19
KHAN-MD, RAZA M	82	Urology	1.49	122
KIM-MD, RONALD J	41	Urology	1.49	61
SAFFRIN-MD, ROBERT S	99	Urology	1.49	148
Grand Total	1,361			2,559

Referrals by Specialty to ASTC

Specialty	Cases Referred to ASTC	Avg OR Hours/Case with set up-clean up* by specialty	Hours needed
Otolaryngology	80	1.63	130
General Surgery	320	1.73	554
Orthopedic Surg.	486	2.12	1030
Neurosurgery	240	2.06	494
Urology	235	1.49	350
Total	1,361		2,559

The hours per case (total time the patient was in the OR, plus the set up and clean up) were the average for that specialty in 2013 at Advocate Condell Medical Center.

1110.1540 Non-Hospital Based Ambulatory Surgical Treatment Center Services

(g) Service Accessibility

Service Accessibility

The proposed ASTC services being established or added are necessary to improve access for residents of the GSA. The applicant shall document that at least one of the following conditions exists in the GSA:

1) There are no other IDPH-licensed ASTCs within the identified GSA of the proposed project;

2) The other IDPH-licensed ASTC and hospital surgical/treatment rooms used for those ASTC services proposed by the project within the identified GSA are utilized at or above the utilization level specified in 77 Ill. Adm. Code 1100;

3) The ASTC services or specific types of procedures or operations that are components of an ASTC service are not currently available in the GSA or that existing underutilized services in the GSA have restrictive admission policies;

4) The proposed project is a cooperative venture sponsored by two or more persons, at least one of which operates an existing hospital. Documentation shall provide evidence that:

A) The existing hospital is currently providing outpatient services to the population of the subject GSA;

B) The existing hospital has sufficient historical workload to justify the number of surgical/treatment rooms at the existing hospital and at the proposed ASTC, based upon the treatment room utilization standard specified in 77 Ill. Adm. Code 1100;

C) The existing hospital agrees not to increase its surgical/treatment room capacity until the proposed project's surgical/treatment rooms are operating at or above the utilization rate specified in 77 Ill. Adm. Code 1100 for a period of at least 12 consecutive months; and

D) The proposed charges for comparable procedures at the ASTC will be lower than those of the existing hospital.

The proposed Project is a cooperative venture between Advocate Condell Medical Center (Condell, Hospital), Surgical Care Affiliates, and twenty referring physicians. Co-applicants include Advocate Condell Medical Center; Advocate Health and Hospitals Corporation, as the sole shareholder of Advocate Condell Medical Center; Advocate Health Care Network; Evangelical Services Corporation; Surgical Care Affiliates, Inc.; Surgical Care Affiliates, LLC, SCA Surgery Holdings, LLC, SCA-Illinois, LLC; and Advocate-SCA Partners, LLC.

Advocate Condell Medical Center is currently providing outpatient surgical services to the population of the Geographic Service Area, defined for ASTCs as within a 45 minute drive time. The table shown in Attachment 27, Exhibit 1, reveals 2,230 of the 2,269 or 98% of the referring

physicians' outpatient surgery patients reside within the defined Geographic Service Area. The patients that will be referred to the proposed ASTC will be from Condell's historical patient base.

Condell has sufficient historical workload to justify the number of surgical/treatment rooms at the hospital (12) and at the proposed ASTC (2).

	IP Hours	OP Hours	Total Hours	Min. Hrs / OR	ORs Supported	Rounded Up
2014	10,251	10,643	20,894	1,500	13.9	14
2013	10,909	9,968	20,877	1,500	13.9	14
2012	10,661	9,517	20,178	1,500	13.5	14

By their signatures, Advocate Condell Medical Center agrees

- Not to increase its surgical/treatment room capacity until the proposed Project's surgical/treatment rooms are operating at or above the utilization rate specified in 77 Ill Adm. Code 1100 for a period of at least 12 consecutive months, and
- The proposed charges for comparable procedures at the ASTC will be lower than those of Condell.

1110.1540 Non-Hospital Based Ambulatory Surgical Treatment Center Services

(h)(1) through (3) Unnecessary Duplication/Maldistribution

1) The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall provide the following information for the proposed GSA zip code areas identified in subsection (c)(2)(A):

- **A) the total population of the GSA (based upon the most recent population numbers available for the State of Illinois); and**
- **B) the names and locations of all existing or approved health care facilities located within the GSA that provide the ASTC services that are proposed by the project.**

2) The applicant shall document that the project will not result in maldistribution of services.

3) The applicant shall document that, within 24 months after project completion, the proposed project:

- **A) will not lower the utilization of other area providers below the utilization standards specified in 77 Ill. Adm. Code 1100; and**
- **B) will not lower, to a further extent, the utilization of other GSA facilities that are currently (during the latest 12-month period) operating below the utilization standards.**

Population

The total population of the 45 minute drive time Geographic Service Area (GSA) is 6,548,257

Other ASTCs

IDPH 2013 data profiles of ASTCs within a 45 minute drive time of the proposed site identified there were 66 facilities located within the defined area. See Attachment 27, Exhibit #4

Only four ASTCs offer the same five services that are proposed to be in the Advocate Condell Ambulatory Surgery Center: general surgery, neurosurgery, orthopedics, otolaryngology, and urology. More than twenty offer four services. It is noteworthy that neurosurgery is not offered in most of the ASTCs. Others focus on a single specialty such as gastroenterology, or pain.

The patients that will be referred to this ASTC will come from Condell's current patient base, which is 98% from the Geographic Service Area. The ASTC is not expected to draw from other facilities. Therefore, this should not diminish the patient case load at any other ASTCs and result in any maldistribution.

Ambulatory Surgery Treatment Centers in Geographic Service Area

1	25 East Same Day Surgery 25 East Washington, Suite 300 Chicago, IL 60602-1708
2	Advanced Ambulatory Surgical Center 2333 North Harlem Avenue Chicago, IL 60707
3	Albany Medical Surgical Center 5086 N. Elston Avenue Chicago, IL 60630
4	Belmont/Harlem Surgery Center, LLC 3101 North Harlem Avenue Chicago, IL 60634
5	Chicago Endoscopy Center, ASTC 3536 W. Fullerton Avenue Chicago, IL 60647
6	Fullerton Kimball Medical & Surgical Center 3412 W. Fullerton Avenue Chicago, IL 60647
7	Fullerton Surgery Center 4849 West Fullerton Chicago, IL 60639
8	Gold Coast Surgicenter, LLC 845 N. Michigan Ave., #985W Chicago, IL 60611
9	Grand Avenue Surgical Center 17 West Grand Avenue Chicago, IL 60654
10	Lakeshore Surgery Center, LLC 7200 North Western Avenue Chicago, IL 60645
11	Novamed Surgery Center of Chicago Northshore 3034 West Peterson Ave. Chicago, IL 60659
12	Peterson Medical Surgi-Center 2300 W. Peterson Ave Chicago, IL 60659
13	River North Same Day Surgery Center One E. Erie St., #300 Chicago, IL 60611
14	Rogers Park One Day Surgery Center, Inc. 7616 N. Paulina Chicago, IL 60626
15	Rush Surgicenter - Professional Building 1725 W. Harrison, Suite 556 Chicago, IL 60612
16	Six Corners Same Day Surgery, LLC 4211 North Cicero Avenue Suite 400 Chicago, IL 60641 A
17	South Loop Endoscopy & Wellness Center LLC 2334-40 South Wabash Chicago, IL 60616
18	Swedish Covenant Surgery Center, LLC 5215 N. California Ave., Suite F800 Chicago, IL 60625
19	The Surgery Center at 900 N. Michigan Avenue, LLC 60 E. Delaware Place, 15th Floor Chicago, IL 60611-1425
20	Western Diversey Surgical Center 2744 N. Western Avenue Chicago, IL 60647
21	Advantage Health Care, Ltd. 203 E. Irving Park Road Wood Dale, IL 60191
22	Aiden Center for Day Surgery, LLC 1580 West Lake Street Addison, IL 60101
23	Ambulatory Surgicenter of Downers Grove, Ltd. 4333 Main Street Downers Grove, IL 60515
24	Ashton Center for Day Surgery 1800 McDonough Rd., Ste . 100 Hoffman Estates, IL 60192
25	Chicago Prostate Cancer Surgery Center 815 Pasqueinelli Drive Westmont, IL 60559
26	DMG Surgical Center, LLC 2725 S. Technology Drive Lombard, IL 60148
27	Dupage Eye Surgery Center, LLC 2015 North Main Street Wheaton, IL 60187
28	Elmhurst Medical & Surgical Center P.C. 340 West Butterfield Rd, Suite 1B Elmhurst, IL 60126
29	Elmhurst Outpatient Surgery Center, LLC 1200 S. York Road, Suite 1400 Elmhurst, IL 60126
30	Elmwood Park Same Day Surgery Center 1614 North Harlem Avenue Elmwood Park, IL 60707-4302
31	Eye Surgery Center of Hinsdale, LLC 950 North York Road, Ste 203 Hinsdale, IL 60521
32	Forest Med-Surg Center 9050 West 81st Street Justice, IL 60458
33	Golf Surgical Center, LLC 8901 Golf Road Des Plaines, IL 60016
34	Hinsdale Surgical Center 908 N. Elm Street, Suite 401 Hinsdale, IL 60521
35	Hoffman Estates Surgery Center, LLC 1555 Barrington Road, Dob #3, Suite 0400 Hoffman Estates, IL 60194
36	Illinois Hand & Upper Extremity Center 515 West Algonquin Road Arlington Heights, IL 60005
37	Illinois Sports Medicine & Orthopedic Surgery Cent 9000 Waukegan Road, Suite 120 Morton Grove, IL 60053

38	Loyola Surgery Center 1 South 224 Summit Suite 201 Oakbrook Terrace, IL 60181
39	Loyola University Ambulatory Surgery Center 2160 S. First Avenue Maywood, IL 60153
40	Magna Surgical Center 7456 South State Road, Ste 300 Bedford Park, IL 60638-6625
41	Midwest Center for Day Surgery 3811 Highland Avenue Downers Grove, IL 60515
42	Midwest Endoscopy Center, LLC 1243 Rickert Drive Naperville, IL 60540
43	Naperville Fertility Center, Inc 3 North Washington Naperville, IL 60540
44	Naperville Surgical Centre 1263 Rickert Drive Naperville, IL 60540
45	Northwest Community Day Surgery Center II, LLC 675 W. Kirchoff Road Arlington Heights, IL 60005
46	Northwest Surgicare 1100 West Central Road, Ste L-4 Arlington Heights, IL 60005
47	Novamed Center for Reconstructive Surgery 6309 West 95th Street Oak Lawn, IL 60453
48	Novamed Surgery Center of River Forest, LLC 7427 West Lake Street River Forest, IL 60305
49	Oak Lawn Endoscopy 9921 Southwest Highway Oak Lawn, IL 60453
50	Ravine Way Surgery Center, LLC 2350 Ravine Way, Suite 500 Glenview, IL 60025
51	Regenerative Surgery Center 1455 Golf Road Des Plaines, IL 60016-1250
52	Salt Creek Surgery Center 530 North Cass Avenue Westmont, IL 60559
53	The Center for Surgery 475 E. Diehl Road Naperville, IL 60563
54	The Glen Endoscopy Center 2551 Compass Road, Suite 115 Glenview, IL 60026
55	The Oak Brook Surgical Centre 2425 W. 22nd Street, Ste. 101 Oak Brook, IL 60523
56	United Shockwave Therapy 120 N. LaGrange Road La Grange, IL 60525
57	Algonquin Road Surgery Center, LLC 2550 West Algonquin Road Lake in the Hills, IL 60516
58	Barrington Pain and Spine Institute 600 Hart Road Ste 300 Barrington, IL 60010
59	Elgin Gastroenterology Endoscopy Center, LLC 745 Fletcher Drive, #201 Elgin, IL 60123
60	Grand Oaks Surgical Center SC 1800 Hollister Dr. Libertyville, IL 60048
61	Hawthorn Surgery Center 1900 Hollister Drive, Ste. 100 Libertyville, IL 60048
62	Lindenhurst Surgery Center 1050 Red Oak Lane Lindenhurst, IL 60046
63	Northshore Endoscopy Center 101 S. Waukegan Road, Ste 980 Lake Bluff, IL 60044
64	Northwestern Grayslake Ambulatory Surgery Center 1475 East Belvidere Road Grayslake, IL 60030
65	Northwestern Grayslake Endoscopy Center, LLC 1475 E. Belvidere Road Suite 303 Grayslake, IL 60030
66	Vernon Square Surgicenter 230 Center Drive Vernon Hills, IL 60061

Source: HFSRB Ambulatory Surgery Treatment Center Profiles - 2013

1110.1540 Non-Hospital Based Ambulatory Surgical Treatment Center Services

(i)(1) Staffing

Staffing the proposed ASTC will be addressed through various means. Advocate Condell Medical Center has a long history of staffing its hospital surgery department. The Advocate system uses a web-based method of recruiting and maintains a list of possible candidates. This facilitates the hiring of qualified staff.

Surgical Care Affiliates (SCA) has many years of experience successfully staffing its other ASTCs. SCA operates 185 surgical facilities, including surgery centers, surgical hospitals, and hospital surgery departments, in 34 states. It employs approximately 5,000 teammates. SCA also utilizes web-based recruiting tools and has an applicant tracking software that allows it to maintain high end quality applicant tracking.

SCA anticipates hiring a lead administrator and director of nursing to begin the process of recruiting. This type of ASTC usually employs around 30 FTE's, clinical and non-clinical to run the facility. The ASTC is essentially day shift, and no Sundays, making it attractive to applicants.

1110.1540 Non-Hospital Based Ambulatory Surgical Treatment Center Services

(i)(2) Medical Director

All physicians will be Board certified in their specialty. The ASTC will follow conditions for coverage established by the Centers for Medicare and Medicaid Services.

The Medical Director shall represent both the clinical and medical needs of the Facility. The Medical Director shall also represent the views of the Medical Staff and be responsible for communicating concerns, conclusions, recommendations and decisions of the Medical Staff to the Governing Body.

In addition, the Medical Director shall review and make recommendations on policies affecting the direct delivery of patient care and the purchase of equipment needed to maintain and improve upon the delivery of patient care at the Facility.

The Medical Staff has the right to a representative on the Governing Body and may elect representatives from each specialty to the Medical Executive Committee that advises the Governing Body. The Medical Staff Representative shall, together with the Medical Director, represent the views and concerns of the Medical Staff.

1110.1540 Non-Hospital Based Ambulatory Surgical Treatment Center Services

(j) Charge Commitment

See Charge Commitment Letter and Comparison of ASTC and Condell Medical Center Charges, Attachment 27, Exhibit #5.

SCA
Surgical Care Affiliates

February 19, 2015

Ms. Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, Second Floor
Springfield, IL 62761

Re: Advocate Condell Ambulatory Surgery Center

Dear Ms. Olson:

This is to certify that the proposed charges for Advocate Condell Ambulatory Surgery Center will be less than the current Advocate Condell Medical Center charges for similar procedures. A listing of the ASTC's proposed charges and a comparison to those most frequently done at the hospital is included with this letter.

This also certifies that Advocate Condell Ambulatory Surgery Center charges will remain unchanged for a period of two years.

Sincerely,

Robert Harmon
Vice President Operations
Surgical Care Affiliates

Dave Cartwright
Vice President Finance and Support Services
Advocate Condell Medical Center

OFFICIAL SEAL
THERESA K KNAR
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/18/16

Theresa K. Knar
Feb. 19, 2015
Lake County

520 Lake Cook Road, Suite 250 | Deerfield, IL 60015 | 205.545.2572 | 800.768.0094 | www.scasurgery.com

Comparison of Advocate Condell Ambulatory Surgery Center fees, and Advocate Condell Medical Center fees

CPT - CPT Code	CPT - CPT Code Description	Total	ASTC Fee	Hospital Fee
63047	REMOVE SPINE LAMINA 1 LM	216	$16,845	$31,611
29881	KNEE ARTHROSCOPY/SURGERY	119	$10,920	$18,476
47562	LAPAROSCOPIC CHOLECYSTEC	119	$16,615	$28,965
52332	CYSTOSCOPY AND TREATMENT	94	$9,110	$22,979
29826	SHOULDER ARTHROSCOPY/SUR	85	$17,360	#N/A
63048	REMOVE SPINAL LAMINA ADD	84	$16,845	#N/A
63030	LOW BACK DISK SURGERY	78	$16,845	$33,242
29827	ARTHROSCOP ROTATOR CUFF	66	$17,360	$33,511
49505	PRP I/HERN INIT REDUC >5	66	$11,155	$20,106
64721	CARPAL TUNNEL SURGERY	64	$6,815	$8,578
29824	SHOULDER ARTHROSCOPY/SUR	49	$11,405	$27,553
44970	LAPAROSCOPY APPENDECTOMY	49	$16,615	$35,364
52648	LASER SURGERY OF PROSTAT	45	$16,445	$23,681
63042	LAMINOTOMY SINGLE LUMBAR	38	$16,845	$31,789
29888	KNEE ARTHROSCOPY/SURGERY	34	$17,360	$47,477
52356	CYSTO/URETERO W/LITHOTRI	33	$14,289	$31,194
69436	CREATE EARDRUM OPENING	30	$6,275	$8,539
29880	KNEE ARTHROSCOPY/SURGERY	29	$10,920	$19,513
30140	RESECT INFERIOR TURBINAT	28	$8,905	$15,045
20680	REMOVAL OF SUPPORT IMPLA	26	$7,660	$11,000
30520	REPAIR OF NASAL SEPTUM	26	$8,905	#N/A
29807	SHOULDER ARTHROSCOPY/SUR	25	$17,360	$31,780
36561	INSERT TUNNELED CV CATH	25	$10,880	$15,089
49652	LAP VENT/ABD HERNIA REPA	25	$10,550	$28,070
26055	INCISE FINGER TENDON SHE	24	$6,170	$10,718
50590	FRAGMENTING OF KIDNEY ST	23	$13,000	$15,113
64450	N BLOCK OTHER PERIPHERAL	22	$3,650	#N/A
19120	REMOVAL OF BREAST LESION	21	$7,360	$13,337
52235	CYSTOSCOPY AND TREATMENT	20	$9,110	$23,353
52281	CYSTOSCOPY AND TREATMENT	19	$7,340	$16,751
64718	REVISE ULNAR NERVE AT EL	19	$6,815	$17,057
25608	TREAT FX RAD INTRA-ARTIC	18	$21,830	$36,916
49650	LAP ING HERNIA REPAIR IN	18	$16,615	$27,668
52352	CYSTOURETERO W/STONE REM	18	$9,110	$20,401
42830	REMOVAL OF ADENOIDS	17	$8,445	$9,903

25607	TREAT FX RAD EXTRA-ARTIC	16	$21,830	$34,094
49585	RPR UMBIL HERN REDUC > 5	16	$11,155	$18,961
52000	CYSTOSCOPY	16	$3,730	$14,672
52310	CYSTOSCOPY AND TREATMENT	15	$4,970	$17,063
29806	SHOULDER ARTHROSCOPY/SUR	14	$17,360	$40,334
26160	REMOVE TENDON SHEATH LES	13	$5,500	$6,955
19301	PARTIAL MASTECTOMY	12	$7,360	$15,846
22551	NECK SPINE FUSEREMOV BE	12	$37,360	$52,300
23515	TREAT CLAVICLE FRACTURE	12	$21,830	$38,553
52353	CYSTOURETERO W/LITHOTRIP	12	$13,330	$24,836
26615	TREAT METACARPAL FRACTUR	11	$14,325	$28,329
26746	TREAT FINGER FRACTURE EA	11	$12,000	$13,467
38525	BIOPSY/REMOVAL LYMPH NOD	11	$8,115	$21,958
52320	CYSTOSCOPY AND TREATMENT	11	$9,110	#N/A
54161	CIRCUM 28 DAYS OR OLDER	11	$7,840	$10,381
11012	DEB SKIN BONE AT FX SITE	10	$4,145	#N/A
12032	INTMD RPR S/A/T/EXT 2.6-	10	$4,145	#N/A
19125	EXCISION BREAST LESION	10	$7,360	$17,869
24685	TREAT ULNAR FRACTURE	10	$14,325	$32,981
26735	TREAT FINGER FRACTURE EA	10	$10,500	$11,426
29828	ARTHROSCOPY BICEPS TENOD	10	$11,405	#N/A
29999	ARTHROSCOPY OF JOINT	10	$10,707	#N/A
31267	ENDOSCOPY MAXILLARY SINU	10	$8,380	$19,735
38500	BIOPSY/REMOVAL LYMPH NOD	10	$8,115	$22,754
42826	REMOVAL OF TONSILS	10	$8,445	$12,288
49654	LAP INC HERNIA REPAIR	10	$10,550	$29,248
52601	PROSTATECTOMY (TURP)	10	$13,330	$24,364
63267	EXCISE INTRSPINL LESION	10	$15,340	$30,697
64910	NERVE REPAIR W/ALLOGRAFT	10	$6,885	$27,230
11400	EXC TR-EXT B9+MARG 0.5 C	9	$3,730	#N/A
11771	REMOVE PILONIDAL CYST EX	9	$7,660	$14,817
24342	REPAIR OF RUPTURED TENDO	9	$15,675	$30,615
25290	INCISE WRIST/FOREARM TEN	9	$9,590	#N/A
26418	REPAIR FINGER TENDON	9	$5,850	$11,781
27814	TREATMENT OF ANKLE FRACT	9	$14,325	$31,895
42820	REMOVE TONSILS AND ADENO	9	$8,445	$11,849
49653	LAP VENT/ABD HERN PROC C	9	$10,550	$30,684
20670	REMOVAL OF SUPPORT IMPLA	8	$5,765	$11,648
22851	APPLY SPINE PROSTH DEVIC	8	$31,535	#N/A
25111	REMOVE WRIST TENDON LESI	8	$6,170	$12,216
29823	SHOULDER ARTHROSCOPY/SUR	8	$10,920	$29,797

29825	SHOULDER ARTHROSCOPY/SUR	8	$10,920	$23,581
29846	WRIST ARTHROSCOPY/SURGER	8	$10,920	$24,125
29877	KNEE ARTHROSCOPY/SURGERY	8	$10,920	$21,624
31535	LARYNGOSCOPY W/BIOPSY	8	$8,380	$17,200
52240	CYSTOSCOPY AND TREATMENT	8	$9,110	$24,507
64831	REPAIR OF DIGIT NERVE	8	$12,650	$22,954
11406	EXC TR-EXT B9+MARG >4.0	7	$5,765	$10,963
11770	REMOVE PILONIDAL CYST SI	7	$7,660	$13,661
23120	PARTIAL REMOVAL COLLAR B	7	$15,675	#N/A
23410	REPAIR ROTATOR CUFF ACUT	7	$15,675	#N/A
29879	KNEE ARTHROSCOPY/SURGERY	7	$10,920	$21,367
47563	LAPARO CHOLECYSTECTOMY/G	7	$16,615	$44,686
52234	CYSTOSCOPY AND TREATMENT	7	$9,110	$17,740
11404	EXC TR-EXT B9+MARG 3.1-4	6	$5,765	$12,701
11606	EXC TR-EXT MAL+MARG >4 C	6	$5,765	#N/A
19101	BIOPSY OF BREAST OPEN	6	$7,360	$18,941
24538	TREAT HUMERUS FRACTURE	6	$9,740	$18,216
26116	EXC HAND TUM DEEP < 1.5	6	$7,660	$13,826
26742	TREAT FINGER FRACTURE EA	6	$4,145	$14,076
26765	TREAT FINGER FRACTURE EA	6	$14,325	#N/A
27650	REPAIR ACHILLES TENDON	6	$15,675	$20,685
27792	TREATMENT OF ANKLE FRACT	6	$14,325	$22,661
29822	SHOULDER ARTHROSCOPY/SUR	6	$10,920	#N/A

#N/A denotes cases of this CPT code that cannot be easily compared. When performed at the hospital, these cases usually entailed several charge codes.

1110.1540 Non-Hospital Based Ambulatory Surgical Treatment Center Services

(k)(1) & (2) Assurances

By their signatures, the applicants attest that a peer review program will be implemented that evaluates whether patient outcomes are consistent with quality standards established by professional organizations for the ASTC services, and if outcomes do not meet or exceed those standards, a quality improvement plan will be initiated.

A letter is included in Attachment 17 that defines the expectation that the volume of cases will be sufficient to meet or exceed the utilization standards in the second year of operation. The volume of cases that the physicians are committing to bring to the ASTC, based on their historical utilization experience, will meet the standards in the first year.

The following Sections DO NOT need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18 month period prior to the submittal of the application):

- **Section 1120.120 Availability of Funds – Review Criteria**
- **Section 1120.130 Financial Viability – Review Criteria**
- **Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)**

VIII. - 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable: **Indicate the dollar amount to be provided from the following sources:**

$5,813,879	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
N/A	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
N/A	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
$4,225,841	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
N/A	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
N/A	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
N/A	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$10,039,720	**TOTAL FUNDS AVAILABLE**	

APPEND DOCUMENTATION AS ATTACHMENT-36, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Letter of Intent for Lease

March 6, 2015

Advocate Condell Ambulatory Surgery Center, LLC
C/O Advocate-SCA Partners, LLC
Attn: Ajay Chokshi

Re: Letter of Intent
825 S. Milwaukee Ave., Libertyville, IL (Libertyville ASC)

Dear Ajay:

This Letter of Intent ("LOI") shall memorialize the terms of the agreement between Advocate Condell Medical Center ("Landlord") and Advocate Condell Ambulatory Surgery Center, LLC ("Tenant") regarding certain terms and conditions of a lease agreement between Landlord and Tenant for Landlord's proposed surgery center building located at 825 S. Milwaukee Ave., Libertyville, Illinois 60048 (the "Property").

Exclusivity Period: Upon the execution of this LOI by Landlord and Tenant, the parties agree to negotiate in good faith and with due diligence the terms and conditions of a lease for the surgery center building ("Building") to be constructed on the Property by Landlord. From the date of final execution of this letter through May 1, 2015, Landlord shall not enter into an agreement, LOI or lease with any party other than Tenant for the rental of the Building on the Property ("Exclusivity Period").

Certificate of Need: The project is contingent upon approval of a Certificate of Need from the Illinois Health Facilities and Services Review Board on or before August 26, 2015. In the event that Tenant does not obtain the approval of its CON application by August 26, 2015, Tenant may terminate the lease by providing Landlord written notice of its intention to do so, and neither party shall have any further rights or obligations under this LOI.

Confidentiality: Landlord and Tenant agree to treat confidentially and not to use for any purpose detrimental to any other party or to disclose to any other person or entity, other than such party's respective employees, attorneys, accountants and other agents and representatives who need to know such information for purposes of evaluating the contemplated potential transaction between Landlord and Tenant any non-public information previously or hereafter provided (whether in written, machine-readable or oral form) by any other party, or any terms of the transactions contemplated by this LOI (collectively, the "Confidential Information"), except as may otherwise by required to file the Certificate of Need application or by applicable law, subpoena, court or governmental order or the rules of any applicable securities exchange.

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Notwithstanding anything to the contrary in this LOI, the terms of the Exclusivity Period, and Certificate of Need and Confidentiality provisions shall be binding upon Landlord and Tenant. The lease shall also include the following business terms and conditions:

Project/Process Information:	The parties shall agree upon a tentative project timeline. Landlord will select one of its approved general contractors to construct the building core and shell which shall be delivered to Tenant in a cold shell. To minimize construction costs for the Tenant and significantly reduce construction time, Tenant shall engage the same general contractor for its tenant build-out as selected by Landlord for its core and shell improvements.
Rent Commencement:	The rent shall commence the earlier of (i) six (6) months after completion of the cold shell base building and turnover to Tenant for construction of its tenant improvements, or (ii) upon a certificate of occupancy issued by the Village of Libertyville for the Building.
Site:	The site is an approximately 7.88 acre parcel of land.
Building:	The lease will be for a 1-story, approximately 11,912 rentable square-foot building.
Adjacent Building:	It is intended that simultaneous to the construction of the Building, Landlord or a related entity shall construct a medical office building on the Site, however nothing shall require Landlord or its related entity to do so.
Site Plan:	The preliminary project site plan, floor plans, and building renderings have been provided as part of this proposal.
Utilities:	Sanitary, storm sewer, telephone, fiber, water, gas and electric utilities are available to the property and will be sufficient for the Tenant's intended use.
Lease Term:	Ten (10) year initial lease term.
Leased Premises:	Approximately 11,912 rentable square feet.
Base Rent:	$34.00 per square foot NNN. Rent shall be absolute net to Landlord and Tenant shall pay its prorata share of all costs associated with the Property (taxes and CAM).
Escalations:	3% PSF annually.
Operating Expenses & Real Estate Taxes:	Tenant shall be responsible for operating expenses and real estate taxes for the Property. It is anticipated that Tenant shall self-manage the Building and pay directly the expenses of maintaining the Premises. Landlord shall be

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	responsible for managing all of the common areas of the Property and Tenant shall pay its prorata share of all Operating Expenses. Operating expenses shall include all costs of managing, operating, maintaining, and repairing the Building, including, but not limited to, all costs, expenditures, fees and charges for: (A) operation, maintenance, and repair of the Building (B) utilities and services including waste management; (C) compensation for persons who perform direct duties in connection with the operation, management, maintenance and repair of the Building; (D) property, liability, rental income and other insurance relating to the Property; (E) licenses, permits and inspections; (F) complying with the requirements of any law, statute, ordinance or governmental rule or regulation or any orders pursuant thereto (collectively "Laws"); (G) amortization of capital improvements required to comply with Laws, or which are intended to reduce operating costs or improve the efficiency of any building systems; (H) accounting, legal and other professional services; (I) costs and expenses of operating, managing, owning and maintaining the Parking Facility and the common areas of the Property; and (J) any other cost, expenditure, fee or charge which in accordance with generally accepted property management practices would be considered an expense of managing, operating, maintaining and repairing the Property.
Security Deposit:	None, subject to review of Tenant's financial statements.
Signage:	Tenant will have rights to place signage in and around the Building, subject to compliance with local codes.
Hours of Operation:	Tenant will have 100% control over building hours, subject to local codes, and the HVAC equipment.
Electricity, Gas & Water:	Electricity, gas and water for the Building shall be separately metered and billed directly to Tenant.
Parking:	Parking will be provided in compliance with the Libertyville building code.
Environmental/Code Compliance:	The building construction materials will not contain any asbestos or other potentially hazardous materials. The Building and Site will be constructed to be in compliance with all governmental requirements, including but not limited to the American with Disabilities Act (ADA). The Building and parking lot will provide handicap parking, accessible routes and entrances, along with compliance with all other state and federal accessibility code requirements. Tenant shall properly dispose of hazardous medical wastes in compliance with all applicable laws.
Restoration of Premises:	Tenant will lease the premises in "as-is" broom clean condition, and Tenant shall have the right to remove any and all trade fixtures installed during its leasehold.

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Security & Life Safety: Life safety systems shall be in compliance with local codes.

Effect of Letter of Intent: The parties acknowledge and agree that, except for the sections on the Confidentiality, Certificate of Need and Exclusivity Period of this Letter of Intent, this is a non-binding Letter of Intent, and that accordingly, no party shall have any liability to any other party if the parties fail to execute and deliver definitive written agreements with respect to the transaction contemplated herein. Notwithstanding the foregoing, the parties agree that the sections on the Confidentiality, Certificate of Need and Exclusivity Period of this Letter of Intent are intended to be legally binding upon the parties from and after the execution of this Letter of Intent by the parties, and the parties acknowledge and agree that the obligations of the parties contained in the sections on the Confidentiality, Certificate of Need and Exclusivity Period is supported by sufficient consideration and are valid, binding and enforceable. Each party shall be solely responsible for all fees and expenses incurred by it in going forward with the transactions described herein. This Letter of Intent and the obligations of the parties hereunder may be amended, modified or waived only by a writing signed by the parties.

If the foregoing terms and conditions of this Letter accurately represent our agreement on key business terms, please acknowledge by executing a copy and returning it to Advocate Condell Medical Center, 801 S. Milwaukee Ave, Libertyville, IL 60048 Attn.: Dominica Tallarico on or before 5.00 pm _____, 2015. Upon receipt of a duly executed copy of this Letter, Landlord shall prepare a draft lease agreement for review by Tenant.

Should you have questions, please do not hesitate to call.

Sincerely,
Advocate Condell Medical Center

By _____
Dominica Tallarico
Its: Hospital President

Date 3/6/15

ACKNOWLEDGED & AGREED
Advocate Condell Ambulatory Surgery Center, LLC

By _____

Its: President

Date 3/6/2015

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IX. 1120.130 - Financial Viability

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. All of the projects capital expenditures are completely funded through internal sources
2. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
3. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT-37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

MOODY'S
INVESTORS SERVICE

New Issue: Moody's assigns Aa2 to Advocate Health Care Network, IL's Series 2014 bonds; outlook stable

Global Credit Research - 21 Nov 2014

Aa2, Aa2/VMIG 1, and Aa2/P-1 ratings affirmed on $1 billion of debt

ILLINOIS FINANCE AUTHORITY
Hospitals & Health Service Providers
IL

Moody's Rating

ISSUE	RATING
Revenue Bonds, Series 2014	Aa2
Sale Amount $304,435,000	
Expected Sale Date 12/03/14	
Rating Description Revenue: Other	

Moody's Outlook STA

Opinion

NEW YORK, November 21, 2014 --Moody's Investors Service has assigned an Aa2 rating to Advocate Health Care Network's (Advocate) $304 million of Series 2014 fixed rate revenue bonds. The rating outlook is stable. At this time, we are affirming the Aa2, Aa2/VMIG 1 and Aa2/P-1 ratings on Advocate's outstanding bonds (see Rated Debt section).

SUMMARY RATING RATIONALE

The Aa2 long-term rating is based on Advocate's status as the largest system in the greater Chicago area with good geographic diversity and well positioned individual hospitals, consistent and adequate operating margins, moderate debt levels driving exceptional debt measures, strong and growing investment portfolio, and funded pension plan. The system's challenges include an increasingly competitive and consolidating healthcare market, moderate margins compared with Aa2-rated peers, and expected increases in capital spending, although at manageable levels relative to cashflow.

STRENGTHS

*Advocate maintains a leading market position in greater Chicagoland with good geographic coverage and individual hospitals that maintain leading or prominent market shares in their local markets. The system's geographic reach and diversification is expanding with positive additions to system.

*Margins have been consistent over the last several years with operating cashflow margins in the 10-11% range; in 2013, most hospitals were profitable.

*The system has a conservative and balanced approach to financing capital needs. Debt measures based on annualized nine-month 2014 performance are strong with a low 31% debt-to-operating revenue, exceptional Moody's adjusted peak debt service coverage of over 8 times, and favorably low Moody's adjusted debt-to-cashflow of 2.0 times

*The balance sheet is strong and growing with 370 days of cash on hand at September 30, 2014, providing a strong 297% coverage of debt.

*Debt structure risks are manageable relative to cash and investments with over 600% cash-to-demand debt and

500% monthly liquidity-to-demand debt based on fiscal year end 2013.

*Advocate has demonstrated strong management capabilities evidenced by the organization's historical ability to absorb operating challenges and continue to generate consistently solid operating cashflow, meet or exceed operating budgets, execute strategies effectively including integrating newly acquired hospitals, and commitment to very good disclosure practices.

*The system's defined benefit pension plan is fully funded at 100%.

*Advocate's pending merger with NorthShore University HealthSystem (Aa2 stable) is credit positive for both organizations. The systems' aligned strategies, proven management and strong financial resources will position the new organization to meet the challenges of a rapidly changing industry.

CHALLENGES

*Most of Advocate's hospitals operate in increasingly competitive markets, with major consolidation and competitors expanding facilities and aligning with physicians.

*Operating income and operating cashflow margins are below similarly-rated peers, in part due to the system's close integration with a large number of physicians.

*Capital spending is anticipated to increase, although capital needs can be funded with cashflow; the system has a history of closely managing capital spending relative to cashflow and adjusting to operating shortfalls if necessary.

DETAILED CREDIT DISCUSSION

USE OF PROCEEDS: Proceeds from the Series 2014 bonds will be used to refund all of the Advocate Sherman Series 2007A bonds and a portion of the Advocate Series 2008D bonds.

LEGAL SECURITY: Obligated group includes the Advocate Health Care Network (system parent), Advocate Health and Hospitals Corporation (operates most of the system's hospitals), Advocate North Side Health Network, and Advocate Condell Medical Center. Security is a general, unsecured obligation of the obligated group. No additional indebtedness tests. Subsequent to this debt issuance Advocate Sherman Hospital will become part of the obligated group.

INTEREST RATE DERIVATIVES: Advocate has a total of $326 million of swaps associated with the Series 2008C bonds for which Advocate pays a fixed rate of 3.6% and receives 61.7% of LIBOR plus 26 basis points. The swaps mature in 2038 and the counterparties are Wells Fargo and PNC. As of September 30, 2014 the mark-to-market on the swaps was a negative $64 million and no collateral was posted.

MARKET/COMPETITIVE POSITION: INTEGRATED SYSTEM WITH BROAD GEOGRAPHIC COVERAGE SUPPORTS LEADING POSITION IN COMPETITIVE MARKET

Advocate has pursued an effective strategy to develop an integrated and full service system that has resulted in broad geographic coverage. The system controls 12 acute care facilities, a large home health care operation, and is clinically aligned with approximately 4,000 physicians, about 1,100 of whom are employed as part of Advocate Medical Group or have long-term contractual arrangements. Based on data provided by management, Advocate maintains a leading market position in the greater Chicagoland area with an 18% share for twelve months ended June 2014, compared with Presence Health at 9% and Northwestern Medicine at 9%. While most of Advocate's hospitals face local competition, the system's hospitals are large and very prominent providers with six of the twelve generating close to or over 15,000 admissions annually and the largest (Advocate Christ Medical Center) generating close to 40,000 admissions.

Despite good regional and local market positions, Advocate's hospitals face increasing competition. While Chicagoland had remained relatively fragmented, over the last several years there have been a number of large mergers or acquisitions. Within the last year, the largest include the merger of Elmhurst Memorial and Edward Hospital and the merger of Northwestern Medicine and Cadence Health. Several other combinations have been announced and are in due diligence phases.

Earlier this year, Advocate announced its intent to merge with NorthShore University HealthSystem (Aa2 stable), which is credit positive for both organizations as they combine to form Advocate NorthShore Health Partners. The systems' aligned strategies, proven management, and strong financial resources will position the new organization to meet the challenges of a rapidly changing industry.

Advocate and NorthShore have complementary strategies, which will reduce typical merger-related transition risks. Both systems are closely aligned with a large number of physicians and have advanced information technology capabilities, both of which are necessary in order to assume more risk for the healthcare of the population and to provide higher quality at reduced cost. The combined system will have a broad market position in and around Chicagoland, providing increased and coordinated access to healthcare.

Advocate and NorthShore's corporate structures are highly integrated and centralized, enabling the organizations to reduce costs and realize efficiencies from past mergers quickly and with minimal disruption. These strengths will be critical as the systems manage challenges related to integrating the operations of the new system. The agreement is subject to multiple regulatory approvals and the systems will be reviewing the optimal debt structure over the next several months. Closing is expected in early 2015.

In addition to selective mergers and acquisitions, a major strategy of the system relates to partnerships with payers and transitioning to managing populations under value-based strategies, shifting from fee-for-service models. Advocate has a large contract with Blue Cross under this new model and participates in the Medicare shared savings model. Combined, these arrangements represent over 500,000 lives and require the system to manage under these risk-based models. Compared with other healthcare systems, we believe Advocate is better positioned to manage risk given the system's advanced strategies related to physician alignment and integration, information systems, historical experience with managing under capitated contracts, and strong financial resources. Under these arrangements, Advocate reports exceeding or meeting established benchmarks.

OPERATING PERFORMANCE: STABLE OPERATING MARGINS, DESPITE VOLUME DECLINES

Like other providers in the region, Advocate has experienced declines in inpatient admissions as use rates in the area decline and volumes shift to outpatient services. Same-facility total system admissions were down 6% and 4% in fiscal year 2013 and through nine months of fiscal year 2014, respectively. Most of the decline was due to a shift to observation cases as well as Advocate's strategies to reduce hospital utilization under its value-based contractual arrangements.

Despite admissions declines, revenue growth has been good and the system is maintaining margins and exceeding budget. The system generated $253 million (5.2%) of operating income in 2013 (excluding investment income on self-insurance funds, which are substantial), compared with $223 million (4.9%) of operating income in 2012. Operating cashflow was $519 million (10.6%) in fiscal year 2013, compared with $460 million (10.1%) in 2012. Same-facility revenue growth (excluding the effect of a partial year of Sherman Health System) was 5% (following 3% in 2012). Fiscal year 2013 benefitted from about $21 million of retroactive Medicaid assessment program payments.

Through nine months of fiscal year 2014, operating cashflow was $383 million (10.0%), compared with $374 million (10.4%) in the prior year period. Same-facility revenue growth was 4%, driven by higher acuity and lower self-pay. Advocate's total bad debt and charity care is down approximately $60 million in 2014 on a same-facility basis, in part reflecting benefits of Medicaid expansion. Advocate has benefitted from the state's Medicaid assessment program and will receive incremental funding if CMS approves an extension of the program.

Advocate has been implementing a major cost reduction program with a target of $600 million by 2017 and expects to achieve about half of that goal by the end of 2014, contributing to consistent operating performance.

BALANCE SHEET PROFILE: STRONG AND GROWING LIQUIDITY POSITION COMBINED WITH MODERATE DEBT AND WELL FUNDED PENSION PLANS

Unrestricted investments grew significantly in fiscal year 2013 to a very strong $4.4 billion (361 days) at yearend, an increase of almost $750 million from fiscal yearend 2012. Investments as of September 30, 2014 grew to $4.7 billion. Cash growth was due to good investment returns and operating margins as well as bond proceeds used for capital. Based on data provided by management, over time Advocate's investment allocation has shifted to include a higher allocation to alternative investments (14% hedge funds and 8% private equity), more typical of systems with Advocate's size and resources. The system does not expect further changes in allocation.

Capital spending is projected to increase in 2014 to $500 million (over two times depreciation) and could remain at this elevated level. The largest projects include a bed tower and ambulatory care facility at Christ Hospital and Medical Center and outpatient center at the Illinois Masonic Medical Center, and modernization of Good Shepherd facilities. While higher spending than in the past, Advocate can fund this capital with operating cashflow.

Advocate's debt structure includes variable rate bonds with mandatory tenders within the next 12 months. If these

bonds are not remarketed, the system will use its own liquidity to pay the tenders, which supports the Aa2/VMIG 1 ratings on these bonds. As of September 30, 2014, there are three series with a combined $65.1 million mandatory tenders within twelve months. Given the modest size of these staggered obligations, infrequent and known tender dates, and Advocate's experienced treasury management, the system has flexibility to use its large investment portfolio to fund any tenders on short notice if needed. The system has over $585 million of assets that can be liquidated on a daily basis and another $1.7 billion that can be liquidated within a week. Additionally, the system has the Series 2011B bonds ($70 million), which bear interest at the Windows interest rate mode. This structure allows flexibility in planning for an unremarketed tender since it requires a seven-month advance notice of a put. Assignment of the P-1 rating to the Windows mode bonds is based on Moody's market access approach to self-liquidity on longer-term variable rate instruments and reflects our estimation of Advocate's ability to timely pay mandatory tenders at the close of the "Mandatory Tender Window".

OUTLOOK

The stable outlook is based on our expectation that the system will continue to maintain solid operating performance and a strong market position and balance future capital spending and debt with cash flow and liquidity strength.

WHAT COULD CHANGE THE RATING UP

A rating upgrade will be considered with sustained and significant improvement in operating margins and growth in the system's size to provide greater geographic diversity.

WHAT COULD CHANGE THE RATING DOWN

A rating downgrade will be considered if there is greater than expected increase in debt, prolonged decline in operating performance or material weakening of balance sheet strength. A materially dilutive acquisition or merger would also warrant consideration for a downgrade.

KEY INDICATORS

Assumptions & Adjustments:

-Based on financial statements for Advocate Health Care Network and Subsidiaries

-First number reflects audit year ended December 31, 2013

-Second number reflects unaudited nine months ended September 30, 2014, annualized

-Investment returns normalized at 6% unless otherwise noted

-Comprehensive debt includes direct debt, operating leases, and pension obligation, if applicable

-Monthly liquidity to demand debt ratio is not included if demand debt is de minimis

-Non-recurring items or adjustments: none

*Inpatient admissions: 164,555; 166,063

*Observation stays: 47,683; 54,561

*Medicare % of gross revenues: 37%; N/A

*Medicaid % of gross revenues: 15%; N/A

*Total operating revenues ($): $4.9 billion; $5.1 billion

*Revenue growth rate (%) (3 yr CAGR): 4.9%; N/A

*Operating margin (%): 5.2%; 4.3%

*Operating cash flow margin (%): 10.6%; 10.0%

*Debt to cash flow (x): 2.1 times; 2.0 times

*Days cash on hand: 361 days; 370 days

*Maximum annual debt service (MADS) ($): $102 million; $99 million (proforma)

*MADS coverage with reported investment income (x): 7.7 times; 8.5 times

*Moody's-adjusted MADS Coverage with normalized investment income (x): 8.1 times; 8.4 times

*Direct debt ($): $1.6 billion; $1.6 billion

*Cash to direct debt (%): 273%; 297%

*Comprehensive debt: $2.0 billion; N/A

*Cash to comprehensive debt (%): 217%; N/A

*Monthly liquidity to demand debt (%): 500%; N/A

RATED DEBT (as of September 30, 2014)

- Series 1993C ($17 million), Series 2008D ($159 million; to be partially refunded), Series 2010A ($37 million), Series 2010B ($52 million), Series 2010C ($26 million), Series 2010D ($99 million), Series 2011A-1 ($6 million), Series 2011A-2 ($32 million), Series 2012 ($145 million), Series 2013A ($96 million) fixed rate bonds: Aa2

- Series 2003 ($22 million Series A; $21 million Series C), Series 2008C-3B ($22 million) variable rate annual put bonds, supported by self-liquidity: Aa2/VMIG 1

- Series 2008A ($120 million) variable rate multi-annual put bonds: Aa2

- Series 2008C-1 ($128 million), Series 2008C-2B ($58 million) variable rate bonds supported with SBPAs from JPMorgan Chase (expire August 1, 2016 and August 1, 2017, respectively): Aa2/VMIG 1

- Series 2008C-3A ($87 million) variable rate bonds supported by SBPAs from Northern Trust Company (expires August 1, 2017): Aa2/VMIG 1

- Series 2008C-2A ($49 million) variable rate bonds supported by SBPA from Wells Fargo Bank (expires August 1, 2019): Aa2/VMIG 1

-Series 2011B Windows variable rate bonds ($70 million): Aa2/P-1

The principal methodology used in this rating was Not-for-Profit Healthcare Rating Methodology published in March 2012. The additional methodology used in the short-term rating for bonds supported by self-liquidity was Rating Methodology for Municipal Bonds and Commercial Paper Supported by a Borrower's Self-Liquidity published in January 2012. The additional methodology used in the short-term rating for bonds supported by SBPAs was Variable Rate Instruments Supported by Conditional Liquidity Facilities published in May 2013. Please see the Credit Policy page on www.moodys.com for a copy of these methodologies.

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For ratings issued on a program, series or category/class of debt, this announcement provides certain regulatory disclosures in relation to each rating of a subsequently issued bond or note of the same series or category/class of debt or pursuant to a program for which the ratings are derived exclusively from existing ratings in accordance with Moody's rating practices. For ratings issued on a support provider, this announcement provides certain regulatory disclosures in relation to the rating action on the support provider and in relation to each particular rating action for securities that derive their credit ratings from the support provider's credit rating. For provisional ratings, this announcement provides certain regulatory disclosures in relation to the provisional rating assigned, and in relation to a definitive rating that may be assigned subsequent to the final issuance of the debt, in each case where the transaction structure and terms have not changed prior to the assignment of the definitive rating in a manner that would have affected the rating. For further information please see the ratings tab on the issuer/entity page for the respective issuer on www.moodys.com.

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FitchRatings

FITCH RATES ADVOCATE HEALTH CARE'S (IL) SERIES 2014 BONDS 'AA'; OUTLOOK STABLE

Fitch Ratings-Chicago-21 November 2014: Fitch Ratings has assigned an 'AA' rating to the following Illinois Finance Authority revenue bonds to be issued on behalf of Advocate Health Care (Advocate):

--$304.4 million series 2014.

In addition, Fitch affirms the 'AA' rating on approximately $1.2 billion of revenue bonds issued by the Illinois Health Facilities Authority and the Illinois Finance Authority on behalf of Advocate.

Fitch also affirms the 'F1+' short-term ratings on the following Illinois Finance Authority bonds based upon self-liquidity provided by Advocate:

--$43.2 million put bonds, series 2003A&C;
--$22 million put bonds, series 2008C-3B;
--$70 million variable rate demand bonds, series 2011B.

The series 2014 bonds are expected to be fixed rate, and used to advance refund certain bonds issued by Advocate Sherman Health (ASH) and Advocate, as well as pay costs of issuance. The series 2014 fixed rate bonds are expected to price the week of Dec. 1, 2014 via negotiated sale.

The Rating Outlook is Stable.

SECURITY
The bonds are unsecured obligations of the obligated group.

KEY RATING DRIVERS

LIGHT DEBT BURDEN: The affirmation at 'AA' incorporates Advocate's 2014 financing, which will seek to refund ASHH debt and a portion of existing Advocate bonds. This issuance will not impact Advocate's relatively low debt burden. Advocate's pro-forma maximum annual debt service (MADS) of $99 million equates to a light 1.9% of annualized 2014 revenues which combined with solid cash flow generation results in strong coverage of 8.3x by EBITDA through the nine months ended Sept. 30, 2014.

ROBUST LIQUIDITY: Advocate's strong operating cash flow generation continues to support substantial balance sheet strength and support steady capital improvement. At Sept. 30, 2014, Advocate's unrestricted cash and investments totaled over $4.7 billion. Liquidity metrics were robust with 370.1 days cash on hand (DCOH), a pro forma cushion ratio of 47.1x and cash and investments equating to 296.5% of long-term debt; all of which exceed Fitch's respective 'AA' category medians of 277.1, 26.5x and 178.5%.

SOLID MARKET POSITION: Advocate maintains a leading position within its Chicago metropolitan service area that is more than double its nearest competitor, and remains the largest provider in the state. The merger with Sherman Health (Elgin, IL) (effective June 1, 2013) has supported a stronger market presence and clinical footprint. Still, Fitch notes the service area remains highly competitive, and the regulatory environment in Illinois remains challenging.

STRONG CLINICAL INTEGRATION: Advocate's high level of integration with its clinicians has produced better care coordination, operating efficiencies, effective contracting, physician engagement, and should position it well to navigate continued pressures on reimbursement and clinical quality metrics.

RATING SENSITIVITIES

NORTHSHORE MERGER: Advocate and NorthShore University Health System (not rated by Fitch) signed a definitive affiliation agreement in Sept. 2014 to merge. The merger would result in the largest health system by revenue in the state, and would likely support further operating efficiencies across the organization. Fitch views this announcement positively and will assess any rating impact if and when the transaction finalizes, which could be as early as spring 2015.

CREDIT PROFILE

Advocate is an integrated health care system serving the Chicago metropolitan area and central Illinois. The system includes 12 acute care hospitals and a children's hospital (totaling approximately 3,600 licensed beds), several large physician groups, primary and specialty physician services, home health, hospice care, and outpatient centers. Total revenues in audited fiscal 2013 (Dec. 31 fiscal year end) were $4.9 billion.

Fitch's analysis is based on the consolidated system. The obligated group consists of Advocate Health Care Network Corp, Advocate Health and Hospitals, Advocate North Side Health Network, and Advocate Condell Medical Center. ASH will become a member of the obligated group following the issuance of the series 2014 bonds. As of Dec. 31, 2013, the obligated group (excluding ASH) represented approximately 90.5% of total assets and 90.6% of total operating revenues of the consolidated system.

SERIES 2014 PLAN OF FINANCE

Advocate plans to issue $304.4 million in series 2014 fixed rate bonds, which will be used to advance refund the 2007A ASH debt and a portion of Advocate's series 2008D bonds. In conjunction with the issuance, ASH will become a member of the obligated group and its existing indenture discharged.

Fitch used MADS of $99 million and the series 2014 bonds have a 2038 maturity, while the remaining debt has a final maturity of 2051. Advocate's pro forma debt burden remains low for the rating, and is among the lowest in Fitch's rated portfolio. Pro forma MADS equates to a light 1.9% of interim Sept. 30, 2014 revenue while debt to EBITDA was also a light 1.9x.

Advocate's solid profitability combined with its low debt burden results in strong historical coverage of pro forma MADS. From 2010-2013, Advocate has generated annual operating EBITDA margins between 11.5% and 12.7% and net EBITDA margins between 12.8% and 17.5%. As a result, historical coverage of pro forma MADS by EBITDA has been strong at 5.7x, 7.3x and 9.3x in 2011, 2012 and 2013, respectively. Through the nine months ended Sept. 30, 2014, coverage of pro forma MADS by EBITDA was 8.3x.

MANAGEABLE DEBT PLANS

Advocate's five-year capital plan totals only $600 million, which is a lower rate of spending than the prior three years. Fitch believes the capital plan is very manageable and can easily be supported via cash flow without an impact on liquidity.

SELF-LIQUIDITY RATING

The 'F1+' rating reflects Advocate's availability of highly liquid resources to cover the mandatory tender on debt that is subject to unremarketed puts. At Sept 30, 2014, Advocate's eligible cash and investment position available for same-day settlement would cover the maximum mandatory tender on any given date well in excess of Fitch's criteria of 1.25x. Advocate provided Fitch with

an internal procedures letter outlining the procedures to meet any unremarketed puts. In addition, Advocate provides monthly liquidity reports to Fitch to monitor the sufficiency of Advocate's cash and investment position relative to its mandatory put exposure.

DEBT PROFILE

Following the series 2014 issuance, Advocate will have approximately $1.49 billion in long-term debt outstanding. Approximately $825.6 million (55%) is fixed rate, $321 million is variable rate demand debt supported by standby bond purchase agreements (SBPAs), $120.3 million is multi-annual tender bonds with long-term interest rates and have mandatory tenders in 2019 and 2020, $100 million is variable rate direct placement debt, $70 million of variable rate bonds in a windows mode, and $60.6 million is multi-annual tender bonds that have a mandatory tender in 2015.

Advocate is party to $326.3 million notional in swap agreements, which had an aggregate negative $64.4 million mark-to-market as of Sept. 30, 2014. No collateral was required to be posted as of Sept 30, 2014.

DISCLOSURE

Advocate's disclosure includes annual audited financial statements as well as quarterly unaudited balance sheet, income statement, cash flow statement, an extensive MD&A, and utilization statistics. The information is posted to the Municipal Securities Rulemaking Board's EMMA system. In addition, management holds routine calls with rating agencies and with investors. Fitch considers Advocate's disclosure standards to be best practice.

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Additional information is available at 'www.fitchratings.com'

Applicable Criteria and Related Research:
'Nonprofit Hospitals and Health Systems Rating Criteria' (May 30, 2014)
'Rating U.S. Public Finance Short-Term Debt' (Dec 9, 2013)

Applicable Criteria and Related Research:
Rating U.S. Public Finance Short-Term Debt
http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=724680

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Related Criteria And Research

Illinois Finance Authority
Advocate Health Care Network; System

Credit Profile		
US$304.435 mil rfdg bnds (Advocate Hlth Care Network) ser 2014 dtd 12/18/2014 due 08/01/2038		
Long Term Rating	AA/Positive	New
Illinois Fin Auth, Illinois		
Advocate Hlth Care Network, Illinois		
Series 2008D, 2010A-D, 2011A, 2012, and 2013A		
Long Term Rating	AA/Positive	Affirmed, Removed from CreditWatch

Rationale

Standard & Poor's Ratings Services assigned its 'AA' long-term rating to the Illinois Finance Authority's $304.435 million series 2014 fixed-rate bonds issued for Advocate Health Care Network (AHCN). Standard & Poor's also affirmed its 'AA' long-term rating and, where applicable, its 'AA/A-1+' and 'AA/A-1' ratings on various other series of bonds issued by the authority on behalf of AHCN, and removed the long-term ratings from CreditWatch with positive implications, where they had been placed on Sept. 12, 2014. The outlook is positive.

We withdrew the long-term ratings on the series 2003A (remarketed July 1, 2014), 2003C (remarketed April 25, 2014), and 2008C-3B bonds (remarketed July 1, 2014) and maintained the short-term ratings on the bonds, as the bonds were remarketed in the long-term rate mode on the dates above with a mandatory tender on dates within one year. In accordance with ours criteria, those bonds require only a short-term rating given the remarketing and mandatory tender within a year (and no optional puts).

The 'A-1+' short-term component of the rating on the series 2003A, 2003C, and 2008C-3B mandatory tender bonds and 2011B windows bonds reflects our view of the credit strength inherent in the 'AA' long-term rating on AHCN's debt and the sufficiency of AHCN's unrestricted assets to provide liquidity support for the aforementioned bonds. Standard & Poor's Fund Ratings and Evaluations Group assesses the liquidity of AHCN's unrestricted investment portfolio to determine the adequacy and availability of these funds to guarantee the timely purchase of the bonds tendered in the event of a failed remarketing. We monitor the liquidity and sufficiency of AHCN's investment portfolio on a monthly basis.

The 'A-1+' short-term component of the rating on the issuer's series 2008C-2A and 2008C-3A bonds and the 'A-1' short-term component of the rating on the series 2008C-1 and 2008C-2B bonds reflect the standby bond purchase agreements (SBPAs) in effect from various financial institutions. They further reflect our view of the likelihood of payment of tenders and our view of liquidity facilities that cover all of the bond series. (For more information, see the Financial Profile section.)

The positive outlook reflects our view of AHCN and NorthShore University Health System's announcement of a

definitive agreement to merge into a unified organization (Advocate NorthShore Health Partners, or ANHP). The outlook also reflects our belief that each health care system already demonstrates very strong enterprise and financial profiles, and that together they could improve further. We believe that this merger could also further position the system well for population health management, as ANHP's footprint would provide coverage for the Chicago metropolitan area. The agreement still requires approval from multiple areas, including the Federal Trade Commission, but management anticipates closing as early as the first quarter of calendar 2015. The two organizations have created initial working group teams across the two organizations, but are limited as to what they can do and discuss until they receive final approvals. AHCN will also spend significant capital during the next few years, and a higher rating would also depend partly on AHCN's ability to manage overall balance sheet strength through most of that spending.

The 'AA' long-term rating reflects our view of AHCN's strength as the Chicago area's largest health system (with total operating revenue of $4.9 billion in 2013) as well as its good operating performance, strong and consistent coverage, and stable and healthy unrestricted reserves with modest debt for the rating. In addition, AHCN's strong physician relationships and practice in managing care under capitated risk and through shared savings programs, including the Medicare accountable care organization demonstration project, are credit strengths in light of some of the anticipated changes related to health care reform. Management plans to increase capital spending (primarily from cash flow) during the next few years and we will evaluate the impact of this on the balance sheet. Operating margins show signs of compression, and we believe AHCN's focus on managing expenses and backfilling volumes that may be lost as a result of lower utilization (which is in turn linked to both better care management and fewer readmissions) is important to maintaining healthy cash flow and coverage over the near term.

The 'AA' long-term rating further reflects our view of AHCN's:

- Position as Chicagoland's largest and most successfully integrated health delivery system, with approximately 3,600 licensed beds and more than 6,400 physicians, 4,000 of whom are affiliated with Advocate Physician Partners, a joint venture between AHCN and clinically and financially aligned physicians with the purpose of providing cost-effective health care to patients in the communities AHCN serves;
- Good financial profile, with operating margins of more than 4.0% for the past four years but with a slightly lighter unaudited operating margin of 3.9% through the first three quarters of fiscal 2014, and consistently strong pro forma maximum annual debt service (MADS) coverage of 7x or greater for the past few years;
- Robust balance sheet measures, as demonstrated by still light pro forma leverage of 22% and by solid unrestricted reserves of 375 days' cash on hand and unrestricted reserves to pro forma debt of 315% as of Sept. 30, 2014; and
- Incremental growth in ACHN's leading market share through 2013 to 17.8% primarily as a result of the acquisition of Advocate Sherman in 2013.

Partly offsetting the above strengths, in our view, are AHCN's:

- Strong competition in the greater Chicago market -- other systems and large academic medical centers -- coupled with volume pressures related to both industry and economic issues as well as health care reform; and
- Heightened capital spending during the next few years as a few major projects have started, which could dampen unrestricted reserve growth during the short term.

The approximately $304 million series 2014 bond proceeds (along with $17.9 million of debt service reserve and other funds) will go toward refinancing all of Advocate Sherman's series 2007A bonds and a portion of Advocate Health's

series 2008D bonds.

Total long-term debt at Sept. 30, 2014 was $1.6 billion, which includes about $37 million of capital leases and other loans. Pro forma debt declines slightly as a result of the use of a debt service reserve fund to refinance Advocate Sherman's series 2007A bonds. Long-term debt (and related ratios) includes debt classified on the audited financial statements as a current liability subject to short-term remarketing agreements. ACHN's rated bonds are the general, unsecured joint, and several obligations of the obligated group, which consists of the parent, AHCN; Advocate Health and Hospitals Corp., which includes most of AHCN's acute care facilities; Advocate North Side Health Network, which includes Advocate Illinois Masonic Center; and Advocate Condell Medical Center. With this refinancing, Advocate Sherman will become part of the obligated group and Advocate Sherman's separate master trust indenture will be terminated. The rating is based on our view of AHCN's group credit profile and the obligated group's "core" status in that the obligated group accounts for the vast majority of total operating income and assets. Accordingly, we rate the AHCN obligated group at the level of the group credit profile and we used AHCN's consolidated financial results.

Outlook

The positive outlook reflects our view of AHCN's continued market leadership, extensive physician network, and solid financial profile coupled with a potentially much stronger presence if the regulators and various parties approve the NorthShore affiliation. AHCN does spend a fair amount of capital, and we believe that AHCN could manage that while maintaining its balance sheet strength, but we will also monitor that over the next couple of years. We could consider raising the rating if the affiliation concludes with a smooth transition and the overall financial profile of AHCN and the combined organization remains strong.

We could maintain our existing rating if the affiliation with NorthShore is delayed significantly or not finalized over the outlook period, if capital spending causes material challenges to AHCN's balance sheet, or if the overall financial profile weakens.

Given our view of AHCN's strong market position, consistent financial profile, and good financial flexibility, we are also unlikely to lower the rating during the next year or two.

Enterprise Profile

Market position and organizational profile

AHCN has a total of 12 acute care hospitals (including an integrated children's hospital operating mainly on two campuses), mostly in the greater Chicagoland market; 956 employed full-time equivalent (FTE) physicians through Advocate Medical Group (AMG) and BroMenn's Hospital's medical group; soon-to-be six home health offices, pharmacies, clinic, and outpatient sites; and several joint venture operations. AHCN maintains a professional services agreement with Dreyer Medical Group, a 163 FTE multispecialty physician group in the western suburbs of Chicago. AHCN also has long-term teaching affiliations with the University of Illinois at Chicago Health Sciences Center, Rosalind Franklin University, and Midwestern University. As part of these affiliations, AHCN trains about 600 residents in 31 AHCN residency programs. In addition, the wide geographic reach of both AHCN's acute care and

non-acute-care services helps support its strong business position in the very competitive Chicagoland market. Although we anticipate that AMG will continue to grow, we understand that management is also focused on optimizing and running the group more efficiently. We believe that affiliation with NorthShore University Health System (NSUHS) could be a significant positive, as both enterprise profiles are strong and would provide a footprint that covers almost the entire broader Chicago area. NSUHS and AHCN have similar balance sheet profiles with stronger operating performance at AHCN. In addition, AHCN's revenue is 2.7x that of NSUHS.

AHCN's inpatient market share (including observation visits) in the Chicago metropolitan area was a leading 17.8% at Dec. 31, 2013, an increase from around 16% a year earlier primarily as a result of the acquisition of Advocate Sherman. The next highest market share belongs to Presence with about 9.4%, followed by Northwestern Medicine at 9.2%. NSUHS maintains a market share of 4.9%. In addition to its good presence in the Chicago metropolitan area, AHCN has established a presence in the central Illinois market with BroMenn Hospital. AHCN continues to evaluate acquisition opportunities, but none beyond NorthShore University Heath System is pending. We believe that overall competition in the market could increase because of recent consolidations and restructurings as well as new hospital construction. (Centegra Health System plans to build a new hospital about 16 miles from Advocate Good Shepherd and about 10 miles from Advocate Sherman during the next few years.)

Volumes

In fiscal 2013, AHCN acquired Sherman Hospital, and this boosted many of its volume metrics for both fiscal 2013 and through interim 2014 (as 2014 will be the first full year with Advocate Sherman). However, in terms of "same store" growth (and excluding Advocate Sherman), most inpatient volumes were flat-to-down and outpatient and observation visits were slightly mixed. Inpatient admissions (excluding Advocate Sherman) were down 5.6% in fiscal 2013 and down 3.8% through Sept. 30, 2014 compared with the prior-year period. Outpatient visits (excluding Advocate Sherman) were down 0.4% in 2013 but up 0.4% through Sept. 30, 2014 compared with the prior-year period. Management aims to modestly increase inpatient volume (including observation visits) and outpatient volume during the next few years, but given market and industry dynamics, we believe that growth may depend more on AHCN's ability to capture additional market share.

Management

AHCN has generally had a very strong and stable management team, in our view. CEO James Skogsbergh has been with the organization for 12 years, and many of the other key senior management positions have had limited turnover. We believe the management team is forward-thinking as relates to physician employment and integration through both employed AMG physicians and AHCN's relationship with many independent physicians. Many of these independent physicians, along with AMG physicians, are part of Advocate Physician Partners, a joint venture between AHCN and independent physicians that aligns these parties both clinically and financially through a focus on quality and efficiencies. In addition, we believe that AHCN's participation in both capitated contracts and some risk-sharing programs with certain payors will likely position AHCN well for the anticipated changes evolving out of health care reform. If the affiliation with NorthShore University Health System is finalized, we believe that the co-leadership of the two CEOs will be helpful as the system works through the transition.

Financial Profile

Income statement

AHCN's operating margin remained strong, in our view, in fiscal 2013 and has attenuated slightly through the first three unaudited quarters of fiscal 2014 ended Sept. 30. ACHN had healthy operating income of $239.3 million (4.9% margin) for fiscal 2013 (ended Dec. 31) compared with fiscal 2012 operating income of $232.0 million (5.1% margin) and on par with fiscal 2011's operating income. (We adjust operating income to exclude investment income on self-insurance trust assets, joint venture income, and unrestricted contributions -- all of which we include in non-operating income.) Management attributes overall sound margins in 2013 to a structured focus on expenses, part of a multiyear systemwide effort to reduce cost structure, and continued one-time revenue benefits, including federal reimbursement for electronic health records ($23 million), interest expense from the state for heightened days in accounts receivable for Medicaid, and additional provider fee money that was for the prior year. Operating revenue continued to increase, growing 7.7% in fiscal 2013 to $4.9 billion, while expenses grew at a similar rate of 7.9% to $4.6 billion. Through unaudited Sept. 30, 2014, operating income was $252.8 million (3.9% margin) down from the prior year as a result of the additional Medicaid provider fees received last year as well as about $10 million of one-time interest payments from the state on the heightened Medicaid receivables.

AHCN is ahead of budget through Sept. 30, 2014 primarily as a result of better-than-budgeted expense management and anticipates finishing fiscal 2014 with margins similar to those at Sept. 30, 2014. Management reports that fiscal 2015 results could be lighter than those of fiscal 2014 (although the budget has not been finalized) from a margin standpoint with forecasts showing some continued softening of operating margins in the out years. The decrease in margins is related to a number of assumptions, including continued reimbursement and volume pressures related to health care reform as well as other expense assumptions and physician investment. If cash flow remains strong, however, we anticipate that the heightened capital spending in the next few years could affect the balance sheet less than anticipated .

Excess income (excluding unrealized gains and adjustments on investments and changes in swap valuation) continued to be very strong, in our view, at $506.7 million (10.4% margin) in fiscal 2013 compared with $494.0 million (10.3% margin) in 2012, contributing to very robust 7.7x pro forma MADS coverage (and 5.0x operating-lease-adjusted pro forma MADS coverage). Excess margins have varied, predominantly because of investment market fluctuations, but have historically been in the 5%-7% range. Through the first three unaudited quarters of fiscal 2014, pro forma MADS coverage was healthy at 8.3x. AHCN's coverage calculations benefit from a pro forma debt burden that we consider low, at 1.9%.

Balance sheet

AHCN's balance sheet is strong, in our view, and has improved and grown year over year for the past several years. Unrestricted reserves have continued to strengthen during the past few years, increasing by a healthy 30% from year-end 2012 to Sept. 30, 2014 to $4.8 billion, or about 375 days' cash on hand. At Sept. 30, 2014, debt levels remained modest, in our view, with pro forma leverage at 22% and unrestricted reserves to pro forma long-term debt at 315%. From recent debt issuances, about $34 million remains in the project fund for future capital spending. Average age of plant has decreased slightly to 9.8 years at Sept. 30, 2014. As anticipated, capital expenditures have

steadily increased to $386 million in 2013 and $350 million through interim 2014 (with a forecast of $500 million for full-year 2014). Management has forecast capital spending around $600 million to $700 million for the next two years before it decreases (with around 2x annual depreciation expense). (For more details on the larger capital projects, see our report published July 10, 2013 on RatingsDirect.) We understand that AHCN will fund most capital spending through cash flow. AHCN's target investment portfolio is reasonable, in our opinion, given AHCN's unrestricted reserves, with a target allocation of 30% equities; 45% of hedge funds, real assets, and private equity; and 25% fixed income. AHCN had unfunded commitments of about $487.5 million for its private equity investments at Sept. 30, 2014. AHCN also maintains two pension plans, one of which is frozen, and together they were funded at about 100% at Dec. 31, 2013.

Debt structure and contingent liabilities

Total debt is approximately $1.6 billion. On a pro forma basis, about 57% is fixed with the remainder in some type of variable-rate mode. The split of the variable-rate debt is:

- $120.3 million in long-term interest rate mode that goes out at least five years before a mandatory tender (2008A-1, 2008A-2, and 2008A-3);
- $65.1 million in long-term interest rate mode that has a mandatory tender within one year (2003A, 2003C, and 2008C-3B);
- $70.0 million in windows mode that provides seven months' notice before a mandatory tender would occur (series 2011B);
- $100.0 million in direct placement bonds (2011C and 2011D); and
- $321.3 million in weekly variable-rate demand mode backed by various liquidity facilities (see below).

Specifically, the providers of the liquidity facilities of the $321.3 million as of this report are as follows:

- Series 2008C-1: JPMorgan Chase Bank (A-1), Aug. 1, 2016;
- Series 2008C-2A: Wells Fargo Bank N.A. (A-1+), Aug. 1, 2019;
- Series 2008C-2B: JPMorgan Chase Bank, Aug. 1, 2017; and
- Series 2008C-3A: Northern Trust (A-1+), Aug. 1, 2017.

AHCN provides liquidity support for the abovementioned variable-rate debt that is not backed by bank liquidity facilities. Based on AHCN's liquidity analysis provided to Standard & Poor's Funds Group, AHCN can amply cover its total $65.1 million of mandatory tenders within the year. (As of Sept. 30, 2014, AHCN had unrestricted reserves of $1.6 billion based on the funds group analysis and $1.0 billion based on discounted analysis.) In addition, management maintains about $200 million of available lines of credit, on which there were no draws as of Sept. 30, 2014.

AHCN also maintains three floating- to fixed-rate swaps with a total notional amount of $326.3 million. The counterparties are Wells Fargo Bank and PNC Bank N.A. As of Sept. 30, 2014, the liability on the swaps was $64.4 million with no collateral posting required.

Related Criteria And Research

Related Criteria

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- General Criteria: Group Rating Methodology, Nov. 19, 2013
- USPF Criteria: Commercial Paper, VRDO, And Self-Liquidity, July 3, 2007
- USPF Criteria: Contingent Liquidity Risks, March 5, 2012
- General Criteria: Methodology: Industry Risk, Nov. 20, 2013

Related Research

- Glossary: Not-For-Profit Health Care Ratios, Oct. 26, 2011
- The Outlook For U.S. Not-For-Profit Health Care Providers Is Negative From Increasing Pressures, Dec. 10, 2013
- U.S. Not-For-Profit Health Care System Ratios: Operating Performance Weakened In 2013, Aug. 13, 2014
- Health Care Providers And Insurers Pursue Value Initiatives Despite Reform Uncertainties, May 9, 2013

Ratings Detail (As Of November 26, 2014)

Illinois Fin Auth, Illinois

Advocate Hlth Care Network, Illinois

series 2008A-1/A-2/A-3		
Long Term Rating	AA/Positive	Affirmed, Removed from CreditWatch
series 2011B windows		
Long Term Rating	AA/A-1+/Positive	Affirmed, Removed from CreditWatch
ser 2008C-2A		
Long Term Rating	AA/A-1+/Positive	Affirmed, Removed from CreditWatch
ser 2008C-3B		
Long Term Rating	NR/A-1+	Affirmed
Series 2003A		
Long Term Rating	NR/A-1+	Affirmed
Series 2003C		
Long Term Rating	NR/A-1+	Affirmed
Series 2008C-1, 2008C-2B		
Long Term Rating	AA/A-1/Positive	Affirmed, Removed from CreditWatch
Series 2008C-3A		
Long Term Rating	AA/A-1+/Positive	Affirmed, Removed from CreditWatch

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IX. 1120.130 - Financial Viability

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
Enter Historical and/or Projected Years:				Year 2 of ASTC
Current Ratio				3.70
Net Margin Percentage				8.76%
Percent Debt to Total Capitalization				n/a
Projected Debt Service Coverage				n/a
Days Cash on Hand				45.84
Cushion Ratio				n/a

1. Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

2. Variance

   Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Yr 1 and Yr 2 Condell ASC
Surgical Care Affiliates, Inc.
Financial Viability Standards for IL CON Application

		Yr 1	Yr2
1	**Current Ratio**		
	Current Assets	950,000	1,000,000
	Current Liabilities	350,000	270,000
	Current Ratio	**2.71**	**3.70**
	Required	1.5 or more	1.5 or more
	Met?	Yes	Yes
2	**Net Margin Percentage**		
	Net Income	(581,023)	447,374
	Net Operating Revenues	2,397,300	5,109,845
	Net Margin Percentage	**-24.24%**	**8.76%**
	Required	3.5% or more	3.5% or more
	Met?	**NO**	Yes
3	**Long-Term Debt to Capitalization**		
	Long-Term Debt	-	-
	Long-Term Debt plus Net Assets	5,684,771	4,944,903
	Net Margin Percentage	**0.00%**	**0.00%**
	Required	80% or less	80% or less
	Met?	n/a	n/a
4	**Projected Debt Service Coverage**		
	Net Income	(581,023)	447,374
	Depreciation & Amortization	838,670	718,860
	Interest Expense	-	-
		257,647	**1,166,234**
	Expected Principal Payments	-	-
	Expected Interest Expense	-	-
	Projected Debt Service Coverage		
	Required	1.75 or more	1.75 or more
	Met?	n/a	n/a

5 Days Cash on Hand

Cash	330,000	390,000
Operating Expenses	2,139,653	3,823,801
Depreciation Expense	838,670	718,860
Days Cash on Hand	**92.58**	**45.84**
Required	45 or more days	45 or more days
Met?	Yes	Yes

6 Cushion Ratio

Cash	330,000	390,000
Expected Principal Payments	-	-
Expected Interest Expense	-	-
Days Cash on Hand		
Required	3.0 or more	3.0 or more
Met?	n/a	n/a

X. 1120.140 - Economic Feasibility

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
   A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
   B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

1) That the selected form of debt financing for the project will be at the lowest net cost available;
2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1) Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT -39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

A letter attesting to the conditions of financing follows as Attachment 39, Exhibit 1.

SCA
Surgical Care Affiliates

February 19, 2015

Ms. Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, Second Floor
Springfield, IL 62761

Re: Advocate Condell Ambulatory Surgery Center

Dear Ms. Olson:

This letter is to attest to the fact that the total estimated project costs and related costs will be funded with cash and equivalents, including a lease, investment securities, unrestricted funds, and funded depreciation.

Sincerely,

Robert Harmon
Vice President Operations
Surgical Care Affiliates

Subscribed and sworn before me this 19th day of February, 2015.

Notary Public

OFFICIAL SEAL
THERESA K KNAR
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/18/16

Lake County

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Cost & Gross Square Feet by Department or Service									
	A	B	C	D	E	F	G	H	
Dept. / Area	Cost/Sq Ft		Gross Sq Ft		Gross Sq Ft		Const. $		Total Cost
	New	Mod	New	Circ.	Mod	Circ.	A x C	B x E	G + H
Reviewable									
OR / Recovery	$ 503		3,487	15%			$ 1,754,451		$ 1,754,451
All Other Clinical	$ 503		3,300	15%			$ 1,660,363		$ 1,660,363
Contingency	$ 45		6,787				$ 307,626		$ 307,626
Total Reviewable + Contingency	$ 548		6,787				$ 3,722,440		$ 3,722,440
Non Reviewable									
Non-clinical	$ 501		4,162	15%			$ 2,084,855		$ 2,084,855
Non Reviewable Contingency	$ 45		4,162				$ 188,646		$ 188,646
Total Non Reviewable + Contingency	$ 546		4,162				$ 2,273,501		$ 2,273,501
Total	$ 502		10,949				$ 5,499,669		$ 5,499,669
Contingency	$ 45		10,949				$ 496,272		$ 496,272
Total + Contingency	$ 548		10,949				$ 5,995,941		$ 5,995,941

Projected Operating Costs		
	2018	Cost per EPD
Operating Cost	$ 3,823,800	$ 1,529

Impact of Project on Capital Costs		
	2018	Cost per EPD
Capital Costs	$ 828,319	$331

XI. Safety Net Impact Statement

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE AND DISCONTINUATION PROJECTS:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 43.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT-40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The proposed Project will not have a negative effect on the existing safety net services available to the community. The proposed new ASTC will develop and implement a charity care policy to mirror the charity care policy of Advocate Condell Medical Center. This includes seeing Medicare, Medicaid and charity care patients. (Note: The Hospital sees a higher percentage of charity cases as a result of the patients that present in the Emergency Department and Urgent Care.). The statistics for Condell are shown below.

Advocate Condell Medical Center Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year 2011**	**Year 2012**	**Year 2013**
Inpatient	560	770	714
Outpatient	5,334	2,935	2,853
Total	**5,894**	**3,705**	**3,567**
Charity (cost In dollars)			
Inpatient	$ 5,997,000	$ 6,056,000	$ 8,548,000
Outpatient	$ 3,572,000	$ 6,056,000	$ 5,372,000
Total	**$ 9,569,000**	**$ 12,112,000**	**$ 13,920,000**
MEDICAID			
Medicaid (# of patients)	**Year**	**Year**	**Year**
Inpatient	2,861	2,876	2,403
Outpatient	40,286	40,381	37,104
Total	**43,147**	**43,257**	**39,507**
Medicaid (revenue)			
Inpatient	$ 24,331,619	$ 17,781,997	$ 20,689,925
Outpatient	$ 11,970,979	$ 11,275,418	$ 14,282,512
Total	**$ 36,302,598**	**$ 29,057,415**	**$ 34,972,437**

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.

2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.

3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. (20 ILCS 3960/3) Charity Care must be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 44.

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS ATTACHMENT-41, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The proposed new ASTC will develop and implement a charity care policy to mirror the charity care policy of Advocate Condell Medical Center. This includes seeing Medicare, Medicaid and charity care patients. (Note: The Hospital sees a higher percentage of charity cases as a result of the patients that present in the Emergency Department and Urgent Care.) The projected use is as follows:

Payer Sources	Payer Mix
Private insurance/Managed Care	59.2%
Medicaid	8.6%
Medicare	23.7%
Charity	2.6%
Others	5.9%
TOTAL	100.0%

The anticipated Charity Care expense is as follows:

Charity Care	
Expected Year 2 Patient Revenue	$4,626,260
Amount of Charity Care (charges)	$ 116,732
Cost of Charity Care	$ 96,445

APPENDIX

Physician Referral Letters

Referral letters from 20 physicians are found in this Appendix of the application. They demonstrate the physicians' commitment to send surgical cases to the proposed ASTC from their volume they have done at Advocate Condell Medical Center. The cases total 1,361 surgeries, which represent 2,559 hours of operating room time including set up and clean up. The time was based on the experience of each specialty in 2013 at Advocate Condell Medical Center.

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Toll-free: (855) 526-1100 Fax: (847) 362-3351
info@ACSNeuro.com

Jonathan S. Citow M.D., F.A.C.S.
Board Certified Neurosurgeon
Robert K. Erickson M.D.
Board Certified Neurosurgeon
Juan C. Alzate M.D.
Board Certified Neurosurgeon
Bradley T. Bagan, M.D.
Board Certified Neurosurgeon
Igor Yalovetskiy, PA-C
Certified Physician Assistant
Alexandra Vigilante, PA-C
Certified Physician Assistant
Kolette Rutledge, PA-C
Certified Physician Assistant
Irene Kwon, PA-C
Certified Physician Assistant

January 9, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a neurosurgeon specializing in minimally invasive spine and brain surgery. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the ZIP codes of the origin of the patients. The listing shows that I performed 102 outpatient surgical procedures on patients. Of those, 97% percent were from within the geographic service area.

I expect to refer at least 65 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Juan Alzate, MD

Subscribed and sworn before me this 9 day of Jan 2015

Notary Public

OFFICIAL SEAL
ELISSA NISSON
Notary Public - State of Illinois
My Commission Expires Aug 3, 2017

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Juan Alzate

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53105	Burlington	1
53140	Kenosha	1
53142	Kenosha	3
53144	Kenosha	1
53158	Pleasant Prairie	1
53168	Salem	1
53177	Sturtevant	1
53181	Twin Lakes	1
60002	Antioch	4
60014	Crystal Lake	2
60015	Deerfield	1
60020	Fox Lake	1
60030	Grayslake	5
60031	Gurnee	7
60035	Highland Park	2
60045	Lake Forest	1
60046	Lake Villa	4
60047	Lake Zurich	2
60048	Libertyville	2
60050	McHenry	1
60051	McHenry	4
60060	Mundelein	9
60061	Vernon Hills	6
60064	North Chicago	1
60070	Prospect Heights	1
60073	Round Lake	7
60074	Palatine	1
60077	Skokie	1
60081	Spring Grove	1
60083	Wasdworth	1
60084	Wauconda	1
60085	Waukegan	9
60087	Waukegan	5

60088	Great Lakes	2
60089	Buffalo Grove	1
60096	Winthrop Harbor	1
60099	Zion	4
60154	Westchester	1
60173	Schaumburg	1
	Subtotal	99

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
Lake Geneva	53147	1
Williams Bay	53191	1
Aurora	60506	1
	Subtotal	3

Total	102
Percent from within the geographic service area	97%

Source: Advocate Condell Medical Center records

Greenleaf Orthopaedic Associates, S.C.
105 N. Greenleaf Street
Gurnee, IL 60031
847-623-3090

February 3, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a physician specializing in Orthopedics. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue, in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the zip codes of the origin of the patients. The listing shows that I performed 86 outpatient surgical procedures on patients. Of those, 96.5% percent were from within the geographic service area.

I expect to refer at least 48 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Gregory Caronis, M.D.
Greenleaf Orthopaedic Associates, S.C.
105 N. Greenleaf Street
Gurnee, IL 60031

Subscribed and sworn before me this 18 day of Feb 2015

Angela M. Sutherland
Notary Public

OFFICIAL SEAL
ANGELA M SUTHERLAND
Notary Public - State of Illinois
My Commission Expires Apr 16, 2016

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Gregory Caronis

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53128	Genoa City	1
53142	Kenosha	1
53143	Kenosha	1
53158	Pleasant Prairie	1
60002	Antioch	7
60030	Grayslake	6
60031	Gurnee	7
60041	Ingleside	1
60045	Lake Forest	1
60046	Lake Villa	4
60048	Libertyville	4
60050	McHenry	1
60051	McHenry	2
60060	Mundelein	16
60061	Vernon Hills	4
60064	North Chicago	2
60073	Round Lake	9
60081	Spring Grove	1
60083	Wadsworth	2
60084	Wauconda	1
60085	Waukegan	4
60089	Buffalo Grove	3
60099	Zion	3
60108	Bloomingdale	1
	Subtotal	83

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
61704	Bloomington	2
99712	Fairbanks, AK	1
	Subtotal	3

Total	86
Percent from within the geographic service area	96.5%

Source: Advocate Condell Medical Center records

THE AMERICAN CENTER FOR
SPINE & NEUROSURGERY
Excellence in Minimally Invasive Care

712 S. Milwaukee Avenue, Libertyville, IL 60048
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Certified Physician Assistant
Kolette Rutledge, PA-C
Certified Physician Assistant
Irene Kwon, PA-C
Certified Physician Assistant

January 9, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a neurosurgeon specializing in minimally invasive spine and brain surgery. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the ZIP codes of the origin of the patients. The listing shows that I performed 234 outpatient surgical procedures on patients. Of those, 95% percent were from within the geographic service area.

I expect to refer at least 145 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Jonathan Citow, MD

Subscribed and sworn before me this 9 day of Jan, 2015

Elissa Nisson
Notary Public

OFFICIAL SEAL
ELISSA NISSON
Notary Public - State of Illinois
My Commission Expires Aug 3, 2017

Surgery Medical Imaging Pain Management Physical Therapy Premium Services

www.ACSNeurosurgery.com

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Jonathon Citow

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53128	Genoa City	3
53144	Kenosha	2
53158	Pleasant Prairie	1
53168	Salem	1
53179	Trevor	1
53182	Union Grove	1
53405	Racine	1
60002	Antioch	10
60007	Elk Grove Village	1
60010	Barrington	4
60014	Crystal Lake	3
60015	Deerfield	6
60020	Fox Lake	1
60022	Glencoe	2
60030	Grayslake	12
60031	Gurnee	12
60035	Highland Park	4
60041	Ingleside	5
60042	Island Lake	1
60044	Lake Bluff	2
60045	Lake Forest	3
60046	Lake Villa	15
60047	Lake Zurich	5
60048	Libertyville	11
60050	McHenry	3
60051	McHenry	4
60053	Morton Grove	2
60056	Mount Prospect	1
60060	Mundelein	14
60061	Vernon Hills	7
60062	Northbrook	4
60068	Park Ridge	1

60069	Lincolnshire	4
60070	Prospect Heights	1
60073	Round Lake	16
60074	Palatine	1
60076	Skokie	1
60081	Spring Grove	3
60083	Wadsworth	1
60084	Wauconda	4
60085	Waukegan	5
60087	Waukegan	3
60089	Buffalo Grove	10
60090	Wheeling	2
60096	Winthrop Harbor	1
60097	Wonder Lake	2
60098	Woodstock	3
60099	Zion	6
60101	Addison	1
60102	Algonquin	1
60103	Bartlett	1
60108	Bloomingdale	1
60110	Carpentersville	1
60126	Elmhurst	1
60143	Itasca	1
60156	Lake in the Hills	2
60174	Saint Charles	1
60609	Chicago	1
60625	Chicago	1
60642	Evergreen Park II	1
60645	Chicago	1
60646	Lincolnwood	1
60656	Harwood Heights	1
60714	Niles	1
	Subtotal	223

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
33160	North Miami Beach, FL	1
34145	Marco Island, FL	1
34229	Osprey, FL	1
51448	Kiron, IA	1
53121	Elkhorn, WI	1
60457	Hickory Hills	1

60504	Aurora	1
60506	Aurora	1
61062	Pearl City	1
61938	Mattoon	1
96003	Redding, CA	1
	Subtotal	11

Total	234
Percent from within the geographic service area	95%

Source: Advocate Condell Medical Center records

UROPARTNERS

Kristopher N Atzeff, MD • Justin J Cohen, MD • H Merrill Matschke, MD • Ronald J Kim, MD

900 N Westmoreland, Ste 228, Lake Forest, IL 60045 Phone: 847-295-0010 • Fax: 847-295-5433
1475 E Belvidere, Ste 312, Grayslake, IL 60030 Phone: 847-986-3030 • Fax: 847-986-3035
www.uropartners.com

January 13, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a physician specializing in Urology. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months at Advocate Condell Medical Center by the zip codes of the home address of the patients. The listing shows that I performed 22 outpatient surgical procedures on patients. Of those, 100% percent were from within the geographic service area.

I expect to refer at least 13 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as patient preference, referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Justin J. Cohen, M.D.

Uropartners, LLC
900 N. Westmoreland, Suite 228
Lake Forest, IL 60045

Subscribed and sworn before me this 13th day of Jan, 2015

Notary Public Theresa K. Knar

OFFICIAL SEAL
THERESA K KNAR
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/18/16

Lake County

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Justin Cohen

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
60030	Grayslake	5
60060	Mundelein	4
60031	Gurnee	2
60085	Waukegan	2
60002	Antioch	1
60020	Fox Lake	1
60045	Lake Forest	1
60048	Libertyville	1
60073	Round Lake	1
60083	Wadsworth	1
60084	Wauconda	1
60087	Waukegan	1
60088	Great Lakes	1
	Subtotal	22

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
	Subtotal	0

Total	22
Percent from within the geographic service area	100%

Source: Advocate Condell Medical Center records

Greenleaf Orthopaedic Associates, S.C.
105 N. Greenleaf Street
Gurnee, IL 60031
847-623-3090

February 3, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a physician specializing in Orthopedics. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue, in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the zip codes of the origin of the patients. The listing shows that I performed 130 outpatient surgical procedures on patients. Of those, 100% percent were from within the geographic service area.

I expect to refer at least 74 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Roger Collins, M.D.
Greenleaf Orthopaedic Associates, S.C.
105 N. Greenleaf Street
Gurnee, IL 60031

Subscribed and sworn before me this 2nd day of Feb, 2015

Angel Kutzer
Notary Public

OFFICIAL SEAL
ANGEL A KUTZER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:07/19/16

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Roger Collins

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53144	Kenosha	3
53158	Pleasant Prairie	2
53177	Sturtevant	1
53168	Salem	2
60002	Antioch	7
60004	Arlington Heights	1
60030	Grayslake	16
60031	Gurnee	14
60041	Ingleside	2
60044	Lake Bluff	1
60045	Lake Forest	1
60046	Lake Villa	9
60047	Lake Zurich	3
60048	Libertyville	11
60051	McHenry	2
60060	Mundelein	13
60061	Vernon Hills	2
60064	North Chicago	1
60069	Lincolnshire	1
60073	Round Lake	16
60081	Spring Grove	1
60084	Wauconda	1
60085	Waukegan	8
60087	Waukegan	4
60089	Buffalo Grove	1
60090	Wheeling	1
60096	Winthrop Harbor	1
60099	Zion	2
60187	Wheaton	1
60532	Lisle	1
60639	Belmont Cragin	1
	Subtotal	130

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
	Subtotal	0

Total	130
Percent from within the geographic service area	100%

Source: Advocate Condell Medical Center records

THE AMERICAN CENTER FOR
SPINE & NEUROSURGERY
Excellence in Minimally Invasive Care

712 S. Milwaukee Avenue, Libertyville, IL 60048
Toll-free: (855) 526-1100 Fax: (847) 362-3351
info@ACSNeuro.com

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Alexandra Vigilante, PA-C
Certified Physician Assistant
Kolette Rutledge, PA-C
Certified Physician Assistant
Irene Kwon, PA-C
Certified Physician Assistant

January 9, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a neurosurgeon specializing in minimally invasive spine and brain surgery. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the ZIP codes of the origin of the patients. The listing shows that I performed 50 outpatient surgical procedures on patients. Of those, 96% percent were from within the geographic service area.

I expect to refer at least 30 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Robert Erickson, MD

Subscribed and sworn before me this 9 day of Jan, 2015

Notary Public

OFFICIAL SEAL
ELISSA NISSON
Notary Public - State of Illinois
My Commission Expires Aug 3, 2017

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Robert Erickson

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53144	Kenosha	2
53158	Pleasant Prairie	1
53181	Twin Lakes	1
60002	Antioch	2
60014	Crystal Lake	1
60030	Grayslake	4
60031	Gurnee	3
60041	Ingleside	1
60044	Lake Bluff	1
60045	Lake Forest	1
60046	Lake Villa	6
60048	Libertyville	2
60051	McHenry	3
60060	Mundelein	2
60061	Vernon Hills	2
60062	Northbrook	1
60064	North Chicago	1
60073	Round Lake	5
60074	Palatine	1
60083	Wadsworth	1
60085	Waukegan	1
60087	Waukegan	1
60089	Buffalo Grove	1
60096	Winthrop Harbor	1
60099	Zion	2
60402	Berwyn	1
	Subtotal	48

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
46375	Schererville IN	1
60115	Dekalb	1
	Subtotal	2

Total	50
Percent from within the geographic service area	96%

Source: Advocate Condell Medical Center records

Advocate Medical Group
100 Village Green Drive, Suite 120 || Lincolnshire, IL 60069 || T 847-634-1766 F 8547-634-2894 || amgdoctors.com

January 12, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a physician specializing in Orthopedics. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue, in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the zip codes of the origin of the patients. The listing shows that I performed 164 outpatient surgical procedures on patients. Of those, 98.8% percent were from within the geographic service area.

I expect to refer at least 96 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

C Frank MD

Charles E Frank, M.D.

AMG-Lincolnshire
100 Village Green Drive, Suite 120
Lincolnshire, IL 60069

Subscribed and sworn before me this 12th day of January 2015

Notary Public

Official Seal
Lisa Wolf
Notary Public State of Illinois
My Commission Expires 09/06/2016

A faith-based health system serving individuals, families and communities

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Charles Frank

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53104	Bristol	2
53142	Kenosha	1
53158	Pleasant Prairie	1
53179	Trevor	1
60002	Antioch	4
60004	Arlington Heights	3
60010	Barrington	2
60015	Deerfield	2
60016	Des Plaines	1
60030	Grayslake	10
60031	Gurnee	5
60035	Highland Park	3
60041	Ingleside	2
60044	Lake Bluff	1
60045	Lake Forest	1
60046	Lake Villa	8
60047	Lake Zurich	8
60048	Libertyville	19
60051	McHenry	2
60053	Morton Grove	1
60060	Mundelein	25
60061	Vernon Hills	6
60062	Northbrook	3
60067	Palatine	1
60069	Lincolnshire	3
60070	Prospect Heights	3
60073	Round Lake	8
60074	Palatine	3
60076	Skokie	1
60081	Spring Grove	1
60084	Wauconda	3
60085	Waukegan	2
60087	Waukegan	1

60089	Buffalo Grove	14
60090	Wheeling	4
60096	Winthrop Harbor	1
60097	Wonder Lake	1
60099	Zion	3
60107	Streamwood	1
60647	Logan Square	1
	Subtotal	162

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
49006	Kalamazoo, MI	1
60538	Montgomery, IL	1
	Subtotal	2

Total	164
Percent from within the geographic service area	98.8%

Source: Advocate Condell Medical Center records

Lake County Surgeons, P.C.
1 S Greenleaf
Suite A
Gurnee, IL 60031

February 5, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a physician specializing in General Surgery. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue, in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the zip codes of the origin of the patients. The listing shows that I performed 74 outpatient surgical procedures on patients. Of those, 100 percent were from within the geographic service area.

I expect to refer at least 44 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Laurence F. Gibson, M.D.

Lake County Surgeons, P.C.
1 S Greenleaf
Suite A
Gurnee, IL 60031

OFFICIAL SEAL
THERESA K KNAR
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/18/16

Lake County

Subscribed and sworn before me this 6th day of Feb, 2015

Notary Public Theresa K. Knar

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Laurence Gibson

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
60030	Grayslake	11
60073	Round Lake	10
60031	Gurnee	6
60060	Mundelein	6
60085	Waukegan	6
60002	Antioch	5
60048	Libertyville	4
60046	Lake Villa	3
60064	North Chicago	3
60041	Ingleside	2
60042	Island Lake	2
60087	Waukegan	2
60099	Zion	2
53144	Kenosha	1
53158	Pleasant Prairie	1
53181	Twin Lakes	1
60020	Fox Lake	1
60050	McHenry	1
60051	McHenry	1
60061	Vernon Hills	1
60079	Waukegan	1
60084	Wauconda	1
60089	Buffalo Grove	1
60090	Wheeling	1
60126	Elmhurst	1
	Subtotal	74

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
	Subtotal	0

Total	74
Percent from within the geographic service area	100%

Source: Advocate Condell Medical Center records

LAKE COUNTY HEAD & NECK SPECIALISTS, S.C.
N. M. DESAI, M.D., F.A.C.S.
E. G. NELSON, M.D., F.A.C.S.
BENJAMIN C. JOHNSON, M.D.

222 S. Greenleaf
Suite 100
Gurnee, IL 60031
(847) 662-4442
Fax: (847) 662-4410

1880 W. Winchester Ct.
Suite 103
Libertyville, IL 60048
(847) 367-5770

(Physician's Letterhead)

Date 1-16-15

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a physician specializing in Otolaryngology. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue, in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the zip codes of the origin of the patients. The listing shows that I performed 132 outpatient surgical procedures on patients. Of those, 100% percent were from within the geographic service area.

I expect to refer at least 80 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

_____(signature of physician)
(Benjamin Johnson,M.D.)
Lake County Head & Neck Specialists, S.C.
1880 W Winchester Ct
Ste. 103
Libertyville, Illinois 60048

Subscribed and sworn before me this 16 day of Jan, 2015

_____
Notary Public

"OFFICIAL SEAL"
Neriz Campos
Notary Public, State of Illinois
My Commission Expires February 7, 2015

Ear, Nose and Throat

Head and Neck Surgery

Audiology

Hearing Aid Sales & Service

EAR NOSE THROAT

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Benjamin Johnson

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53168	Salem	1
53181	Twin Lakes	1
60002	Antioch	1
60014	Crystal Lake	1
60020	Fox Lake	2
60030	Grayslake	12
60031	Gurnee	8
60035	Highland Park	1
60041	Ingleside	1
60045	Lake Forest	3
60046	Lake Villa	13
60048	Libertyville	19
60060	Mundelein	14
60061	Vernon Hills	5
60062	Northbrook	2
60073	Round Lake	16
60081	Spring Grove	2
60083	Wasdworth	4
60084	Wauconda	1
60085	Waukegan	9
60087	Waukegan	6
60088	Great Lakes	1
60089	Buffalo Grove	1
60096	Winthrop Harbor	2
60097	Wonder Lake	1
60099	Zion	4
60706	Harwood Heights	1
	Subtotal	132

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
	Subtotal	0

Total	132
Percent from within the geographic service area	100%

Source: Advocate Condell Medical Center records

UROLOGY PARTNERS

Raza M. Khan, M.D., F.A.C.S.
Robert S. Saffrin, M.D., F.A.C.S.
Nejd F. Alsikafi, M.D., F.A.C.S.
Sutchin R. Patel, M.D.

3 S. Greenleaf, Suite J
Gurnee, Illinois 60031
Phone: 847.599.1111
Fax: 847.599.1148

151 W. Golf
Libertyville, Illinois 60048
Phone: 847.680.3803
Fax: 847.680.3811

www.urologyspecialist.com

January 7, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a physician specializing in Urology. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue, in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the zip codes of the origin of the patients. The listing shows that I performed 133 outpatient surgical procedures on patients. Of those, 97.7% percent were from within the geographic service area.

I expect to refer at least 82 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

R. M. Khan

Raza M. Khan, M.D.

Subscribed and sworn before me this 12 day of Jan, 2015

Notary Public

OFFICIAL SEAL
KATHERINE A WALTERS
Notary Public - State of Illinois
My Commission Expires Nov 8, 2016

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Raza Khan

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53142	Kenosha	1
53158	Pleasant Prairie	2
60002	Antioch	10
60015	Deerfield	1
60020	Fox Lake	4
60026	Glenview	1
60030	Grayslake	6
60031	Gurnee	8
60041	Ingleside	4
60045	Lake Forest	2
60046	Lake Villa	13
60047	Lake Zurich	2
60048	Libertyville	11
60050	McHenry	1
60056	Mount Prospect	1
60060	Mundelein	10
60061	Vernon Hills	7
60064	North Chicago	4
60073	Round Lake	16
60074	Palatine	2
60079	Waukegan	1
60083	Wadsworth	4
60084	Wauconda	1
60085	Waukegan	11
60087	Waukegan	3
60089	Buffalo Grove	1
60099	Zion	3
	Subtotal	130

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
48331	Farmington, MI	2
95124	San Jose, CA	1
	Subtotal	3

Total	133
Percent from within the geographic service area	97.7%

Source: Advocate Condell Medical Center records

UROPARTNERS

Kristopher N Atzeff, MD • Justin J Cohen, MD • H Merrill Matschke, MD • Ronald J Kim, MD

900 N Westmoreland, Ste 228, Lake Forest, IL 60045 Phone: 847-295-0010 • Fax: 847-295-5433
1475 E Belvidere, Ste 312, Grayslake, IL 60030 Phone: 847-986-3030 • Fax: 847-986-3035
www.uropartners.com

January 12, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a physician specializing in Urology. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue, in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the zip codes of the origin of the patients. The listing shows that I performed 67 outpatient surgical procedures on patients. Of those, 98.5% percent were from within the geographic service area.

I expect to refer at least 41 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Ronald J. Kim, M.D.

Uropartners, LLC
1475 E. Belvidere Rd, Suite 312
Grayslake, IL 60030

OFFICIAL SEAL
THERESA K KNAR
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/18/16

Subscribed and sworn before me this 12th day of Jan, 2015

Notary Public Theresa K. Knar

Lake County

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Ronald Kim

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
60002	Antioch	5
60030	Grayslake	15
60031	Gurnee	1
60035	Highland Park	1
60041	Ingleside	1
60044	Lake Bluff	1
60046	Lake Villa	7
60048	Libertyville	8
60060	Mundelein	8
60061	Vernon Hills	5
60064	North Chicago	1
60073	Round Lake	7
60083	Wasdworth	1
60085	Waukegan	1
60087	Waukegan	2
60089	Buffalo Grove	1
60099	Zion	1
	Subtotal	66

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
60877	Elkhart, IN	1
	Subtotal	1

Total	67
Percent from within the geographic service area	98.5%

Source: Advocate Condell Medical Center records

Michael F. Scheer, M.D., F.A.C.S.
Daniel A. Liesen, M.D.
20 Tower Court, Suite A.
Gurnee, IL 60031
847-244-3525
847-244-3560 fax

Scheer Surgical, S.C.
General Surgery

January 14, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Olson:

I am a physician specializing in General Surgery. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue, in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the zip codes of the origin of the patients. The listing shows that I performed 79 outpatient surgical procedures on patients. Of those, 97.5 percent were from within the geographic service area.

I expect to refer at least 47 patients to the proposed ASTC within twelve months after the project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Daniel L. Liesen, M.D., F.A.C.S.

Surgeons of Northern Illinois
20 Tower Court, Suite A
Gurnee IL 60031

Subscribed and sworn before me this 2nd day of Feb., 2015

Notary Public

OFFICIAL SEAL
AUDREY POST
Notary Public - State of Illinois
My Commission Expires May 29, 2016

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Daniel Liesen

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53105	Burlington	1
53140	Kenosha	1
53158	Pleasant Prairie	1
53168	Salem	1
60002	Antioch	3
60020	Fox Lake	1
60030	Grayslake	6
60031	Gurnee	6
60041	Ingleside	3
60042	Island Lake	1
60045	Lake Forest	2
60046	Lake Villa	5
60048	Libertyville	6
60051	McHenry	1
60060	Mundelein	2
60061	Vernon Hills	4
60064	North Chicago	3
60073	Round Lake	5
60081	Spring Grove	1
60083	Wadsworth	1
60085	Waukegan	10
60087	Waukegan	3
60090	Wheeling	1
60096	Winthrop Harbor	1
60099	Zion	7
60625	Ravenswood	1
	Subtotal	77

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
54165	Seymour, WI	1
60450	Morris, IL	1
	Subtotal	2

Total	79
Percent from within the geographic service area	97.5%

Source: Advocate Condell Medical Center records

Advocate Medical Group
100 Village Green Drive, Suite 120 || Lincolnshire, IL 60069 || T 847-634-1766 F 8547-634-2894 || amgdoctors.com

January 8, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a physician specializing in Orthopedics. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue, in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the zip codes of the origin of the patients. The listing shows that I performed 79 outpatient surgical procedures on patients. Of those, 98.7% percent were from within the geographic service area.

I expect to refer at least 45 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Joseph A Meis, M.D.

AMG-Lincolnshire
100 Village Green Drive, Suite 120
Lincolnshire, IL 60069

Subscribed and sworn before me this 8th day of January, 2015

Notary Public

Official Seal
Lisa Wolf
Notary Public State of Illinois
My Commission Expires 09/06/2016

A faith-based health system serving individuals, families and communities

CCON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Joseph Meis

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53158	Pleasant Prairie	1
53403	Racine	1
60002	Antioch	1
60004	Arlington Heights	2
60015	Deerfield	6
60020	Fox Lake	2
60030	Grayslake	2
60031	Gurnee	4
60045	Lake Forest	2
60046	Lake Villa	2
60047	Lake Zurich	6
60048	Libertyville	7
60050	McHenry	1
60051	McHenry	1
60060	Mundelein	14
60061	Vernon Hills	6
60062	Northbrook	1
60067	Palatine	2
60069	Lincolnshire	1
60073	Round Lake	4
60084	Wauconda	2
60089	Buffalo Grove	8
60090	Wheeling	1
60609	New City	1
	Subtotal	78

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
61107	Rockford, IL	1
	Subtotal	1

Total	79
Percent from within the geographic service area	98.7%

Source: Advocate Condell Medical Center records

Advocate Medical Group
100 Village Green Drive, Suite 120 || Lincolnshire, IL 60069 || T 847-634-1766 F 8547-634-2894 || amgdoctors.com

January 8, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a physician specializing in Orthopedics. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue, in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the zip codes of the origin of the patients. The listing shows that I performed 190 outpatient surgical procedures on patients. Of those, 97.9% percent were from within the geographic service area.

I expect to refer at least 114 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Mark A Neault, M.D.

AMG-Lincolnshire
100 Village Green Drive, Ste 120
Lincolnshire, IL 60069

Subscribed and sworn before me this 8th day of January, 2015

Notary Public

Official Seal
Lisa Wolf
Notary Public State of Illinois
My Commission Expires 09/06/2016

A faith-based health system serving individuals, families and communities

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Mark Neault

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53143	Kenosha	2
53179	Trevor	2
60002	Antioch	6
60004	Arlington Heights	3
60015	Deerfield	7
60022	Glencoe	1
60030	Grayslake	19
60031	Gurnee	8
60035	Highland Park	3
60041	Ingleside	3
60042	Island Lake	1
60044	Lake Bluff	2
60045	Lake Forest	8
60046	Lake Villa	13
60047	Lake Zurich	10
60048	Libertyville	18
60050	McHenry	1
60051	McHenry	3
60056	Mount Prospect	1
60060	Mundelein	17
60061	Vernon Hills	8
60068	Park Ridge	2
60069	Lincolnshire	3
60070	Prospect Heights	1
60073	Round Lake	9
60076	Skokie	2
60081	Spring Grove	1
60084	Wauconda	4
60088	Great Lakes	1
60089	Buffalo Grove	11
60090	Wheeling	2
60099	Zion	1

60103	Bartlett	2
60156	Lake in the Hills	1
60201	Evanston	2
60301	Oak Park	1
60618	Avondale/N Center	1
60622	Wicker Park	1
60631	Norwood Park	1
60642	Evergreen Park II	1
60646	Lincolnwood	1
60647	Logan Square	1
60656	Harwood Heights	1
	Subtotal	186

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
29418	North Charleston, SC	1
56258	Marshall, MN	1
60506	Aurora, IL	1
61242	Cordova, IL	1
	Subtotal	4

Total	190
Percent from within the geographic service area	97.9%

Source: Advocate Condell Medical Center records

Michael F. Scheer, M.D., F.A.C.S.
Daniel A. Liesen, M.D.
20 Tower Court, Suite A.
Gurnee, IL 60031
847-244-3525
847-244-3560 fax

Scheer Surgical, S.C.
General Surgery

January 14, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Olson:

I am a physician specializing in General Surgery. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue, in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the zip codes of the origin of the patients. The listing shows that I performed 82 outpatient surgical procedures on patients. Of those, 98.8 percent were from within the geographic service area.

I expect to refer at least 49 patients to the proposed ASTC within twelve months after the project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Amit Parikh
Amit Parikh, D.O.

Surgeons of Northern Illinois
20 Tower Court, Suite A
Gurnee IL 60031

OFFICIAL SEAL
AUDREY POST
Notary Public - State of Illinois
My Commission Expires May 29, 2016

Subscribed and sworn before me this 2nd day of Feb., 2015

Audrey Post
Notary Public

OFFICIAL SEAL
AUDREY POST
Notary Public - State of Illinois
My Commission Expires May 29, 2016

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Amit Parikh

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53104	Bristol	1
53179	Trevor	1
60002	Antioch	5
60015	Deerfield	1
60030	Grayslake	5
60031	Gurnee	8
60041	Ingleside	2
60046	Lake Villa	4
60048	Libertyville	6
60051	McHenry	1
60060	Mundelein	7
60061	Vernon Hills	5
60064	North Chicago	3
60073	Round Lake	13
60083	Wasdworth	1
60084	Wauconda	1
60085	Waukegan	8
60087	Waukegan	4
60089	Buffalo Grove	1
60096	Winthrop Harbor	1
60099	Zion	1
60107	Streamwood	1
60156	Lake in the Hills	1
	Subtotal	81

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of	Name of City Linked to Zip Code	Number of OP Cases in Past

Patients		12 Months
92562	Murrieta, CA	1
	Subtotal	1
	Total	82
	Percent from within the geographic service area	98.8%

Source: Advocate Condell Medical Center records

UROPARTNERS
Raza M. Khan, M.D., F.A.C.S.
Robert S. Saffrin, M.D., F.A.C.S.
Nejd F. Alsikafi, M.D., F.A.C.S.
Sutchin R. Patel, M.D.

3 S. Greenleaf, Suite J
Gurnee, Illinois 60031
Phone: 847.599.1111
Fax: 847.599.1148

151 W. Golf
Libertyville, Illinois 60048
Phone: 847.680.3803
Fax: 847.680.3811

www.urologyspecialist.com

January 7, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a physician specializing in Urology. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue, in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the zip codes of the origin of the patients. The listing shows that I performed 166 outpatient surgical procedures on patients. Of those, 99% percent were from within the geographic service area.

I expect to refer at least 99 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Robert S. Saffrin, M.D.

Subscribed and sworn before me this 7 day of Jan, 2015

Notary Public

OFFICIAL SEAL
KATHERINE A WALTERS
Notary Public - State of Illinois
My Commission Expires Nov 8, 2016

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Robert Saffrin

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53104	Bristol	1
53142	Kenosha	1
53144	Kenosha	1
53158	Pleasant Prairie	1
53168	Salem	1
60002	Antioch	12
60020	Fox Lake	1
60030	Grayslake	10
60031	Gurnee	10
60041	Ingleside	3
60044	Lake Bluff	2
60045	Lake Forest	2
60046	Lake Villa	11
60047	Lake Zurich	3
60048	Libertyville	9
60050	McHenry	1
60051	McHenry	2
60060	Mundelein	16
60061	Vernon Hills	1
60064	North Chicago	2
60073	Round Lake	26
60085	Waukegan	18
60087	Waukegan	10
60088	Great Lakes	2
60089	Buffalo Grove	2
60090	Wheeling	1
60096	Winthrop Harbor	1
60097	Wonder Lake	1
60099	Zion	12
60102	Algonquin	1
60517	Woodridge	1
	Subtotal	165

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
25143	Nitro, WV	1
	Subtotal	1

Total	166
Percent from within the geographic service area	99.4%

Source: Advocate Condell Medical Center records

Michael F. Scheer, M.D., F.A.C.S.
Daniel A. Liesen, M.D.
20 Tower Court, Suite A.
Gurnee, IL 60031
847-244-3525
847-244-3560 fax

Scheer Surgical, S.C.
General Surgery

January 14, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Ms. Olson:

I am a physician specializing in General Surgery. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue, in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the zip codes of the origin of the patients. The listing shows that I performed 80 outpatient surgical procedures on patients. Of those, 100 percent were from within the geographic service area.

I expect to refer at least 48 patients to the proposed ASTC within twelve months after the project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Michael F. Scheer, M.D., F.A.C.S.

Surgeons of Northern Illinois
20 Tower Court, Suite A
Gurnee IL 60031

Subscribed and sworn before me this 2 day of Feb, 2015

Notary Public

OFFICIAL SEAL
AUDREY POST
Notary Public - State of Illinois
My Commission Expires May 29, 2016

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Michael Scheer

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53105	Burlington	1
53158	Pleasant Prairie	1
53170	Silver Lake	1
60002	Antioch	2
60030	Grayslake	4
60031	Gurnee	7
60041	Ingleside	1
60045	Lake Forest	1
60046	Lake Villa	6
60047	Lake Zurich	1
60048	Libertyville	12
60060	Mundelein	4
60061	Vernon Hills	7
60073	Round Lake	6
60079	Waukegan	1
60081	Spring Grove	1
60083	Wadsworth	3
60085	Waukegan	15
60087	Waukegan	2
60089	Buffalo Grove	1
60090	Wheeling	1
60098	Woodstock	1
60611	Ontario Street	1
	Subtotal	80

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of	Name of City Linked to Zip Code	Number of OP Cases in Past

Patients		12 Months
	Subtotal	0

Total	80
Percent from within the geographic service area	100%

Source: Advocate Condell Medical Center records

Lake County Surgeons, P.C.
1 S Greenleaf
Suite A
Gurnee, IL 60031

January 9, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a physician specializing in General Surgery. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue, in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the zip codes of the origin of the patients. The listing shows that I performed 71 outpatient surgical procedures on patients. Of those, 100% percent were from within the geographic service area.

I expect to refer at least 44 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Aaron M. Siegel, M.D.

Lake County Surgeons, P.C.
1 S Greenleaf
Suite A
Gurnee, IL 60031

OFFICIAL SEAL
THERESA K KNAR
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/18/16

Subscribed and sworn before me this 21st day of Jan 2015

Notary Public Theresa K. Knar

Lake County

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Aaron Siegel

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
60020	Fox Lake	1
60041	Ingleside	1
60042	Island Lake	1
60047	Lake Zurich	1
60051	McHenry	1
60061	Vernon Hills	1
60064	North Chicago	1
60071	Richmond	1
60083	Wadsworth	1
60084	Wauconda	1
60048	Libertyville	2
60060	Mundelein	2
60087	Waukegan	2
60002	Antioch	3
60010	Barrington	3
60030	Grayslake	3
60046	Lake Villa	4
60099	Zion	4
60031	Gurnee	6
60073	Round Lake	13
60085	Waukegan	19
	Subtotal	71

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
	Subtotal	0

Total	71
Percent from within the geographic service area	100%

Source: Advocate Condell Medical Center records

Lake County Surgeons, P.C.
1 S Greenleaf
Suite A
Gurnee, IL 60031

January 9, 2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a physician specializing in General Surgery. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue, in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the zip codes of the origin of the patients. The listing shows that I performed 146 outpatient surgical procedures on patients. Of those, 97.9 percent were from within the geographic service area.

I expect to refer at least 88 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Paul Strohmayer, M.D.

Lake County Surgeons, P.C.
1 S Greenleaf
Suite A
Gunree, IL 60031

OFFICIAL SEAL
THERESA K KNAR
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/18/16

Lake County

Subscribed and sworn before me this 12th day of Jan, 2015

Notary Public

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Paul Strohmayer

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53104	Bristol	2
53105	Burlington	1
60002	Antioch	11
60020	Fox Lake	1
60030	Grayslake	11
60031	Gurnee	14
60035	Highland Park	2
60040	Highwood	3
60041	Ingleside	7
60046	Lake Villa	5
60047	Lake Zurich	3
60048	Libertyville	11
60051	McHenry	2
60060	Mundelein	11
60061	Vernon Hills	5
60064	North Chicago	5
60073	Round Lake	15
60084	Wauconda	2
60085	Waukegan	14
60087	Waukegan	4
60099	Zion	11
60142	Huntley	1
60176	Schiller Park	1
60647	Logan Square	1
	Subtotal	143

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53147	Lake Geneva, WI	1
60643	Chicago, IL	1
61115	Machesney Park, IL	1
	Subtotal	3

Total	146
Percent from within the geographic service area	97.9%

Source: Advocate Condell Medical Center records

HAND & ORTHOPEDIC SURGERY CENTERS

PAUL E. PAPIERSKI, MD
TARUNA MADHAV CRAWFORD, MD
MARCUS G. TALERICO, MD
GREGORY E. CROVETTI, MD

Date: 01/07/2015

Kathryn J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Ms. Olson:

I am a physician specializing in Orthopedics. I am writing in support of the establishment of the proposed ambulatory surgery treatment center (ASTC) at Condell Drive and Milwaukee Avenue, in Libertyville. The table attached to this letter shows the outpatient surgical procedures I have performed in the recent 12 months to Advocate Condell Medical Center by the zip codes of the origin of the patients. The listing shows that I performed 183 outpatient surgical procedures on patients. Of those, 98.4% percent were from within the geographic service area.

I expect to refer at least 109 patients to the proposed ASTC within twelve months after project completion, all from my volume of work currently referred to Advocate Condell Medical Center. I will continue to do procedures at other facilities where I have medical staff privileges, as referrals or managed care contracts dictate.

I certify these referrals have not been used to support another pending or approved certificate of need application. The information provided in this letter is true and correct to the best of my knowledge.

Sincerely,

Marcus G. Talerico, M.D.
Chicago Hand & Orthopedic Surgery Centers
1419 Peterson Road
Libertyville, IL 60048

OFFICIAL SEAL
THERESA K KNAR
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 11/18/16

Lake County

Subscribed and sworn before me this 07 of January, 2015

Notary Public Theresa K. Knar

Schaumburg	Oakbrook terrace	Libertyville
855-4my-ortho	630-317-7007	855-4my-ortho
2000 E Algonquin Rd, Ste 109	1 TransAm Plaza Dr, Ste 460	1419 E Peterson Rd

CON Application for Proposed Ambulatory Surgery Treatment Center in Libertyville

Referring Physician Dr. Marcus Talerico

Outpatient surgical patients seen at Advocate Condell Medical Center from November 2013 to October 2014 are shown in the tables below.

Patients from Within the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
53128	Genoa City	1
53142	Kenosha	1
53143	Kenosha	1
60002	Antioch	7
60004	Arlington Heights	3
60010	Barrington	1
60014	Crystal Lake	3
60020	Fox Lake	3
60030	Grayslake	13
60031	Gurnee	5
60034	Hebron	1
60040	Highwood	1
60041	Ingleside	1
60045	Lake Forest	1
60046	Lake Villa	14
60047	Lake Zurich	3
60048	Libertyville	12
60051	McHenry	3
60060	Mundelein	14
60061	Vernon Hills	10
60064	North Chicago	3
60067	Palatine	1
60073	Round Lake	25
60081	Spring Grove	3
60083	Wasdworth	4
60084	Wauconda	1
60085	Waukegan	15
60087	Waukegan	4
60088	Great Lakes	3
60089	Buffalo Grove	4
60090	Wheeling	1
60096	Winthrop Harbor	1

60097	Wonder Lake	1
60099	Zion	9
60118	Dundee	2
60123	Elgin	1
60164	Melrose Park	1
60192	Hoffman Estates	1
60201	Evanston	1
60607	Chicago	1
	Subtotal	180

Patients Residing Outside the Geographic Service Area of the Proposed ASTC

Zip Code Origin of Patients	Name of City Linked to Zip Code	Number of OP Cases in Past 12 Months
60490	Bolingbrook	1
61038	Garden Prairie	1
61705	Bloomington	1
	Subtotal	3

Total	183
Percent from within the geographic service area	98.4%

Source: Advocate Condell Medical Center records

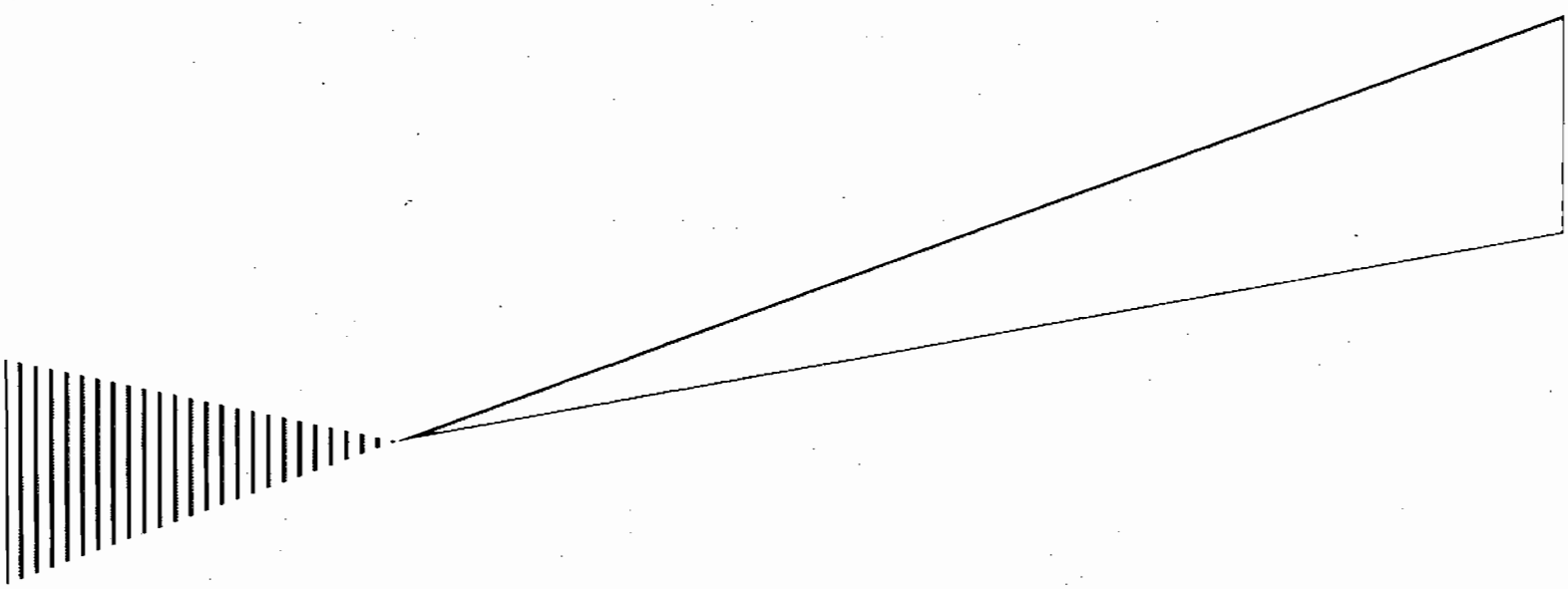
Financial Reports

The remaining pages of this application are the 2014 Consolidated Financial Statements and Supplementary Information for Advocate Health Care Network and Subsidiaries, followed on page 332 by the United States Securities and Exchange Commission Annual Report for Surgical Care Affiliates, Inc. for the fiscal year ending December 31, 2013.

Consolidated Financial Statements and Supplementary Information

Advocate Health Care Network and Subsidiaries
Years Ended December 31, 2014 and 2013
With Reports of Independent Auditors

Ernst & Young LLP



Building a better working world

Advocate Health Care Network and Subsidiaries

Consolidated Financial Statements and Supplementary Information

Years Ended December 31, 2014 and 2013

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Ernst & Young LLP
155 North Wacker Drive
Chicago, IL 60606-1787

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Fax: +1 312 879 4000
ey.com

Building a better working world

Report of Independent Auditors

The Board of Directors
Advocate Health Care Network

We have audited the accompanying consolidated financial statements of Advocate Health Care Network and subsidiaries, which comprise the consolidated balance sheets as of December 31, 2014 and 2013, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

A member firm of Ernst & Young Global Limited

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Advocate Health Care Network and subsidiaries at December 31, 2014 and 2013, and the consolidated results of their operations and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

March 6, 2015

A member firm of Ernst & Young Global Limited

Advocate Health Care Network and Subsidiaries

Consolidated Balance Sheets

(Dollars in Thousands)

	December 31	
	2014	**2013**
Assets		
Current assets:		
Cash and cash equivalents	**$ 272,912**	$ 563,229
Short-term investments	**19,456**	19,401
Assets limited as to use	**91,747**	89,660
Patient accounts receivable, less allowances for uncollectible accounts of $219,447 in 2014 and $181,254 in 2013	**633,743**	567,033
Amounts due from primary third-party payors	**16,850**	10,107
Prepaid expenses, inventories, and other current assets	**267,792**	256,322
Collateral proceeds received under securities lending program	**19,768**	19,165
Total current assets	**1,322,268**	1,524,917
Assets limited as to use:		
Internally and externally designated investments limited as to use	**5,169,099**	4,715,519
Investments under securities lending program	**19,145**	19,013
	5,188,244	4,734,532
Prepaid pension expense and other noncurrent assets	**116,535**	132,382
Interest in health care and related entities	**150,327**	152,103
Reinsurance receivable	**161,545**	172,318
Deferred costs and intangible assets, less allowances for amortization	**44,236**	51,231
	5,660,887	5,242,566
Property and equipment – at cost:		
Land and land improvements	**257,699**	251,296
Buildings	**2,708,787**	2,514,922
Movable equipment	**1,467,513**	1,358,608
Construction-in-progress	**449,958**	313,065
	4,883,957	4,437,891
Less allowances for depreciation	**2,332,932**	2,155,428
	2,551,025	2,282,463
	$ 9,534,180	$ 9,049,946

	December 31	
	2014	**2013**
Liabilities and net assets/shareholders' equity		
Current liabilities:		
Current portion of long-term debt	**$ 20,042**	$ 17,810
Long-term debt subject to short-term remarketing arrangements	**130,635**	135,130
Accounts payable	**335,414**	291,306
Accrued salaries and employee benefits	**373,365**	409,192
Accrued expenses	**130,656**	120,526
Amounts due to primary third-party payors	**309,591**	274,780
Current portion of accrued insurance and claims costs	**119,587**	112,412
Obligations to return collateral under securities lending program	**19,768**	19,440
Total current liabilities	**1,439,058**	1,380,596
Noncurrent liabilities:		
Long-term debt, less current portion	**1,458,375**	1,452,109
Pension plan liability	**37,441**	23,737
Accrued insurance and claims cost, less current portion	**712,169**	678,470
Accrued losses subject to reinsurance recovery	**161,545**	172,318
Obligations under swap agreements, net of collateral posted	**86,246**	47,908
Other noncurrent liabilities	**186,953**	166,373
	2,642,729	2,540,915
Total liabilities	**4,081,787**	3,921,511
Net assets/shareholders' equity:		
Unrestricted	**5,284,721**	4,968,578
Temporarily restricted	**118,991**	111,335
Permanently restricted	**48,019**	47,566
	5,451,731	5,127,479
Non-controlling interest	**662**	956
Total net assets/shareholders' equity	**5,452,393**	5,128,435
Total liabilites and net assets/shareholders' equity	**$ 9,534,180**	$ 9,049,946

See accompanying notes to consolidated financial statements.

Advocate Health Care Network and Subsidiaries

Consolidated Statements of Operations and Changes in Net Assets
(Dollars in Thousands)

	Year Ended December 31	
	2014	**2013**
Unrestricted revenues, gains, and other support		
Net patient service revenue	**$ 4,786,197**	$ 4,468,468
Provision for uncollectible accounts	**(289,597)**	(253,989)
	4,496,600	4,214,479
Capitation revenue	**413,508**	389,516
Other revenue	**321,285**	334,007
	5,231,393	4,938,002
Expenses		
Salaries, wages, and employee benefits	**2,637,606**	2,510,470
Purchased services and operating supplies	**1,313,401**	1,211,483
Contracted medical services	**152,646**	135,570
Insurance and claims costs	**118,037**	108,349
Other	**382,641**	404,988
Depreciation and amortization	**239,651**	211,648
Interest	**56,811**	55,299
	4,900,793	4,637,807
Operating income	**330,600**	300,195
Nonoperating income (loss)		
Investment income	**136,945**	287,727
Change in fair value of interest rate swaps	**(38,338)**	41,236
Fair value of net assets acquired	**–**	151,663
Loss on refinancing of debt	**(45,470)**	(46)
Other nonoperating items, net	**(14,130)**	(15,455)
	39,007	465,125
Revenues in excess of expenses	**369,607**	765,320

Advocate Health Care Network and Subsidiaries

Consolidated Statements of Operations and Changes in Net Assets (continued)
(Dollars in Thousands)

	Year Ended December 31	
	2014	**2013**
Unrestricted net assets		
Revenues in excess of expenses	**$ 369,607**	$ 765,320
Net assets released from restrictions and used for capital purchases	**10,558**	4,201
Postretirement benefit plan adjustments	**(64,018)**	70,912
Other	**(4)**	(21)
Increase in unrestricted net assets	**316,143**	840,412
Temporarily restricted net assets		
Contributions for medical education programs, capital purchases, and other purposes	**24,388**	27,778
Contribution of net assets of Sherman Hospital	**–**	719
Realized gains on investments	**5,325**	2,959
Unrealized (losses) gains on investments	**(1,106)**	3,768
Net assets released from restrictions and used for operations, medical education programs, capital purchases, and other purposes	**(20,951)**	(14,240)
Increase in temporarily restricted net assets	**7,656**	20,984
Permanently restricted net assets		
Contributions for medical education programs, capital purchases, and other purposes	**453**	1,889
Contribution of net assets of Sherman Hospital	**–**	263
Increase in permanently restricted net assets	**453**	2,152
Increase in net assets	**324,252**	863,548
Change in non-controlling interest	**(294)**	(26)
Net assets/shareholders' equity at beginning of year	**5,128,435**	4,264,913
Net assets/shareholders' equity at end of year	**$ 5,452,393**	$ 5,128,435

See accompanying notes to consolidated financial statements.

Advocate Health Care Network and Subsidiaries

Consolidated Statements of Cash Flows

(Dollars in Thousands)

	Year Ended December 31	
	2014	**2013**
Operating activities		
Increase in net assets	**$ 323,958**	$ 863,522
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation, amortization, and accretion	**236,236**	208,828
Provision for uncollectible accounts	**289,597**	253,989
Change in deferred income taxes	**(3,835)**	(5,893)
(Gains) losses on disposal of property and equipment	**(1,297)**	5,909
Loss on refinancing of debt	**45,470**	46
Change in fair value of interest rate swaps	**38,338**	(41,236)
Postretirement benefit plan adjustments	**64,018**	(70,912)
Contribution of certain net assets of Sherman Hospital, net of $12,280 cash received	**–**	(152,645)
Restricted contributions and gains on investments, net of assets released from restrictions used for operations	**(10,393)**	(10,039)
Changes in operating assets and liabilities:		
Trading securities	**(629,369)**	(476,014)
Patient accounts receivable	**(356,307)**	(243,799)
Amounts due to/from primary third-party payors	**28,068**	5,035
Accounts payable, accrued salaries and employee benefits, accrued expenses, and other noncurrent liabilities	**(7,608)**	160,561
Other assets	**(10,929)**	409
Accrued insurance and claims cost	**40,874**	9,393
Net cash provided by operating activities	**46,821**	507,154
Investing activities		
Purchases of property and equipment	**(507,788)**	(385,695)
Proceeds from sale of property and equipment	**6,349**	2,590
Cash acquired in the acquisition of Sherman Hospital	**–**	12,280
Purchases of investments designated as non-trading	**(69,229)**	(352,931)
Sales of investments designated as non-trading	**223,805**	431,263
Other	**13,615**	(66,043)
Net cash used in investing activities	**(333,248)**	(358,536)
Financing activities		
Proceeds from issuance of debt	**341,559**	119,956
Payments of long-term debt	**(374,509)**	(144,014)
Collateral received (posted) under swap agreements	**–**	4,330
Proceeds from restricted contributions and gains on investments	**29,060**	36,394
Net cash (used in) provided by financing activities	**(3,890)**	16,666
(Decrease) increase in cash and cash equivalents	**(290,317)**	165,284
Cash and cash equivalents at beginning of year	**563,229**	397,945
Cash and cash equivalents at end of year	**$ 272,912**	$ 563,229

See accompanying notes to consolidated financial statements.

1. Organization and Summary of Significant Accounting Policies

Organization

Advocate Health Care Network (the System) is a nonprofit, faith-based health care organization dedicated to providing comprehensive health care services, including inpatient acute and non-acute care, primary and specialty physician services, and various outpatient services to communities in northern and central Illinois. Additionally, through long-term academic and teaching affiliations, the System trains resident physicians. The System is affiliated with the United Church of Christ and the Evangelical Lutheran Church of America. Substantially all expenses of the System are related to providing health care services.

On June 1, 2013, the System and Sherman Hospital completed an affiliation agreement pursuant to which the System became the sole corporate member of Sherman Hospital. Additionally, on June 1, 2013, the name of Sherman Hospital was changed to Advocate Sherman Hospital (Sherman). The affiliation was accounted for as an acquisition in accordance with the authoritative guidance on not-for-profit mergers and acquisitions and is described in Note 13. The operations of Sherman have been included in the System's consolidated financial statements since the affiliation date.

Mission and Community Benefit

As a faith-based health care organization, the mission, values, and philosophy of the System form the foundation for its strategic priorities. The System's mission is to serve the health care needs of individuals, families, and communities through a holistic philosophy rooted in the fundamental understanding of human beings as created in the image of God. The System's core values of compassion, equality, excellence, partnership, and stewardship guide its actions to provide health care services to its communities. Consistent with the values of compassion and stewardship, the System makes a major commitment to patients in need, regardless of their ability to pay. This care is provided to patients who meet the criteria established under the System's charity care policy. Patients eligible for consideration can earn up to 600% of the federal poverty level. Qualifying patients can receive up to 100% discounts from charges and extended payment plans. In 2014, with the implementation of the Affordable Care Act (ACA) and Illinois' expansion of the Medicaid program, the System experienced a shift in payors from self-pay to Medicaid and Medicaid managed care. As a result, the amount of gross charges forgone under the charity policy and the cost of providing the related care decreased in 2014. In 2014 and 2013, $272,314 and $467,899, respectively, of patient charges were forgone under this

1. Organization and Summary of Significant Accounting Policies (continued)

policy. The System's cost of providing charity care in 2014 and 2013, as determined using the 2013 Medicare cost-to-charge ratio, was $70,796 and $122,219, respectively. In addition to contributing to the shift from self-pay to Medicaid and Medicaid managed care, the ACA also contains a number of provisions intended to improve quality and reduce spending related to the Medicare program. The reduction in spending on the Medicare program, which includes readmission penalties, a reduction in disproportionate share payments, and reduction in payment rates, is intended to offset the cost of expanding coverage under the ACA. The result of these provisions is a continued reduction in the amount of reimbursement hospitals will receive under the Medicare program.

The System also provides programs in response to the community needs identified through each hospital's community health needs assessment (CHNA), such as the Matter of Balance program to reduce fall risk in the senior population, or the Coordinated Approach to Child Health (CATCH) program implemented in schools to address childhood obesity. In addition, a wide-range of other community programs and activities are offered throughout the System including health education, immunizations for children, support groups, health screenings, health fairs, pastoral care, home-delivered meals, transportation services, seminars and speakers, crisis lines, publication of health magazines, medical residency and internships, research and language assistance, and other subsidized health services. These activities are provided free of charge or at a fee that is below the cost of providing them. The cost of these activities and the costs of uncompensated care for 2014 will be included in a community benefit report that will be filed with the Office of the Attorney General for the State of Illinois in June 2015.

Principles of Consolidation

Included in the System's consolidated financial statements are all of its wholly owned or controlled subsidiaries. All significant intercompany transactions have been eliminated in consolidation.

1. Organization and Summary of Significant Accounting Policies (continued)

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates, assumptions, and judgments that affect the reported amounts of assets and liabilities and amounts disclosed in the notes to the consolidated financial statements at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Although estimates are considered to be fairly stated at the time made, actual results could differ materially from those estimates.

Cash Equivalents

The System considers all highly liquid investments with a maturity of three months or less when purchased to be cash equivalents.

Investments

The System has designated substantially all of its investments as trading. Certain debt-related investments are designated as non-trading. Investments in debt and equity securities with readily determinable fair values are measured at fair value using quoted market prices or other observable inputs. The non-trading portfolio consists mainly of cash equivalents, money market, and commercial paper. Investments in limited partnerships that invest in marketable securities and derivative products (hedge funds) are reported using the equity method of accounting based on information provided by the respective partnership. Investments in private equity limited partnerships with ownership percentages of 5% or greater are recorded on the equity method of accounting, while those with ownership percentages of 5% or less are recorded on the cost method of accounting. Investment income or loss (including realized gains and losses, interest, dividends, changes in equity of limited partnerships, and unrealized gains and losses) is included in investment income unless the income or loss is restricted by donor or law or is related to assets designated for self-insurance programs. Investment income on self-insurance trust funds is reported in other revenue. Unrealized gains and losses that are restricted by donor or law are reported as a change in temporarily restricted net assets.

1. Organization and Summary of Significant Accounting Policies (continued)

Assets Limited as to Use

Assets limited as to use consist of investments set aside by the Board of Directors for future capital improvements and certain medical education and health care programs. The Board of Directors retains control of these investments and may, at its discretion, subsequently use them for other purposes. Additionally, assets limited as to use include investments held by trustees under debt agreements and self-insurance trusts.

Patient Service Revenue and Accounts Receivable

Patient accounts receivable are stated at net realizable value. The System evaluates the collectability of its accounts receivable based on the length of time the receivable is outstanding, major payor sources of revenue, historical collection experience, and trends in health care insurance programs to estimate the appropriate allowance and provision for uncollectible accounts. For receivables associated with services provided to patients who have third-party coverage, the System analyzes contractually due amounts and provides an allowance for contractual allowances and an allowance and a provision for uncollectible accounts for patient responsibilities under such contracts that are deemed not realizable. For receivables associated with self-pay patients, the System records a significant provision for uncollectible accounts in the period of service on the basis of its past experience, which indicates that many patients do not pay the portion of their bill for which they are financially responsible. These adjustments are accrued on an estimated basis and are adjusted as needed in future periods.

The allowance for uncollectible accounts as a percentage of accounts receivable increased from 24% in 2013 to 26% in 2014 primarily due to a shift in payor class, an increase in the number of patients with higher co-insurance and deductible plans and an increase in the aging of accounts receivable. The System's combined allowance for uncollectible accounts receivable, uninsured discounts, and charity care covered 100% of self-pay accounts receivable at December 31, 2014 and 2013.

The System has agreements with third-party payors that provide for payments to the System at amounts different from its established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for service rendered, including estimated adjustments under reimbursement agreements with third-party payors, certain of which are subject to audit by administering agencies. These adjustments are accrued on an estimated basis and are adjusted as needed in future periods.

1. Organization and Summary of Significant Accounting Policies (continued)

Net patient service revenue recognized in the period from these major payor sources is as follows for the years ended December 31:

	2014	2013
Third-party payors	**$ 4,512,176**	$ 4,040,300
Self-pay	**274,021**	428,168
Total all payors	**$ 4,786,197**	$ 4,468,468

Inventories

Inventories, consisting primarily of medical supplies and pharmaceuticals, are stated at the lower of cost (first-in, first-out) or market value.

Reinsurance Receivables

Reinsurance receivables are recognized in a manner consistent with the liabilities relating to the underlying reinsured contracts.

Deferred Costs

Deferred costs consist primarily of noncurrent deferred tax assets and deferred bond issuance costs. Deferred bond issuance costs are amortized over the life of the bonds using the effective interest method.

Asset Impairment

The System considers whether indicators of impairment are present and performs the necessary tests to determine if the carrying value of an asset is appropriate. Impairment write-downs, except for those related to investments, are recognized in operating income at the time the impairment is identified.

1. Organization and Summary of Significant Accounting Policies (continued)

Property and Equipment

Provisions for depreciation of property and equipment are based on the estimated useful lives of the assets ranging from 3 to 80 years using the straight-line method.

Asset Retirement Obligations

The System recognizes its legal obligations associated with the retirement of long-lived assets that result from the acquisition, construction, development, or normal operations of long-lived assets when these obligations are incurred. The obligations are recorded as a noncurrent liability and are accreted to present value at the end of each period. When the obligation is incurred, an amount equal to the present value of the liability is added to the cost of the related asset and is depreciated over the life of the related asset. The obligations at December 31, 2014 and 2013, were $20,821 and $19,197, respectively.

Derivative Financial Instruments

The System has entered into derivative transactions to manage its interest rate risk. Derivative instruments are recorded as either assets or liabilities at fair value. Subsequent changes in a derivative's fair value are recognized in nonoperating income (loss).

General and Professional Liability Risks

The provision for self-insured general and professional liability claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those assets whose use by the System has been limited by donors to a specific time period or purpose. Permanently restricted net assets consist of gifts with corpus values that have been restricted by donors to be maintained in perpetuity. Temporarily restricted net assets and earnings on permanently restricted net assets are used in accordance with the donor's wishes primarily to purchase property and equipment or to fund medical education or other health care programs.

1. Organization and Summary of Significant Accounting Policies (continued)

Assets released from restriction to fund purchases of property and equipment are reported in the consolidated statements of operations and changes in net assets as increases to unrestricted net assets. Those assets released from restriction for operating purposes are reported in the consolidated statements of operations and changes in net assets as other revenue. When restricted, earnings are recorded as temporarily restricted net assets until amounts are expended in accordance with the donor's specifications.

Capitation Revenue

The System has agreements with various managed care organizations under which the System provides or arranges for medical care to members of the organizations in return for a monthly payment per member. Revenue is earned each month as a result of agreeing to provide or arrange for their medical care.

Other Nonoperating Items, Net

Other nonoperating items, net primarily consist of provisions for environmental remediation, contributions to charitable organizations, valuation adjustments for investments on the equity method of accounting, and income taxes.

Revenues in Excess of Expenses and Changes in Net Assets

The consolidated statements of operations and changes in net assets include revenues in excess of expenses as the performance indicator. Changes in unrestricted net assets, which are excluded from revenues in excess of expenses, primarily include contributions of long-lived assets (including assets acquired using contributions, which by donor restriction were to be used for the purposes of acquiring such assets) and postretirement benefit adjustments.

1. Organization and Summary of Significant Accounting Policies (continued)

Grants

Grant revenue is recognized in the period it is earned based on when the applicable project expenses are incurred and project milestones are achieved. Grant payments received in advance of related project expenses are recorded as deferred revenue until the expenditure has been incurred. The System records grant revenue in other revenue in the consolidated statements of operations and changes in net assets.

Under certain provisions of the American Recovery and Reinvestment Act of 2009, federal incentive payments are available to hospitals, physicians, and certain other professionals when they adopt certified electronic health record (EHR) technology or become "meaningful users" of EHRs in ways that demonstrate improved quality, safety, and effectiveness of care. These incentive payments are being accounted for in the same manner as grant revenue.

New Accounting Pronouncement

In May 2014, the Financial Accounting Standards Board issued guidance related to recognizing revenue from contracts with customers. This new guidance dictates that the standard be applied either retrospectively to each prior reporting period presented, or retrospectively with the cumulative effect of initially applying the revenue recognition standard recognized at the date of initial application. This new guidance is effective for fiscal years and interim periods within those fiscal years beginning after December 15, 2016. The System is evaluating the effect this guidance will have on its consolidated financial statements.

Reclassifications in the Consolidated Financial Statements

Certain reclassifications were made to the 2013 consolidated financial statements and footnotes to conform to the classifications used in 2014. There was no impact on previously reported 2013 net assets or revenues in excess of expenses.

2. Contractual Arrangements With Third-Party Payors

The System provides care to certain patients under payment arrangements with Medicare, Medicaid, Health Care Service Corporation, d/b/a Blue Cross and Blue Shield of Illinois (Blue Cross), and various other health maintenance and preferred provider organizations. Services provided under these arrangements are paid at predetermined rates and/or reimbursable costs, as defined. Reported costs and/or services provided under certain of the arrangements are subject to audit by the administering agencies. Changes in Medicare and Medicaid programs and reduction of funding levels could have a material adverse effect on the future amounts recognized as net patient service revenue.

Amounts earned from the above payment arrangements accounted for 93% and 94% of the System's net patient service revenue, net of the provision for uncollectible accounts, in 2014 and 2013, respectively. For the years ended December 31, 2014 and 2013, the System earned 29% and 30%, respectively, of net patient service revenue net of the provision for uncollectible accounts, from Blue Cross; 11% from the Medicaid program; and 24% and 25%, respectively, from the Medicare program. Provision has been made in the consolidated financial statements for contractual adjustments, representing the difference between the established charges for services and actual or estimated payment. The extreme complexity of laws and regulations governing the Medicare and Medicaid programs renders at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Changes in the estimates that relate to prior years' third-party payment arrangements resulted in increases in net patient service revenue of $6,419 and $20,899 for the years ended December 31, 2014 and 2013, respectively.

Also, in 2013 the Centers for Medicare and Medicaid Services approved the enhanced Medicaid assessment system retroactive to June 10, 2012. In 2013 the System recognized $26,601 in net patient service revenue and $15,871 in other operating expenses for the first 18 months covered by this system.

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2. Contractual Arrangements With Third-Party Payors (continued)

In connection with the State of Illinois' Hospital Assessment Program, including the enhanced Medicaid assessment system, the System recognized $202,590 and $224,082 of net patient service revenue and $142,212 and $154,873 of program assessment expense in other expense in 2014 and 2013, respectively.

The System's concentration of credit risk related to accounts receivable is limited due to the diversity of patients and payors. The System grants credit, without collateral, to its patients, most of whom are local residents and insured under third-party payor arrangements. The System has established guidelines for placing patient balances with collection agencies, subject to terms of certain restrictions on collection efforts as determined by the System. Amounts due to/from primary third-party payors in the consolidated balance sheets primarily relate to the Blue Cross, Medicare, or Medicaid programs. At both December 31, 2014 and 2013, 18% of net patient accounts receivable were due under contracts with Blue Cross and 20% and 22%, respectively, were due from the Medicaid program. Net patient accounts receivable due from the Medicare program were 13% and 15% at December 31, 2014 and 2013, respectively.

The System has entered into various capitated physician provider agreements, including Humana Health Plan, Inc. and Humana Insurance Company and their affiliates (collectively, Humana); Cigna-HealthSpring; and WellCare Health Plans, Inc. For the years ended December 31, 2014 and 2013, capitation revenues received under the Humana agreements amounted to 42% and 38%, respectively; 14% and 13%, respectively, from Cigna-HealthSpring agreements; and 13% and 14%, respectively, from WellCare Health Plans, Inc. agreements.

Provision has been made in the consolidated financial statements for the estimated cost of providing certain medical services under the aforementioned capitated arrangements. The System accrues a liability for reported, as well as an estimate for incurred but not recorded (IBNR), contracted medical services. The liability represents the expected ultimate cost of all reported and unreported claims unpaid at year-end. The System uses the services of a consulting actuary to determine the estimated cost of the IBNR claims. Adjustments to the estimates are reflected in current year operations. At December 31, 2014 and 2013, the liabilities for unpaid medical claims amounted to $23,268 and $21,107, respectively, and are included in accrued expenses in the consolidated balance sheets.

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3. Cash and Cash Equivalents and Investments (Including Assets Limited as to Use)

Investments (including assets limited as to use) and other financial instruments at December 31 are summarized as follows:

	2014	2013
Assets limited as to use:		
Designated for self-insurance programs	$ 779,395	$ 807,145
Internally and externally designated for capital improvements, medical education, and health care programs	4,474,371	3,836,378
Externally designated under debt agreements	7,080	161,656
Investments under securities lending program	19,145	19,013
	5,279,991	4,824,192
Other financial instruments:		
Cash and cash equivalents and short-term investments	292,368	582,630
	$ 5,572,359	$ 5,406,822

The composition and carrying value of assets limited as to use, short-term investments, and cash and cash equivalents at December 31 are set forth in the following table:

	2014	2013
Cash and short-term investments	$ 362,473	$ 956,883
Corporate bonds and other debt securities	498,086	326,163
United States government obligations	254,478	199,689
Government mutual funds	310,075	502,072
Bond and other debt security mutual funds	300,017	479,855
Commodity mutual funds	3,497	4,631
Hedge funds	1,661,622	895,222
Private equity limited partnership funds	444,827	336,536
Equity securities	1,201,133	1,083,000
Equity funds	536,151	605,553
Guaranteed investment contract	–	17,218
	$ 5,572,359	$ 5,406,822

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3. Cash and Cash Equivalents and Investments (Including Assets Limited as to Use) (continued)

For private equity investments carried at cost, the System regularly compares the net asset value (NAV), which is a proxy for the fair value, to the recorded cost of these investments for potential other-than-temporary impairment. The cost of these investments is $384,435 and $292,177, and the NAV of these based on estimates determined by the investments' management was $443,862 and $335,569 at December 31, 2014 and 2013, respectively. In 2014 and 2013, the System identified and recorded $15,041 and $5,381, respectively, of impairment losses that are included in investment income in the consolidated statements of operations and changes in net assets.

At December 31, 2014 and 2013, the System has commitments to fund private equity investments an additional $491,822 and $364,934, respectively. The unfunded commitments at December 31, 2014, are expected to be funded over the next six years.

Investment returns for assets limited as to use, cash and cash equivalents, and short-term investments comprise the following for the years ended December 31:

	2014	2013
Interest and dividend income	**$ 167,822**	$ 151,877
Net realized gains	**120,033**	121,330
Net unrealized (losses) gains	**(99,803)**	69,520
	$ 188,052	$ 342,727

Investment returns are included in the consolidated statements of operations and changes in net assets for the years ended December 31 as follows:

	2014	2013
Other revenue	**$ 46,888**	$ 48,273
Investment income	**136,945**	287,727
Realized and unrealized gains on investments – temporarily restricted net assets	**4,219**	6,727
	$ 188,052	$ 342,727

3. Cash and Cash Equivalents and Investments (Including Assets Limited as to Use) (continued)

As part of the management of the investment portfolio, the System has entered into an arrangement whereby securities owned by the System are loaned primarily to brokers and investment banks. The loans are arranged through a bank. Borrowers are required to post collateral in the form of highly rated government securities for securities borrowed equal to approximately 103% and 102% in 2014 and 2013, respectively, of the value of the security on a daily basis at a minimum. The bank is responsible for reviewing the creditworthiness of the borrowers. The System has also entered into an arrangement whereby the bank is responsible for the risk of borrower bankruptcy and default. At December 31, 2014 and 2013, the System loaned $19,145 and $19,013, respectively, in securities and accepted collateral for these loans in the amount of $19,768 and $19,440, respectively, of which $19,768 and $19,165, respectively, represent cash collateral and are included in current liabilities and current assets, respectively, in the accompanying consolidated balance sheets.

4. Fair Value Measurements

The System accounts for certain assets and liabilities at fair value. The hierarchy below lists three levels of fair value based on the extent to which inputs used in measuring fair value are observable in active markets. The System categorizes each of its fair value measurements in one of the three levels based on the highest level of input that is significant to the fair value measurement in its entirety. These levels are:

Level 1: Quoted prices in active markets for identified assets or liabilities.

Level 2: Inputs, other than quoted prices in active markets, that are observable either directly or indirectly.

Level 3: Unobservable inputs in which there is little or no market data, which then requires the reporting entity to develop its own assumptions about what market participants would use in pricing the asset or liability.

4. Fair Value Measurements (continued)

The following section describes the valuation methodologies the System uses to measure financial assets and liabilities at fair value. In general, where applicable, the System uses quoted prices in active markets for identical assets and liabilities to determine fair value. This pricing methodology applies to Level 1 investments such as domestic and international equities, United States Treasuries, exchange-traded mutual funds, and agency securities. If quoted prices in active markets for identical assets and liabilities are not available to determine fair value, then quoted prices for similar assets and liabilities or inputs other than quoted prices that are observable either directly or indirectly are used. These investments are included in Level 2 and consist primarily of corporate notes and bonds, foreign government bonds, mortgage-backed securities, commercial paper, and certain agency securities. The fair value for the obligations under swap agreements included in Level 2 is estimated using industry standard valuation models. These models project future cash flows and discount the future amounts to a present value using market-based observable inputs, including interest rate curves. The fair values of the obligation under swap agreements include fair value adjustments related to the System's credit risk.

The Sherman Series 2007A Bonds required a debt service reserve fund that was invested in a guaranteed investment contract (GIC) that was included as a Level 2 investment. This investment represented a privately negotiated agreement between Sherman and various banks. Although the investment was not traded on any market and was nontransferable for the duration of the bonds, the underlying assets were traded in active markets. As described in Note 6, the Sherman Series 2007A Bonds were advanced refunded in December 2014 and the GIC was terminated.

The System's investments are exposed to various kinds and levels of risk. Equity securities and equity mutual funds expose the System to market risk, performance risk, and liquidity risk for both domestic and international investments. Market risk is the risk associated with major movements of the equity markets. Performance risk is the risk associated with a company's operating performance. Fixed income securities and fixed income mutual funds expose the System to interest rate risk, credit risk, and liquidity risk. As interest rates change, the value of many fixed income securities is affected, including those with fixed interest rates. Credit risk is the risk that the obligor of the security will not fulfill its obligations. Liquidity risk is affected by the willingness of market participants to buy and sell particular securities. Liquidity risk tends to be higher for equities related to small capitalization companies and certain alternative investments. Due to the volatility in the capital markets, there is a reasonable possibility of subsequent changes in fair value resulting in additional gains and losses in the near term.

4. Fair Value Measurements (continued)

The following are assets and liabilities measured at fair value on a recurring basis at December 31, 2014:

Description	2014	Fair Value Measurements at Reporting Date Using: Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and short-term investments	$ 362,473	$ 348,076	$ 14,397	$ –
Corporate bonds and other debt securities	498,086	–	498,086	–
United States government obligations	254,478	–	254,478	–
Government mutual funds	310,075	310,075	–	–
Bond and other debt security mutual funds	300,017	8,588	291,429	–
Commodity mutual funds	3,497	3,497	–	–
Equity securities	1,201,133	1,201,133	–	–
Equity funds	536,151	97,270	438,881	–
Investments at fair value	3,465,910	$ 1,968,639	$ 1,497,271	$ –
Investments not at fair value	2,106,449			
Total investments	$ 5,572,359			
Collateral proceeds received under securities lending program	$ 19,768		$ 19,768	
Liabilities				
Obligations under swap agreements (see Note 7)	$ (86,246)		$ (86,246)	
Obligations to return collateral under securities lending program	$ (19,768)		$ (19,768)	

4. Fair Value Measurements (continued)

The following are assets and liabilities measured at fair value on a recurring basis at December 31, 2013:

Description	2013	Fair Value Measurements at Reporting Date Using: Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets				
Cash and short-term investments	$ 956,883	$ 952,558	$ 4,325	$ –
Corporate bonds and other debt securities	326,163	–	326,163	–
United States government obligations	199,689	–	199,689	–
Government mutual funds	502,072	421,257	80,815	–
Bond and other debt security mutual funds	479,855	294,710	185,145	–
Commodity mutual funds	4,631	4,631	–	–
Equity securities	1,083,000	1,083,000	–	–
Equity funds	605,553	490,473	115,080	–
Guaranteed investment contract	17,218	–	17,218	–
Investments at fair value	4,175,064	$ 3,246,629	$ 928,435	$ –
Investments not at fair value	1,231,758			
Total investments	$ 5,406,822			
Collateral proceeds received under securities lending program	$ 19,165		$ 19,165	
Liabilities				
Obligations under swap agreements (see Note 7)	$ (47,908)		$ (47,908)	
Obligations to return collateral under securities lending program	$ (19,440)		$ (19,440)	

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4. Fair Value Measurements (continued)

The carrying values of cash and cash equivalents, accounts receivable and payable, accrued expenses, and short-term borrowings are reasonable estimates of their fair values due to the short-term nature of these financial instruments.

Investments not at fair value include hedge funds and private equity limited partnerships (alternative investments). The fair values of the alternative investments that do not have readily determinable fair values are determined by the general partner or fund manager taking into consideration, among other things, the cost of the securities or other investments, prices of recent significant transfers of like assets, and subsequent developments concerning the companies or other assets to which the alternative investments relate. Based on the inputs in determining the estimated fair value of these investments, these assets would be considered Level 3.

The valuation for the estimated fair value of long-term debt is completed by a third-party service and takes into account a number of factors including, but not limited to, any one or more of the following: (i) general interest rate and market conditions; (ii) macroeconomic and/or deal-specific credit fundamentals; (iii) valuations of other financial instruments that may be comparable in terms of rating, structure, maturity, and/or covenant protection; (iv) investor opinions about the respective deal parties; (v) size of the transaction; (vi) cash flow projections, which in turn are based on assumptions about certain parameters that include, but are not limited to, default, recovery, prepayment, and reinvestment rates; (vii) administrator reports, asset manager estimates, broker quotations, and/or trustee reports, and (viii) comparable trades, where observable. Based on the inputs in determining the estimated fair value of debt, this liability would be considered Level 2. The estimated fair value of long-term debt based on quoted market prices for the same or similar issues was $1,632,090 and $1,573,401 at December 31, 2014 and 2013, respectively, which included consideration of third-party credit enhancements, of which there was no effect.

5. Interest in Health Care and Related Entities

During 2000, in connection with the acquisition of a medical center, the System acquired an interest in the net assets of the Masonic Family Health Foundation (the Foundation), an independent organization, under the terms of an asset purchase agreement (the Agreement). The use of substantially all of the Foundation's net assets is designated to support the operations and/or capital needs of one of the System's medical facilities. Additionally, 90% of the Foundation's investment yield, net of expenses, on substantially all of the Foundation's investments is designated for the support of one of the System's medical facilities. The Foundation must pay the System, annually, 90% of the investment yield or an agreed-upon percentage of the beginning of the year net assets.

The interest in the net assets of this organization amounted to $88,205 and $91,400 as of December 31, 2014 and 2013, respectively, which is reflected in interest in health care and related entities in the consolidated balance sheets. The System's interest in the investment yield is reflected in the consolidated statements of operations and changes in net assets and amounted to $3,755 and $13,348 for the years ended December 31, 2014 and 2013, respectively. Cash distributions received by the System from the Foundation under terms of the Agreement amounted to $4,720 and $4,531 during the years ended December 31, 2014 and 2013, respectively. In addition to the amounts distributed under the Agreement, the Foundation contributed $408 and $931 to the System for program support of one of its medical facilities during the years ended December 31, 2014 and 2013, respectively.

The System has a 50% membership and governance interest in Advocate Health Partners (d/b/a Advocate Physician Partners) (APP), which has been accounted for on an equity basis. The System's carrying value in this interest was $0 at December 31, 2014 and 2013. Financial information relating to this interest as of and for the years ended December 31, 2014 and 2013, is as follows:

	2014	2013
Assets	**$ 150,049**	$ 144,491
Liabilities	**151,294**	145,086
Revenues in excess of expenses	–	–

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5. Interest in Health Care and Related Entities (continued)

The System contracts with APP for certain operational and administrative services. Total expenses incurred for these services were $27,583 and $25,291 in 2014 and 2013, respectively, which is included in purchased services and operating supplies and other in the consolidated statements of operations and changes in net assets. At December 31, 2014 and 2013, the System had an accrued liability to APP for those services for $1,293 and $1,226, respectively, which is included in accrued expenses in the consolidated balance sheets.

APP purchased claims processing and certain management services from the System in the amounts of $7,645 and $8,810 in 2014 and 2013, respectively, which is included in other revenue in the consolidated statements of operations and changes in net assets. Under terms of an agreement with the System, APP reimburses the System for salaries, benefits, and other expenses that are incurred by the System on APP's behalf. The amount billed for these services in 2014 and 2013 was $25,372 and $23,018, respectively, which is included in other revenue in the consolidated statements of operations and changes in net assets. The System had a receivable from APP at December 31, 2014 and 2013, for claims processing and management services of $2,825 and $3,326, respectively, which is included in prepaid expenses, inventories, and other current assets in the consolidated balance sheets.

6. Long-Term Debt

Long-term debt, net of unamortized original issue discount or premium, consisted of the following at December 31:

	2014	2013
Revenue bonds and revenue refunding bonds, Illinois Finance Authority Series:		
1993C, 6.00%, principal payable in varying annual installments through April 2018	**$ 17,259**	$ 19,857
2003A (weighted-average rate of 2.24% and 4.38% during 2014 and 2013, respectively), principal payable in varying annual installments through November 2022; interest based on prevailing market conditions at time of remarketing	**19,680**	21,930
2003C (weighted-average rate of 0.18% and 0.22% during 2014 and 2013, respectively), principal payable in varying annual installments through November 2022; interest based on prevailing market conditions at time of remarketing	**18,980**	21,225
2007A Sherman, 5.50%, principal payable in varying annual installments through August 2037	**–**	176,970
2008A (weighted-average rate of 5.00% and 4.76% during 2014 and 2013, respectively), principal payable in varying annual installments through November 2030; interest based on prevailing market conditions at time of remarketing	**137,711**	141,306
2008C (weighted-average rate of 0.20% and 0.37% during 2014 and 2013, respectively), principal payable in varying annual installments through November 2038; interest based on prevailing market conditions at time of remarketing	**343,270**	343,270
2008D, 5.00% to 5.50%, principal payable in varying annual installments through November 2038	**18,433**	156,125
2010A, 5.50%, principal payable in varying annual installments through April 2044	**37,267**	37,277
2010B, 5.38%, principal payable in varying annual installments through April 2044	**52,199**	52,192
2010C, 5.38%, principal payable in varying annual installments through April 2044	**25,539**	25,536

6. Long-Term Debt (continued)

	2014	2013
Revenue bonds and revenue refunding bonds, Illinois Finance Authority Series (continued):		
2010D, 4.00% to 5.25%, principal payable in varying annual installments through April 2038	**$ 101,412**	$ 110,289
2011A, 3.00% to 5.00%, principal payable in varying annual installments through April 2041	**38,058**	38,511
2011B (weighted-average rate of 0.17% and 0.21% during 2014 and 2013, respectively), principal payable in varying annual installments through April 2051, subject to a put provision that provides for a cumulative seven-month notice and remarketing period; interest tied to a market index plus a spread	**70,000**	70,000
2011C (weighted-average rate of 0.81% and 0.83% during 2014 and 2013, respectively), principal payable in varying annual installments through April 2049, subject to a put provision at the end of the initial seven-year period; interest tied to a market index plus a spread	**50,000**	50,000
2011D (weighted-average rate of 0.91% and 0.93% during 2014 and 2013, respectively), principal payable in varying annual installments through April 2049, subject to a put provision at the end of the initial 10-year period; interest tied to a market index plus a spread	**50,000**	50,000
2012, 4.00% to 5.00%, principal payable in varying annual installments through June 2047	**149,712**	149,852
2013A, 3.00% to 5.00%, principal payable in varying annual installments through June 2031	**101,312**	102,946
2014, 4.00% to 5.00%, principal payable in varying annual installments through August 2038	**341,479**	–
Capital lease obligations	**30,180**	30,711
Other	**6,561**	7,052
	1,609,052	1,605,049
Less current portion of long-term debt	**20,042**	17,810
Less long-term debt subject to short-term remarketing arrangements	**130,635**	135,130
	$ 1,458,375	$ 1,452,109

Maturities of long-term debt, capital leases, and sinking fund requirements, assuming remarketing of the variable rate demand revenue refunding bonds, for the five years ending December 31, 2019, are as follows: 2015 – $20,042; 2016 – $19,717; 2017 – $20,929; 2018 – $22,258; and 2019 – $30,310.

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6. Long-Term Debt (continued)

The System's outstanding bonds are secured by obligations issued under the Amended and Restated Master Trust Indenture dated as of September 1, 2011, with Advocate Health Care Network, Advocate Health and Hospitals Corporation, Advocate Condell, and Advocate North Side (the Obligated Group or Restricted Affiliates) and U.S. Bank National Association, as master trustee (the System Master Indenture). Under the terms of the bond indentures and other arrangements, various amounts are to be on deposit with trustees, and certain specified payments are required for bond redemption and interest payments. The System Master Indenture and other debt agreements, including a bank credit agreement, also place restrictions on the System and require the System to maintain certain financial ratios.

Prior to the issuance of the Series 2014 Bonds, Sherman and Sherman West Court were members of an obligated group (Sherman Obligated Group) created pursuant to a master trust indenture dated as of August 1, 1991, as supplemented and amended (Sherman Master Indenture) with The Bank of New York Mellon Trust Company, N.A., as master trustee. In connection with the issuance of the Series 2014 Bonds, Sherman became a member of the Obligated Group under the System Master Indenture and the Sherman Master Indenture was discharged.

The System's unsecured variable rate revenue bonds, Series 2003A of $19,680, Series 2003C of $18,980, Series 2008C-3B of $21,975, and Series 2011B of $70,000, while subject to a long-term amortization period, may be put to the System at the option of the bondholders in connection with certain remarketing dates. To the extent that bondholders may, under the terms of the debt, put their bonds within a maximum of 12 months after December 31, 2014, the principal amount of such bonds has been classified as a current obligation in the accompanying consolidated balance sheets. Management believes the likelihood of a material amount of bonds being put to the System is remote. However, to address this possibility, the System has taken steps to provide various sources of liquidity, including assessing alternate sources of financing, including lines of credit and/or unrestricted assets as a source of self-liquidity.

The System has standby bond purchase agreements with banks to provide liquidity support for the Series 2008C Bonds. In the event of a failed remarketing of a Series 2008C Bond upon its tender by an existing holder and subject to compliance with the terms of the standby bond purchase agreement, the standby bank would provide the funds for the purchase of such tendered bonds, and the System would be obligated to repay the bank for the funds it provided for such bond purchase (if such bond is not subsequently remarketed), with the first installment of such repayment commencing on the date one year and one day after the bank purchases the bond. As

6. Long-Term Debt (continued)

of December 31, 2014 and 2013, there were no bank-purchased bonds outstanding. The agreements expire as follows: $129,456 in August 2016; $145,919 in August 2017; and $49,829 in August 2019.

On July 5, 2013, Sherman retired $105,700 of the Sherman Bonds (Series 1997 bonds).

On August 8, 2013, the Illinois Finance Authority, for the benefit of the System, issued its Revenue Bonds, Series 2013A, in the amount of $96,905. The proceeds of the Series 2013A Bonds were used, together with other funds available to the System, to finance, refinance, or reimburse the System for a portion of the costs related to the acquisition, construction, renovation, and equipping of certain capital projects and to pay certain costs of issuing the Series 2013A Bonds.

In 2013, the Series 2008A-1 Bonds and Series 2008A-2 Bonds, which currently bear interest at a fixed interest rate set for a specified period, were remarketed at a premium for an approximate seven-year period, and a portion of the outstanding par was redeemed in the amount of $9,095 and $7,735, respectively.

On December 18, 2014, the Illinois Finance Authority, for the benefit of the System, issued its Revenue Bonds, Series 2014, in the amount of $304,770. The proceeds of the Series 2014 Bonds were used to advance refund the Series 2007A Sherman Bonds and a portion of the Series 2008D Bonds, and to pay certain costs of issuing the Series 2014 Bonds.

The System maintains an interest rate swap program on certain of its variable rate debt as described in Note 7.

Interest paid, net of capitalized interest, amounted to $62,659 and $56,038 in 2014 and 2013, respectively. The System capitalized interest of $7,513 and $5,065 in 2014 and 2013, respectively.

At December 31, 2014, the System had lines of credit with banks aggregating to $250,000. These lines of credit provide for various interest rates and payment terms and expire as follows: $25,000 in February 2015, $75,000 in March 2015, $50,000 in November 2016 and $100,000 in December 2016. These lines of credit may be used to redeem bonded indebtedness, to pay costs related to such redemptions, for capital expenditures, or for general working capital purposes. At December 31, 2014, no amounts were outstanding on these lines of credit. In February 2015, the $25,000 line of credit was extended to February 2016 and the $75,000 line of credit was extended to March 2018 and increased to $100,000.

7. Derivatives

The System has interest rate-related derivative instruments to manage exposure of its variable rate debt instruments and does not enter into derivative instruments for any purpose other than risk management. By using derivative financial instruments to manage the risk of changes in interest rates, the System exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes the System, which creates credit risk for the System. When the fair value of a derivative contract is negative, the System owes the counterparty, and therefore, it does not possess credit risk. The System minimizes the credit risk in derivative instruments by entering into transactions that may require the counterparty to post collateral for the benefit of the System based on the credit rating of the counterparty and the fair value of the derivative contract. Market risk is the adverse effect on the value of a financial instrument that results from a change in interest rates. The market risk associated with interest rate changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken. The System also mitigates risk through periodic reviews of its derivative positions in the context of its total blended cost of capital.

At December 31, 2014, the System maintains an interest rate swap program on its Series 2008C variable rate demand revenue bonds. These bonds expose the System to variability in interest payments due to changes in interest rates. The System believes that it is prudent to limit the variability of its interest payments. To meet this objective and to take advantage of low interest rates, the System entered into various interest rate swap agreements to manage fluctuations in cash flows resulting from interest rate risk. These swaps convert the variable rate cash flow exposure on the variable rate demand revenue bonds to synthetically fixed cash flows. The notional amount under each interest rate swap agreement is reduced over the term of the respective agreement to correspond with reductions in the principal outstanding under various bond series. The following is a summary of the outstanding positions under these interest rate swap agreements at December 31, 2014 and 2013:

Bond Series	Notional Amount	Maturity Date	Rate Received	Rate Paid
2008C-1	$ 129,900	November 1, 2038	61.7% of LIBOR + 26 bps	3.60%
2008C-2	108,425	November 1, 2038	61.7% of LIBOR + 26 bps	3.60
2008C-3	88,000	November 1, 2038	61.7% of LIBOR + 26 bps	3.60

7. Derivatives (continued)

The swaps are not designated as hedging instruments, and therefore, hedge accounting has not been applied. As such, unrealized changes in fair value of the swaps are included as a component of nonoperating income (loss) in the consolidated statements of operations and changes in net assets as changes in the fair value of interest rate swaps. The net cash settlement payments, representing the realized changes in fair value of the swaps, are included as interest expense in the consolidated statements of operations and changes in net assets.

The fair value of derivative instruments is as follows:

	December 31	
	2014	**2013**
Consolidated balance sheet location		
Obligations under swap agreements	**$ (86,246)**	$ (47,908)
Collateral posted under swap agreements	**–**	–
Obligations under swap agreements, net	**$ (86,246)**	$ (47,908)

Amounts recorded in the consolidated statements of operations and changes in net assets for the derivatives are as follows:

	Year Ended December 31	
	2014	**2013**
Consolidated statement of operations and changes in net assets location		
Net cash payments on interest rate swap agreements (interest expense)	**$ 10,734**	$ 10,518
Change in the fair value of interest rate swaps (nonoperating)	**$ (38,338)**	$ 41,236

7. Derivatives (continued)

The aggregate fair value of all swap instruments with credit risk-related contingent features that are in a liability position was $86,246 and $47,908 at December 31, 2014 and 2013, respectively, for which the System has posted collateral of $0 at December 31, 2014 and 2013. The swap instruments contain provisions that require the System's debt to maintain an investment grade credit rating from certain major credit rating agencies. If the System's debt were to fall below investment grade on the valuation date, it would be in violation of these provisions and the counterparty to the derivative instruments could request immediate payment or demand immediate and ongoing full overnight collateralization on derivative instruments in net liability positions. If the credit risk-related contingent features underlying these swap agreements were triggered on December 31, 2014, the System would be required to post $86,246 in collateral with the counterparties.

8. Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at December 31:

	2014	2013
Purchases of property and equipment	**$ 33,118**	$ 28,215
Medical education and other health care programs	**85,873**	83,120
	$ 118,991	$ 111,335

Permanently restricted net assets generate investment income, which is used to benefit the following purposes at December 31:

	2014	2013
Purchases of property and equipment	**$ 1,000**	$ 1,000
Medical education and other health care programs	**47,019**	46,566
	$ 48,019	$ 47,566

9. Retirement Plans

The System maintains defined benefit pension plans, the Advocate Health Care Network Pension Plan (Advocate Plan) and Condell Health Network Retirement Plan (Condell Plan) (collectively, the Plans), which cover a majority of its employees (associates). The Condell Plan was frozen effective January 1, 2008, to new participants, and participants ceased to accrue additional pension benefits. The System may elect to terminate the Condell Plan in the future subject to the provisions set forth in Employee Retirement Income Security Act of 1974.

A summary of changes in the plan assets, projected benefit obligation, and the resulting funded status of the Advocate Plan is as follows:

	2014	2013
Change in plan assets:		
Plan assets at fair value at beginning of year	**$ 800,469**	$ 727,394
Actual return on plan assets	**50,958**	77,242
Employer contributions	**30,960**	31,680
Benefits paid	**(46,565)**	(35,847)
Plan assets at fair value at end of year	**$ 835,822**	$ 800,469
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	**$ 774,688**	$ 761,362
Service cost	**45,224**	43,989
Interest cost	**37,484**	30,183
Actuarial loss (gain)	**54,080**	(24,999)
Benefits paid	**(46,565)**	(35,847)
Projected benefit obligation at end of year	**$ 864,911**	$ 774,688
Plan assets (less) greater than projected benefit obligation	**$ (29,089)**	$ 25,781
Accumulated benefit obligation at end of year	**$ 780,706**	$ 702,689

9. Retirement Plans (continued)

A summary of changes in the plan assets, projected benefit obligation, and the resulting funded status of the Condell Plan is as follows:

	2014	2013
Change in plan assets:		
Plan assets at fair value at beginning of year	**$ 39,668**	$ 40,720
Actual return on plan assets	**2,461**	3,909
Employer contributions	**25,306**	270
Benefits paid	**(3,941)**	(5,231)
Plan assets at fair value at end of year	**$ 63,494**	$ 39,668
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	**$ 63,405**	$ 73,469
Interest cost	**2,862**	2,726
Actuarial loss (gain)	**9,520**	(7,559)
Benefits paid	**(3,941)**	(5,231)
Projected benefit obligation at end of year	**$ 71,846**	$ 63,405
Plan assets less than projected benefit obligation	**$ (8,352)**	$ (23,737)
Accumulated benefit obligation at end of year	**$ 71,846**	$ 63,405

9. Retirement Plans (continued)

The Condell Plan paid lump sums totaling $3,130 and $3,864 in 2014 and 2013, respectively. These amounts are greater than the sum of the plan's service cost and interest cost for 2014 and 2013. As a result, the System recognized a settlement charge in the amount of $903 and $771 in 2014 and 2013, respectively.

	2014	2013
Net Plans' pension expense consists of the following for the years ended December 31:		
Service cost	**$ 45,224**	$ 43,989
Interest cost	**40,346**	32,909
Expected return on plan assets	**(58,131)**	(55,734)
Amortization of:		
Prior service credit	**(4,823)**	(4,823)
Recognized actuarial loss	**10,284**	17,412
Settlement/curtailment	**903**	771
Net Plans' pension expense	**$ 33,803**	$ 34,524

The amount of actuarial loss and prior service cost (credit) included in other changes in unrestricted net assets expected to be recognized in net periodic pension cost during the fiscal year ending December 31, 2015, is $14,531 and $(4,823), respectively.

For the defined benefit plans previously described, changes in plans assets and benefit obligations recognized in unrestricted net assets during 2014 and 2013 include an actuarial loss (gain) of $57,126 and $(76,159), respectively, and net prior service credit of $4,823 in both years.

Included in unrestricted net assets at December 31 are the following amounts that have not yet been recognized in net pension expense:

	2014	2013
Unrecognized prior credit	**$ (18,594)**	$ (23,417)
Unrecognized actuarial loss	**218,492**	161,366
	$ 199,898	$ 137,949

9. Retirement Plans (continued)

Employer contributions were paid from employer assets. No plan assets are expected to be returned to the employer. All benefits paid under the Plans were paid from the Plans' assets. The System anticipates making $32,880 in contributions to the Plans' assets during 2015. Expected associate benefit payments are 2015 – $54,290; 2016 – $62,800; 2017 – $63,040; 2018 – $67,850; 2019 – $72,470; and 2020 through 2024 – $387,900.

The Plans' asset allocation and investment strategies are designed to earn returns on plan assets consistent with a reasonable and prudent level of risk. Investments are diversified across classes, economic sectors, and manager style to minimize the risk of loss. The System uses investment managers specializing in each asset category and, where appropriate, provides the investment manager with specific guidelines that include allowable and/or prohibited investment types. The System regularly monitors manager performance and compliance with investment guidelines.

The System's target and actual pension asset allocations for the Advocate Plan are as follows:

	2014		2013	
Asset Category	**Target**	**Actual**	**Target**	**Actual**
Domestic and international equity securities	**35.0%**	**37.8%**	42.5%	47.5%
Alternative investments	**45.0**	**40.6**	27.5	25.9
Cash and fixed income securities	**20.0**	**21.6**	30.0	26.6
	100.0%	**100.0%**	100.0%	100.0%

9. Retirement Plans (continued)

Fair value methodologies for Level 1 and Level 2 are consistent with the inputs described in Note 4. Real estate commingled funds for which an active market exists are included in Level 2. Fair value for Level 3 represents the Plans' ownership interests in the NAVs of the respective private equity partnerships, hedge funds, and real estate commingled funds for which active markets do not exist. The System opted to use the NAV per share, or its equivalent, as a practical expedient for fair value of the Plans' interest in hedge funds and private equity funds. The alternative investment assets consist of marketable securities as well as securities and other assets that do not have readily determinable fair values. The fair values of the alternative investments that do not have readily determinable fair values are determined by the general partner or fund manager taking into consideration, among other things, the cost of the securities or other investments, prices of recent significant transfers of like assets, and subsequent developments concerning the companies or other assets to which the alternative investments relate. There is inherent uncertainty in such valuations, and the estimated fair values may differ from the values that would have been used had a ready market for these investments existed. Private equity partnerships and real estate commingled funds typically have finite lives ranging from five to ten years, at the end of which all invested capital is returned. For hedge funds, the typical lockup period is one year, after which invested capital can be redeemed on a quarterly basis with at least 30 days' but no more than 90 days' notice. The Plans' investment assets are exposed to the same kinds and levels of risk as described in Note 4.

At December 31, 2014 and 2013, the System, on behalf of the Plans, has commitments to fund private equity investments an additional $80,276 and $56,196, respectively. The unfunded commitments at December 31, 2014, are expected to be funded over the next six years.

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9. Retirement Plans (continued)

The following are the Plans' financial instruments at December 31, 2014, measured at fair value on a recurring basis by the valuation hierarchy defined in Note 4:

	Fair Value Measurements at Reporting Date Using			
Description	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash and cash equivalents	$ 41,944	$ 10,342	$ 31,602	$ –
Equity securities:				
Small cap	1,315	–	1,315	–
Large cap	50,197	41,880	8,317	–
Value equity	35,126	35,126	–	–
Growth equity	37,829	37,829	–	–
U.S. equity	20,494	20,494	–	–
International equity	118,285	30,488	87,797	–
International equity – emerging	75,748	–	75,748	–
Fixed income securities:				
Core plus bonds	77,519	26,603	50,916	–
Long duration bonds	100,147	–	100,147	–
Emerging market bonds	2,170	–	2,170	–
Alternative investments:				
Hedge funds	184,974	–	–	184,974
Private equity funds	80,371	–	–	80,371
Real estate	73,197	–	59,319	13,878
Total	$ 899,316	$ 202,762	$ 417,331	$ 279,223

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9. Retirement Plans (continued)

The table below sets forth a summary of changes in the fair value of the Plans' Level 3 assets for 2014:

	Hedge Funds	Private Equity	Real Estate
Fair value at January 1, 2014	$ 69,639	$ 67,541	$ 17,513
Net purchases and sales	110,070	6,808	(2,989)
Realized gains and losses	–	5,140	3,178
Unrealized gains and losses	5,265	882	(3,824)
Fair value at December 31, 2014	$ 184,974	$ 80,371	$ 13,878

The following are the Plans' financial instruments at December 31, 2013, measured at fair value on a recurring basis by the valuation hierarchy defined in Note 4:

	Fair Value Measurements at Reporting Date Using			
Description	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash and cash equivalents	$ 10,133	$ 8,119	$ 2,014	$ –
Equity securities:				
Small cap	2,442	–	2,442	–
Large cap	66,677	57,074	9,603	–
Value equity	43,439	43,261	178	–
Growth equity	58,214	58,214	–	–
U.S. equity	14,655	13,683	972	–
International equity	154,819	53,793	101,026	–
International equity – emerging	64,609	61,005	3,604	–
Fixed income securities:				
Core plus bonds	157,704	144,985	12,719	–
Long duration bonds	57,534	–	57,534	–
High-yield bonds	1,823	–	1,823	–
Emerging market bonds	990	–	990	–
Alternative investments:				
Hedge funds	69,639	–	–	69,639
Private equity funds	67,541	–	–	67,541
Real estate	69,918	–	52,405	17,513
Total	$ 840,137	$ 440,134	$ 245,310	$ 154,693

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9. Retirement Plans (continued)

The table below sets forth a summary of changes in the fair value of the Plans' Level 3 assets for 2013:

	Hedge Funds	Private Equity	Real Estate
Fair value at January 1, 2013	$ 50,201	$ 68,868	$ 17,207
Net purchases and sales	12,604	(9,558)	(8)
Realized gains and losses	–	6,213	891
Unrealized gains and losses	6,834	2,018	(577)
Fair value at December 31, 2013	$ 69,639	$ 67,541	$ 17,513

Assumptions used to determine benefit obligations at the measurement date are as follows:

	2014	2013
Discount rate – the Plans'	**3.90%**	4.70%
Assumed rate of return on assets – Advocate Plan	**7.25**	7.25
Assumed rate of return on assets – Condell Plan	**5.00**	6.75
Weighted-average rate of increase in future compensation (age-based table) – Advocate Plan	**4.03**	4.15

Assumptions used to determine net pension expense for the fiscal years are as follows:

	2014	2013
Discount rate – the Plans'	**4.70%**	3.85%
Assumed rate of return on assets – Advocate Plan	**7.25**	7.50
Assumed rate of return on assets – Condell Plan	**6.75**	6.75
Weighted-average rate of increase in future compensation (age-based table) – Advocate Plan	**4.15**	4.15

The assumed rate of return on plan assets is based on historical and projected rates of return for asset classes in which the portfolio is invested. The expected return for each asset class was then weighted based on the target asset allocation to develop the overall expected rate of return on assets for the portfolio.

In 2014, the mortality assumption for the Plans' was updated to the RP-2014 mortality tables.

9. Retirement Plans (continued)

In addition to the defined benefit pension plans, the System sponsors various defined contribution plans. The System contributed $39,708 and $40,641 in 2014 and 2013, respectively, which are included in salaries, wages, and employee benefits expense in the consolidated statements of operations and changes in net assets.

10. General and Professional Liability Risks

The System is self-insured for substantially all general and professional liability risks. The self-insurance programs combine various levels of self-insured retention with excess commercial insurance coverage. In addition, various umbrella insurance policies have been purchased to provide coverage in excess of the self-insured limits. Revocable trust funds, administered by a trustee and a captive insurance company, have been established for the self-insurance programs. Actuarial consultants have been retained to determine the estimated cost of claims, as well as to determine the amount to fund into the trust and captive insurance company.

The estimated cost of claims is actuarially determined based on past experience, as well as other considerations, including the nature of each claim or incident and relevant trend factors. Accrued insurance liabilities and contributions to the trust were determined using a discount rate of 3.25% and 3.50% for 2014 and 2013, respectively. Accrued insurance liabilities for the System's captive insurance company were determined using a discount rate of 3.00% for 2014 and 2013. Total accrued insurance liabilities would have been $48,705 and $60,048 greater at December 31, 2014 and 2013, respectively, had these liabilities not been discounted.

The System is a defendant in certain litigation related to professional and general liability risks. Although the outcome of the litigation cannot be determined with certainty, management believes, after consultation with legal counsel, that the ultimate resolution of this litigation will not have any material adverse effect on the System's operations or financial condition.

11. Legal, Regulatory, and Other Contingencies and Commitments

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. During the last few years, as a result of nationwide investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, exclusion from the Medicare and Medicaid programs, and revocation of federal or state tax-exempt status. Moreover, the System expects that the level of review and audit to which it and other health care providers are subject will increase.

Various federal and state agencies have initiated investigations, which are in various stages of discovery, relating to reimbursement, billing practices, and other matters of the System. There can be no assurance that regulatory authorities will not challenge the System's compliance with these laws and regulations, and it is not possible to determine the impact, if any, such claims or penalties would have on the System. As a result, there is a reasonable possibility that recorded amounts will change by a material amount in the near term. To foster compliance with applicable laws and regulations, the System maintains a compliance program designed to detect and correct potential violations of laws and regulations related to its programs.

In 2013 four desktop computers were stolen during a burglary at one of the System's administrative support locations. The computers did not contain patient medical records but did contain certain patient information, including names, addresses, Social Security numbers, and limited billing and clinical information. Affected patients were notified and offered free credit monitoring and identify theft protection. This matter is under investigation by various government agencies, and the System has received notice that it has been named in certain lawsuits regarding this matter. The System continues to monitor and investigate these matters. Although the outcome of these investigations and litigation cannot be determined with certainty, management is not in possession of any information to suggest that the costs relating to the resolution of this incident will have a material adverse effect on the System's operations or financial condition.

11. Legal, Regulatory, and Other Contingencies and Commitments (continued)

On March 17, 2014, the System and certain of its subsidiaries were named as defendants to litigation surrounding the church plan status of the Advocate Plan. On December 31, 2014, the United States District Court for the Northern District of Illinois issued its Decision and Order denying the Defendants' Motion to Dismiss. The System filed a Motion for Interlocutory Appeal, which was granted on January 13, 2015, and has subsequently filed its Petition for Appeal with the Seventh Circuit on January 23, 2015. The appeal remains pending. Regardless of the outcome of such appeal, the System does not believe that this matter will have a material adverse effect on the System's financial position or results of operations.

The System is committed to constructing additions and renovations to its medical facilities and implementing information technology projects, which are expected to be completed in future years. The estimated cost of these commitments is $712,819, of which $505,743 has been incurred as of December 31, 2014.

Future minimum rental commitments at December 31, 2014, for all noncancelable leases with original terms of more than one year are $44,872, $36,057, $32,445, $25,228, and $20,460 for the years ending December 31, 2015 through 2019, respectively, and $93,604 thereafter.

Rent expense, which is included in other expenses, amounted to $77,396 and $69,340 in 2014 and 2013, respectively.

12. Income Taxes and Tax Status

Certain subsidiaries of the System are for-profit corporations. Significant components of the for-profit subsidiaries' deferred tax (liabilities) assets are as follows at December 31:

	2014	2013
Deferred tax assets		
Allowance for uncollectible accounts	**$ 5,278**	$ 6,654
Other accrued expenses	**839**	39
Reserves for incurred but not reported claims	**–**	76
Accrued insurance	**3,985**	6,028
Accrued compensation and employee benefits	**2,360**	2,862
Third-party settlements	**307**	848
Deferred gain (loss) on acquisition	**1,696**	–
Prepaid and other assets	**–**	380
Net operating losses	**15,942**	27,602
Total deferred tax assets	**30,407**	44,489
Less valuation allowance	**15,203**	26,074
Net deferred tax assets, included in deferred costs and intangible assets and prepaid expenses, inventories, and other assets	**15,204**	18,415
Deferred tax liabilities		
Property and equipment	**(3,471)**	(6,316)
Other accrued expenses	**(8,381)**	(7,208)
Deferred gain on acquisition	**–**	(5,736)
Accrued insurance	**(17)**	–
Total deferred tax liabilities, included in other noncurrent liabilities	**(11,869)**	(19,260)
Net deferred tax asset (liability)	**$ 3,335**	$ (845)

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12. Income Taxes and Tax Status (continued)

As of December 31, 2014, the for-profit corporations had $32,585 of federal and $70,545 of state net operating loss carryforwards with unutilized amounts expiring between 2018 and 2033.

During 2014 the valuation allowance decreased by $10,871. This change is due to the expiration of net operating losses that became worthless in the merger of a for-profit entity into its tax exempt parent. The valuation allowance as of the end of 2014 primarily consists of net operating losses that are unlikely to be realized.

Significant components of the for-profit subsidiaries' provision (credit) for income taxes are as follows for the years ended December 31:

	2014	2013
Current:		
Federal	**$ 6,413**	$ 784
State	**1,958**	240
Deferred	**(4,180)**	6,242
	$ 4,191	$ 7,266

Federal and state income taxes paid relating to the System's for-profit corporations were $6,885 and $2,392 in 2014 and 2013, respectively.

The System and all other controlled or wholly owned subsidiaries are exempt from income taxes under Internal Revenue Code Section 501(c)(3). They do, however, operate certain programs that generate unrelated business income. The current tax provision (credit) recorded on this income was $2,361 and $(3,030) for the years ended December 31, 2014 and 2013, respectively.

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13. Sherman Affiliation

On June 1, 2013, the System and Sherman completed their affiliation. The affiliation was accounted for under the purchase accounting guidance, and a contribution of $151,663 was recorded in the consolidated statement of operations and changes in net assets for the year ended December 31, 2013. This contribution reflected the fair value of the unrestricted net assets of Sherman on the date of the affiliation. The total increase in net assets attributable to the affiliation, which included the fair value of temporarily and permanently restricted net assets contributed, was $152,645. No goodwill was recorded as a result of this transaction. In valuing these assets and liabilities, fair values were based on, but not limited to, professional appraisals, discounted cash flows, replacement costs, and actuarially determined values.

The fair value of assets and liabilities of Sherman contributed at June 1, 2013, consisted of the following:

Cash and cash equivalents	$ 12,280
Investments	123,355
Other current assets	65,949
Property and equipment	318,398
Other long-term assets	29,601
Total assets	549,583
Current liabilities, excluding the current portion of long-term debt	69,412
Long-term debt	284,217
Other long-term liabilities	43,309
Total liabilities	396,938
Increase in net assets	$ 152,645

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13. Sherman Affiliation (continued)

Total operating revenue and operating income from the date of affiliation for Sherman of $170,246 and $5,033, respectively, were included in the 2013 consolidated statements of operations and changes in net assets.

Following are the unaudited pro forma results for the year ended December 31, 2013. These results reflect the addition of Sherman's unaudited results for the period January 1 to May 31, 2013, to the System's results for the years ended December 31, 2013.

	December 31, 2013
Total operating revenue	$ 5,062,920
Operating income	301,479
Revenues in excess of expenses	771,600

The pro forma information provided is a compilation of results only and should not be construed to accurately reflect what the actual results would have been had the affiliation been consummated on January 1, 2013, and is not intended to project the System's results of operations for any future periods.

14. Affiliation and Merger

On September 11, 2014, the System and NorthShore University Health System entered into a definitive merger and affiliation agreement (the Agreement) to form Advocate NorthShore Health Partners (ANHP), an integrated delivery system to be comprised of sixteen hospitals, a broad network of clinically integrated employed and affiliated physicians, outpatient centers and home health services across northern and central Illinois. The transaction is anticipated to be completed in 2015, subject to the required regulatory approval of the Federal Trade Commission. The System can provide no assurance that the transaction will, or will not, occur.

15. Subsequent Events

The System evaluated events occurring between January 1, 2014 and March 6, 2015, which is the date when the consolidated financial statements were issued.

Supplementary Information

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Report of Independent Auditors on Supplementary Information

The Board of Directors
Advocate Health Care Network

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying details of consolidated balance sheet and details of consolidated statement of operations and changes in net assets and shareholders' equity are presented for the purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Ernst & Young LLP

March 6, 2015

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A member firm of Ernst & Young Global Limited

Advocate Health Care Network and Subsidiaries

Details of Consolidated Balance Sheet
(Dollars in Thousands)

December 31, 2014

	Consolidated	Eliminations	Advocate Health Care Network	Advocate Health and Hospitals Corporation and Subsidiaries	Advocate Network Services, Incorporated and Subsidiaries	Advocate Charitable Foundation	Advocate Insurance SPC	Advocate Sherman Hospital and Subsidiaries
Assets								
Current assets:								
Cash and cash equivalents	$ 272,912	$ –	$ 3,878	$ 192,696	$ 53,069	$ 1	$ 151	$ 23,117
Short-term investments	19,456	–	–	–	–	19,456	–	–
Assets limited as to use	91,747	–	–	78,257	216	–	13,274	–
Patient accounts receivable, less allowances for uncollectible accounts	633,743	(1,590)	–	565,930	20,165	–	–	49,238
Amounts due from primary third-party payors	16,850	–	–	16,627	–	–	–	223
Intercompany receivables	–	(43,253)	7,175	22,596	9,417	924	433	2,708
Prepaid expenses, inventories, and other current assets	267,792	–	–	170,232	20,521	44,589	18,100	14,350
Collateral proceeds received under securities lending program	19,768	–	–	19,768	–	–	–	–
Total current assets	1,322,268	(44,843)	11,053	1,066,106	103,388	64,970	31,958	89,636
Assets limited as to use:								
Internally and externally designated investments limited as to use	5,169,099	–	330,277	4,426,935	77,760	123,924	102,426	107,777
Investments under securities lending program	19,145	–	–	19,145	–	–	–	–
Investment in subsidiaries	–	(184,196)	184,196	–	–	–	–	–
Intercompany receivables	–	(261,169)	85,280	175,889	–	–	–	–
Prepaid pension expense and other noncurrent assets	116,535	–	–	108,866	498	4,521	–	2,650
Interest in health care and related entities	150,327	–	–	124,407	23,055	–	–	2,865
Reinsurance receivable	161,545	–	–	8,231	–	–	141,701	11,613
Deferred costs and intangible assets, less allowances for amortization	44,236	(5,297)	–	39,215	8,913	–	–	1,405
	5,660,887	(450,662)	599,753	4,902,688	110,226	128,445	244,127	126,310
Property and equipment – at cost:								
Land and land improvements	257,699	–	–	209,122	14,915	–	–	33,662
Buildings	2,708,787	–	–	2,405,149	60,157	355	–	243,126
Movable equipment	1,467,513	–	–	1,360,879	58,719	1,450	–	46,465
Construction-in-progress	449,958	–	–	446,637	2,380	–	–	941
	4,883,957	–	–	4,421,787	136,171	1,805	–	324,194
Less allowances for depreciation	2,332,932	–	–	2,213,984	84,534	1,692	–	32,722
	2,551,025	–	–	2,207,803	51,637	113	–	291,472
	$ 9,534,180	$ (495,505)	$ 610,806	$ 8,176,597	$ 265,251	$ 193,528	$ 276,085	$ 507,418

Advocate Health Care Network and Subsidiaries

Details of Consolidated Balance Sheet (continued)
(Dollars in Thousands)

	Consolidated	Eliminations	Advocate Health Care Network	Advocate Health and Hospitals Corporation and Subsidiaries	Advocate Network Services, Incorporated and Subsidiaries	Advocate Charitable Foundation	Advocate Insurance SPC	Advocate Sherman Hospital and Subsidiaries
Liabilities and net assets and shareholders' equity								
Current liabilities:								
Current portion of long-term debt	$ 20,042	$ –	$ –	$ 18,239	$ 1,683	$ –	$ –	$ 120
Current portion of intercompany long-term debt	–	(6,100)	–	–	–	–	–	6,100
Long-term debt subject to short-term remarketing arrangements	130,635	–	–	130,635	–	–	–	–
Accounts payable	335,414	–	–	314,463	8,439	225	44	12,243
Accrued salaries and employee benefits	373,365	–	–	348,801	9,838	1,266	–	13,460
Accrued expenses	130,656	(1,590)	–	111,241	4,290	308	14,050	2,357
Amounts due to primary third-party payors	309,591	–	–	269,258	4,592	–	–	35,741
Current portion of accrued insurance and claims costs	119,587	–	–	80,453	1,580	–	31,283	6,271
Intercompany payables	–	(37,152)	–	13,061	8,742	3,869	518	10,962
Obligations to return collateral under securities lending program	19,768	–	–	19,768	–	–	–	–
Total current liabilities	1,439,058	(44,842)	–	1,305,919	39,164	5,668	45,895	87,254
Noncurrent liabilities:								
Long-term debt, less current portion	1,458,375	–	–	1,453,617	3,753	–	–	1,005
Intercompany payables	–	(261,169)	–	–	–	–	–	261,169
Pension plan liability	37,441	–	–	36,850	591	–	–	–
Accrued insurance and claims cost, less current portion	712,169	–	–	676,371	7,365	–	28,191	242
Accrued losses subject to reinsurance recovery	161,545	–	–	8,231	–	–	141,701	11,613
Obligations under swap agreements, net of collateral posted	86,246	–	–	86,246	–	–	–	–
Other noncurrent liabilities	186,953	–	131	141,445	41,772	2,726	–	879
	2,642,729	(261,169)	131	2,402,760	53,481	2,726	169,892	274,908
Total liabilities	4,081,787	(306,011)	131	3,708,679	92,645	8,394	215,787	362,162
Net assets/shareholders' equity:								
Unrestricted	5,284,721	42,748	610,675	4,466,843	–	19,344	–	145,111
Temporarily restricted	118,991	–	–	1,075	–	117,771	–	145
Permanently restricted	48,019	–	–	–	–	48,019	–	–
Common stock	–	(1)	–	–	1	–	–	–
Additional paid-in capital	–	(177,163)	–	–	177,163	–	–	–
Non-controlling interest	662	–	–	–	662	–	–	–
Retained (deficit) earnings/partnership losses	–	(55,078)	–	–	(5,220)	–	60,298	–
Total net assets/shareholders' equity	5,452,393	(189,494)	610,675	4,467,918	172,606	185,134	60,298	145,256
	$ 9,534,180	$ (495,505)	$ 610,806	$ 8,176,597	$ 265,251	$ 193,528	$ 276,085	$ 507,418

Advocate Health Care Network and Subsidiaries

Details of Consolidated Statement of Operations and Changes in Net Assets and Shareholders' Equity
(Dollars in Thousands)

Year Ended December 31, 2014

	Consolidated	Eliminations	Advocate Health Care Network	Advocate Health and Hospitals Corporation and Subsidiaries	Advocate Network Services, Incorporated and Subsidiaries	Advocate Charitable Foundation	Advocate Insurance SPC	Sherman Health Insurance Co.	Advocate Sherman Hospital and Subsidiaries
Unrestricted revenues, gains, and other support									
Net patient service revenue	$ 4,786,197	$ (18,142)	$ –	$ 4,306,374	$ 191,318	$ –	$ –	$ –	$ 306,647
Provision for uncollectible accounts	(289,597)	–	–	(263,733)	(8,188)	–	–	–	(17,676)
	4,496,600	(18,142)	–	4,042,641	183,130	–	–	–	288,971
Capitation revenue	413,508	–	–	351,683	61,773	–	–	–	52
Other revenue	321,285	(57,762)	–	291,226	50,391	1,668	30,502	–	5,260
	5,231,393	(75,904)	–	4,685,550	295,294	1,668	30,502	–	294,283
Expenses									
Salaries, wages, and employee benefits	2,637,606	–	7	2,379,834	117,888	7,237	–	–	132,640
Purchased services and operating supplies	1,313,401	(36,438)	–	1,116,800	130,243	904	202	6	101,684
Contracted medical services	152,646	(18,141)	–	160,217	10,570	–	–	–	–
Insurance and claims costs	118,037	(20,708)	–	121,669	2,495	15	12,643	–	1,923
Other	382,641	(616)	(2)	346,421	17,107	2,679	(3,491)	12	20,531
Depreciation and amortization	239,651	(1,731)	–	212,507	6,830	55	–	–	21,990
Interest	56,811	(2,976)	–	47,816	175	–	–	–	11,796
	4,900,793	(80,610)	5	4,385,264	285,308	10,890	9,354	18	290,564
Operating income (loss)	330,600	4,706	(5)	300,286	9,986	(9,222)	21,148	(18)	3,719
Nonoperating income (loss)									
Investment income (loss)	136,945	(2,865)	10,356	122,911	5,444	–	(2,233)	12	3,320
Change in fair value of interest rate swaps	(38,338)	–	–	(38,338)	–	–	–	–	–
Loss on refinancing of debt	(45,470)	–	–	(29,954)	–	–	–	–	(15,516)
Other nonoperating items, net	(14,130)	(1,725)	–	(6,290)	(5,138)	(11)	–	–	(966)
Revenues in excess of (less than) expenses	369,607	116	10,351	348,615	10,292	(9,233)	18,915	(6)	(9,443)
Unrestricted net assets									
Net assets released from restrictions and used for capital purchases	10,558	–	–	10,628	–	–	–	–	(70)
Transfers to/from Advocate Health Care Network and subsidiaries	–	120	(1,784)	–	–	9,300	–	(7,636)	–
Postretirement benefit plan adjustments	(64,018)	–	–	(64,018)	–	–	–	–	–
Other	(4)	–	–	–	–	(4)	–	–	–
Increase (decrease) in unrestricted net assets	316,143	236	8,567	295,225	10,292	63	18,915	(7,642)	(9,513)

Advocate Health Care Network and Subsidiaries

Details of Consolidated Statement of Operations and Changes in Net Assets and Shareholders' Equity (continued)
(Dollars in Thousands)

	Consolidated	Eliminations	Advocate Health Care Network	Advocate Health and Hospitals Corporation and Subsidiaries	Advocate Network Services, Incorporated and Subsidiaries	Advocate Charitable Foundation	Advocate Insurance SPC	Sherman Health Insurance Co.	Advocate Sherman Hospital and Subsidiaries
Temporarily restricted net assets									
Contributions for medical education programs, capital purchases, and other purposes	$ 24,388	$ –	$ –	$ –	$ –	$ 24,388	$ –	$ –	$ –
Realized gains on investments	5,325	–	–	16	–	5,309	–	–	–
Unrealized gains on investments	(1,106)	–	–	(9)	–	(1,097)	–	–	–
Transfers to/from Advocate Health Care Network and subsidiaries	–	–	–	–	–	60	–	–	(60)
Net assets released from restriction and used for operations, medical education programs, capital purchases, and other purposes	(20,951)	–	–	(12)	–	(20,939)	–	–	–
Increase (decrease) in temporarily restricted net assets	7,656	–	–	(5)	–	7,721	–	–	(60)
Permanently restricted net assets									
Contributions for medical education programs, capital purchases, and other purposes	453	–	–	–	–	453	–	–	–
Increase in permanently restricted net assets	453	–	–	–	–	453	–	–	–
Increase (decrease) in net assets	324,252	236	8,567	295,220	10,292	8,237	18,915	(7,642)	(9,573)
Change in non-controlling interest	(294)	–	–	–	(294)	–	–	–	–
Net assets/shareholders' equity at beginning of year	5,128,435	(189,730)	602,108	4,172,698	162,608	176,897	41,383	7,642	154,829
Net assets/shareholders' equity at end of year	$ 5,452,393	$ (189,494)	$ 610,675	$ 4,467,918	$ 172,606	$ 185,134	$ 60,298	$ –	$ 145,256

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Advocate Health and Hospitals Corporation and Subsidiaries

Details of Consolidated Balance Sheet
(Dollars in Thousands)

December 31, 2014

	Consolidated	Eliminations	Advocate Health and Hospitals Corporation	Advocate Northside Health System	Advocate Condell Medical Center	Midwest Heart Specialists	EHS Home Health Care Services, Inc. and Subsidiary	Eliminations	EHS Home Health Care Service, Inc.	Advocate Hospice
Assets										
Current assets:										
Cash and cash equivalents	$ 192,696	$ –	$ 148,055	$ 11,984	$ 19,919	$ 3,507	$ 9,231	$ –	$ 6,472	$ 2,759
Assets limited as to use	78,257	–	78,257	–	–	–	–	–	–	–
Patient accounts receivable, less allowances for uncollectible accounts	565,930	–	465,163	52,796	40,746	–	7,225	–	4,259	2,966
Amounts due from primary third-party payors	16,627	–	14,039	1,063	1,525	–	–	–	–	–
Accounts receivable from Advocate Health Care Network and subsidiaries	22,596	–	21,096	483	146	1	870	–	828	42
Intercompany receivables	–	(45,191)	26,699	13,097	5,017	30	348	(242)	514	76
Prepaid expenses, inventories, and other current assets	170,232	–	142,068	19,878	7,965	144	177	–	167	10
Collateral proceeds received under securities lending program	19,768	–	19,768	–	–	–	–	–	–	–
Total current assets	1,066,106	(45,191)	915,145	99,301	75,318	3,682	17,851	(242)	12,240	5,853
Assets limited as to use:										
Internally and externally designated investments limited as to use	4,426,935	–	4,235,026	87,778	77,228	6,695	20,208	–	17,449	2,759
Investments under securities lending program	19,145	–	19,145	–	–	–	–	–	–	–
Accounts receivable from Advocate Health Care Network and subsidiaries	175,889	–	175,889	–	–	–	–	–	–	–
Prepaid pension expense and other noncurrent assets	108,866	–	108,866	–	–	–	–	–	–	–
Interest in health care and related entities	124,407	(15,869)	51,021	89,255	–	–	–	–	–	–
Reinsurance receivable	8,231	–	8,100	–	131	–	–	–	–	–
Deferred costs and intangible assets, less allowances for amortization	39,215	–	39,215	–	–	–	–	–	–	–
	4,902,688	(15,869)	4,637,262	177,033	77,359	6,695	20,208	–	17,449	2,759
Property and equipment – at cost:										
Land and land improvements	209,122	–	112,769	41,430	54,923	–	–	–	–	–
Buildings	2,405,149	–	2,022,620	142,701	239,085	–	743	–	743	–
Movable equipment	1,360,879	–	1,234,419	65,586	56,613	–	4,261	–	4,196	65
Construction-in-progress	446,637	–	330,822	102,216	13,599	–	–	–	–	–
	4,421,787	–	3,700,630	351,933	364,220	–	5,004	–	4,939	65
Less allowances for depreciation	2,213,984	–	2,002,101	118,819	88,489	–	4,575	–	4,531	44
	2,207,803	–	1,698,529	233,114	275,731	–	429	–	408	21
	$ 8,176,597	$ (61,060)	$ 7,250,936	$ 509,448	$ 428,408	$ 10,377	$ 38,488	$ (242)	$ 30,097	$ 8,633

Advocate Health and Hospitals Corporation and Subsidiaries

Details of Consolidated Balance Sheet (continued)
(Dollars in Thousands)

	Consolidated	Eliminations	Advocate Health and Hospitals Corporation	Advocate Northside Health System	Advocate Condell Medical Center	Midwest Heart Specialists	EHS Home Health Care Services, Inc. and Subsidiary	Eliminations	EHS Home Health Care Service, Inc.	Advocate Hospice
Liabilities and net assets										
Current liabilities:										
Current portion of long-term debt	$ 18,239	$ –	$ 17,574	$ –	$ 665	$ –	$ –	$ –	$ –	$ –
Long-term debt subject to short-term remarketing arrangements	130,635	–	130,635	–	–	–	–	–	–	–
Accounts payable	314,463	–	263,764	23,221	20,296	184	6,998	–	5,412	1,586
Accrued salaries and employee benefits	348,801	–	318,128	14,054	11,459	–	5,160	–	4,344	816
Accrued expenses	111,241	–	97,782	10,407	1,554	35	1,463	–	1,345	118
Amounts due to primary third-party payors	269,258	–	191,589	35,209	37,029	–	5,431	–	5,402	29
Current portion of accrued insurance and claims costs	80,453	–	80,453	–	–	–	–	–	–	–
Notes and accounts payable to Advocate Health Care Network and subsidiaries	13,061	–	10,712	885	626	–	838	–	732	106
Intercompany payables	–	(45,191)	18,417	15,084	9,752	1	1,937	(242)	1,522	657
Obligations to return collateral under securities lending program	19,768	–	19,768	–	–	–	–	–	–	–
Total current liabilities	1,305,919	(45,191)	1,148,822	98,860	81,381	220	21,827	(242)	18,757	3,312
Noncurrent liabilities:										
Long-term debt, less current portion	1,453,617	–	1,424,101	–	29,516	–	–	–	–	–
Pension plan liability	36,850	–	28,498	–	8,352	–	–	–	–	–
Accrued insurance and claims cost, less current portion	676,371	–	676,371	–	–	–	–	–	–	–
Accrued losses subject to reinsurance recovery	8,231	–	8,100	–	131	–	–	–	–	–
Obligations under swap agreements, net of collateral posted	86,246	–	86,246	–	–	–	–	–	–	–
Other noncurrent liabilities	141,445	–	137,009	3,658	95	683	–	–	–	–
	2,402,760	–	2,360,325	3,658	38,094	683	–	–	–	–
Total liabilities	3,708,679	(45,191)	3,509,147	102,518	119,475	903	21,827	(242)	18,757	3,312
Net assets:										
Unrestricted	4,466,843	–	3,740,714	406,930	308,933	(6,395)	16,661	–	11,340	5,321
Temporarily restricted	1,075	–	1,075	–	–	–	–	–	–	–
Additional paid-in capital	–	(15,869)	–	–	–	15,869	–	–	–	–
Total net assets	4,467,918	(15,869)	3,741,789	406,930	308,933	9,474	16,661	–	11,340	5,321
	$ 8,176,597	$ (61,060)	$ 7,250,936	$ 509,448	$ 428,408	$ 10,377	$ 38,488	$ (242)	$ 30,097	$ 8,633

Advocate Health and Hospitals Corporation and Subsidiaries

Details of Consolidated Statement of Operations and Changes in Net Assets and Shareholders' Equity
(Dollars in Thousands)

Year Ended December 31, 2014

	Consolidated	Eliminations	Advocate Health and Hospitals Corporation	Advocate Northside Health System	Advocate Condell Medical Center	Midwest Heart Specialists	EHS Home Health Care Services, Inc. and Subsidiary	Eliminations	EHS Home Health Care Service, Inc.	Advocate Hospice
Unrestricted revenues, gains, and other support										
Net patient service revenue	$ 4,306,374	$ (69)	$ 3,437,238	$ 433,573	$ 347,451	$ –	$ 88,181	$ –	$ 68,123	$ 20,058
Provision for uncollectible accounts	(263,733)	–	(212,681)	(29,497)	(19,561)	91	(2,085)	–	(1,847)	(238)
	4,042,641	(69)	3,224,557	404,076	327,890	91	86,096	–	66,276	19,820
Capitation revenue	351,683	–	351,211	152	–	–	320	–	313	7
Other revenue	291,226	(75,171)	329,635	21,169	11,382	396	3,815	(1,963)	5,654	124
	4,685,550	(75,240)	3,905,403	425,397	339,272	487	90,231	(1,963)	72,243	19,951
Expenses										
Salaries, wages, and employee benefits	2,379,834	–	2,021,102	169,459	125,220	19	64,034	–	53,598	10,436
Purchased services and operating supplies	1,116,800	(69,462)	918,829	128,482	123,451	116	15,384	(1,963)	9,577	7,770
Contracted medical services	160,217	(69)	160,286	–	–	–	–	–	–	–
Insurance and claims costs	121,669	(413)	107,391	8,864	5,458	8	361	–	242	119
Other	346,421	(5,296)	292,676	31,279	23,016	17	4,729	–	3,793	936
Depreciation and amortization	212,507	–	182,002	14,312	15,243	676	274	–	266	8
Interest	47,816	–	45,359	–	2,457	–	–	–	–	–
	4,385,264	(75,240)	3,727,645	352,396	294,845	836	84,782	(1,963)	67,476	19,269
Operating income (loss)	300,286	–	177,758	73,001	44,427	(349)	5,449	–	4,767	682
Nonoperating income (loss)										
Investment income (loss)	122,911	–	123,832	(2,121)	581	453	166	–	106	60
Change in fair value of interest rate swaps	(38,338)	–	(38,338)	–	–	–	–	–	–	–
Loss on refinancing of debt	(29,954)	–	(29,954)	–	–	–	–	–	–	–
Other nonoperating items, net	(6,290)	–	(5,537)	28	(26)	(608)	(147)	–	(147)	–
Revenues in excess of (less than) expenses	348,615	–	227,761	70,908	44,982	(504)	5,468	–	4,726	742
Unrestricted net assets										
Net assets released from restrictions and used for capital purposes	10,628	–	7,923	2,484	221	–	–	–	–	–
Postretirement benefit plan adjustments	(64,018)	–	(55,949)	–	(8,069)	–	–	–	–	–
Increase (decrease) in unrestricted net assets	295,225	–	179,735	73,392	37,134	(504)	5,468	–	4,726	742

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Advocate Health and Hospitals Corporation and Subsidiaries

Details of Consolidated Statement of Operations and Changes in Net Assets and Shareholders' Equity (continued
(Dollars in Thousands)

	Consolidated	Eliminations	Advocate Health and Hospitals Corporation	Advocate Northside Health System	Advocate Condell Medical Center	Midwest Heart Specialists	EHS Home Health Care Services, Inc. and Subsidiary	Eliminations	EHS Home Health Care Service, Inc.	Advocate Hospice
Temporarily restricted net assets										
Realized gains on investments	$ 16	$ –	$ 16	$ –	$ –	$ –	$ –	$ –	$ –	$ –
Unrealized gains on investments	(9)	–	(9)	–	–	–	–	–	–	–
Net assets released from restriction and used for operations, medical education programs, capital purchases, and other purposes	(12)	–	(12)	–	–	–	–	–	–	–
Decrease in temporarily restricted net assets	(5)	–	(5)	–	–	–	–	–	–	–
Increase (decrease) in net assets	295,220	–	179,730	73,392	37,134	(504)	5,468	–	4,726	742
Net assets at beginning of year	4,172,698	(15,869)	3,562,059	333,538	271,799	9,978	11,193	–	6,614	4,579
Net assets at end of year	$ 4,467,918	$ (15,869)	$ 3,741,789	$ 406,930	$ 308,933	$ 9,474	$ 16,661	$ –	$ 11,340	$ 5,321

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Advocate Sherman Hospital and Subsidiaries

Details of Consolidated Balance Sheet

(Dollars in Thousands)

December 31, 2014

	Consolidated	Eliminations	Advocate Sherman Hospital	Sherman West Court	Sherman Choice
Assets					
Current assets:					
Cash and cash equivalents	$ 23,117	$ –	$ 20,475	$ 2,284	$ 358
Patient accounts receivable, less allowances for uncollectible accounts	49,238	–	48,143	1,095	–
Amounts due from primary third-party payors	223	–	223	–	–
Accounts receivable from Advocate Health Care Network and subsidiaries	2,708	–	2,618	90	–
Intercompany receivables	–	(403)	381	21	1
Prepaid expenses, inventories, and other current assets	14,350	–	14,085	2	263
Total current assets	89,636	(403)	85,925	3,492	622
Assets limited as to use:					
Internally and externally designated investments limited as to use	107,777	–	107,777	–	–
Intercompany receivables	–	(3,867)	3,867	–	–
Prepaid pension expense and other noncurrent asset	2,650	–	2,650	–	–
Interest in health care and related entities	2,865	–	2,865	–	–
Reinsurance receivable	11,613	–	11,613	–	–
Deferred costs and intangible assets, less allowances for amortization	1,405	–	1,405	–	–
	126,310	(3,867)	130,177	–	–
Property and equipment – at cost:					
Land and land improvements	33,662	–	32,504	1,158	–
Buildings	243,126	–	240,564	2,562	–
Movable equipment	46,465	–	46,395	70	–
Construction-in-progress	941	–	941	–	–
	324,194	–	320,404	3,790	–
Less allowances for depreciation	32,722	–	32,414	308	–
	291,472	–	287,990	3,482	–
	$ 507,418	$ (4,270)	$ 504,092	$ 6,974	$ 622

Advocate Sherman Hospital and Subsidiaries

Details of Consolidated Balance Sheet (continued)

(Dollars in Thousands)

	Consolidated	Eliminations	Advocate Sherman Hospital	Sherman West Court	Sherman Choice
Liabilities and net assets					
Current liabilities:					
Current portion of long-term debt	$ 120	$ –	$ 120	$ –	$ –
Current portion of intercompany long-term debt	6,100	(283)	6,100	283	–
Accounts payable	12,243	–	11,811	432	–
Accrued salaries and employee benefits	13,460	–	12,958	502	–
Accrued expenses	2,357	–	1,555	180	622
Amounts due to primary third-party payors	35,741	–	35,741	–	–
Current portion of accrued insurance and claims costs	6,271	–	6,271	–	–
Notes and accounts payable to Advocate Health Care Network and subsidiaries	10,962	–	10,778	182	2
Intercompany payables	–	(120)	22	75	23
Total current liabilities	87,254	(403)	85,356	1,654	647
Noncurrent liabilities:					
Long-term debt, less current portion	1,005	–	1,005	–	–
Long-term intercompany debt, less current portion	–	(3,867)	–	3,867	–
Notes and accounts payable to Advocate Health Care Network and subsidiaries	261,169	–	261,169	–	–
Accrued insurance and claims cost, less current portion	242	–	242	–	–
Accrued losses subject to reinsurance recovery	11,613	–	11,613	–	–
Other noncurrent liabilities	879	–	879	–	–
	274,908	(3,867)	274,908	3,867	–
Total liabilities	362,162	(4,270)	360,264	5,521	647
Net assets:					
Unrestricted	145,111	–	143,683	1,453	(25)
Temporarily restricted	145	–	145	–	–
Total net assets	145,256	–	143,828	1,453	(25)
	$ 507,418	$ (4,270)	$ 504,092	$ 6,974	$ 622

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Advocate Sherman Hospital and Subsidiaries

Details of Consolidated Statement of Operations and Changes in Net Assets and Shareholders' Equity

(Dollars in Thousands)

Year Ended December 31, 2014

	Consolidated	Eliminations	Advocate Sherman Hospital	Sherman West Court	Health Visions, Inc.	Sherman Choice
Unrestricted revenues, gains, and other support						
Net patient service revenue	$ 306,647	$ –	$ 295,713	$ 10,462	$ 472	$ –
Provision for uncollectible accounts	(17,676)	–	(17,491)	(185)	–	–
	288,971	–	278,222	10,277	472	–
Capitation revenue	52	–	52	–	–	–
Other revenue	5,260	(357)	5,579	37	1	–
	294,283	(357)	283,853	10,314	473	–
Expenses						
Salaries, wages, and employee benefits	132,640	–	124,964	6,597	1,079	–
Purchased services and operating supplies	101,684	(271)	99,393	2,298	257	7
Insurance and claims costs	1,923	–	1,663	244	16	–
Other	20,531	–	20,163	279	89	–
Depreciation and amortization	21,990	–	21,793	197	–	–
Interest	11,796	(86)	11,796	86	–	–
	290,564	(357)	279,772	9,701	1,441	7
Operating income (loss)	3,719	–	4,081	613	(968)	(7)
Nonoperating income (loss)						
Investment income	3,320	–	3,320	–	–	–
Loss on refinancing of debt	(15,516)	–	(15,516)	–	–	–
Other nonoperating items, net	(966)	–	(966)	–	–	–
Revenues (less than) in excess of expenses	(9,443)	–	(9,081)	613	(968)	(7)
Net assets released from restrictions and used for capital purposes	(70)	–	(70)	–	–	–
Transfers to/from Advocate Health Care Network and subsidiaries	–	2,130	(9,423)	–	7,293	–
(Decrease) increase in unrestricted net assets	(9,513)	2,130	(18,574)	613	6,325	(7)
Temporarily restricted net assets						
Transfers to/from Advocate Health Care Network and subsidiaries	(60)	–	–	(60)	–	–
Decrease in temporarily restricted net assets	(60)	–	–	(60)	–	–
(Decrease) increase in net assets	(9,573)	2,130	(18,574)	553	6,325	(7)
Net assets at beginning of year	154,829	(2,130)	162,402	900	(6,325)	(18)
Net assets at end of year	$ 145,256	$ –	$ 143,828	$ 1,453	$ –	$ (25)

Advocate Northside Health System and Subsidiaries

Details of Consolidated Balance Sheet

(Dollars in Thousands)

December 31, 2014

	Consolidated	Eliminations	Advocate Northside Health System	HispanoCare, Inc.
Assets				
Current assets:				
Cash and cash equivalents	$ 11,984	$ –	$ 11,684	$ 300
Patient accounts receivable, less allowances for uncollectible accounts	52,796	–	52,796	–
Amounts due from primary third-party payors	1,063	–	1,063	–
Accounts receivable from Advocate Health Care Network and subsidiaries	483	–	483	–
Intercompany receivables	13,097	(17)	13,113	1
Prepaid expenses, inventories, and other current assets	19,878	–	19,877	1
Total current assets	99,301	(17)	99,016	302
Assets limited as to use:				
Internally and externally designated investments limited as to use	87,778	–	87,778	–
Interest in health care and related entities	89,255	–	89,255	–
	177,033	–	177,033	–
Property and equipment – at cost:				
Land and land improvements	41,430	–	41,430	–
Buildings	142,701	–	142,701	–
Movable equipment	65,586	–	65,579	7
Construction-in-progress	102,216	–	102,216	–
	351,933	–	351,926	7
Less allowances for depreciation	118,819	–	118,812	7
	233,114	–	233,114	–
	$ 509,448	$ (17)	$ 509,163	$ 302

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Advocate Northside Health System and Subsidiaries

Details of Consolidated Balance Sheet (continued)

(Dollars in Thousands)

	Consolidated	Eliminations	Advocate Northside Health System	HispanoCare, Inc.
Liabilities and net assets				
Current liabilities:				
Accounts payable	$ 23,221	$ –	$ 23,221	$ –
Accrued salaries and employee benefits	14,054	–	14,034	20
Accrued expenses	10,407	–	10,407	–
Amounts due to primary third-party payors	35,209	–	35,209	–
Notes and accounts payable to Advocate Health Care Network and subsidiaries	885	–	883	2
Intercompany payables	15,084	(17)	15,085	16
Total current liabilities	98,860	(17)	98,839	38
Noncurrent liabilities:				
Other noncurrent liabilities	3,658	–	3,658	–
	3,658	–	3,658	–
Total liabilities	102,518	(17)	102,497	38
Net assets:				
Unrestricted	406,930	–	406,666	264
Total net assets	406,930	–	406,666	264
	$ 509,448	$ (17)	$ 509,163	$ 302

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Advocate Northside Health System and Subsidiaries

Details of Consolidated Statement of Operations and Changes in Net Assets and Shareholders' Equity
(Dollars in Thousands)

Year Ended December 31, 2014

	Consolidated	Eliminations	Advocate Northside Health System	HispanoCare, Inc.
Unrestricted revenues, gains, and other support				
Net patient service revenue	$ 433,573	$ –	$ 433,573	$ –
Provision for uncollectible accounts	(29,497)	–	(29,497)	–
	404,076	–	404,076	–
Capitation revenue	152	–	152	–
Other revenue	21,169	–	21,123	46
	425,397	–	425,351	46
Expenses				
Salaries, wages, and employee benefits	169,459	–	169,287	172
Purchased services and operating supplies	128,482	–	128,456	26
Insurance and claims costs	8,864	–	8,864	–
Other	31,279	–	31,161	118
Depreciation and amortization	14,312	–	14,311	1
	352,396	–	352,079	317
Operating income (loss)	73,001	–	73,272	(271)
Nonoperating income (loss)				
Investment (loss) income	(2,121)	–	(2,122)	1
Other nonoperating items, net	28	–	28	–
Revenues in excess of (less than) expenses	70,908	–	71,178	(270)
Unrestricted net assets				
Net assets released from restrictions and used for capital purposes	2,484	–	2,484	–
Transfers to/from Advocate Health Care Network and subsidiaries	–	–	(100)	100
Increase (decrease) in unrestricted net assets	73,392	–	73,562	(170)
Unrestricted net assets at beginning of year	333,538	–	333,104	434
Unrestricted net assets at end of year	$ 406,930	$ –	$ 406,666	$ 264

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Evangelical Services Corporation and Subsidiaries
d/b/a Advocate Network Services, Inc. and Subsidiaries

Details of Consolidated Balance Sheet
(Dollars in Thousands)

December 31, 2014

	Consolidated	Eliminations	Advocate Network Services, Inc.	High Technology, Inc.	Advocate Home Care Products, Inc.	Dreyer Clinic, Inc.	Advocate Health Centers, Inc.	BroMenn Medical Group
Assets								
Current assets:								
Cash and cash equivalents	$ 53,069	$ –	$ 16,946	$ 13,568	$ 5,408	$ 11,815	$ 2,670	$ 2,662
Assets limited as to use	216	–	–	–	–	–	–	216
Patient accounts receivable, less allowances for uncollectible accounts	20,165	–	–	1,527	3,055	15,581	–	2
Accounts receivable from Advocate Health Care Network and subsidiaries	9,417	–	7,839	95	825	176	143	339
Intercompany receivables	–	(23,775)	21,228	342	2	179	1,099	925
Prepaid expenses, inventories, and other current assets	20,521	–	10,429	97	1,232	8,726	37	–
Total current assets	103,388	(23,775)	56,442	15,629	10,522	36,477	3,949	4,144
Assets limited as to use:								
Internally and externally designated investments limited as to use	77,760	–	42,932	11,337	10,183	–	10,787	2,521
Investments in subsidiaries	–	(168,856)	168,856	–	–	–	–	–
Prepaid pension expense and other noncurrent assets	498	–	–	–	–	498	–	–
Interest in health care and related entities	23,055	–	7,503	–	–	1,869	–	13,683
Deferred costs and intangible assets, less allowances for amortization	8,913	–	6,933	–	–	1,980	–	–
	110,226	(168,856)	226,224	11,337	10,183	4,347	10,787	16,204
Property and equipment – at cost:								
Land and land improvements	14,915	–	6,138	1,004	–	7,773	–	–
Buildings	60,157	–	2,381	9,442	330	48,004	–	–
Movable equipment	58,719	–	8,243	16,048	7,690	26,738	–	–
Construction-in-progress	2,380	–	–	93	3	2,284	–	–
	136,171	–	16,762	26,587	8,023	84,799	–	–
Less allowances for depreciation	84,534	–	11,315	20,402	5,709	47,108	–	–
	51,637	–	5,447	6,185	2,314	37,691	–	–
	$ 265,251	$ (192,631)	$ 288,113	$ 33,151	$ 23,019	$ 78,515	$ 14,736	$ 20,348

Evangelical Services Corporation and Subsidiaries
d/b/a Advocate Network Services, Inc. and Subsidiaries

Details of Consolidated Balance Sheet (continued)
(Dollars in Thousands)

	Consolidated	Eliminations	Advocate Network Services, Inc.	High Technology, Inc.	Advocate Home Care Products, Inc.	Dreyer Clinic, Inc.	Advocate Health Centers, Inc.	BroMenn Medical Group
Liabilities and shareholder's equity								
Current liabilities:								
Current portion of long-term debt	$ 1,683	$ –	$ –	$ –	$ –	$ 1,683	$ –	$ –
Accounts payable	8,439	–	991	581	1,864	4,760	41	202
Accrued salaries and employee benefits	9,838	–	3,016	744	580	5,497	1	–
Accrued expenses	4,290	–	340	1,076	37	2,147	665	25
Amounts due to primary third-party payors	4,592	–	–	–	768	3,824	–	–
Current portion of accrued insurance and claims costs	1,580	–	–	–	–	–	1,364	216
Notes and accounts payable to Advocate Health Care Network and subsidiaries	8,742	–	4,413	549	1,036	884	1,252	608
Intercompany payables	–	(23,775)	2,546	398	272	18,412	2,145	2
Total current liabilities	39,164	(23,775)	11,306	3,348	4,557	37,207	5,468	1,053
Noncurrent liabilities:								
Long-term debt, less current portion	3,753	–	–	–	–	3,753	–	–
Pension plan liability	591	–	400	100	91	–	–	–
Accrued insurance and claims cost, less current portion	7,365	–	–	–	–	–	6,638	727
Other noncurrent liabilities	41,772	–	39,022	–	–	2,750	–	–
	53,481	–	39,422	100	91	6,503	6,638	727
Total liabilities	92,645	(23,775)	50,728	3,448	4,648	43,710	12,106	1,780
Shareholders' equity:								
Common stock	1	(5,163)	1	3,250	50	1,862	–	1
Additional paid-in capital	177,163	(195,679)	177,163	22,294	9,098	36,115	87,081	41,091
Non-controlling interest	662	–	–	–	–	662	–	–
Retained (deficit) earnings	(5,220)	31,986	60,221	4,159	9,223	(3,834)	(84,451)	(22,524)
Total shareholders' equity	172,606	(168,856)	237,385	29,703	18,371	34,805	2,630	18,568
	$ 265,251	$ (192,631)	$ 288,113	$ 33,151	$ 23,019	$ 78,515	$ 14,736	$ 20,348

Evangelical Services Corporation and Subsidiaries
d/b/a Advocate Network Services, Inc. and Subsidiaries

Details of Consolidated Statement of Operations and Changes in Net Assets and Shareholders' Equity

(Dollars in Thousands)

Year Ended December 31, 2014

	Consolidated	Eliminations	Advocate Network Services, Inc.	High Technology, Inc.	Advocate Home Care Products, Inc.	Dreyer Clinic, Inc.	Advocate Health Centers, Inc.	BroMenn Medical Group
Unrestricted revenues, gains, and other support								
Net patient service revenue	$ 191,318	$ –	$ –	$ 22,533	$ 23,406	$ 144,856	$ (22)	$ 545
Provision for uncollectible accounts	(8,188)	–	–	(1,332)	(2,741)	(4,437)	171	151
	183,130	–	–	21,201	20,665	140,419	149	696
Capitation revenue	61,773	–	–	–	1,674	60,099	–	–
Other revenue	50,391	(8,037)	42,229	104	4,102	9,142	–	2,851
	295,294	(8,037)	42,229	21,305	26,441	209,660	149	3,547
Expenses								
Salaries, wages, and employee benefits	117,888	–	27,126	7,517	6,118	77,188	(2)	(59)
Purchased services and operating supplies	130,243	(8,037)	5,075	9,580	14,723	108,372	238	292
Contracted medical services	10,570	–	–	–	–	10,570	–	–
Insurance and claims costs	2,495	–	81	380	149	999	129	757
Other	17,107	–	3,009	936	1,779	11,180	174	29
Depreciation and amortization	6,830	–	226	1,527	607	4,470	–	–
Interest	175	(3,040)	1	–	–	182	–	3,032
	285,308	(11,077)	35,518	19,940	23,376	212,961	539	4,051
Operating income (loss)	9,986	3,040	6,711	1,365	3,065	(3,301)	(390)	(504)

Evangelical Services Corporation and Subsidiaries
d/b/a Advocate Network Services, Inc. and Subsidiaries

Details of Consolidated Statement of Operations and Changes in Net Assets and Shareholders' Equity (continued)

(Dollars in Thousands)

	Consolidated	Eliminations	Advocate Network Services, Inc.	High Technology, Inc.	Advocate Home Care Products, Inc.	Dreyer Clinic, Inc.	Advocate Health Centers, Inc.	BroMenn Medical Group
Nonoperating income (loss)								
Investment income (loss)	$ 5,444	$ (3,040)	$ 1,251	$ 4,909	$ 1,421	$ 4	$ 739	$ 160
Other nonoperating items, net	(5,138)	–	(3,000)	(45,013)	(1,701)	3,297	(972)	42,251
Revenues in excess of (less than) expenses	10,292	–	4,962	(38,739)	2,785	–	(623)	41,907
Unrestricted net assets								
Transfers to/from Advocate Health Care Network and subsidiaries	–	(2,098)	25,000	(15,000)	(10,000)	2,098	–	–
Increase (decrease) in unrestricted net assets	10,292	(2,098)	29,962	(53,739)	(7,215)	2,098	(623)	41,907
Change in non-controlling interest	(294)	–	–	–	–	(294)	–	–
Decrease in non-controlling interest	(294)	–	–	–	–	(294)	–	–
Total change in shareholders' equity	9,998	(2,098)	29,962	(53,739)	(7,215)	1,804	(623)	41,907
Shareholders' equity (deficit) at beginning of year	162,608	(166,758)	207,423	83,442	25,586	33,001	3,253	(23,339)
Shareholders' equity at end of year	$ 172,606	$ (168,856)	$ 237,385	$ 29,703	$ 18,371	$ 34,805	$ 2,630	$ 18,568

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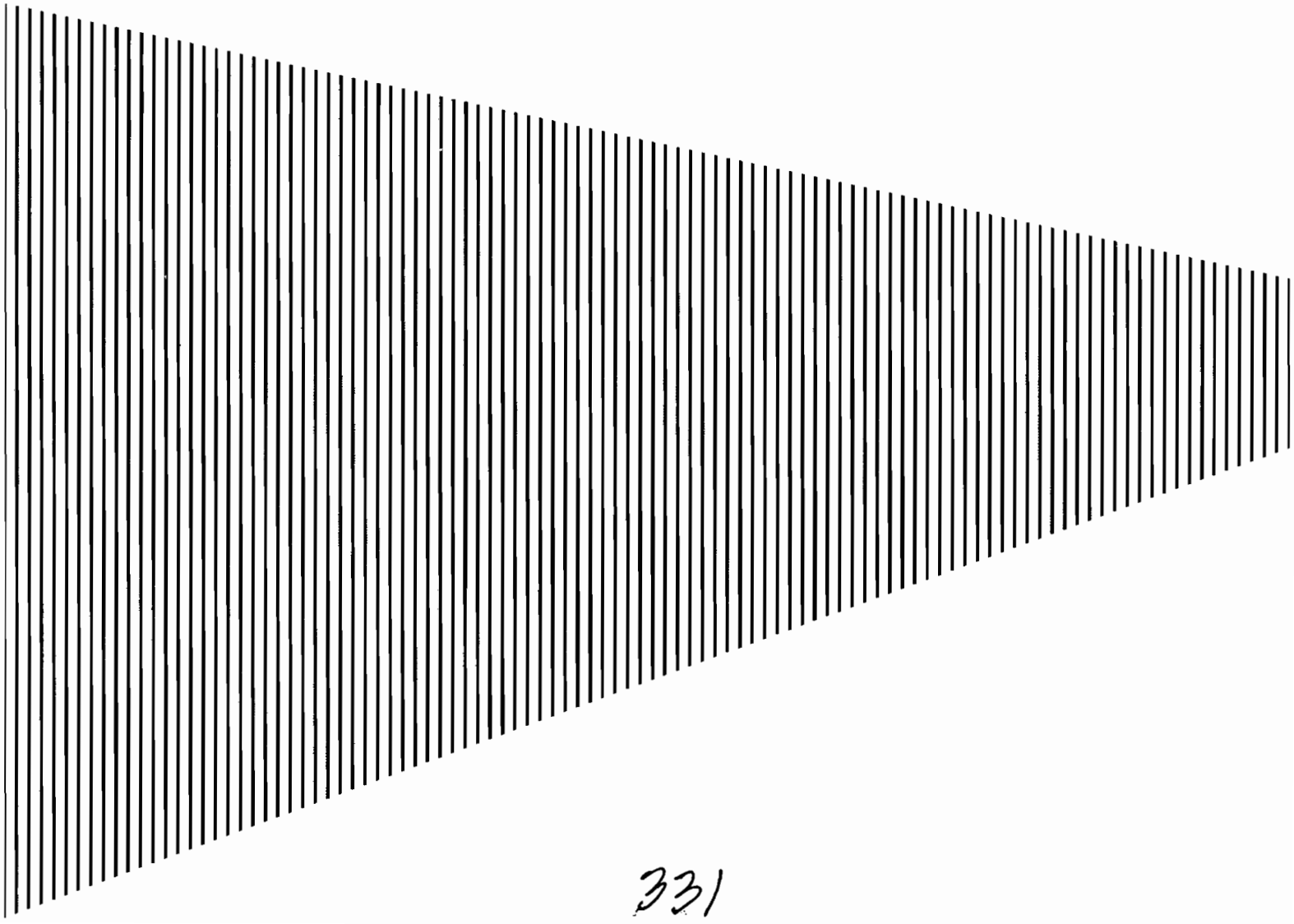

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

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, 2013
Commission file number: 001-36154

SURGICAL CARE AFFILIATES, INC.
(Exact name of registrant as specified in its charter)

Delaware	**20-8740447**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
520 Lake Cook Road, Suite 250 Deerfield, IL	**60015**
(Address of principal executive offices)	**(Zip Code)**

(847) 236-0921
(Registrant's telephone number, including area code)

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

Title of Each Class	Name of Exchange on Which Registered
Common Stock, par value $0.01 per share	**The NASDAQ Stock Market LLC**

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 (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☐	Accelerated filer ☐
Non-accelerated filer ☒	Smaller reporting company ☐

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

The aggregate market value of the registrant's voting and non-voting common stock held by non-affiliates of the registrant (without admitting that any person whose shares are not included in such calculation is an affiliate) computed by reference to the price at which the common stock was last sold on March 20, 2014 was $455,520,019. The registrant has provided this information as of March 20, 2014 because its common stock was not publicly traded as of the last business day of its most recently completed second fiscal quarter.

Indicate the number of shares outstanding of each of the registrant's classes of common stock, as of the latest practicable date.

Class of Common Stock	Outstanding at March 20, 2014
Common stock, par value $0.01 per share	**38,261,138 shares**

SURGICAL CARE AFFILIATES, INC.
FORM 10-K
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GENERAL

Unless the context otherwise indicates or requires, references in this Annual Report on Form 10-K to "Surgical Care Affiliates," the "Company," "we," "us" and "our" refer to ASC Acquisition LLC and its consolidated affiliates prior to our conversion from a Delaware limited liability company to a Delaware corporation on October 30, 2013 and to Surgical Care Affiliates, Inc. and its consolidated subsidiaries after our conversion from a Delaware limited liability company to a Delaware corporation on October 30, 2013. In addition, unless the context otherwise indicates or requires, the term "SCA" refers to Surgical Care Affiliates, LLC, our direct operating subsidiary.

Pursuant to the conversion, every 10.25 outstanding membership units of ASC Acquisition LLC were converted into one share of common stock of Surgical Care Affiliates, Inc., and options to purchase membership units of ASC Acquisition LLC were converted into options to purchase shares of common stock of Surgical Care Affiliates, Inc. at a ratio of 10.25 membership units of ASC Acquisition LLC underlying such options to each one share of common stock of Surgical Care Affiliates, Inc. underlying such converted options. In connection with the conversion, the exercise prices of such converted options were adjusted accordingly. In addition, every 10.25 outstanding restricted equity units of ASC Acquisition LLC were converted into one restricted stock unit ("RSU") of Surgical Care Affiliates, Inc. All information included in this Annual Report on Form 10-K is presented giving effect to the conversion.

On October 29, 2013, the Company's Registration Statement on Form S-1 (File No. 333-190998) and the Company's Registration Statement on Form 8-A each became effective, and the Company became subject to the reporting requirements of the Securities Exchange Act of 1934, as amended (the "Exchange Act").

FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K contains forward-looking statements that reflect our current views with respect to, among other things, future events and financial performance, which involve substantial risks and uncertainties. Certain statements made in this Annual Report on Form 10-K are "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Exchange Act. Forward-looking statements include any statement that, without limitation, may predict, forecast, indicate or imply future results, performance or achievements instead of historical or current facts and may contain words like "anticipates," "approximately," "believes," "budget," "can," "could," "continues," "contemplates," "estimates," "expects," "forecast," "intends," "may," "might," "objective," "outlook," "predicts," "probably," "plans," "potential," "project," "seeks," "shall," "should," "target," "will," or the negative of these terms and other words, phrases, or expressions with similar meaning.

Any forward-looking statements contained in this Annual Report on Form 10-K are based upon our historical performance and on our current plans, estimates and expectations in light of information currently available to us. The inclusion of forward-looking information should not be regarded as a representation by us that the future plans, estimates or expectations will be achieved. Such forward-looking statements are subject to various risks and uncertainties and assumptions relating to our operations, financial results, financial condition, business, prospects, growth strategy and liquidity. Forward-looking statements involve risks and uncertainties which may cause actual results to differ materially from those projected in the forward-looking statements, and the Company cannot give assurances that such statements will prove to be correct. Except as required by law, we undertake no obligation to update any forward-looking statement, whether as a result of new information or otherwise. Given these uncertainties, the reader should not place undue reliance on forward-looking statements as a prediction of actual results. Factors that could cause actual results to differ materially from those projected or estimated by us include those that are discussed in "Part I, Item 1A. Risk Factors".

Part I

Item 1. BUSINESS

Overview

We are a leading national provider of solutions to physicians, health systems and payors to optimize surgical care. We operate one of the largest networks of outpatient surgery facilities in the United States, which as of December 31, 2013, was comprised of 171 ambulatory surgery centers ("ASCs"), five surgical hospitals and one sleep center with 11 locations. Our business model is focused on building strategic relationships with leading health systems, physician groups and payors to acquire and develop facilities in an aligned economic model that enables better access to lower cost, high-quality care. As of December 31, 2013, we owned and operated facilities in partnership with 43 leading health systems and approximately 2,000 physician partners. We believe that our partnership strategy and comprehensive suite of solutions will enable continued growth by capitalizing on increasing demand for high quality, cost-effective settings of care, the increasing need for scaled partners in healthcare, the transition to a coordinated care delivery model and the trend of physician and health system consolidation.

The healthcare industry is in the midst of a transition characterized by increasing focus on cost containment and clinical outcomes, driven by recent regulatory efforts and new payment and delivery models, such as Accountable Care Organizations ("ACOs"). In this environment, improving clinical quality and reducing the cost of surgical delivery, which represents one of the largest components of medical spending in the United States, will be of greater focus. We believe we are a critical part of the solution because we provide a lower-cost delivery alternative that (1) we believe enhances the quality of care and patient experience, (2) provides a strategic approach for physicians that improves productivity and economic alignment, (3) enables our health system partners to expand access within their markets while addressing the pressures resulting from changing payment models and (4) offers an efficient and lower-cost alternative for payors, employers and other health plan sponsors.

Our scale of operations allows us to provide our affiliated physicians and health system partners with a comprehensive suite of services that support clinical quality, operational efficiency and enhanced financial performance. In addition to a growing network of lower-cost, high quality ASCs, we offer tools and systems in the areas of clinical benchmarking, clinical best practices, operating efficiency, care coordination and supply chain management. Our partnership model aligns the interests of our partners in achieving strong clinical and operational outcomes.

Following the purchase of our company in 2007 by TPG Global, LLC (together with its affiliates, "TPG"), MTS-SCA Acquisition LLC ("MTS") and certain of our current and former directors, our senior leadership team has transformed our strategic approach from operating a scaled network of facilities to providing a comprehensive suite of solutions to multiple constituents along the surgical care continuum. We have experienced significant growth in our provider partnerships and enhanced our focus on clinical outcomes and patient experience, resulting in strong and consistent performance in our key financial and operating metrics. We believe our comprehensive solution set has established SCA facilities as a site of choice to patients, physicians, health systems and payors, as reflected in (1) our patient and physician Net Promoter Scores, which are measures of loyalty based on asking patients or physicians whether they would recommend our facilities to a friend or family member or colleague, as applicable, (2) growth in physician partners to approximately 2,000 as of December 31, 2013, with approximately 7,500 physicians performing procedures in our affiliated facilities in 2013 and (3) growth in health system partnerships from 18 to 43 from December 31, 2007 to December 31, 2013.

Our commitment to patient care, our outstanding teammates, our health system partnerships and our investments in systems and processes to drive results, coupled with strong industry trends, have enabled us to build a track record of growth. Our consolidated total net operating revenues increased from $744.9 million in 2011 to $802.0 million in 2013, representing a 3.8% compounded annual growth rate ("CAGR"). Given the significant increase in the number of our nonconsolidated facilities, driven by the success of our health system

and physician partnership growth strategy, we also review an internal supplemental operating measure that does not comply with generally accepted accounting principles ("GAAP") called systemwide net operating revenues growth, which includes both consolidated and nonconsolidated facilities (without adjustment based on our percentage of ownership). Our systemwide net operating revenues grew by 15.2%, 16.4% and 17.0% during the years-ended December 31, 2013, 2012 and 2011, respectively. Our net losses increased from $9.7 million in 2011 to $51.3 million in 2013, our Adjusted EBITDA-NCI increased from $116.7 million in 2011 to $142.9 million in 2013, representing a 10.7% CAGR and our Adjusted Net Income increased from $28.1 million in 2011 to $49.3 million in 2013, representing a 32.5% CAGR. Adjusted EBITDA-NCI and Adjusted Net Income are non-GAAP financial measures and should not be considered substitutes for and are not comparable to our GAAP net income. See "Management's Discussion and Analysis of Financial Condition and Results of Operations — Adjusted EBITDA-NCI and Adjusted Net Income Reconcilements" for an explanation of Adjusted EBITDA-NCI and Adjusted net income and a reconciliation to the most directly comparable GAAP financial measures.

The revenues and expenses of affiliated facilities in which we do not have a controlling interest but do have an equity interest are not directly included in our consolidated GAAP results, rather only the net income earned from such facilities is reported on a net basis in the line item *Equity in net income of nonconsolidated affiliates,* and we refer to such facilities as our "nonconsolidated facilities."

We present Adjusted EBITDA-NCI because we believe it is useful for investors to analyze our operating performance on the same basis as that used by our management. Our management believes Adjusted EBITDA-NCI can be useful to facilitate comparisons of operating performance between periods because it excludes the effect of depreciation and amortization, which represents a non-cash charge to earnings, income tax, interest expense and other expenses or income not related to the normal, recurring operations of our business. In addition, Adjusted EBITDA-NCI is considered a non-GAAP financial measure and should not be considered a substitute for and is not comparable with net income or net operating income as determined in accordance with GAAP.

Strategic Partnerships with Leading Health Systems

In 2008, recognizing the trend towards branded integrated delivery systems in healthcare, we began to selectively partner with leading health systems in specific markets. From December 31, 2007 to December 31, 2013, we have grown the number of our health system partners from 18 to 43. Our health system partners include many of the leaders in healthcare delivery, such as Indiana University Health, Inc. ("IUH"), MemorialCare, Sutter Health and Texas Health Resources ("THR"), among others. We believe we are a partner of choice to leading health systems because of our comprehensive suite of surgical solutions, expertise in clinical operations and efficiency programs and developmental expertise. Partnering with leading health systems allows us to enter new markets in a capital-efficient way that provides us with immediate relevance to our partners, physicians and payors, translating into greater stability and growth opportunity. Our material health system partners are IUH, MemorialCare, Sutter Health and THR.

When we partner with a health system in a three-way joint venture, we typically hold a noncontrolling ownership interest in a holding company that owns a majority or controlling ownership interest in the facility, while the health system partner holds the controlling interest in the holding company.

We typically have co-development arrangements with our health system partners to jointly develop a network of outpatient surgical facilities. These co-development arrangements are an important source of differentiation and growth for our business. For example, through our relationship with Sutter Health, as of December 31, 2013, we have acquired and developed 17 facilities since 2007. Our success with high quality health system partners has also led them in some cases to have us manage the surgical departments of their hospital sites through our recently introduced hospital management solutions.

In addition to expanding the number of co-developed facilities within our existing partnerships, we continue to establish new partnerships with market-leading providers. During the twelve-months ended December 31,

2013, we added relationships with 15 new health system partners for an initial 27 affiliated facilities. Our co-development arrangements are often informal, but in some cases, we enter into formal co-development agreements with our health system partners. In these agreements, we agree to collaborate on the identification of opportunities for the acquisition or development of new facilities within a defined geographic area. The co-development agreements generally have a duration of one or two years, with the option to renew upon mutual agreement. Some of the co-development agreements contain termination provisions that allow either party to terminate the agreement upon 60 to 120 days' notice or for cause and others are silent as to termination. For example, our co-development agreement with IUH provides that the Company and IUH will collaborate in good faith to identify, solicit and cultivate potential opportunities for the acquisition of facilities in Indiana. The co-development agreement with IUH provides that it will continue for so long as the partnership between the Company and IUH continues.

Our Affiliated Facilities

Our network of facilities includes:

- *ASCs.* Like hospitals, ASCs serve as locations where physicians on each individual facility's medical staff perform surgeries on their patients. Our ASCs provide the facilities, equipment, supplies and clinical support staff necessary to provide non-emergency surgical services to patients not requiring hospitalization. Surgeries in ASCs are typically reimbursed at significantly lower rates than in a hospital setting, and ASCs generally operate with greater efficiency and lower costs. For the year-ended December 31, 2013, our ASCs represented 87.7% of our net operating revenues.
- *Surgical hospitals.* Our surgical hospitals allow physicians to perform a broader range of surgical procedures, including more complex surgeries, and allow patients to stay in the hospital for up to three days. For the year-ended December 31, 2013, our surgical hospitals represented 10.3% of our net operating revenues.
- *Hospital surgery departments.* We also contract with hospitals to manage in-hospital surgery departments, which can focus exclusively on supporting physicians in the performance of surgeries on patients who do not require hospitalization (on an outpatient basis) or provide a full array of surgeries, including emergency surgeries, as well as surgeries on hospital inpatients and patients who will be admitted post-procedure. We believe managing hospital surgery departments strengthens our relationships with our hospital partners, as we are engaged across the continuum of surgical care. For the year-ended December 31, 2013, such hospital surgery departments represented 0.1% of our net operating revenues.

Physicians at our facilities provide surgical services in a wide variety of specialties, including orthopedics, ophthalmology, gastroenterology, pain management, otolaryngology (ear, nose and throat, or "ENT"), urology, spine and gynecology, as well as other general surgery procedures. As of December 31, 2013, we consolidated the operations of 87 of our 177 affiliated facilities, had 60 nonconsolidated affiliated facilities and held no ownership in 30 affiliated facilities that contract with us to provide management services only. We provide management services to all but two of our 177 facilities.

Our Industry

Medical costs account for a substantial percentage of spending in America. The United States spent $2.7 trillion on healthcare in 2011, according to Centers for Medicare and Medicaid Services ("CMS"), and the percentage of gross domestic product devoted to healthcare has increased from 7.2% in 1970 to 17.9% in 2011. Surgical delivery is one of the largest components of medical costs in the United States, currently representing approximately 30% of medical spending for individuals with commercial insurance, according to our estimates.

Against this backdrop, we believe that we are well positioned to benefit from trends currently affecting the markets in which we compete, including:

Continued Migration of Procedures out of Hospitals

According to the American Hospital Association, from 1991 to 2011, outpatient surgeries increased from 52.3% of total surgery volumes to 64.2%. In addition, a significant share of outpatient surgeries shifted from hospitals to free-standing facilities over a similar period. 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 certain surgical procedures. Improvements in anesthesia have also shortened the recovery time for many patients by minimizing post-operative side effects such as nausea and drowsiness, thereby avoiding, in some cases, overnight hospitalization. These medical advancements have significantly increased the number of procedures that can be performed in a surgery center and have fueled the migration of surgical procedures out of hospitals and into outpatient settings. We expect that continued advancements in healthcare delivery and regulatory reform will further this trend.

Growing Focus on Containment of Healthcare Costs

Because of an increased focus on controlling the growth of healthcare expenditures in our economy, constituents across the healthcare continuum, including government payors, private insurance companies and self-insured employers, are implementing meaningful cost containment measures. These initiatives have contributed to the shift in the delivery of healthcare services away from traditional inpatient hospitals to more cost-effective settings, such as ASCs. For example, based on 2014 Medicare fee schedules, a procedure in an ASC costs, on average, 55% of what the same procedure costs when performed in a hospital surgery department, according to the Ambulatory Surgery Center Association. The cost differential creates savings for the government, Medicare plans, commercial payors and patients when a procedure is performed at an ASC instead of a hospital-based surgery department. We expect this cost effectiveness will continue to fuel the migration of procedures into the ASC setting.

In addition, as self-insured employers look to reduce their overall healthcare costs, they are shifting increased financial responsibility to patients through higher co-pays and deductibles. These changes to health plan design, coupled with increased pricing transparency, have encouraged patients to seek out more cost-effective options for their healthcare delivery. Because of their cost advantage and high patient satisfaction, ASCs stand to benefit from this increase in consumerism.

Opportunities Created by Healthcare Legislation

We anticipate that recent healthcare legislation will create greater opportunities for cost-effective providers of healthcare. The Patient Protection and Affordable Care Act ("PPACA") and other related healthcare reform activities are expected to promote the transition from traditional fee-for-service payment models to more "at risk" or "capitated" models in which providers receive a flat fee per member per month from payors, regardless of the cost of care. These changes will be reflected through the creation of ACOs or other payment model reforms. This shift will create financial incentives for "at-risk" providers to direct patient procedures into the most cost-effective settings, such as ASCs. We believe health systems, which are expected to remain the center of the delivery network in many markets, are resolving to shift many types of surgical cases out of their hospital surgery departments into the lower-cost ASC setting. Given that, according to management estimates, surgical spending currently represents approximately 30% of all medical spending for individuals with commercial insurance, the shift to "at risk" payment models is likely to create greater interest from health systems in expanding their delivery networks to include lower-cost surgical facilities.

Dynamics Impacting Health Systems

Many hospitals and health systems anticipate strategic and financial challenges stemming from healthcare reform and growing efforts to contain healthcare costs. In response, many health systems are focused on

strategies to reduce operating costs, build market share, align with physicians, create additional service lines, expand their geographic footprint and prepare for new payment models, including ACOs, which are networks of doctors, hospitals and other healthcare providers who share responsibility for providing coordinated care to patients with the goal of reducing overall spending. As a result, a growing number of health systems are entering into strategic partnerships with select provider organizations that can provide focused expertise, scaled operating systems, best practices, speed of execution and financial capital.

These same trends have led many health systems to focus on increasing the efficiency and reducing the operating costs of their hospital surgery departments, which can be significant contributors to the profitability of an acute care hospital. We believe that efforts by hospital surgery departments to increase efficiency and reduce costs will continue to create demand for perioperative consulting and management services.

Increased Pressure on Physicians and Physician Groups

Physicians in many markets are increasingly interested in affiliating with leading health systems, especially in the context of an operating partner that can help ensure the continued efficiency of their practices. Uncertainty regarding reimbursement along with increased financial and administrative burdens resulting from healthcare legislation have contributed to the trend toward health system partnerships. As a result, physicians in many markets are pursuing partnerships with surgical providers and health systems in order to gain greater stability, access to scaled clinical and operating systems and a pathway to participating in new payment models. This is creating opportunities for providers with expertise and a track record of structuring partnerships with health systems and physicians in a way that creates value for all constituents.

Continued Provider Consolidation Driven by Changing Environment

We believe that consolidation among healthcare providers will continue due to cost pressures, a changing regulatory environment and the requirements imposed by new payment and delivery models. Our industry remains highly fragmented relative to other healthcare sectors, with the three largest companies in our industry operating an aggregate of only 12% of approximately 5,300 Medicare-certified ASCs in the United States as of December 31, 2013. We expect consolidation to continue, as larger operators like us bring to bear the benefits of systems, processes and larger-scale relationships.

Our Competitive Strengths

We believe that our commitment to outstanding patient care, our strategy and our market position align us to benefit from trends in the U.S. healthcare market. An environment that demands better access to high-quality care, improved patient experience, health system and physician partnership and continuous clinical and administrative improvement and efficiency aligns very well with our competitive strengths:

Multi-Pronged Growth Strategy Based on Aligned Economic Model and Diverse Business Mix

Our business model is focused on building strategic relationships with leading health systems, physician groups and payors to acquire, develop and operate facilities in an aligned economic model. The alignment of strategic and financial interests through shared ownership is an integral component of our ability to achieve strong results — clinically, operationally and financially. We believe our business model, which is aligned with secular industry trends demanding high quality, cost-effective settings of care, the need for more scaled partners in healthcare and the transition to a coordinated care delivery model, enables the following multiple growth avenues and positions us for long-term sustainable growth:

- *Strong same-site growth.* We believe that several factors will contribute to continued same-site growth: (1) a significant majority of our facilities are multi-specialty (149 of our 177 affiliated facilities), (2) a payor mix weighted toward non-governmental payors (60% of our consolidated net patient revenues and 77% of net patient revenues at our nonconsolidated facilities for the year-ended December 31,

2013 came from commercial payors), (3) our partnerships with leading health systems, (4) our strong physician satisfaction and (5) the continued focus of our regional facility leadership on physician recruitment, leveraging our tools and systems.

- *In-market expansion and co-development with existing leading health system partnerships.* We have partnered with many leading health systems in the country, and we are generally in the early stages of developing those health system partnerships. These partnerships create an opportunity for continued growth through expanding our footprint of facilities in the markets of our health system partners.
- *New health system partnerships.* Many factors are driving health systems to increasingly seek out partners, including the need for focused expertise and scaled operating systems and the need for human and financial capital. These dynamics will contribute to our ability to add new health system partnerships to our existing portfolio.
- *Additional services across our broad suite of solutions.* We provide a broad suite of solutions to meet the specific needs of our health system and physician partners in the communities they serve. These solutions include, among others, development of market growth strategies, multiple physician alignment models (including joint ventures and clinical co-management agreements), perioperative consulting and management services to assist health systems in increasing the efficiency of their own hospital surgery departments, supply chain management, data analytics and benchmarking and analytics to support the transition to new payment models. These additional services enhance patient care and strengthen our partnerships with health systems, physicians and payors while providing additional economic benefits to us.
- *Opportunistic acquisitions.* Our partnership model with leading health systems enables us to be a strategic acquirer in multiple geographic markets within the fragmented ASC industry. From June 30, 2010 to December 31, 2013, we acquired or entered into management agreements with 33 facilities in our existing markets and 34 facilities in new markets. Also during this same time period, we placed two de novo facilities into operation in our existing markets.

Strategic Partnerships with Leading Health Systems

We have positioned ourselves for the continued shift toward large scale, integrated delivery systems by selectively partnering with health systems that hold market-leading positions in their primary service areas. From December 31, 2007 to December 31, 2013, we have grown the number of our health system partners from 18 to 43, including many of the leaders in healthcare delivery, such as IUH, Sutter Health, THR and MemorialCare, among others. We believe we are a partner of choice to leading health systems because of our comprehensive suite of surgical solutions, expertise in clinical operations and efficiency programs and development expertise. Partnering with leading health systems allows us to enter new markets in a capital-efficient way that provides us with immediate relevance to our patients, physicians and payors, translating into greater stability and growth opportunity. Historically, our partnerships have delivered above-market same-site revenue growth, as well as growth from the co-development of additional facilities alongside our health system partners.

Leading National Brand and Scaled Franchise

We believe a healthcare environment characterized by cost pressure, regulatory change, increased consumerism and consolidation favors large scale competitors with strong reputations. We are one of the largest multi-specialty operators of ASCs in the United States, operating in 34 states, with 171 ASCs, five surgical hospitals and one sleep center with 11 locations. We operate a large surgical services purchasing platform that provides us substantial purchasing advantages as our dedicated supply chain team works with our facilities, health system partners and affiliated physicians across the country. Through our partnerships with locally branded health systems, we have established strong brand recognition among physicians in many communities, and we believe our national presence and leading reputation provide us with a greater opportunity to establish strategic relationships with local health systems and physicians. Our facilities have also developed a strong reputation among patients in our communities as a result of our principal focus on patient care and clinical

quality. We provide each patient with a survey regarding their experience at our facility which is generally provided in person after their procedure has been performed or through the mail. According to our patient surveys conducted during 2013, we have a Net Promoter Score of approximately positive 97. This Net Promoter Score is a measure of loyalty ranging from negative 100 to positive 100 based on asking patients whether they would recommend our facilities to a friend or family member. The overall response rate for these surveys has been, on average, approximately 63% in 2013, which represented an average of approximately 32,000 responses received per month in 2013.

Proprietary and Expanding Suite of Technology-Enabled Solutions

New payment models and increasing pressure on health systems and physicians to contain costs are forcing providers to make new investments in areas such as information systems and data analytics in an effort to become more efficient and meet the demands for improved clinical outcomes. We have developed a comprehensive set of proprietary technology tools that enable health systems, physicians and payors to optimize patient experience, clinical outcomes, physician productivity and operating performance. Our proprietary technology tool set includes:

- *SCA Quality Index.* We measure patient satisfaction, clinical outcomes and licensure and accreditation inspection readiness for each affiliated facility and combine those measures into our SCA Quality Index to track quality metrics and increasingly to support the transition to new payment models.
- *Operating system.* Our operating system provides detailed benchmarking of key operational measures (including on-time starts, turn-times, staffing ratios and supply expense metrics) that allows management to identify, monitor and adjust areas such as case mix, staffing and operating costs to improve overall performance.
- *Proprietary case-costing system (which we call the "Every Case Optimized System" or "ECOSystem™").* Our ECOSystem™ provides detailed labor cost, supply cost and contribution margin data by procedure code, physician, facility and payor to monitor key expenses and margins, allowing us to benchmark best practices by case type.
- *Supply chain management system.* Our supply chain management system provides detailed analysis on supply cost management to improve purchasing efficiency and costs.

Our data-driven insight and ability to measure performance metrics such as clinical outcomes and patient satisfaction as well as optimize performance through our ECOSystem™ have been integral in achieving clinical and operational excellence to date and position us for success in the payment models of the future, such as ACOs, bundled payments and capitated models.

Strategic Partner to Physicians

The evolving healthcare landscape, including regulatory changes, increasing administrative burden, payor consolidation, shifting competitive landscape and transition to new payment models, is increasing pressure on physicians. We offer physicians an attractive solution to help them operate successfully in this environment as we design our facilities, structure our strategic relationships and adopt staffing, scheduling and clinical systems and protocols with the aim of increasing physicians' productivity and promoting their professional and financial success. Our approximately 2,000 physician partners (as of December 31, 2013), many of whom are leading practitioners in their respective fields and geographies, value the efficiency and convenience that our facilities provide. Our technology solutions allow our physicians to optimize clinical, operational and financial results. Our success in forming productive relationships with physicians is reflected in both the growth in the number of our physician partners and our Net Promoter Score of positive 90, according to our physician surveys conducted during November and December of 2013, which had a response rate of approximately 87% (which response rate is calculated on a weighted basis based on the number of cases performed by a physician at our facilities). This Net Promoter Score is a measure of loyalty ranging from negative 100 to positive 100 based on asking each of the physicians who utilize our facilities whether they would recommend performing cases at our facilities to a

physician colleague. We monitor physician satisfaction on a facility-by-facility basis, survey all of our physicians who utilize our facilities at least on an annual basis and use physician feedback to drive continuous improvement on a local and national basis.

Proven Management Team

Our senior leadership team of Andrew Hayek, President and Chief Executive Officer, Peter Clemens, Executive Vice President and Chief Financial Officer, Michael A. Rucker, Executive Vice President and Chief Operating Officer, Joseph T. Clark, Executive Vice President and Chief Development Officer, and Richard L. Sharff, Jr., Executive Vice President, General Counsel and Corporate Secretary, averages approximately 20 years of experience in the healthcare industry and has transformed our strategic approach to provide solutions to physicians, health systems and payors to optimize surgical care. Under this management team, we have experienced significant growth in our provider partnerships and enhanced our focus on clinical outcomes and patient experience, resulting in strong and consistent performance in our key financial and operating metrics and positioning us well for long-term growth.

Our Business Strategy

We seek to provide outstanding patient care and clinical quality, and we seek to create measurable clinical, operational and financial advantages for our partners by leveraging our tools and processes, knowledge and experience and talented leaders in each market. The key components of our strategy include:

- Delivering outstanding patient care and clinical outcomes;
- Driving strong and consistent same-site performance;
- Capitalizing on existing health system partnerships poised for growth;
- Developing new health system partnerships;
- Leveraging our core competencies to expand into new service lines;
- Establishing partnerships that take advantage of new payment models; and
- Consolidating a fragmented industry.

Delivering Outstanding Patient Care and Clinical Outcomes

We are committed to outstanding patient care and clinical quality. Our culture and operating systems reinforce this focus and commitment. We measure patient satisfaction, clinical outcomes and licensure and accreditation inspection readiness for each affiliated facility and combine those measures into our SCA Quality Index, which we monitor closely to identify areas for improvement and track progress. We also develop and implement clinical toolkits, clinical training and best practice sharing across our network to drive ongoing improvement in clinical outcomes. Our Regional Quality Councils ("RQCs") enable identification and sharing of best practices across our affiliated facilities. Each RQC is composed of at least one representative, such as a Regional Quality Coordinator or a Center Quality Coordinator, from each facility in the applicable region. Each RQC meets on at least a quarterly basis to share and compare clinical and operational experiences and to develop best practices, which are shared with governing boards at each facility. We have also developed focused training resources that are available to our physicians, nurses and surgical technicians at our affiliated facilities, including through a proprietary, learning computer portal called the Clinical Excellence Universe (or "CEU"). Our training programs include new teammate trainings, telephone and web conferences focusing on key clinical issues, continuing education programs, leadership development programs and initiatives aimed at enhancing our culture of patient safety.

Driving Strong and Consistent Same-Site Performance

Achieving strong performance on a same-site basis is important for us to drive organic revenue growth as well as support consistent operating performance for SCA and our partners. We believe that our partnership

model aligns incentives such that we and our partners can achieve improved long-term performance. We also believe that our ability to affiliate with physicians as an extension of their practices is an important driver to sustained same-site performance. Our clinical protocols and proprietary technology tools are designed to improve physician productivity and increase the number of procedures performed in our facilities while improving both physician and patient satisfaction. In addition, our ability to attract physicians through recruitment initiatives provides an additional opportunity for us to drive same-site growth. This alignment with partner hospitals and physicians has contributed to annual same site systemwide net operating revenues growth of 8.8% in 2013, 5.8% in 2012 and 5.5% in 2011. We have shown an ability to improve facility-level profitability by gaining physician alignment around more efficient supply utilization, reducing clinical variation, more effectively contracting with payors and lowering administrative costs.

Capitalizing on Existing Health System Partnerships Poised for Growth

We believe that development of our existing health system relationships is an important part of our continued growth. While our facility count has grown significantly from 131 to 177 affiliated facilities from December 31, 2007 to December 31, 2013, our growth in health system partners has been even stronger, more than doubling from 18 to 43 over the same time period. We believe this recent growth in health system partnerships creates significant opportunities. Our aligned model incentivizes our partners to work closely with us to identify strategically important and financially accretive growth opportunities in the markets we serve. Our experience has shown that demonstrated results in achieving exceptional patient care and strong physician partnerships have encouraged our partners to expand their relationships with us. For example, through our relationship with Sutter Health, as of December 31, 2013, we have acquired and developed 17 facilities since 2007. Our success with high quality health system partners has also led such partners, in some cases, to have us manage the surgical departments of their hospital sites through our recently introduced perioperative management solutions. Given that many of our health system partnerships have been developed recently, including relationships with 15 new health system partners in the twelve-months ended December 31, 2013 alone, we believe we are in the early stages of a significant opportunity to expand the scope of these relationships in the near-term, similar to our experience to date.

Developing New Health System Partnerships

We are focused on developing new health system partnerships, and we expect this to continue as we position ourselves as a partner of choice to physician groups, health systems and payors. While we have demonstrated a track record of success among a group of leading health systems, we believe that our current footprint represents only a small percentage of potential health system partnerships and that we have substantial long-term opportunities to add new relationships. In addition, industry dynamics, such as a challenging reimbursement environment and an increased emphasis on achieving cost savings with improved clinical outcomes, are encouraging health systems with which we do not already have relationships to seek partners. We believe that our expertise developing tools that ensure improved outcomes, drive cost savings and support efficiencies in the clinical setting will further strengthen our value proposition as a partner of choice for new health system relationships.

Leveraging Our Core Competencies to Expand into New Service Lines

We intend to leverage significant expertise related to the provision of surgical solutions in the form of expansion into new lines of service. Our relationships and operating systems provide a strong platform from which we can deliver a broader range of solutions designed to achieve excellent clinical outcomes while improving efficiency and generating significant savings in the healthcare system. As an example, we launched our perioperative consulting services to health system partners to optimize physician engagement, operating and cost efficiency, margin enhancement, market share growth and the development of new service lines. As of December 31, 2013, we provided such services to 14 facilities, and we have a dedicated team of professionals focused on expanding this business, as we believe it represents a significant area of potential growth. In addition to providing a high growth and diversified revenue stream, our perioperative consulting business also serves as a sales channel for potential health system partnerships. By demonstrating our value proposition and operational

expertise with the effective management of their surgical operations, we believe we are better positioned for partnering with the health system's current and prospective ASCs.

In addition to perioperative consulting, we also offer additional services relating to the delivery of surgical care, including management services (where we manage a surgical facility in which we do not have an ownership interest), clinical co-management consulting services (for hospital surgery departments interested in having certain of their non-employee physicians participate in management) and supply chain management and data analytics, to better serve patients' needs and strengthen our partnerships with our health system and physician partners as well as with payors.

Establishing Partnerships that Take Advantage of New Payment Models

We expect the evolving reimbursement landscape in healthcare to create opportunities to partner with physicians and payors in new payment models. We believe payment models such as "at risk" and "capitated" models, in which the providers receive a flat fee per member per month from payors regardless of the cost of care, drive surgical care to more cost-efficient settings, such as ASCs. We plan to continue working creatively with our various partners and potential partners to structure arrangements that provide solutions to the challenges created by the variety of new payment models.

For example, one of our partners is a large, integrated multi-specialty physician group and one of the original five ACOs piloted under a Dartmouth College/Brookings Institute-supported initiative in ACO healthcare delivery focused on improving care quality and bending the cost curve. As of December 31, 2013, we had four joint venture surgical facilities with this physician group, which takes capitated risk, and we have been able to improve the cost of surgical delivery for its patient base by shifting surgical case volume to our facilities.

As the various risk-based payment models evolve and grow in frequency, physicians and health systems that launch "at risk" payment models will need robust analytics and capabilities to improve the efficiency of surgical delivery. We plan to leverage our experience, data systems and physician engagement models to help health systems, physicians, employers and payors implement and successfully manage new payment models.

Consolidating a Fragmented Industry

Greater operating scale allows us to invest in better clinical, operational and financial systems and deliver outstanding results for our patients and partners. Therefore, we are focused on continuing to add new affiliated facilities where we see opportunities to grow volumes by recruiting new physicians and improve profitability by leveraging our scale, technology and operating efficiencies while delivering outstanding patient care. We expect our acquisition activity to continue as we continue to position ourselves as a partner of choice to health systems and physician groups. Given that we operate in a relatively fragmented segment of the healthcare industry, with the three largest companies operating an aggregate of only 12% of the approximately 5,300 Medicare-certified ASCs in the United States as of December 31, 2013, we believe there are and will continue to be robust opportunities to invest and partner in new facilities. We believe our scale, operational expertise and value-added services and solutions differentiate us and provide us with the ability to selectively acquire attractive assets in attractive markets where we can create value, both in the near term as well as over the longer term. We plan to continue to leverage our proven strategy for target identification, thorough diligence, transaction execution and integration which we have systematically implemented in acquisitions of 13 consolidated and 32 nonconsolidated facilities from January 1, 2010 to December 31, 2013.

Operations

General

Our operations consist primarily of our ownership and management of surgery centers. Our affiliated facilities provide the space, equipment and medical support staff necessary for physicians to perform non-emergency surgical procedures. Our typical ASC is a freestanding facility with fully-equipped operating and procedure rooms and ancillary areas for reception, preparation, recovery and administration. Our surgical

hospitals provide medical services similar to those provided by our ASCs and can also accommodate more complicated procedures requiring patients to stay overnight. The typical staff of an affiliated facility includes an administrator, registered nurses and operating room technicians, as well as personnel in a business office performing tasks such as billing and collecting. In addition, at each affiliated facility, a physician who serves as the medical director is responsible for medical direction and certain administrative services at the facility, including ensuring that clinical activities are performed in accordance with the facility's policies and procedures and serving as a liaison between the facility's administration and its medical staff. Our affiliated facilities generally have service agreements with anesthesiologists and certified registered nurse anesthetists ("CRNAs") to provide anesthesiology services. Generally, those anesthesiologists and CRNAs are independent contractors of the affiliated facilities and are responsible for their own clinical and billing activities; in a few cases, those individuals are employed by the affiliated facility. Otherwise, the physicians that utilize our facilities are not employees of our facilities. We typically assist each of our affiliated facilities with marketing, payor contracting, purchasing and other strategic and operational services, including the preparation of financial statements.

Each affiliated facility is licensed in accordance with local and state requirements. All but three of our affiliated facilities are also certified as Medicare providers. The affiliated facilities are available for use only by licensed physicians and other qualified healthcare providers. To ensure consistent quality of care, each affiliated facility has a medical executive committee comprised of local physicians that reviews the qualifications of each physician who applies to practice at the affiliated facility. In addition, as of December 31, 2013, 165 of our 171 ASCs and all five of our surgical hospitals were accredited by either The Joint Commission or the Accreditation Association for Ambulatory Health Care ("AAAHC"), the two major national organizations that establish standards relating to the physical plant, administration, quality of patient care and operation of medical staffs of various types of healthcare facilities. Five of our six remaining ASCs that were not accredited as of December 31, 2013 are actively pursuing accreditation. We believe that accreditation is the quality benchmark used by commercial payors for inclusion of a facility in their network. Some payors may not include a facility in their network unless the facility is accredited.

Billing and Payment

Our affiliated facilities derive their net patient revenues by collecting fees from patients, insurance companies, government programs and other third-party payors in exchange for providing the facility and related services for surgical procedures. The surgeons and, in most cases, anesthesiologists and CRNAs at our affiliated facilities bill their patients or relevant other payors directly for their professional services; therefore, such services are not included in our billing for a procedure.

Each affiliated facility uses a patient accounting system to manage scheduling, billing and collection, accounts receivable management and other essential operational functions. We have implemented systems to centralize financial data from most affiliated facilities into our corporate data systems. These systems support our access to information on a timely basis and enhance our ability to provide each affiliated facility with financial statements and other financial data services.

Revenues at our affiliated facilities consist primarily of net patient service revenues that are recorded based upon established billing rates less allowances for contractual adjustments. Revenues are recorded during the period in which the healthcare services are provided, based upon the estimated amounts due from patients and third-party payors, including commercial health plans, commercial insurance companies, employers, workers' compensation plans and federal and state agencies (under the Medicare and Medicaid programs). We utilize the payment history specific to each affiliated facility by payor to record estimated contractual allowances, and we employ other analytical tools to ensure the appropriateness of these estimates. Third-party payor contractual payment terms are generally based upon predetermined rates per procedure or discounted fee-for-service rates.

It is our general practice, where possible, to verify a patient's insurance and collect estimated co-payments prior to rendering services. Claims are submitted electronically if the payor accepts electronic claims. We require claims submitted to third-party payors to be paid within timeframes that are generally consistent with industry standard practices, which vary based upon payor type.

In general, we or our health system partners negotiate contracts directly with non-governmental third-party payors and employers. The rates paid by governmental third-party payors are set by such payor and are not subject to negotiations. We market our affiliated facilities directly to non-governmental third-party payors and employers in order to communicate the cost advantages of surgery centers versus hospitals. Payor marketing activities are conducted by reimbursement teammates and facility administrators, with important assistance from our physician partners. We emphasize the high-quality healthcare, cost advantages and convenience of our affiliated facilities.

Patients are generally not responsible for the difference between our established charges and amounts reimbursed for such services under Medicare, Medicaid and negotiated third-party payor contracts, but they are responsible for any exclusions, deductibles, co-payments or coinsurance features of their coverage.

Clinical and Operating Systems

We have developed a number of tools to track and compare results from our affiliated facilities and across our network. We believe these systems are an important strength and provide us data to improve results, training and efficiency across our affiliated facilities.

Our clinical systems allow detailed benchmarking of clinical outcomes endorsed by the National Quality Forum, patient satisfaction and accreditation inspection readiness. We have extensive tools to prepare for regulatory surveys. We strongly encourage all of our ASCs and surgical hospitals to seek and to maintain accreditation by an independent agency, either The Joint Commission or the AAAHC. All of our facilities that have sought such accreditation have successfully completed the survey process and have received a three-year term of accreditation, which is only provided after the accrediting organization has concluded that the facility is in substantial compliance with the relevant organizational standards. Our clinical education system, the CEU, provides tailored education programs to our approximately 2,900 clinicians, as of December 31, 2013, across the country.

Our operating systems provide detailed benchmarking of key operational measures (including on-time starts, turn-times, staffing ratios and supply expense metrics). Management uses these tools to measure operating results against target thresholds and to identify, monitor and adjust areas such as case mix, staffing, operating costs, teammate expenses and accounts receivable management.

Our case-costing system, the ECOSystem™, provides detailed labor cost, supply cost and contribution margin data by procedure code, physician, facility and payor. This ECOSystem™ data allows us to work with our physicians to benchmark their performance on a detailed level and show them precise steps they can take to optimize clinical, operational and financial results. We also have a dedicated supply chain team that works with our facilities and affiliated physicians across the country to aggregate the approximately $220 million spent on surgical supplies in 2013 and to use that purchasing power to negotiate more favorable company-wide contracts with vendors.

Our detailed data also allows us to work in partnership with payors to optimize the cost of surgery for their covered members. Surgery is one of the largest components of medical costs, typically representing approximately 30% of total medical spending for individuals with commercial insurance, according to our estimates. Because of this, we are increasingly focused on working with commercial payors, Medicare Advantage plans and capitated physician groups to help them reduce the total medical spend (or rate of medical spend growth) for their population while maintaining or improving the quality of care.

Facility Level Ownership Structure

Almost all of our affiliated facilities are owned in partnership with local physicians. As of December 31, 2013, we had approximately 2,000 aggregate physician partners. The amount of physician ownership in our

facilities ranges widely based on local market conditions. Physician ownership of our consolidated facilities typically ranges from 10% to 50%. When we partner with a health system in a three-way joint venture, we typically hold a non-controlling ownership interest in a holding company that owns a majority or controlling ownership interest in the facility, and the health system partner holds the controlling interest in the holding company.

Our facilities are organized as limited partnerships ("LPs") or general partnerships, limited liability companies ("LLCs") or limited liability partnerships ("LLPs"). In ventures that do not include a health system partner, we typically serve as the general partner (or its equivalent) of the entity, as well as the day-to-day manager of the facility owned by the entity. In our three-way joint ventures that include a health system partner, we typically serve as a noncontrolling member of an LLC that is co-owned with the health system, and that LLC serves as the general partner (or its equivalent) of the facility. In such three-way ventures, we typically enter into a management agreement to handle most of the day-to-day management functions for the facilities owned by the LLC, and the health system negotiates fee schedules with payors and provides other miscellaneous services.

Our affiliated facilities typically pay a monthly management fee to us and, where we have an ownership interest, a monthly or quarterly *pro rata* distribution of cash in excess of current obligations, less amounts held in reserve for working capital and certain other anticipated expenditures. The partnership and LLC agreements typically provide for, among other things, limited voting rights for our limited partners and limited rights to transfer ownership interests. We have developed a "model" agreement that includes provisions to restrict a physician partner from owning an interest in a competing surgery center or surgical hospital during the period in which the physician owns an interest in our facility and for a period of two years after they no longer own an interest in our facility. Similarly, our model agreement for ASCs requires our physician partners to certify that they are using the applicable facility in a way that is consistent with the regulatory guidance on what constitutes use of the facility as an "extension of their office practice." In multi-specialty ASCs, this means, among other things, that at least one-third of their eligible cases are performed at our facility. These provisions give us (or our health system partner) the right to repurchase equity from physician partners who do not meet this threshold. Our agreements also typically give us the right, but do not require us, to repurchase equity interests from physician partners who retire or trigger certain other repurchase provisions in the agreements. However, some of our agreements do not include some or any of these model provisions.

Certain of our operating agreements have termination dates by which the agreement expires by its terms. In these situations, if we wish to continue the business, we would attempt to negotiate an amendment to the agreement and, if necessary, to renegotiate material terms of the agreement to prevent such termination. None of our current operating agreements terminate in 2014. See "Risk Factors — Risks Related to Our Business — Certain of our partnership and operating agreements contain termination dates that will require us to amend and possibly renegotiate such agreements."

In addition, certain of our agreements contain provisions that give our partners or other members rights that include, but are not limited to, rights to purchase our interest, rights to require us to purchase the interests of our partners or other members or rights requiring the consent of our partners and other members prior to our transferring our ownership interest in a facility or prior to a change in control of us or certain of our subsidiaries.

Almost all of our partnership and operating agreements contain restrictions on actions that we can take, even though we may be the general partner or the managing member, including rights of our partners and other members to approve the sale of substantially all of the assets of the entity, to dissolve the partnership or LLC, and to amend the partnership or operating agreement. Many of our agreements also restrict our ability in certain instances to compete with our existing facilities or with our partners. Where we hold only a limited partner or a non-managing member interest, the general partner or managing member may take certain actions without our consent, although we typically have certain protective rights to approve major decisions, such as the sale of substantially all of the assets of the entity, the dissolution of the partnership or LLC, and the amendment of the partnership or operating agreement. See "Risk Factors — Risks Related to Our Business — Certain of our partnership and operating agreements contain provisions giving rights to our partners and other members that may be adverse to our interests."

Further, some of our partnership and LLC agreements provide that the partnership, LLC, general partner or managing member, as applicable, will purchase all of the physicians' ownership interests at fair market value if certain regulatory events occur, including, for example, if it becomes illegal for the physicians to own an interest in a facility, refer patients to a facility or receive cash distributions from a facility. See "Risk Factors — Risks Related to Healthcare Regulation — If laws or regulations governing physician ownership of our facilities change, we may be obligated to purchase some or all of the ownership interests of our physician partners or renegotiate some of our partnership and operating agreements with our physician partners and management agreements with our surgical facilities." From time to time, we may extend loans to the partnerships or LLCs on commercially reasonable and fair market value terms in order to fund capital expenditures, leasehold improvements or other cash requirements. See "Risk Factors — Risks Related to Our Business — We make significant loans to the partnerships and LLCs that own and operate certain of our facilities."

Resyndications

We periodically provide physicians who use our facilities the opportunity to purchase ownership interests (or increase their ownership interests) in those facilities, which we call "resyndication." We believe that periodic resyndication of ownership interests helps our facilities maintain a core group of physicians who actively use the facility as an extension of their office practice and are incentivized to ensure that the facilities make the necessary investments and follow the necessary practices to provide high-quality and cost-efficient patient care services.

In addition to selling our equity interest, a key component of our resyndication strategy is repurchasing equity interests from existing physician partners and re-selling that equity to non-partner physicians or to other existing physician partners. Where feasible, we seek to redistribute equity from existing to new physician partners before selling our own equity or new equity in our facilities. However, we will continue to sell portions of our existing ownership where we believe it is in our overall best interest.

Case and Payor Mix

We seek to maintain diversity of case mix in our portfolio to insulate us from potential negative effects that could stem from emphasizing one particular case type. The following chart breaks down our consolidated net patient revenues by specialty and by type of payor for the year-ended December 31, 2013.

Case Mix	Year-Ended December 31, 2013	Payor Mix	Year-Ended December 31, 2013
Orthopedic	30%	Commercial health insurance payors	60%
Ophthalmology	17	Medicare	20
Gastroenterology	13	Workers' compensation	11
Pain	8	Patients and other third-party payors	6
ENT	8	Medicaid	3
General Surgery	24		
Total	100%	Total	100%

Seasonality

In recent years, our facilities have experienced a disproportionate allocation of payor mix throughout the year. Our facilities typically see a relatively higher percentage of patients with governmental payors in the first half of the year and a relatively higher percentage of patients with commercial payors in the second half of the year. We believe this trend is a result of the continuing sharing of the cost of care with patients by employers and insurers through increased annual deductibles, which are not typically met until later in the year.

Facilities

The following table sets forth information relating to our facilities and corporate offices as of December 31, 2013:

Facility	*Location*	*Date of Acquisition or Affiliation[1]*	*Capacity[2] ORs*	*Capacity[2] PRs*	*Our Beneficial Ownership Percentage[3]*
Alabama					
*Birmingham Outpatient Surgery Center, Ltd.	Birmingham, AL	6/29/2007	8	1	34.4%
*Florence Surgery Center, L.P.	Florence, AL	6/29/2007	4	—	50.0%
*Gadsden Surgery Center, Ltd.	Gadsden, AL	6/29/2007	4	2	57.5%
*Mobile-SC, LTD.	Mobile, AL	6/29/2007	4	3	33.0%
Surgery Center of Cullman, LLC	Cullman, AL	6/29/2007	4	3	33.3%
Surgicare of Mobile, Ltd.	Mobile, AL	6/29/2007	5	3	30.0%
*Tuscaloosa Surgical Center, L.P.	Tuscaloosa, AL	6/29/2007	5	7	30.0%
Alaska					
*Alaska Surgery Center, Limited Partnership	Anchorage, AK	6/29/2007	8	1	38.1%
California					
Los Angeles Facilities					
*Antelope Valley Surgery Center, L.P.	Lancaster, CA	6/29/2007	4	2	80.6%
*Arcadia Outpatient Surgery Center, L.P.	Arcadia, CA	6/29/2007	4	—	48.7%
Channel Islands Surgicenter, L.P.	Oxnard, CA	6/29/2007	3	2	25.4%
Digestive Disease Center, L.P.	Laguna Hills, CA	12/31/2012	—	3	25.0%
*Glenwood Surgical Center, L.P.	Riverside, CA	6/29/2007	3	3	50.0%
*Golden Triangle Surgicenter, L.P.	Murrieta, CA	6/29/2007	3	1	67.5%
Greater Long Beach Endoscopy Center	Long Beach, CA	6/29/2007	3	3	20.0%
Hoag Outpatient Centers, LLC	Newport Beach, CA	6/1/2013	—	3	5.0%
*Inland Surgery Center, L.P.	Redlands, CA	6/29/2007	4	1	44.5%
Kerlan-Jobe Surgery Center, LLC	Los Angeles, CA	6/29/2007	4	—	Managed-only
MemorialCare Surgical Center at Orange Coast, LLC	Fountain Valley, CA	4/1/2013	3	—	Managed-only
MemorialCare Surgical Center at Saddleback, LLC (Saddleback)	Laguna Hills, CA	12/27/2012	4	6	25.9%
MemorialCare Surgical Center at Saddleback, LLC (Laguna Hills)	Laguna Hills, CA	12/27/2012	4	1	25.9%
*Newport Beach Endoscopy Center, LLC	Newport Beach, CA	6/29/2007	2	2	39.5%
*Santa Monica Surgical Partners, L.L.C.	Santa Monica, CA	11/1/2012	5	—	28.5%
*Surgicare of La Veta, Ltd., a California Limited Partnership	Orange, CA	6/29/2007	5	1	20.0%
*Thousand Oaks Endoscopy Center, LLC	Thousand Oaks, CA	6/29/2007	—	2	51.0%
*Upland Outpatient Surgical Center, L.P.	Upland, CA	6/29/2007	2	1	92.8%
Sacramento Facilities					
Fort Sutter Surgery Center, a California Limited Partnership (K. Street)	Sacramento, CA	6/29/2007	3	3	29.0%
Fort Sutter Surgery Center, a California Limited Partnership (Scripps Drive)	Sacramento, CA	6/29/2007	4	1	29.0%
Sacramento Surgery Center Associates, L.P.	Sacramento, CA	1/1/2011	2	2	25.3%
South Placer Surgery Center, L.P.	Roseville, CA	5/1/2012	2	1	25.0%
Sutter Alhambra Surgery Center, L.P.	Sacramento, CA	6/29/2007	3	—	25.0%

Facility	*Location*	*Date of Acquisition or Affiliation[1]*	*Capacity[2] ORs*	*Capacity[2] PRs*	*Our Beneficial Ownership Percentage[3]*
San Diego Facilities					
*Grossmont Surgery Center, L.P.	La Mesa, CA	6/29/2007	3	2	21.6%
*Pomerado Outpatient Surgical Center, L.P.	San Diego, CA	6/29/2007	4	1	60.8%
*San Diego Endoscopy Center	San Diego, CA	6/29/2007	—	3	45.0%
UCSD Ambulatory Surgery Center, LLC	San Diego, CA	11/30/2007	3	—	20.0%
San Francisco Facilities					
East Bay Endoscopy Center, L.P.	Emeryville, CA	7/1/2011	—	2	25.0%
Golden Gate Endoscopy Center, LLC	San Francisco, CA	7/1/2011	—	3	25.0%
Marin Health Ventures, LLC	Greenbrae, CA	8/1/2008	2	1	25.0%
Mountain View Endoscopy Center, LLC	Mountain View, CA	7/1/2011	—	1	20.0%
Peninsula Eye Surgery Center, LLC	Mountain View, CA	12/1/2012	2	—	25.0%
Presidio Surgery Center, LLC	San Francisco, CA	6/29/2007	5	1	Managed-only
San Francisco Endoscopy Center LLC	San Francisco, CA	7/1/2011	—	3	8.0%
Santa Rosa Surgery Center, L.P.	Santa Rosa, CA	6/29/2007	4	1	25.6%
Sutter Street Endoscopy Center, LLC	San Francisco, CA	7/1/2011	—	1	25.0%
Walnut Creek Endoscopy Center LLC	Walnut Creek, CA	7/1/2011	—	2	25.0%
Other California Facilities					
Auburn Surgical Center, L.P.	Auburn, CA	6/29/2007	2	1	49.5%
*Bakersfield Physicians Plaza Surgical Center, L.P.	Bakersfield, CA	6/29/2007	5	—	79.0%
Mirage Endoscopy Center, LP	Rancho Mirage, CA	6/1/2013	—	1	Managed-only
North Coast Surgery Center, Ltd., a California Limited Partnership	Oceanside, CA	6/29/2007	4	—	27.3%
Redding Surgery Center, LLC	Redding, CA	10/1/2013	2	—	25.0%
San Luis Obispo Surgery Center, a California Limited Partnership	San Luis Obispo, CA	6/29/2007	3	—	45.9%
Santa Barbara Endoscopy Center, LLC	Santa Barbara, CA	7/1/2011	—	1	25.0%
*Santa Cruz Endoscopy Center, LLC	Santa Cruz, CA	7/1/2011	—	1	40.0%
Colorado					
Colorado Springs Health Partners Ambulatory Surgery Center	Colorado Springs, CO	6/29/2007	5	—	Managed-only
Pueblo Ambulatory Surgery Center Limited Partnership	Pubelo, CO	6/29/2007	5	—	12.3%
Surgery Center of Fort Collins, LLC	Fort Collins, CO	6/29/2007	4	—	25.0%
Surgical Center at Premier, LLC	Colorado Springs, CO	6/29/2007	5	2	38.0%
Connecticut					
*Connecticut Surgery Center, Limited Partnership	Hartford, CT	8/22/2007	2	1	65.0%
*Danbury Surgical Center, L.P.	Danbury, CT	8/22/2007	4	2	46.5%
*Hartford Surgery Center, LLC	Hartford, CT	8/22/2007	2	—	91.0%
Norwalk Surgery Center, LLC	Norwalk, CT	6/1/2013	2	2	4.8%
*Surgery Center of Fairfield County, LLC	Trumbull, CT	8/22/2007	4	2	38.0%

Facility	*Location*	*Date of Acquisition or Affiliation[1]*	*Capacity[2] ORs*	*Capacity[2] PRs*	*Our Beneficial Ownership Percentage[3]*
Florida					
*Boca Raton Outpatient Surgery & Laser Center, LTD.	Boca Raton, FL	6/29/2007	6	2	30.0%
*Citrus Regional Surgery Center, L.P.	Lecanto, FL	6/29/2007	5	1	56.0%
*E Street Endoscopy, LLC	Clearwater, FL	8/2/2010	1	2	51.0%
*Emerald Coast Surgery Center, L.P.	Fort Walton Beach, FL	6/29/2007	5	3	35.0%
*Indian River Surgery Center, Ltd.	Vero Beach, FL	6/29/2007	4	2	87.0%
*Melbourne Surgery Center, LLC	Melbourne, FL	6/29/2007	4	1	69.3%
*Orlando Center for Outpatient Surgery, L.P.	Orlando, FL	6/29/2007	4	1	55.3%
*Sarasota Endoscopy Center, L.P.	Sarasota, FL	6/29/2007	1	2	82.1%
*The Brevard Specialty Surgery Center, LLC	Melbourne, FL	10/1/2013	3	4	69.3%
*Winter Park Surgery Center, L.P.	Winter Park, FL	6/29/2007	4	2	18.1%
Georgia					
Atlanta Facilities					
Atlanta Advanced Surgery Center, LLC	Atlanta, GA	7/1/2012	5	2	Managed-only
*Perimeter Center for Outpatient Surgery, L.P.	Atlanta, GA	6/29/2007	4	2	53.0%
Other Georgia Facilities					
*Gainesville Surgery Center, L.P.	Gainesville, GA	6/29/2007	4	3	42.6%
Gwinnett Advanced Surgery Center, LLC	Snellville, GA	7/1/2012	3	1	Managed-only
Hawaii					
*Aloha Surgical Center, L.P.	Kahului, HI	6/29/2007	4	—	94.8%
Castle Ambulatory Surgery Center, LLC	Kailua, HI	6/1/2013	2	2	10.0%
Honolulu Surgery Center, L.P.	Honolulu, HI	6/29/2007	5	2	48.4%
Iowa					
Mississippi Medical Plaza, L.C. (Endoscopy)	Davenport, IA	6/1/2013	7	—	Managed-only
Mississippi Medical Plaza, L.C.	Davenport, IA	6/1/2013	—	4	Managed-only
*Surgery Centers of Des Moines, Ltd., an Iowa Limited Partnership	Des Moines, IA	6/29/2007	4	1	67.8%
*Surgery Centers of Des Moines, Ltd., an Iowa Limited Partnership (West)	West Des Moines, IA	6/29/2007	10	—	67.8%
Tri-State Surgery Center, L.L.C.	Dubuque, IA	6/1/2013	3	2	Managed-only
Idaho					
*Treasure Valley Hospital Limited Partnership	Boise, ID	6/29/2007	4	—	40.4%
Treasure Valley Surgery Center — Nampa, LP	Nampa, ID	6/28/2012	5	—	25.2%
Illinois					
Chicago Facilities					
*Hawthorn Place Outpatient Surgery Center, L.P.	Libertyville, IL	2/1/2008	3	1	38.0%
*Loyola Ambulatory Surgery Center at Oakbrook, L.P.	Oakbrook Terrace, IL	2/1/2008	3	—	45.0%
*Northwest Surgicare, Ltd., an Illinois Limited Partnership	Arlington Heights, IL	2/1/2008	5	1	57.0%

Facility	*Location*	*Date of Acquisition or Affiliation[1]*	*Capacity[2] ORs*	*Capacity[2] PRs*	*Our Beneficial Ownership Percentage[3]*
Other Illinois Facilities					
*Belleville Surgical Center, Ltd., an Illinois Limited Partnership	Belleville, IL	2/1/2008	4	—	98.3%
*Joliet Surgery Center Limited Partnership	Joliet, IL	11/1/2009	4	1	52.4%
Indiana					
Indianapolis Facilities					
Beltway Surgery Centers, L.L.C. — Glen Lehman Endoscopy Suite	Indianapolis, IN	2/15/2012	—	8	24.5%
Beltway Surgery Centers, L.L.C. (BSC-GI)	Indianapolis, IN	7/1/2011	4	4	24.5%
Beltway Surgery Centers, L.L.C. (BSC-MS)	Indianapolis, IN	7/1/2011	8	1	24.8%
Beltway Surgery Centers, L.L.C. — Indiana Hand to Shoulder Beltway Surgery Center	Indianapolis, IN	12/31/2012	3	1	24.8%
Eagle Highlands Surgery Center, LLC	Indianapolis, IN	7/1/2011	7	—	24.7%
Eagle Highlands Surgery Center, LLC — Meridian South Surgery Center	Indianapolis, IN	7/24/2013	4	—	24.7%
Indiana Endoscopy Centers, LLC (Avon)	Avon, IN	7/1/2011	—	4	25.0%
Indiana Endoscopy Centers, LLC (Downtown)	Indianapolis , IN	7/1/2011	—	4	25.0%
Indiana Endoscopy Centers, LLC (Fishers)	Fishers, IN	7/1/2011	—	3	25.0%
Indiana University Health Saxony Surgery Center LLC	Fishers, IN	3/5/2012	4	1	Managed-only
ROC Surgery LLC	Indianapolis, IN	7/1/2011	6	—	28.5%
Senate Street Surgery Center, LLC	Indianapolis, IN	7/1/2011	8	2	25.4%
Other Indiana Facility					
Ball Outpatient Surgery Center, LLC	Muncie, IN	7/1/2011	5	2	27.6%
Kansas					
KU Medwest Ambulatory Surgery Center, L.L.C.	Shawnee, KS	6/1/2013	3	1	Managed-only
Lawrence Surgery Center, L.L.C.	Lawrence, KS	6/1/2013	4	—	Managed-only
Kentucky					
Lexington Surgery Center, Ltd.	Lexington, KY	6/29/2007	6	6	35.0%
Louisville S.C., Ltd.	Louisville, KY	6/29/2007	4	1	29.9%
Owensboro Ambulatory Surgical Facility, Ltd.	Owensboro, KY	6/29/2007	6	2	30.7%
Premier Surgery Center of Louisville, L.P.	Louisville, KY	6/29/2007	4	4	25.0%
*Somerset Surgery Center, Limited Partnership	Somerset, KY	6/29/2007	2	1	72.0%
Louisiana					
*B.R.A.S.S. Partnership in Commendam	Baton Rouge, LA	6/29/2007	4	1	56.4%

Facility	*Location*	*Date of Acquisition or Affiliation[1]*	*Capacity[2] ORs*	*Capacity[2] PRs*	*Our Beneficial Ownership Percentage[3]*
Maryland					
*Montgomery Surgery Center Limited Partnership	Rockville, MD	6/29/2007	4	2	68.0%
Suburban Outpatient Surgery Center, LLC	Bethesda, MD	7/1/2011	4	1	Managed-only
*The Surgery Center of Easton, L.P.	Easton, MD	6/29/2007	1	1	67.0%
Minnesota					
HealthEast Surgery Center-Maplewood, LLC	Maplewood, MN	6/1/2013	4	—	10.0%
*St. Cloud Outpatient Surgery, Ltd., a Minnesota Limited Partnership	St. Cloud, MN	6/29/2007	11	—	20.2%
*Surgicare of Minneapolis, Ltd., a Minnesota Limited Partnership	Edina, MN	6/29/2007	3	—	59.5%
Missouri					
South County Surgical Center, LLC	St. Louis, MO	5/1/2009	2	2	27.6%
Mississippi					
*Mississippi Surgical Center Limited Partnership	Jackson, MS	7/1/2010	6	6	51.0%
*Surgicare of Jackson, Ltd., a Mississippi Limited Partnership	Jackson, MS	6/29/2007	5	1	40.0%
Montana					
*Northern Rockies Surgery Center, L.P.	Billings, MT	6/29/2007	4	—	59.3%
Nebraska					
Bergan Mercy Surgery Center, LLC	Omaha, NE	6/1/2013	3	2	4.6%
Lakeside Ambulatory Surgical Center, LLC	Omaha, NE	6/1/2013	4	1	Managed-only
Nebraska Spine Hospital, LLC	Omaha, NE	6/1/2013	6	1	5.0%
New Jersey					
Ambulatory Surgery Center at Virtua Washington Township LLC	Sewell, NJ	6/1/2013	2	—	Managed-only
*East Brunswick Surgery Center, LLC	East Brunswick, NJ	12/31/2013	4	1	51.0%
Memorial Ambulatory Surgery Center, LLC	Mt. Holly, NJ	6/1/2013	4	1	Managed-only
South Jersey Musculoskeletal Institute LLC	Sewell, NJ	6/1/2013	3	2	Managed-only
Summit Surgical Center LLC	Voorhees, NJ	6/1/2013	7	3	Managed-only
*Surgical Center of South Jersey, Limited Partnership	Mount Laurel, NJ	6/29/2007	4	2	88.2%
Vantage Surgical Center Associates, LLC.	Medford, NJ	6/1/2013	3	1	Managed-only
Nevada					
*The Surgical Center at Tenaya, L.P.	Las Vegas, NV	6/29/2007	4	1	20.0%

Facility	*Location*	*Date of Acquisition or Affiliation[1]*	*Capacity[2] ORs*	*Capacity[2] PRs*	*Our Beneficial Ownership Percentage[3]*
North Carolina					
*Blue Ridge Day Surgery Center, L.P.	Raleigh, NC	6/29/2007	6	1	45.5%
*Charlotte Surgery Center, Limited Partnership	Charlotte, NC	6/29/2007	7	—	42.0%
*Fayetteville Ambulatory Surgery Center, L.P.	Fayetteville, NC	6/29/2007	11	3	46.2%
Greensboro Specialty Surgery Center, LLC	Greensboro, NC	6/29/2007	3	2	24.5%
*Surgical Center of Greensboro, LLC	Greensboro, NC	6/29/2007	13	—	50.0%
*The Eye Surgery Center of the Carolinas, L.P.	Southern Pines, NC	6/29/2007	3	1	50.0%
Ohio					
Endoscopy Center West, LLC	Cincinnati, OH	6/29/2007	—	2	20.0%
Middletown Surgery Center, LLC	Franklin, OH	6/1/2013	2	2	Managed-only
OhioHealth Sleep Services, LLC	Multiple Locations, OH	6/1/2013	N/A	N/A	Managed-only[4]
Polaris Surgery Center, LLC	Westerville, OH	6/1/2013	4	1	Managed-only
Samaritan North Surgery Center, Ltd.	Dayton, OH	6/1/2013	4	2	Managed-only
The Hand Center, LLC	Columbus, OH	6/1/2013	2	—	Managed-only
Upper Arlington Surgery Center, Ltd.	Columbus, OH	6/1/2013	6	1	Managed-only
Whitehall Surgery Center, Ltd.	Columbus, OH	6/1/2013	4	2	Managed-only
Oklahoma					
*Surgical Hospital of Oklahoma, L.L.C.	Oklahoma City, OK	9/1/2009	7	—	60.0%
*Three Rivers Surgical Care, L.P.	Muskogee, OK	6/29/2007	2	3	40.5%
Oregon					
*McKenzie Surgery Center, L.P.	Eugene, OR	6/29/2007	4	2	92.0%
*Salem Surgery Center, Ltd., an Oregon Limited Partnership	Salem, OR	6/29/2007	5	—	71.0%
Pennsylvania					
*Grandview Surgery Center, LTD.	Camp Hill, PA	6/29/2007	4	2	20.0%
Lackawanna Physicians Ambulatory Surgery Center, LLC	Dickson City, PA	12/31/2012	3	2	34.7%
*Mt. Pleasant Surgery Center, L.P.	Mt. Pleasant, PA	6/29/2007	4	—	93.4%
*Paoli Surgery Center, L.P.	Paoli, PA	6/29/2007	4	1	38.6%
Rhode Island					
*Blackstone Valley Surgicare Acquisition, L.P.	Johnston, RI	6/29/2007	5	2	93.0%
Rhode Island Hospital Surgery Center at Wayland Square	Providence, RI	6/29/2007	3	1	Managed-only
South Carolina					
*Charleston Surgery Center Limited Partnership	North Charleston, SC	6/29/2007	4	2	58.4%
Tennessee					
Memphis Surgery Center, LTD., L.P.	Memphis, TN	6/29/2007	4	1	37.5%
*SCA Nashville Surgery Center, L.L.C.	Nashville, TN	6/29/2007	5	1	60.0%
*Surgery Center of Clarksville, L.P.	Clarksville, TN	6/29/2007	4	2	75.6%

Facility	*Location*	*Date of Acquisition or Affiliation[1]*	*Capacity[2] ORs*	*Capacity[2] PRs*	*Our Beneficial Ownership Percentage[3]*
Texas					
Dallas / Fort Worth Facilities					
*Cleburne Surgical Center, LLC	Cleburne, TX	12/1/2013	2	1	25.0%[5]
*Denton Surgery Center, LLC	Denton, TX	10/1/2012	3	2	35.0%[5]
Fort Worth Endoscopy Center (Southwest)	Fort Worth, TX	8/17/2007	3	1	Managed-only
Fort Worth Endoscopy Center	Fort Worth, TX	8/17/2007	2	1	Managed-only
*Greenville Surgery Center, LLC	Dallas, TX	6/29/2007	4	1	39.4%[5]
*Surgical Caregivers of Fort Worth, LLC	Fort Worth, TX	6/29/2007	7	2	25.0%[5]
*Texas Health Craig Ranch Surgery Center, LLC	McKinney, TX	4/8/2013	5	1	32.3%[5]
*Texas Health Flower Mound Orthopedic Surgery Center, LLC	Flower Mound, TX	9/25/2013	4	—	25.0%[5]
Other Texas Facilities					
*Austin Center For Outpatient Surgery, L.P.	Austin, TX	6/29/2007	5	2	58.0%
*Corpus Christi Endoscopy Center, L.L.P.	Corpus Christi, TX	7/1/2011	2	3	19.5%
*Pasteur Plaza Surgery Center, L.P.	San Antonio, TX	6/29/2007	3	1	66.6%
*SCA Houston Hospital for Specialized Surgery, L.P.	Houston, TX	6/29/2007	6	2	50.0%
*Waco Surgical Center, Ltd.	Waco, TX	6/29/2007	4	2	100.0%
Utah					
*Salt Lake Surgical Center, L.P.	Salt Lake City, UT	6/29/2007	7	—	91.3%
Wisconsin					
Wausau Surgery Center, L.P.	Wausau, WI	6/29/2007	4	1	26.0%
*Wauwatosa Surgery Center, Limited Partnership	Wauwatosa, WI	6/29/2007	4	—	51.0%

Corporate Offices	*Location*
Corporate Headquarters	Deerfield, IL
Operations Center	Birmingham, AL

* Indicates a consolidated facility. All other facilities are nonconsolidated, unless otherwise indicated that the facility is managed-only.

(1) Facilities noted as acquired on June 29, 2007, August 17, 2007, August 22, 2007, February 1, 2008 and November 1, 2009 were all acquired as part of the purchase of our company in 2007 by TPG and certain co-investors. The facilities that are listed as acquired after June 2007 were carved out of the initial acquisition closing, and were acquired upon completion of certain post-closing matters.

(2) Includes operating rooms ("ORs") and procedure rooms ("PRs") for ASCs and surgical hospitals.

(3) Many of our facilities are held through one or more intermediate holding companies. These intermediate holding companies are typically structured to be owned jointly with our partners, resulting in partial ownership of the intermediate holding company by us. The intermediate holding company itself typically only owns a portion of the facility, with the remaining portion owned by others, including our physician partners. Our beneficial ownership percentage presented in the table above represents our percentage of ownership in the facility as calculated by multiplying our percentage of ownership in the intermediate holding company by the intermediate holding company's percentage of ownership in the facility.

(4) Represents one facility with eleven locations.

(5) We do not currently hold an equity ownership interest in this facility, rather we hold a promissory note that is convertible into equity. The percentage represents what our beneficial ownership percentage will be upon conversion of the promissory note. Because this promissory note provides us with the power to direct the activities that most significantly impact the economic performance of this entity, we consolidate this facility into our financial results, as it meets the requirements to be a variable interest entity ("VIE"). See Note 3 "Summary of Significant Accounting Policies — Variable Interest Entities" of our consolidated financial statements included elsewhere in this Annual Report on Form 10-K for further discussion.

We lease the majority of the facilities where our surgery centers and surgical hospitals conduct their operations from third parties. The terms of these leases generally range in length from three years up to ten years, and many of our leases contain options to extend the lease period, in some cases for up to an additional 15 years. In many cases, these leases are currently in the extension period. Various facility leases include provisions for rent escalation to recognize increased operating costs or require us to pay certain maintenance and utility costs. Certain leases contain annual escalation clauses based on changes in the Consumer Price Index, while others have fixed escalation terms. In addition, in the normal course of operations, several of our leases will be set to expire during any calendar year, and as of December 31, 2013, leases for 55 of our facilities are set to expire during the next three years. We do not expect difficulties in locating comparable facilities should we choose not to, or be otherwise unable to, extend one or more of our existing leases. Our leases do not typically provide for early termination rights in the absence of a tenant default.

Our corporate headquarters is located in Deerfield, Illinois at 520 Lake Cook Road, Suite 250, where we currently lease approximately 7,526 square feet of space. This lease expires in March 2017. In addition, certain of our corporate operational functions are located in Birmingham, Alabama at 3000 Riverchase Galleria, Suite 500, where we currently lease approximately 40,390 square feet of space. This lease expires in March 2015.

Acquisitions and Strategic Relationships

We pursue our growth strategy in the ASC and surgical hospital markets by making selective acquisitions of existing surgical facilities and groups of facilities. We actively seek opportunities where there are identifiable profit growth opportunities based on location, market dynamics and case mix, and where we can partner with committed physicians who are motivated to improve their facilities.

Our growth strategy includes entering into strategic relationships with hospitals and health systems. We believe that our core competencies in developing and operating outpatient surgery facilities are of value to major health systems attempting to retain their share of the outpatient surgery market. We also believe we offer hospitals and health systems an attractive alternative for expansion in ways that conserve capital, create investment vehicles for existing medical staff and provide a low-risk entry into new markets.

Marketing

Our sales and marketing efforts are directed primarily at physicians, who are principally responsible for referring patients to our facilities. We market our facilities to physicians by emphasizing (1) the high level of patient satisfaction with our surgery centers, which is based on patient surveys that we administer concerning our affiliated facilities, (2) the quality and responsiveness of our services and (3) the practice efficiencies provided by our facilities. In those U.S. markets in which we have partnered with a healthcare system, we coordinate the marketing effort with the healthcare system and generally benefit from this strategy. We and our health system partners also directly negotiate agreements with third-party payors, which generally focus on the pricing, number of facilities in the market and affiliation with physician groups in a particular market.

Competition

In each of our markets we face competition from other providers of ambulatory surgical care in developing ASC and surgical hospital joint ventures, acquiring existing facilities, attracting patients and negotiating commercial payor contract pricing. We believe we are the third largest ASC operator in the United States, based

on the number of ASCs and surgical hospitals operated. United Surgical Partners, Inc., AmSurg Corp., HCA Healthcare Corporation, Symbion, Inc. and Surgery Partners are the largest national ASC operators. However, due to industry fragmentation, we commonly compete for business with hospitals partnering with physicians or with local physician groups who develop independent ASCs without a corporate partner, including those who use consultants to perform management services for a fee without an ongoing equity interest. We believe we compete effectively because of our size, quality of our management services, experience and reputation for providing quality care.

We often compete with other healthcare providers that provide outpatient procedures. In particular, we compete with the outpatient departments of acute care hospitals, which often perform the same procedures as we do in our freestanding facilities. We believe that, in comparison to acute care hospitals, our surgery centers and surgical hospitals compete favorably on the basis of cost, quality, efficiency and responsiveness to physician needs in a more comfortable and convenient environment for the patient. To a lesser, but growing, extent, we also face competition from physicians performing less complex outpatient procedures, such as pain management and certain gastrointestinal procedures, in their own offices.

Teammates

As of December 31, 2013, we employed approximately 5,000 full-time equivalent teammates, working in all of our affiliated facilities. While each facility varies depending on its size, case volume and case types, we employ an average of approximately 30 full-time equivalent teammates at our ASCs, and an average of approximately 71 full-time equivalent teammates at our surgical hospitals. While we provide "full-time equivalent" information, a number of our teammates work on flexible schedules rather than full-time, which increases our staffing efficiency. As a result, these teammates also do not participate in our benefits structure, which we believe reduces the relative cost of our benefits plans to us.

With the exception of one anesthesiologist, we do not employ the physicians who affiliate with us and use our affiliated facilities. However, we generally offer certain physicians the opportunity to purchase equity interests in the facilities they use. None of our teammates is represented by a collective bargaining agreement.

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 teammates act in full compliance with all applicable laws, regulations and company policies. Under the regulatory compliance program, every teammate 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 teammates 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 compliance officer. 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.

Government Regulation

The healthcare industry is subject to extensive regulation by federal, state and local governments. Government regulation affects our business by controlling growth, requiring licensing or certification of facilities, regulating how facilities are used and controlling payment for services provided. Our ability to conduct

our business and to operate profitably will depend in part upon obtaining and maintaining all necessary licenses, certificates of need and other approvals, and complying with applicable healthcare laws and regulations. See "Risk Factors — Risks Related To Healthcare Regulation."

Licensure, Accreditation and Certificate of Need Regulations

Our facilities are also subject to state and local licensing requirements ranging from the quality of care to compliance with building codes and environmental protection laws. Governmental and other authorities periodically inspect our facilities to assure continued compliance with these regulations. Failure to comply with these regulations could result in the suspension or revocation of a facility's license or other penalties.

In addition, as of December 31, 2013, 165 of our 171 ASCs and all five of our surgical hospitals were accredited by either The Joint Commission or the AAAHC, the two major national organizations that establish standards relating to the physical plant, administration, quality of patient care and operation of medical staffs of various types of healthcare facilities. Five of our six remaining ASCs that were not accredited as of December 31, 2013 plan to apply for accreditation in the near future. These accredited facilities are subject to periodic surveys by the accrediting body to ensure that they are in compliance with the applicable standards. Generally, our healthcare facilities must be in operation for at least six months before they are eligible for accreditation. Many commercial payors require our facilities to be accredited in order to be a participating provider under their health plans.

Capital expenditures for the construction of new facilities, the addition of capacity or the acquisition, relocation, change of ownership or change of control of existing facilities may be reviewable by state regulators under certificate of need ("CON") laws. A CON is a permit issued by a state health planning authority evidencing the authority's opinion that a proposed facility or expansion is consistent with the need for the services to be offered by the facility. States with CON laws often place limits on the number of facilities or operating rooms in a region, or restrict providers' ability to build, relocate, expand or change the ownership control of healthcare facilities and services. In some states, approvals are required for capital expenditures exceeding certain specified amounts or involving certain facilities or services, including ASCs and surgical hospitals. As of December 31, 2013, we operated in 16 states with CON laws, and in two such states our facilities were exempt from the CON laws.

Medicare and Medicaid Programs

Medicare is a federally funded and administered health insurance program, primarily for individuals entitled to social security benefits who are age sixty-five years or older or who are disabled. Medicare prospectively determines fixed payment amounts for procedures performed at ASCs and updates these amounts annually. These amounts are adjusted for regional wage variations. For the years-ended December 31, 2013, 2012 and 2011, approximately 20%, 21% and 20%, respectively, of our net patient revenues were attributable to Medicare payments.

To participate in the Medicare program and receive Medicare payments, our facilities must comply with regulations promulgated by CMS. Among other things, these regulations, known as "conditions for coverage" for ASCs and "conditions of participation" for hospitals, set forth requirements relating to the facility's equipment, personnel, policies, standards of medical care and compliance with state and local laws and regulations. All of our ASCs and surgical hospitals are certified in the Medicare program and are subject to on-site, unannounced surveys by state survey agencies working on behalf of CMS. The frequency of on-site ASC surveys by state survey agencies has increased in recent years. Failure to comply with Medicare's conditions for coverage and conditions of participation may result in loss of payment or other governmental sanctions, including termination of participation in the Medicare program. We have established ongoing quality assurance activities to monitor our facilities' compliance with these conditions.

Medicaid is a health insurance program jointly funded by state and federal governments that provides medical assistance to qualifying low-income persons. Each state Medicaid program has the option to provide payment for

ASC services. All of the states in which we currently operate provide Medicaid coverage for some ASC services; however, these states may elect to discontinue covering services, and states into which we expand our operations may not cover or continue to cover surgery center services. Medicaid programs pay us a fixed payment for our services, and the amounts paid vary state to state. For the years-ended December 31, 2013, 2012 and 2011, approximately 3%, 3% and 4%, respectively, of our net patient revenues were attributable to Medicaid payments.

Health Reform Initiatives

There have been numerous legislative and regulatory initiatives on the federal and state levels for comprehensive reforms affecting the payment for and availability of healthcare services. Most notably, the PPACA, as amended by the Health Care and Education Affordability Reconciliation Act of 2010 (collectively, the "Health Reform Law"), was enacted in March 2010 and represents significant change for the healthcare industry.

The Health Reform Law includes provisions designed to change how healthcare services are covered, delivered and reimbursed through, among other things, expanded coverage of uninsured individuals, reduced growth in Medicare program spending and the establishment of programs where reimbursement is tied to quality. The Health Reform Law also reforms certain aspects of health insurance, expands existing efforts to tie Medicare and Medicaid payments to performance and quality and contains provisions intended to strengthen fraud and abuse enforcement. The Health Reform Law includes a number of reforms that will directly affect our facilities, including, without limitation, the reforms summarized below.

Based on the Congressional Budget Office's February 2014 projection, the Health Reform Law will expand health insurance coverage to approximately 25 million individuals currently lacking coverage by 2024. The primary public program through which the Health Reform Law will expand coverage of uninsured individuals is Medicaid. The most significant changes will expand the categories of individuals eligible for Medicaid coverage and permit individuals with relatively higher incomes to qualify. The Health Reform Law requires all state Medicaid programs to provide, and the Federal government to subsidize, Medicaid coverage to virtually all adults under 65 years old with incomes at or under 133% of the federal poverty level. The Health Reform Law also requires states to apply a "5% income disregard" to the Medicaid eligibility standard such that Medicaid eligibility will effectively be extended to those with incomes up to 138% of the federal poverty level. However, while the United States Supreme Court (the "Supreme Court") upheld the constitutionality of key provisions of the Health Reform Law in June 2012, the Court declared unconstitutional provisions that would have allowed the U.S. Department of Health and Human Services ("HHS") to penalize states that do not implement the Medicaid expansion provisions of the law with the loss of existing federal Medicaid funding. As a result, some states have chosen not to implement the Medicaid expansion, and fewer individuals will be covered by a state Medicaid program than would have been covered had the Supreme Court upheld the Health Reform Law in its entirety.

In the private sector, the Health Reform Law will expand health insurance coverage through a range of requirements applicable to health insurers, employers and individuals. For example, as of January 1, 2014, health insurers are prohibited from imposing annual coverage limits, dropping coverage, excluding individuals on the basis of pre-existing conditions or denying coverage for any individual who is willing to pay the premiums for such coverage. In addition, certain larger employers that do not offer health insurance benefits to their employees will be required to make "shared responsibility payments" if an employee obtains government-subsidized coverage through the Health Insurance Marketplace. The Health Reform Law also requires individuals to maintain health insurance for a minimum defined set of benefits or pay a tax penalty, subject to certain exceptions. Individuals must have obtained health insurance coverage by March 31, 2014, in order to avoid tax penalties. To facilitate the purchase of health insurance, the Health Reform Law provides for the establishment of the Health Insurance Marketplace, a system of state and federal health insurance exchanges through which qualified health insurance coverage may be obtained.

Aside from the expansion of health insurance coverage, the Health Reform Law provides for reductions in Medicare, Medicaid and other federal healthcare program spending. The Health Reform Law includes a

provision requiring CMS to apply a negative productivity adjustment to the indexes used to update Medicare payment rates on an annual basis. The productivity adjustment is equal to the 10-year moving average of changes in the annual economy-wide private nonfarm business multi-factor productivity measure, as reported by the Bureau of Labor Statistics each year. Hospital and ASC services were subject to this productivity adjustment starting in calendar year 2011. The practical impact of the productivity adjustment for hospital and ASC services is to reduce the amount of annual rate increases from Medicare, potentially to an amount below zero (that is, the index-based increase may be outweighed by the productivity adjustment and as a result reimbursement rates would decline). In addition to the productivity adjustment, for our surgical hospitals, the Health Reform Law requires a downward adjustment for each of the following federal fiscal years as follows: 0.3% in 2014; 0.2% in 2015 and 2016; and 0.75% in 2017, 2018 and 2019.

Additionally, pursuant to the Health Reform Law, HHS submitted a report to Congress in 2011 outlining HHS's plan to implement a value-based purchasing program for ASCs. While the report describes efforts to improve quality and payment efficiency in ASCs and examines the steps required to design and implement an ASC value-based purchasing program, Congress has not yet authorized CMS to implement such a program. However, CMS has implemented a value-based purchasing program for inpatient hospital services, pursuant to which hospitals that meet or exceed specified quality performance standards will receive greater reimbursement than they would have otherwise and hospitals that do not meet the standards will receive reduced payments. The Health Reform Law also provides for other quality-based payment adjustments for inpatient hospital services, including reductions for "excess readmissions" to hospitals for certain conditions designated by CMS and reductions for hospitals with high rates of conditions acquired by patients while admitted as hospital inpatients.

The Health Reform Law established a new Independent Payment Advisory Board, which, if a Medicare per capita target growth rate is exceeded, will develop and submit proposals for a Medicare spending reduction to the President and Congress beginning in 2014 for implementation in 2015. This Board would have the authority to reduce Medicare payments to certain providers, including ASCs. In addition, the Board is precluded from submitting proposals that reduce Medicare payments prior to December 31, 2019 for providers scheduled to receive a reduction in their payment updates as a result of the Medicare productivity adjustment, which currently includes our facilities.

The Health Reform Law also makes several significant changes to healthcare fraud and abuse laws, provides additional enforcement tools to the government, increases cooperation between agencies by establishing mechanisms for the sharing of information and enhances criminal and administrative penalties for non-compliance. Among other things, the Health Reform Law provides for increased federal funding for healthcare fraud and abuse enforcement activities, expands the scope of the Recovery Audit Contractor ("RAC") program and expands liability under the False Claims Act (the "FCA") for failure to timely repay identified overpayments made by governmental healthcare programs.

The extent to which expanded coverage and associated reimbursement may or may not offset other impacts of the Health Reform Law on our results is not clear at this time. We believe healthcare reform initiatives will continue to develop during the foreseeable future. If adopted, some aspects of previously proposed reforms, such as further reductions in Medicare or Medicaid payments, or additional prohibitions on physicians' financial relationships with facilities to which they refer patients, could adversely affect us in a material way.

Federal Anti-Kickback Statute

State and federal laws regulate relationships among providers of healthcare services, including employment or service contracts and investment relationships. These restrictions include a federal criminal law, referred to as the Anti-Kickback Statute, which prohibits knowingly and willfully offering, paying, soliciting or receiving any form of remuneration in return for:

- referring patients for services or items payable under a federal healthcare program, including Medicare or Medicaid, or

- purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering, any good, facility, service or item for which payment may be made in whole or in part by a federal healthcare program.

Violations of the Anti-Kickback Statute may be punished by a criminal fine of up to $25,000 for each violation or imprisonment, civil money penalties of up to $50,000 per violation and damages of up to three times the total amount of the remuneration and/or exclusion from participation in federal healthcare programs, including Medicare and Medicaid. The Health Reform Law provides that submission of a claim for services or items generated in violation of the Anti-Kickback Statute constitutes a false or fraudulent claim and may be subject to additional penalties under the FCA.

The Anti-Kickback Statute is broad in scope and the applicability of its provisions to many business transactions in the healthcare industry has not yet been subject to judicial or regulatory interpretation. The method by which investors are selected and bought out, the pricing of the issuance and redemption of partnership or LLC units to or from referring physicians and all of our other financial dealings with physicians are subject to regulation by the Anti-Kickback Statute. Courts have found a violation of the Anti-Kickback Statute if just one purpose of the remuneration is to generate referrals, even if there are other lawful purposes. Furthermore, the Health Reform Law provides that knowledge of the law or intent to violate the law is not required to establish a violation of the Anti-Kickback Statute.

The Federal government pays particular attention to joint ventures and other transactions among healthcare providers, particularly joint ventures involving physicians and other referral sources. In 1989, the Office of Inspector General ("OIG"), published a fraud alert that outlined questionable features of "suspect" joint ventures, and the OIG has continued to refer to those fraud alerts in later pronouncements. The OIG has also published regulations containing numerous "safe harbors" that exempt some practices from enforcement under the Anti-Kickback Statute. These safe harbor regulations, if fully complied with, assure participants in particular types of arrangements that the OIG will not treat their participation as a violation of the Anti-Kickback Statute. The safe harbor regulations do not expand the scope of activities that the Anti-Kickback Statute prohibits, nor do they provide that failure to satisfy the terms of a safe harbor constitutes a violation of the Anti-Kickback Statute. The OIG has, however, indicated that failure to satisfy the terms of a safe harbor may subject an arrangement to increased scrutiny.

The OIG has promulgated a safe harbor applicable to ASCs. The ASC safe harbor generally protects ownership or investment interests in a center by physicians who are in a position to refer patients directly to the center and perform procedures at the center on referred patients, if certain conditions are met. More specifically, the ASC safe harbor protects any payment that is a return on an ownership or investment interest to an investor if certain standards are met in one of four categories of ASCs: (1) surgeon-owned surgery centers; (2) single-specialty surgery centers; (3) multi-specialty surgery centers; and (4) hospital/physician surgery centers.

Surgeon-owned surgery centers are those in which all of the physician investors are either general surgeons or surgeons engaged in the same surgical specialty. Single-specialty surgery centers are those in which all of the physician investors — who do not need to be surgeons but who must perform procedures — are engaged in the same medical practice specialty. A gastroenterologist is an example of a physician who is not a surgeon but who performs procedures; an ASC owned exclusively by gastroenterologists and which accepts only gastroenterology procedures is an example of a single-specialty surgery center. Multi-specialty surgery centers may include a mix of physicians (surgeons and non-surgeons) in different specialties. Hospital/physician surgery centers must include at least one hospital investor.

Although the ASC safe harbor sets forth four separate categories, many of the same standards apply to each category. For example, in each case, no ownership interests may be held by a non-physician or non-hospital investor if that investor is (1) employed by the center or another investor, (2) in a position to provide items or services to the center or any of its other investors, or (3) in a position to make or influence referrals directly or indirectly to the center or any of its investors. In addition, in the case of surgeon-owned, single-specialty, and

multi-specialty surgery centers, at least one-third of each physician investor's medical practice income from all sources for the previous fiscal year or twelve-month period must be derived from performing outpatient procedures on the list of Medicare covered procedures for ASCs. For multi-specialty surgery centers, the safe harbor also requires that at least one-third of the Medicare-eligible outpatient surgery procedures performed by each physician investor for the previous fiscal year or twelve-month period must be performed at the surgery center in which the investment is made. For hospital/physician surgery centers, the safe harbor includes standards prohibiting the hospital investor and the center from sharing space and equipment except in certain instances, prohibiting the hospital investor from including costs associated with the center on the hospital's cost report, and prohibiting the hospital from being in a position to make or influence referrals to the center or to any other investor in the center.

Entities that own facilities which provide services under the Medicare and Medicaid programs, and their respective physician partners and members, are subject to the Anti-Kickback Statute. In cases where one of our subsidiaries is an investor in the partnership or LLC that owns the facility, and we or our subsidiary provides management and other services to the facility, our arrangements with physician investors do not meet all of the specific terms of the ASC safe harbor or any other safe harbor. See "Risk Factors — Risks Related to Healthcare Regulation — Our surgical facilities do not satisfy the requirements for any of the safe harbors under the Anti-Kickback Statute. If we fail to comply with the Anti-Kickback Statute, we could be subject to criminal and civil penalties, loss of licenses and exclusion from governmental programs, which may result in a substantial loss of revenues."

However, we believe that our operations do not violate the Anti-Kickback Statute. Moreover, we strive to ensure that our management services, lease agreements and other agreements with facilities are consistent with our standards for documented fair market value for services and space provided to or received from the facilities or the physician partners at the facilities.

Federal Physician Self-Referral Law

Section 1877 of the Social Security Act, the federal physician self-referral law commonly referred to as the Stark Law, prohibits any physician from referring patients to any entity for the furnishing of certain "designated health services" otherwise payable by Medicare or Medicaid, if the physician or an immediate family member has a financial relationship with the entity, unless an exception applies. The Stark Law also prohibits entities that provide designated health services otherwise payable by Medicare or Medicaid from billing the Medicare and Medicaid programs for any items or services that result from a prohibited referral and requires the entities to refund amounts received for items or services provided pursuant to the prohibited referral. As defined by the Stark Law, the term "financial relationship" includes both ownership (or investment) interests and compensation arrangements. Unlike safe harbors under the Anti-Kickback Statute with which compliance is voluntary, a financial relationship must comply with every requirement of a Stark Law exception in order to not violate the Stark Law. Persons who violate the Stark Law are subject to potential civil money penalties of up to $15,000 for each bill or claim submitted in violation of the Stark Law and up to $100,000 for each "circumvention scheme" they are found to have entered into, and potential exclusion from the Medicare and Medicaid programs. In addition, the Stark Law requires the denial (or refund, as the case may be) of any Medicare and Medicaid payments received for designated health services that result from a prohibited referral.

CMS has promulgated regulations to implement the Stark Law. Under these regulations, services provided by an ASC that would otherwise constitute "designated health services" are excluded from the definition of that term if the services are reimbursed by Medicare as part of the ASC's composite payment rate. All services provided by our ASCs that would otherwise constitute designated health services are reimbursed by Medicare as part of the composite payment rate and are thus excepted from the Stark Law, with the exception of implants. The Stark Law provides for a special exception for implants, such as intraocular lenses and artificial joints, furnished in ASCs as long as certain regulatory requirements are met. These requirements provide that the implant must be implanted by the referring physician or a member of his or her group practice, that the implant be implanted during a surgical procedure reimbursed as an ASC procedure by Medicare, that the arrangement for

the furnishing of the implant not violate the Anti-Kickback Statute and that the billing for the implant be conducted legally. We believe the operations of our ASCs comply with these requirements and, consequently, that the Stark Law generally does not apply to services provided by our ASCs. See "Risk Factors — Risks Related to Healthcare Regulation — 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 substantial monetary penalties and a significant loss of revenues."

As of December 31, 2013, five of our facilities were surgical hospitals. The Stark Law includes an exception that permits physicians to refer Medicare and Medicaid patients to hospitals in which they have an ownership interest if certain requirements are met. The Health Reform Law dramatically curtailed this exception and prohibits physician ownership in hospitals that did not have a Medicare provider agreement by December 31, 2010. This prohibition does not apply to our five surgical hospitals, each of which had a Medicare provider agreement prior to December 31, 2010 and are therefore able to continue operating with their existing ownership structure in compliance with the applicable exception. However, the law prohibits "grandfathered" hospitals from increasing the percentage of physician ownership, and the law limits to a certain extent their ability to grow because it prohibits such hospitals from increasing the aggregate number of inpatient beds, operating rooms and procedure rooms. In addition, the new law required all our surgical hospitals with physician owners to adopt certain measures addressing potential conflicts of interest, ensuring that physician investments are bona fide and relating to patient safety. We believe our facilities are in compliance with such requirements, but even the assertion of a violation of the Stark Law could have a material adverse effect upon us.

False and Other Improper Claims

The Federal 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. False claims filed with private insurers can also lead to criminal and civil penalties. While the criminal statutes are generally reserved for instances of fraudulent intent, the government applies criminal, civil and administrative penalty statutes to a range of circumstances, including coding errors, billing for services not provided, billing for services that are not medically necessary, improperly classifying the level of care provided, submitting false cost reports and submitting claims resulting from arrangements prohibited by the Stark Law or the Anti-Kickback Statute. Over the past decade or more, the government has accused an increasing number of healthcare providers of violating the FCA, which prohibits a person from knowingly presenting, or causing to be presented, a false or fraudulent claim to the United States. 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. Violations of the FCA can result in awards of treble damages and significant per claim penalties.

Also, under the "qui tam" provisions of the FCA, private parties ("relators" or "whistleblowers") may bring actions against providers on behalf of the Federal government. Such private parties are entitled to share in any amounts recovered by the government through trial or settlement. Qui tam cases are sealed by the court at the time of filing. The only parties privy to the information contained in the complaint are the relator, the Federal government and the presiding court.

Both direct enforcement activity by the government and whistleblower lawsuits under the FCA have increased significantly in recent years and have increased the risk of healthcare companies like us having to defend a false claims action, repay claims paid by the government, pay fines or be excluded from the Medicare and Medicaid programs. In addition, under the Health Reform Law, if we receive an overpayment, we must report and refund the overpayments before the later of 60 days after the overpayment was identified or the date any corresponding cost report is due, if applicable. Any overpayment that is retained after this deadline is considered an obligation subject to an action under the FCA.

Although we believe that our operations materially comply with federal and state laws, they may nevertheless be the subject of a whistleblower lawsuit, or may otherwise be challenged or scrutinized by governmental authorities. See "Risk Factors — Risks Related to Healthcare Regulation — Companies within the

healthcare industry continue to be the subject of federal and state audits and investigations, and we may be subject to such audits and investigations, including actions for false and other improper claims."

State Anti-Kickback, Physician Self-Referral and False Claims Laws

Many states, including those in which we do business, have laws that prohibit payment of kickbacks or other remuneration in return for the referral of patients. Some of these laws apply only to services reimbursable under state Medicaid programs. In most states, these laws have not been subjected to significant judicial and regulatory interpretation. Noncompliance with these laws could subject us to penalties and sanctions and have a material adverse effect on us. However, we believe that our operations are in material compliance with the physician self-referral laws of the states in which our facilities are located.

A number of states, including some of those in which we do business, have their own laws prohibiting the submission of false claims. These laws may be modeled on the FCA and contain qui tam provisions. Some state false claims acts can involve broader liability in terms of the costs that losing defendants must pay or the types of claims that are subject to the act.

Healthcare Industry Investigations and Audits

Federal and state government agencies have increased their civil and criminal enforcement efforts in the healthcare industry. For example, the Health Reform Law includes additional federal funding of $350 million to fight healthcare fraud, waste and abuse. Investigations by government agencies have addressed a wide variety of issues, including billing practices and financial arrangements with referral sources. In addition, the OIG and the U.S. Department of Justice ("DOJ") have, from time to time, established national enforcement initiatives that focus on specific billing practices or other suspected areas of abuse. An investigation of our facilities could result in significant costs, liabilities and penalties, as well as adverse publicity.

In addition, government agencies and their agents may conduct audits of the operations of our facilities. Under the RAC program, CMS contracts with RACs on a contingency basis to conduct post-payment reviews to detect and correct improper Medicare payments. The Health Reform Law expanded the scope of the RAC program to include Medicaid claims by requiring all states to enter into contracts with RACs to audit payments to Medicaid providers. In addition to RACs, other contractors, such as Medicare Administrative Contractors and Medicaid Integrity Contractors ("MICs"), perform payment audits to identify and correct improper payments.

Health Information Privacy and Security Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") contains provisions that require covered entities, including most healthcare providers, to employ systems and procedures designed to protect individually identifiable health information, known as "protected health information." Pursuant to HIPAA, HHS has promulgated privacy and security regulations that extensively regulate the use and disclosure of protected health information and require covered entities to implement administrative, physical and technical safeguards to protect the security of such information. The American Recovery and Reinvestment Act of 2009, as amended ("ARRA"), contains provisions that broaden the scope of the HIPAA privacy and security regulations and strengthen HIPAA's enforcement provisions. As covered entities under HIPAA, both we and our facilities are required to comply with rules governing the use and disclosure of protected health information and to impose those rules, by contract, on any business associate to which such information is disclosed. In other relationships, such as when we provide management or consulting services to another covered entity, we are subject to the rules applicable under HIPAA and ARRA to business associates. Pursuant to a rule issued to implement ARRA, business associates and their subcontractors are subject to direct liability under the HIPAA privacy and security regulations. In addition, a covered entity may be subject to penalties as a result of its business associate violating the HIPAA privacy and regulations if the business associate is found to be an agent of the covered entity.

As required by ARRA, covered entities must report breaches of unsecured protected health information to affected individuals without unreasonable delay and in no case later than 60 days after the discovery of the breach by the covered entity or its agents. Notification must also be made to HHS and, in certain situations involving large breaches, to the media. HHS is required to publish on its website a list of all covered entities that report a breach involving more than 500 individuals. Pursuant to a rule issued to implement ARRA, HHS has created a presumption that all non-permitted uses or disclosures of unsecured protected health information are breaches unless the covered entity or business associate establishes that there is a low probability the information has been compromised. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving individually identifiable information.

Violations of the HIPAA privacy and security regulations may result in civil and criminal penalties. ARRA increased the amount of civil penalties for HIPAA violations, with penalties now ranging up to $50,000 per violation and a maximum civil penalty of $1.5 million in a calendar year for violations of the same requirement. In addition, ARRA authorizes state attorneys general to bring civil actions seeking either injunction or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents.

States may impose more protective privacy and security laws, and both state and federal laws are subject to modification or enhancement of privacy and security protection at any time. Our facilities will continue to remain subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These statutes vary and could impose additional requirements on us and more severe penalties for breaches of privacy.

HIPAA Transactions and Code Sets Standards

HIPAA and its implementing regulations establish electronic data transmission standards that all healthcare providers must use for certain electronic healthcare transactions, such as submitting claims for payment for medical services. The Health Reform Law requires the adoption of standards for additional electronic transactions and provides for the creation of operating rules to promote uniformity in the implementation of each standardized electronic transaction. Under HIPAA, HHS has also published a final rule requiring the use or updated standard code sets for certain diagnoses and procedures known as ICD-10 code sets. Use of the ICD-10 code sets is required beginning October 1, 2014. It is possible that our facilities could experience disruptions or delays in payment due to the implementation of new electronic data transmission standards and the transition to ICD-10 code sets.

Federal Emergency Medical Treatment and Active Labor Act

The Federal Emergency Medical Treatment and Active Labor Act ("EMTALA") applies to our five surgical hospitals. EMTALA requires hospitals participating in the Medicare program, including those without emergency rooms, to evaluate individuals who present with emergencies, provide initial stabilizing treatment and refer or transfer patients where appropriate. Possible liability for a violation of EMTALA includes a civil action by the patient as well as civil monetary penalties and exclusion from participation in the Medicare program.

Antitrust Laws

The Federal government and most states have enacted antitrust laws that prohibit certain types of conduct deemed to be anti-competitive. These laws prohibit price fixing, concerted refusal to deal, market monopolization, price discrimination, tying arrangements, acquisitions of competitors and other practices that have, or may have, an adverse effect on competition. Violations of federal or state antitrust laws can result in various sanctions, including criminal and civil penalties. Antitrust enforcement in the healthcare industry is currently a priority of the Federal Trade Commission (the "FTC").

Some of our operating activities are subject to regulation by the antitrust laws. For example, the exchange of pricing information in connection with the creation of a joint venture or an acquisition, the formation of joint

ventures with large health systems and the negotiation of our commercial payor contracts by our health system partners are all regulated by the antitrust laws. We undertake to conduct all of our business operations in compliance with these laws. The DOJ and the FTC, the two agencies charged with enforcing the federal antitrust laws, have promulgated a series of "Statements of Antitrust Enforcement Policy in Health Care." These statements provide a series of "safety zones." A "safety zone" describes conduct that the FTC and the DOJ will not challenge under the antitrust laws, absent extraordinary circumstances. Our activities do not necessarily fall within any of these safety zones. Nevertheless, we believe that our operations are in compliance with the antitrust laws, but courts or regulatory authorities may reach a contrary conclusion, and such a conclusion could adversely affect our operations.

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 admission 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 diagnosis related group 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.

Reimbursement

Medicare — Ambulatory Surgical Centers

Medicare establishes reimbursement methodologies for various types of healthcare facilities and services. These methodologies have historically been subject to periodic revisions that can have a substantial impact on existing healthcare providers. In accordance with authorization from Congress, CMS makes annual upward or downward adjustments to Medicare payment rates in most areas. These adjustments can result in decreases in actual dollars per procedure or a freeze in reimbursement despite increases in costs.

CMS reimburses providers for outpatient surgery performed in an ASC a prospectively determined rate for covered procedures. The standard payment rate for ASC-covered surgical procedures is calculated as the product of an ASC "conversion factor" and the ASC "relative payment weight" for each separately payable procedure or service. Subject to certain exclusions, covered surgical procedures in an ASC are surgical procedures that are separately paid under the Hospital Outpatient Prospective Payment System ("OPPS") that would not be expected to pose a significant risk to safety when performed in an ASC, and that would not be expected to require overnight stay. Payment for ancillary items and services are packaged into ASC payment for a covered surgical procedure. The lists of, and payment rates for, covered surgical procedures and ancillary services in ASCs are updated in conjunction with the annual proposed and final rulemaking process to update the OPPS and ASC payment system. The Medicare and Medicaid programs are subject to statutory and regulatory changes, possible retroactive and prospective rate adjustments, administrative rulings, freezes and funding reductions, all of which may adversely affect the level of payments to our surgery centers. Further, the Health Reform Law introduced new limitations on the increase in the index by which ASC rates are annually adjusted. See "— Government Regulation — Health Reform Initiatives." For calendar year 2014, Medicare payments for ASC services are to be increased by 1.2% as compared to the prior year, reflecting a 1.7% increase based on the consumer price index and a negative 0.5% productivity adjustment.

CMS has implemented a quality data reporting program for ASCs, known as the ASC Quality Reporting Program. Beginning in October 2012, CMS required ASCs to report on five quality measures. Each year CMS has added to the reporting requirement, with two additional quality measures effective January 2013, and three

additional quality measures effective January 2014. We have implemented procedures at our ASCs to comply with these requirements. Failure to report quality data according to CMS requirements may result in a reduction of the Medicare payment rates in subsequent years.

Medicare — Surgical Hospitals

As of December 31, 2013, five of our facilities are licensed as hospitals and receive reimbursement from Medicare for inpatient services under Medicare's Inpatient Prospective Payment System, under which a hospital receives a fixed amount as reimbursement for inpatient hospital services based on each patient's final assigned Medicare severity diagnosis-related group ("MS-DRG"). Our surgical hospitals generally focus on performing outpatient procedures and perform a relatively low number of Medicare inpatient cases.

Each federal fiscal year (which begins October 1), MS-DRG rates are updated and their weights are recalibrated. The index to update the MS-DRGs known as the "market basket" gives consideration to the inflation experienced by hospitals as well as entities outside the healthcare industry in purchasing goods and services. For several years, however, the percentage increases to the prospective payment rates have been generally lower than the percentage increases in the costs of goods and services for hospitals. Further, the Health Reform Law introduced new limitations on the increase in the market basket. See "— Government Regulation — Health Reform Initiatives."

Our surgical hospitals are subject to a separate Medicare payment system for outpatient services. Most outpatient services provided by surgical hospitals are classified into groups called Ambulatory Payment Classifications ("APCs") that are reimbursed by Medicare under the OPPS. A Medicare payment rate has been established for each APC. Depending on the services provided, a hospital may be paid for more than one APC for a patient visit. For calendar year 2014, CMS has issued a final rule that increases the rate for payments made under OPPS by 1.7%, reflecting a 2.5% increase based on the final inpatient hospital market basket percentage for federal fiscal year 2014, a negative 0.5% productivity adjustment and a negative 0.3% adjustment required by the Health Reform Law.

CMS has implemented a quality data reporting program for hospital outpatient care, known as the Hospital Outpatient Quality Data Reporting Program. CMS has adopted a similar quality data reporting program for hospital inpatient services, known as the Hospital Inpatient Quality Reporting Program. Hospitals that fail to report inpatient or outpatient data required for the quality measures selected by CMS in the form and manner required by CMS may incur a 2% reduction in the annual payment update factor. Therefore, if we fail to provide quality data in the manner and form required by CMS, our surgical hospitals could be subject to a reduction of the Medicare payment update by 2%. Any reduction would apply only to the payment year involved and would not be taken into account in computing the applicable payment update factor for a subsequent payment year.

Pursuant to the Health Reform Law, CMS has implemented a value-based purchasing program for inpatient hospital services, pursuant to which hospitals that meet or exceed specified quality performance standards will receive greater reimbursement than they would have otherwise and hospitals that do not meet the standards will receive reduced payments. The incentives provided through the program are funded by a reduction in payments for inpatient hospital services as follows: 1.25% for 2014; 1.5% for 2015; 1.75% for 2016; and 2% for 2017 and subsequent years. For each federal fiscal year, the total amount collected from these reductions will be pooled and used to fund payments to reward hospitals that meet specified quality performance standards.

Medicaid

Medicaid programs are jointly funded by Federal and state governments. As the Medicaid program is administered by the individual states under the oversight of CMS in accordance with certain regulatory and statutory guidelines, there are substantial differences in reimbursement methodologies and coverage policies from state to state. Many states have experienced shortfalls in their Medicaid budgets and are implementing

significant cuts in Medicaid reimbursement rates. Additionally, certain states control Medicaid expenditures through restricting or eliminating coverage of certain services. Payments from Medicaid constituted approximately 3% of our net patient revenues for the year-ended December 31, 2013.

Cost Reports

Because of our participation in the Medicare and Medicaid programs, we are required to meet certain financial reporting requirements. Federal and some state regulations require the submission by us and our five surgical hospitals of annual cost reports stating the revenues, costs and expenses associated with the services provided to Medicare beneficiaries and Medicaid recipients at those hospitals.

These annual cost reports are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due to us under these reimbursement programs. It generally takes years to settle audits of these cost reports. These audits are used for determining if any under- or over-payments were made by payors under these programs, setting payment levels for future years and detecting fraud. Providers are required to make certain certifications with these cost report submissions, including that they are in compliance with law. Such certifications, if incorrect and submitted knowingly or recklessly, may result in FCA liability. While currently ASCs are not subject to federal cost reporting requirements, it is possible that such requirements, which could be costly for us, will be implemented by CMS in the future.

Third-Party Payors

In addition to paying professional fees directly to the physicians performing medical services, most third-party payors also pay a facility fee to ASCs for the use of surgical facilities and reimburse surgical hospitals for the charges associated with the facilities and services that are provided by the hospitals to the third-party payors' beneficiaries. We receive a majority of our reimbursement from third-party payors pursuant to written contracts between payors and our facilities. These contracts generally require our surgical hospitals and ASCs to offer discounts from their established charges and prohibit us from billing the patient for any amount other than a specified co-payment or deductible.

In some cases, our facilities do not have written contracts prior to providing services, commonly known as "out-of-network" services. Third-party payors have traditionally paid our out-of-network facilities a percentage of their charges. There has been a growing trend in recent years, however, for third-party payors to implement out-of-network fee schedules, which are more comparable to our contracted rates. In addition, some states where we operate have laws which restrict "out-of-network" billing, and a few payors have filed lawsuits claiming fraud and other wrongdoing on the part of ASCs that have engaged in certain out-of-network billing practices. We believe that where our facilities are out-of-network, our practices are appropriate, but we cannot guarantee that a payor will not successfully challenge those practices, which could lead to lower revenues at the facility involved.

Workers' Compensation

Our facilities provide services to injured workers and receive payment from workers' compensation payors pursuant to the various state workers' compensation statutes. Historically, workers' compensation payors have typically paid surgical facilities a higher percentage of the surgical facilities' charges than other third-party payors. However, workers' compensation payment amounts are subject to legislative, regulatory and other payment changes over which we have no control. In recent years, a number of states have implemented workers' compensation fee schedules with rates generally lower than what our facilities have historically been paid for the same services. This trend has been exacerbated in some states by budget deficits and a perceived need to reduce expenditures. A reduction in workers' compensation payment amounts could have a material adverse effect on the revenues of our facilities which perform a significant number of workers compensation cases.

Operational Risks and Insurance

We maintain liability insurance in amounts that we believe are appropriate for our operations. Currently, we maintain professional and general liability insurance coverage for us and our facilities on a claims-made basis of $1.0 million per occurrence and $3.0 million in annual aggregate coverage per surgical facility. We also maintain umbrella liability insurance in the aggregate amount of $10.0 million and excess liability insurance in the aggregate amount of $15.0 million. We also currently maintain property damage insurance with aggregate coverage of $500.0 million and other types of insurance coverage we believe to be consistent with industry practice. Coverage under certain of these policies is contingent upon the policy being in effect when a claim is made regardless of when the events that caused the claim occurred. The cost and availability of such coverage has varied widely in recent years.

In most states, we maintain private market coverage for our workers' compensation risk. The policy limits equal the minimum statutory requirements. In certain states, we procure comparable coverage through various state funds. In the state of Texas, we have elected not to participate in the workers' compensation system and have procured separate coverage, subject to nominal deductibles.

While we believe that our insurance policies are adequate in amount and coverage for our current and anticipated operations based on both management judgment and external benchmarks, we cannot ensure that the insurance coverage will be sufficient to cover all future claims or will continue to be available in adequate amounts or at a reasonable cost.

Environmental Matters

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 also regularly acquire ownership or operational interests in new facilities and properties, some of which may have had a history of commercial or other operations. 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, abutters 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 or obligations under environmental requirements that we would expect to have a material adverse effect on our business, results of operations or financial condition.

Available Information

The Company maintains a web site at http://www.scasurgery.com. The Company makes available on its web site, free of charge, its Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and all amendments to those reports, as soon as it is reasonably practicable after such material is electronically filed with the Securities and Exchange Commission (the "SEC"). These reports are also available on the SEC's website, http://www.sec.gov. You may read and copy any reports that we file with the SEC at its Public Reference Room, located at 100 F Street, N.E., Washington, D.C. 20549. Information on the operation of the Public Reference Room may be obtained by calling the SEC at 1-800-SEC-0330. The Company is not including the information contained on or available through its web site as a part of, or incorporating such information into, this Annual Report on Form 10-K.

Item 1A. RISK FACTORS

The following factors affect our business and the industry in which we operate. The risks and uncertainties described below are not the only ones facing our company. Additional risks and uncertainties not presently known to us or that we currently consider immaterial may also have an adverse effect on us. If any of the matters discussed in the following risk factors were to occur, our business, prospects, results of operations or financial condition could be materially adversely affected.

Risks Related to our Business

We depend on payments from third-party payors, including government healthcare programs, commercial payors and workers' compensation programs. If these payments are reduced or eliminated, or do not increase as our costs increase, our revenues and profitability could decrease.

We depend upon governmental, commercial and workers' compensation third-party sources of payment for the services provided to patients in our surgical facilities. The amount that our surgical facilities receive in payment for their services may be adversely affected by factors we do not control, including Medicare, Medicaid and state regulation changes, cost containment decisions and changes in reimbursement schedules of payors, legislative changes, refinements to the Medicare ASC payment system and refinements by CMS to Medicare's reimbursement policies. Similarly, third-party payors may be successful in negotiating reduced reimbursement schedules with our facilities. Any reduction or elimination of these payments or an increase in the payments at a rate that is less than the increase in our costs could have a material adverse effect on our business, prospects, results of operations and financial condition.

If we or our health system partners are unable to negotiate and enter into favorable contracts or maintain satisfactory relationships and renew existing contracts on favorable terms with non-governmental third-party payors, our revenues and profitability may decrease.

Payments from non-governmental third-party payors represented approximately 60% of our consolidated net patient revenues and 77% of our nonconsolidated net patient revenues for the year-ended December 31, 2013. We receive most of these payments from third-party payors that have contracts with our facilities. These payors use a variety of methods for reimbursement depending on the insurance arrangement involved. These arrangements include preferred provider organizations, health maintenance organizations, as well as prepaid and discounted medical service packages, capitated (fixed fee) contracts, Medicare Advantage Plans and contracts with Independent Physician Associations. If we or our health system partners fail to enter into favorable contracts or to maintain satisfactory relationships and renew existing contracts on favorable terms with these payors, our revenues and profitability may decrease. Other healthcare providers may impact our ability to negotiate increases and other favorable terms in our reimbursement arrangements with non-governmental third-party payors. For example, some of our competitors may negotiate exclusivity provisions with non-governmental third-party payors or otherwise restrict the ability of non-governmental third-party payors to contract with us or our health system partners. Moreover, these third-party payors are increasingly implementing cost containment measures, such as fixed fee schedules and reductions to reimbursement schedules, which may reduce our revenues and profitability now or in the future. Further, the trend toward consolidation among non-governmental third-party payors tends to increase their bargaining power over fee structures. As various provisions of the Health Reform Law are implemented, including the establishment of health insurance exchanges, non-governmental third-party payors increasingly may demand reduced fees. In addition, there is a growing trend for third-party payors and employer-sponsored healthcare plans to take steps to shift the primary cost of care to the plan participant by increasing co-payments, co-insurance and deductibles, and these actions could discourage such patients from seeking treatment at our surgical facilities. Because some commercial third-party payors rely on all or portions of Medicare payment systems to determine payment rates, changes to government healthcare programs that reduce payments under these programs may negatively impact payments from commercial third-party payors. Patient volumes could decrease if we or our health system partners are unable to enter into acceptable contracts with such third-party payors, which could lead to a material adverse effect on our business, prospects, results of operations and financial condition.

For the year-ended December 31, 2013, approximately 3.0% of our net patient revenues was derived from providing "out-of-network" services, where payments to us come from third-party payors with which our surgical facilities do not have contracts. In such cases, we generally charge patients a co-payment and submit claims to the payor, which typically have been paid at higher than comparable contracted rates. However, there is a trend for third-party payors to adopt out-of-network fee schedules that are more comparable to our contracted rates or to discourage their enrollees from seeking treatment at out-of-network surgical facilities. In such situations, we may be forced to choose between not providing services to out-of-network patients and accepting a payor contract with relatively low payment rates. In certain situations, we have seen an increase in case volume upon transitioning to in-network billing, although we may experience an overall decrease in revenues. 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 to in-network billing, or that when we decline to sign a payor contract we will see a sufficient increase in payment rates to compensate for the decrease in volume of cases resulting from being out-of-network.

Significant changes in our payor mix or case mix resulting from fluctuations in the types of cases performed at our facilities could have a material adverse effect on our business, prospects, results of operations and financial condition.

Our results may change from period to period due to fluctuations in payor mix or case mix or other factors relating to the type of cases performed by physicians at our facilities. Payor mix refers to the relative share of total cases provided to patients with, respectively, no insurance, commercial insurance, Medicare coverage, Medicaid coverage and workers' compensation insurance. Since, generally speaking, we receive relatively higher payment rates from commercial and workers' compensation insurers than Medicare and Medicaid, a significant shift in our payor mix toward a higher percentage of Medicare and Medicaid cases, which could occur for reasons beyond our control, could result in a material adverse effect on our business, prospects, results of operations and financial condition. Case mix refers to the relative share of total cases performed by specialty, such as orthopedics, gastroenterology, pain management and otolaryngology. Generally speaking, we derive relatively higher revenues from certain types of cases. For example, orthopedic cases are generally higher revenue cases than pain management procedures, and if an orthopedic case that would have been performed at our facilities was replaced by a pain management case that was performed at our facilities, we would expect the revenue earned from that pain management case to be lower than the revenue that would have been earned for the orthopedic case. Therefore, a significant shift in our case mix toward a higher percentage of lower revenue cases, which could occur for reasons beyond our control, could result in a material adverse effect on our business, prospects, results of operations and financial condition.

As we operate in multiple markets, each with a different competitive landscape, shifts within our payor mix or case mix may not be uniform across all of our affiliated facilities. Rather, these shifts may be concentrated within certain markets due to local competitive factors. Therefore, the results of our individual affiliated facilities, including facilities that are material to our results, may be volatile, which could result in a material adverse effect on our business, prospects, results of operations and financial condition.

Payments we receive from workers' compensation programs are subject to reduction as states implement reduced fee schedules and deal with increased budgeting and economic challenges.

Payments from workers' compensation payors represented approximately 11% of our net patient revenues for the year-ended December 31, 2013. 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. Additionally, budgeting and economic challenges have caused some states to reduce the payments made to us under workers' compensation programs. In 2012, California enacted legislation that reduced the reimbursement rate for patients receiving care through its workers' compensation program by 33% beginning on January 1, 2013. In addition, North Carolina has enacted legislation to reduce its workers' compensation reimbursement rates by 15%, beginning on April 1, 2013. Finally, Indiana has passed legislation that will reduce workers' compensation reimbursement rates by 53%,

which is scheduled to go into effect on July 1, 2014. If the trend of states adopting lower workers' compensation fee schedules continues, or the budgeting and economic challenges faced by states continue, resulting in reductions to reimbursement rates, such occurrences could have a material adverse effect on our business, prospects, results of operations and financial condition.

Our relationships with health systems, including not-for-profit health systems, are important to our growth strategy. If we are not able to maintain good relationships with these health systems, or enter into new relationships, we may be unable to implement our growth strategy successfully, which could adversely affect our profitability.

Our business depends in part upon the success of our health system partners and the strength of our relationships with those healthcare systems. Our business could be adversely affected by any damage to those health systems' reputation or to our relationships with them, or as a result of an irreconcilable dispute with a health system partner. At December 31, 2013, we held ownership interests in 62 facilities in partnership with 30 different health systems. Our health system relationships include local health systems, regional health systems and national health systems. We enter into co-development agreements or have informal co-development arrangements with health systems in which we agree to jointly develop a network of surgical facilities in a defined geographic area. We expect our acquisition activity to continue with the primary focus on the creation of partnerships with health systems. If we are unable to develop and maintain good relationships with such health systems, maintain our existing agreements on terms and conditions favorable to us or enter into relationships with additional health systems on favorable terms, or at all, we may be unable to implement our growth strategies successfully, and such a failure could adversely affect our profitability. In addition, we are increasingly entering into joint ventures that we do not control because we do not have a majority stake in the joint venture or otherwise do not possess sufficient contractual rights to control the entity. Our failure to control such joint ventures may impair our ability to achieve the desired operating results from such joint ventures.

Material changes in revenue rulings published by the Internal Revenue Service (the "IRS"), case law or the interpretation of such rulings and case law could adversely affect our relationships with our not-for-profit health system partners and have a material adverse effect on our business, prospects, results of operations and financial condition.

Our relationships with tax-exempt, not-for-profit health systems and the joint venture agreements that represent these relationships are structured to minimize the possibility of adverse tax consequences to the non-profit systems, such as the imposition of the unrelated business income tax or the loss of tax exemption. These relationships are generally structured with the assistance of counsel to the non-profit systems, who rely on revenue rulings published by the IRS as well as case law relevant to joint ventures between for-profit and not-for-profit healthcare entities. Material changes in these rulings and case law, or the interpretation of such rulings and case law by the IRS, could adversely affect our relationships with our not-for-profit health system partners. Further, our compliance with the rules applicable to tax-exempt entities could have an adverse impact on the margins of facilities we own in partnership with our not-for-profit health system partners. Such rules, revenue rulings, case law and interpretations may preclude us from being able to enter into joint venture agreements or new relationships with not-for-profit health systems, which could have a material adverse effect on our business, prospects, results of operations and financial condition.

We depend on physician utilization of our facilities, which could decrease if we fail to maintain good relationships with physicians or due to other factors outside of our control.

Our business depends upon the efforts and success of the physicians who provide medical services at our facilities, and the strength of our relationships with these physicians. These physicians are not employees of our facilities and are generally not contractually required to use our facilities. We typically do not have contracts with physicians who use our facilities, other than partnership and operating agreements with physicians who own interests in our facilities, provider agreements with physicians who provide anesthesiology services in our surgical facilities and independent contractor agreements with physicians who provide certain limited services to

the facilities, such as medical director services. Physicians who use our surgical facilities usually also use other surgery centers or hospitals. Due to technological advances, physicians may also choose to perform procedures that might otherwise be performed at our surgical facilities in their own offices, such as pain management procedures, endoscopies and cataract removals. Although many physicians who own an interest in our facilities are subject to agreements restricting them from having an ownership interest in competing facilities, these agreements do not restrict physicians from performing procedures at other facilities. Also, these agreements restricting ownership of competing facilities can be difficult to enforce, and we may be unsuccessful in preventing physicians who own an interest in our facilities from acquiring an interest in a competing facility.

We also depend on the quality of care provided by the physicians who provide medical services at our facilities. While those physicians are independent contractors and not employed by us or our facilities and maintain their own liability insurance coverage, the failure of particular groups of physicians who utilize our facilities to provide quality medical care or to otherwise adhere to professional guidelines at our surgical facilities, or any damage to the reputation of a particular group of physicians with whom we are affiliated, could also damage our reputation, subject us to liability and significantly reduce our revenues.

Healthcare reform and other factors are leading more physicians to accept employment by hospitals. The creation of ACOs may cause physicians to accept employment to become part of a network that includes an ACO. In addition, Medicare's push for healthcare providers to invest in technology infrastructure to increase efficiencies may cause more physicians to move from private practice to employment with hospitals and ACOs because an individual physician or small group of physicians may view the costs associated with investing in technology as too large to bear individually. Physicians who accept employment with ACOs, hospitals or other organizations may be less likely to own, or may be contractually restricted from owning, interests in our facilities or, in some cases, restricted from using our facilities.

We have had and are likely to continue to have disputes with physicians who use our facilities or own interests in our facilities. Furthermore, we may in the future have disputes with key groups of physicians and such disputes, if they were to occur, could have a material adverse effect on our business, prospects, results of operations and financial condition. In addition, key groups of physicians may elect to leave a facility for a variety of reasons unrelated to us, including, for example, to be employed by a hospital or health system that competes with our facility. Our revenues and profitability could be reduced if we lose our relationship with key groups of physicians, or if key groups of physicians cease or reduce their use of our facilities, and we are unable to replace those groups of physicians with others who will use our facilities. The financial success of our facilities is in part dependent upon the volume of procedures performed by the physicians who use our facilities, which is affected by the economy, healthcare reform, increases in patient co-payments and deductibles and other factors outside our or their control. 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. Any reduction in our revenues due to a decrease in the use by physicians of our surgical facilities could have a material adverse effect on our business, prospects, results of operations and financial condition.

Physician treatment methodologies and governmental or commercial health insurance controls designed to reduce the number of surgical procedures may reduce our revenues and profitability.

Controls imposed by Medicare, managed Medicare, Medicaid, managed Medicaid, employer-sponsored healthcare plans and commercial health insurance payors designed to reduce surgical volumes, in some instances referred to as "utilization review," could adversely affect our facilities. Although we are unable to predict the effect these changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees may reduce our revenues and profitability. Additionally, trends in physician treatment protocols and commercial health insurance plan design, such as plans that shift increased costs and accountability for care to patients, could reduce our surgical volumes in favor of lower intensity and lower cost treatment methodologies, each of which could, in turn, have a material adverse effect on our business, prospects, results of operations and financial condition.

Our growth strategy depends in part on our ability to attract new physician investors, and to acquire and develop additional surgical facilities, on favorable terms. If we are unable to achieve either of these goals, our future growth could be limited.

We believe that an important component of our financial performance and growth is our ability to provide physicians who use our facilities with the opportunity to purchase ownership interests in our facilities. We may not be successful in attracting new physician investment in our surgical facilities, and that failure could result in a reduction in the quality, efficiency and profitability of our facilities. Based on competitive factors and market conditions, physicians may be able to negotiate relatively higher levels of equity ownership in our facilities, consequently limiting or reducing our share of the profits from these facilities. In addition, physician ownership in our facilities is subject to certain regulatory restrictions, see "— Risks Related to Healthcare Regulation — Our surgical facilities do not satisfy the requirements for any of the safe harbors under the Anti-Kickback Statute. If we fail to comply with the Anti-Kickback Statute, we could be subject to criminal and civil penalties, loss of licenses and exclusion from governmental programs, which may result in a substantial loss of revenues" and "—Risks Related to Healthcare Regulation — 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 substantial monetary penalties and a significant loss of revenues."

In addition, our growth strategy includes the acquisition of existing surgical facilities and the development of new surgical facilities jointly with local physicians and, in some cases, healthcare systems and other strategic partners. From January 2010 to December 31, 2013, we acquired 13 consolidated facilities and 32 noncontrolling interests in facilities accounted for as equity method investments. If we are unable to successfully execute on this strategy in the future, our future growth could be limited. We may be unable to identify suitable acquisition and development opportunities, or to complete acquisitions and new projects in a timely manner and on favorable terms. Our acquisition and development activities require 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 material adverse effect on our business, prospects, results of operations and financial condition, including incurring substantial debt with certain restrictive terms. Further, sufficient capital or financing may not be available to us on satisfactory terms, if at all. In addition, our ability to acquire and develop additional surgical facilities may be limited by state certificate of need programs and other regulatory restrictions on expansion. We also face significant competition from local, regional and national health systems and other owners of surgical facilities in pursuing attractive acquisition candidates.

Shortages of surgery-related products, equipment and medical supplies and quality control issues with such products, equipment and medical supplies could disrupt our operations and adversely affect our case volume, case mix and profitability.

Our operations depend significantly upon our ability to obtain sufficient surgery-related products, drugs, equipment and medical supplies from suppliers on a timely basis. If we are unable to obtain such necessary products, or if we fail to properly manage existing inventory levels, we would be unable to perform certain surgeries, which could adversely affect our case volume or result in a negative shift in our case mix. In addition, as a result of shortages, we could suffer, among other things, operational disruptions, disruptions in cash flows, increased costs and reductions in profitability. At times, supply shortages have occurred in our industry, and such shortages may recur from time to time.

Medical supplies and services can also be subject to supplier product quality control incidents and recalls. In addition to contributing to materials shortages, product quality can affect patient care and safety. Material quality control incidents have occurred in the past and may occur again in the future, for reasons beyond our control, and such incidents can negatively impact our case volume, product costs and our reputation. In addition, we may have to incur costs to resolve quality control incidents related to medical supplies and services regardless of whether they were caused by us. Our inability to obtain the necessary amount and quality of surgery-related products, equipment and medical supplies due to a quality control incident or recall could have a material adverse effect on our business, prospects, results of operations and financial condition.

Competition for staffing, shortages of qualified personnel or other factors could increase our labor costs and adversely affect our results of operations and cash flows.

Our operations are dependent on the efforts, abilities and experience of our management and clinical personnel, particularly nurses. We compete with other healthcare providers in recruiting and retaining qualified management and support personnel responsible for the daily operations of each of our facilities. In some markets, the lack of availability of clinical personnel, such as nurses, has become a significant operating issue facing all healthcare providers. This shortage may require us to continue to enhance wages and benefits to recruit and retain qualified personnel or to contract for more expensive temporary personnel. For the year-ended December 31, 2013, our salary and benefit expenses represented 34.6% of our net operating revenues. We also depend on the available labor pool of semi-skilled and unskilled workers in each of the markets in which we operate.

If our labor costs increase, we may not be able to raise rates to offset these increased costs. Because a significant percentage of our revenues consist of fixed, prospective payments, our ability to pass along increased labor costs is limited. In particular, if labor costs rise at an annual rate greater than our net annual Consumer Price Index basket update from Medicare, our results of operations and cash flows will likely be adversely affected. Any union activity at our facilities that may occur in the future could contribute to increased labor costs. Certain proposed changes in federal labor laws and the National Labor Relations Board's modification of its election procedures could increase the likelihood of employee unionization attempts. Although none of our teammates are currently represented by a collective bargaining agreement, to the extent a significant portion of our employee base unionizes, it is possible our labor costs could increase materially. Our failure to recruit and retain qualified management and medical personnel, or to control our labor costs, could have a material adverse effect on our business, prospects, results of operations and financial condition.

We face intense competition for patients, physicians, strategic relationships and commercial payor contracts.

The healthcare business is highly competitive, and each of the individual geographic areas in which we operate has a different competitive landscape. In each of our markets we compete with other healthcare providers for patients and in contracting with commercial payors. In addition, because the number of physicians available to utilize and invest in our facilities is finite, we face intense competition from other surgery centers, hospitals, health systems and other healthcare providers in recruiting physicians to utilize and invest in our facilities. We are in competition with other surgery centers, hospitals and healthcare systems in the communities we serve to attract patients and provide them with the care they need. There are hospitals and health systems that compete with us in each market in which we operate, and many of them have more established relationships with physicians and payors than we do. To the extent that a majority of physicians within an individual community or market decide to partner with a competing surgery center, hospital or health system and not with us, our affiliated facility in such community may become unprofitable and the value of this asset may decrease, even drastically. In addition, other companies are currently in the same or similar business of developing, acquiring and operating surgical facilities, or may decide to enter this business. We also compete with some of these companies for entry into strategic relationships with health systems and physicians. Moreover, many physicians develop surgical facilities without a corporate partner, using consultants who perform services that we often perform for a fee and who do not take an equity interest in the ongoing operations of the facility. As a result of the differing competitive factors within the markets in which we operate, the individual results of our facilities may be volatile. If we are unable to compete effectively with any of these entities or groups, or to attract a sufficient number of physicians to utilize or invest in our facilities, we may be unable to implement our business strategies successfully, which could have a material adverse effect on our business, prospects, results of operations and financial condition.

We often are subject to malpractice and related legal claims, and we could be required to pay significant damages in connection with those claims, which may not be covered by insurance.

In the ordinary course of business, we are subject to legal actions alleging malpractice or related legal claims arising out of the treatment of patients at our facilities. Many of these actions involve large monetary

claims and significant defense costs. In some cases, it may be difficult to control the level of risk in this area. For example, it is possible that our facilities could inadvertently purchase tainted products from ostensibly reputable suppliers. Other providers are facing substantial litigation costs, and could face substantial damages, in connection with medical malpractice and products liability claims associated with the purchase of tainted epidural steroids, the administration of which by ASCs and other types of providers resulted in the recent nationwide meningitis outbreak. We maintain liability insurance in amounts that we believe are appropriate for our operations, including professional and general liability insurance that provides coverage on a claims-made basis of $1.0 million per occurrence and $3.0 million in annual aggregate coverage per surgical facility. We also maintain umbrella liability insurance in the aggregate amount of $10.0 million and excess liability insurance in the aggregate amount of $15.0 million. See "Business — Operational Risks and Insurance" for additional information regarding our insurance coverage. However, this insurance coverage may not cover all claims against us, and insurance coverage may not continue to be available at a cost satisfactory to us to allow for the maintenance of adequate levels of insurance. If one or more successful claims against us were not covered by or exceeded the coverage of our insurance, it could have a material adverse effect on our business, prospects, results of operations and financial condition.

Our case volume and case mix may be adversely affected due to current and future economic conditions.

The U.S. economy continues to experience difficult conditions. Our case volume and case mix may be adversely affected by patients' inability to pay for procedures in our facilities. Higher numbers of unemployed individuals generally translate into more individuals without healthcare insurance to help pay for procedures, thereby increasing the potential for persons to elect not to have procedures performed. However, a majority of the procedures performed in our surgical facilities are not considered truly elective in nature. Therefore, even procedures normally thought to be non-elective may be delayed or may not be performed if the patient cannot afford the procedure due to a lack of insurance or money to pay their portion of our facility's fee.

In addition, the difficult conditions of the U.S. economy have adversely affected and could continue to adversely affect the budgets of individual states and the Federal government, which has resulted in and could continue to result in attempts to reduce payments made to us by Federal and state government healthcare programs, including Medicare, military services, Medicaid and workers' compensation programs, a reduction in the scope of services covered by those programs and an increase in taxes and assessments on our activities. In the past, the Federal government has entered a shutdown that suspended services deemed non-essential as a result of a failure by Congress to enact regular appropriations. A prolonged shutdown in the future could cause significant regulatory delays, including delays in our ability to obtain Medicare billing numbers or achieve Medicare certification for new facilities. Furthermore, if the Federal government debt incurrence ceiling expires and is not raised by Congress, the Federal government could default on its debts. A prolonged shutdown or a failure to raise the debt ceiling would negatively affect the U.S. economy and could have a material adverse effect on the healthcare industry, our business, results of operations or financial condition.

Many of our facilities are concentrated in certain states, which makes us particularly sensitive to regulatory, economic and other conditions in those states.

Our revenues are particularly sensitive to regulatory, economic and other conditions in certain states where we have a greater concentration of facilities. For the year-ended December 31, 2013, our facilities located in North Carolina, California and Texas represented approximately 14%, 14% and 12%, respectively, of our net patient revenues. Additionally, facilities located in each of Alabama, Alaska, Connecticut, Florida and Idaho represented in excess of 5% of our net patient revenues for the year-ended December 31, 2013. Of our 60 nonconsolidated facilities accounted for as equity method investments, as of December 31, 2013, 26 of these facilities were located in California and 12 of these facilities were located in Indiana. If there were an adverse regulatory, economic or other development in any of the states in which we have a higher concentration of facilities, our case volumes could decline in these states or there could be other unanticipated adverse impacts on our business in those states, which could have a material adverse effect on our business, prospects, results of operations and financial condition.

We have a history of net losses and may not achieve or sustain profitability in the future.

We have historically incurred periods of net losses, including net losses of approximately $51.3 million in 2013, $20.0 million in 2012 and $9.7 million in 2011. We cannot assure you that our revenues will grow or that we will achieve or maintain profitability in the future. Even if we do achieve profitability, we may not sustain or increase profitability on a quarterly or annual basis in the future. Our ability to achieve profitability will be affected by the other risks and uncertainties described in this section and in "Management's Discussion and Analysis of Financial Condition and Results of Operations." If we are not able to achieve, sustain or increase profitability, our business will be adversely affected and our stock price may decline.

Certain of our partnership and operating agreements contain termination dates that will require us to amend and possibly renegotiate such agreements.

Certain of our LP agreements, general partnership agreements and LLC operating agreements have termination dates by which the agreement expires by its terms. In some cases, termination dates are required under the applicable state law governing the form of entity. In these situations we would attempt to negotiate an amendment to the agreement to prevent such termination if we wish to continue the business. Any such amendment could also require us to renegotiate material terms of the agreements with our physician and health system partners. There is no guarantee that we will be able to renegotiate these agreements on terms that are favorable or satisfactory to us or at all. If we are unable to amend or renew our agreements on terms that are satisfactory to us or at all, this could have a material adverse effect on our business, prospects, results of operations and financial condition. None of our operating agreements have termination dates in 2014.

Certain of our partnership and operating agreements contain provisions giving rights to our partners and other members that may be adverse to our interests.

Certain of the agreements governing the LPs, general partnerships and LLCs through which we own and operate our facilities contain provisions that give our partners or other members rights that may, in certain circumstances, be adverse to our interests. These rights include, but are not limited to, rights to purchase our interest in the partnership or LLC, rights to require us to purchase the interests of our partners or other members, or rights requiring the consent of our partners and other members prior to our transferring our ownership interest in a facility or prior to a change in control of us or certain of our subsidiaries. With respect to these purchase rights, the agreements generally include a specified formula or methodology to determine the applicable purchase price, which may or may not reflect fair market value.

In one case, two agreements governing seven facilities that we co-own with Sutter Health give Sutter Health the absolute right to purchase our proportionate interest in the facilities, including our ongoing profits from managing the facilities, after the passage of a certain amount of time. The first of these rights will arise in 2017. The purchase price of our interest will be the fair market value as determined by an independent appraisal. One of these agreements further provides that if Sutter Health forgoes the right to acquire our interest upon the initial trigger date, such right will renew and we must offer Sutter Health the same opportunity every three years. The other agreement gives Sutter Health an ongoing right to purchase our proportionate interest in one facility after the expiration of seven years following the commencement of operations of the center. There are an additional two agreements governing four facilities co-owned with Sutter Health under which Sutter Health has the right to purchase up to 10% of our ownership interest in one facility and up to 10% of our ownership interest in our joint venture entity that owns one facility, also at fair market value. Although the stated purchase price for these acquisitions is fair market value, the purchase of our interests by our partner will prevent us from continuing to recognize ongoing profits from owning and managing these facilities, which could have a material adverse effect on our business, prospects, results of operations and financial condition.

In addition to the purchase and consent rights described above, almost all of our partnership and operating agreements contain restrictions on actions that we can take, even though we may be the general partner or the managing member. Examples of these restrictions include the rights of our partners and other members to approve the sale of substantially all of the assets of the partnership or LLC, to dissolve the partnership or LLC, to

appoint a new or additional general partner or managing member and to amend the partnership or operating agreements. Many of our agreements also restrict our ability in certain instances to compete with our existing facilities or with our partners. Where we hold only a limited partner or a non-managing member interest, the general partner or managing member may take certain actions without our consent, although we typically have certain protective rights to approve major decisions such as the sale of substantially all of the assets of the entity, dissolution of the partnership or LLC and the amendment of the partnership or operating agreement. These management and governance rights held by our partners and other members limit and restrict our ability to make unilateral decisions about the management and operation of the facilities without the approval of our partners and other members.

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

We generally hold our ownership interests in facilities through limited or general partnerships, LLCs or LLPs in which we maintain an ownership interest along with physicians and, in some cases, health systems. As general partner and manager of most 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. We may encounter conflicts between our responsibility to the other interest holders and our own best interests. 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 may be obligated to exercise reasonable, good faith judgment to resolve the disputes and may not be free to act solely in our own best interests. 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 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, it could have a material adverse effect on our business, prospects, results of operations and financial condition.

We may have difficulty operating and integrating newly acquired or developed facilities.

If we acquire or develop additional facilities, we may experience difficulty in retaining or integrating their operations, key physicians, systems and personnel. In some acquisitions, we may have to renegotiate, or risk losing, one or more of the facility's commercial payor contracts. We may also be unable to immediately collect the accounts receivable of an acquired facility while we align the payors' payment systems and accounts with our own systems. Certain transactions can require licensure changes which, in turn, result in disruptions in payment for services. Moreover, the integration of acquired facilities may result in the diversion of our management's time from our existing operations.

If we are not successful in integrating newly acquired surgical facilities, we may not realize the potential benefits of such acquisitions. Likewise, if we are not able to integrate acquired facilities' operations and personnel with ours in a timely and efficient manner, then the potential benefits of the transaction may not be realized. In particular, if we experience the loss of key personnel or if the effort devoted to the integration of acquired facilities diverts significant management or other resources from other operational activities, our operations could be impaired.

In addition, we may acquire 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 that provides coverage on a claims-made basis of $1.0 million per occurrence and $3.0 million in annual aggregate coverage per surgical facility, we do not maintain insurance specifically covering all unknown or contingent liabilities that may have occurred prior to the acquisition of facilities. See "Business — Operational Risks and Insurance" for additional information regarding our insurance coverage. In some cases, our right to indemnification for these liabilities from the seller may be subject to negotiated limits or limits on our ability to enforce indemnification rights.

In developing new facilities, we may be unable to attract physicians to use our facilities or to enter into favorable contracts with commercial payors. In addition, newly developed 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 facilities. Integrating a new facility can be expensive and time consuming and could disrupt our ongoing business and distract our management and other key teammates.

Growth of patient receivables or deterioration in the ability to collect on these accounts, due to changes in economic conditions or otherwise, could have a material adverse effect on our business, prospects, results of operations and financial condition.

The primary collection risks with respect to our patient receivables relate to patient accounts for which the primary third-party payor has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and co-payments) remain outstanding. Our provision for doubtful accounts relates primarily to amounts due directly from patients.

We provide for bad debts principally based upon the type of payor and the age of the receivables. Our allowance for doubtful accounts at December 31, 2013 and 2012 represented approximately 13.0% and 7.2% of our accounts receivable balance, respectively.

Due to the difficulty in assessing future trends, including the effects of changes in economic conditions, we could be required to increase our provision for doubtful accounts. An increase in the amount of patient receivables or a deterioration in the collectability of these accounts could have a material adverse effect on our business, prospects, results of operations and financial condition.

Because our senior management has been key to our growth and success, we may be adversely affected if we lose the services of our senior management.

Our success depends to a significant extent upon the efforts and abilities of our senior management team and key financial and operating teammates. Although we have employment agreements with senior management, we do not maintain "key man" life insurance policies for any of our senior management. Competition for senior management generally, and within the healthcare industry specifically, is intense, and we may not be able to recruit and retain the personnel we need if we were to lose an existing member of senior management. Many of our senior management and other financial and operating key teammates were recruited by us specifically due to their industry experience or specific expertise. The loss of senior management or other key teammates, without adequate replacements, or our inability to attract, retain and motivate sufficient numbers of qualified senior management or other key teammates, could have a material adverse effect on our business, prospects, results of operations and financial condition.

We rely on our controlling stockholder.

We have in recent years depended on our relationship with TPG, our controlling stockholder, to help guide our business plan and we continue to rely on TPG's significant expertise in financial matters. This expertise has been available to us through the representatives TPG has on the Company's board of directors. Representatives of TPG have the ability to appoint, and have appointed, a majority of the seats on our board of directors. In the future, TPG may elect to reduce its ownership in our company or reduce its involvement on our board of directors, which could reduce or eliminate the benefits we have historically achieved through our relationship with it. See "— Risks Related to Our Common Stock — TPG has significant influence over us, including control over decisions that require the approval of stockholders, which could limit your ability to influence the outcome of key transactions, including a change of control, and which may result in conflicts with us or you in the future."

We have a substantial amount of indebtedness, which may adversely affect our available cash flow and our ability to operate our business, remain in compliance with debt covenants and make payments on our indebtedness.

We have a substantial amount of indebtedness. As of December 31, 2013, we had approximately $645.7 million of indebtedness (excluding capital leases), which includes $602.5 million under our Senior Secured Credit Facilities (as defined herein). We also have $132.3 million of unused commitments under our Class B Revolving Credit Facility. At December 31, 2013, we had approximately $1.7 million in letters of credit outstanding.

Our substantial level of indebtedness increases the possibility that we may be unable to generate cash sufficient to pay, when due, the principal of, interest on or other amounts due in respect of our indebtedness. Our substantial indebtedness, combined with our other financial obligations and contractual commitments, could have important consequences. For example, it could:

- make it more difficult for us to satisfy our obligations with respect to our indebtedness, and any failure to comply with the obligations under any of our debt instruments, including restrictive covenants, could result in an event of default under such instruments;
- make us more vulnerable to adverse changes in general economic, industry and competitive conditions and adverse changes in government regulation;
- require us to dedicate a substantial portion of our cash flow from operations to payments on our indebtedness, thereby reducing the availability of our cash flow to fund working capital, capital expenditures, acquisitions and other general corporate purposes;
- limit our flexibility in planning for, or reacting to, changes in our business and the industry in which we operate;
- place us at a competitive disadvantage compared to our competitors that are less highly leveraged and therefore able to take advantage of opportunities that our indebtedness prevents us from exploiting; and
- limit our ability to borrow additional amounts for working capital, capital expenditures, acquisitions, debt service requirements, execution of our business strategy or other purposes.

Any of the above listed factors could have a material adverse effect on our business, prospects, results of operations and financial condition. Furthermore, our interest expense could increase if interest rates increase because a portion of our debt under our Senior Secured Credit Facilities bears interest at floating rates, which could adversely affect our cash flows. If we do not have sufficient earnings to service our debt, we may be required to refinance all or part of our existing debt, sell assets, borrow more money or sell securities, none of which we can guarantee we will be able to do.

In addition, our Senior Secured Credit Facilities contain restrictive covenants that limit our ability to engage in activities that may be in our long-term best interests. A breach of any of these restrictive covenants, if not cured or waived, could result in an event of default that could trigger acceleration of our indebtedness and may result in the acceleration of or default under any other debt to which a cross-acceleration or cross-default provision applies, which could have a material adverse effect on our business and financial condition. Utilization of the Class B Revolving Credit Facility is subject to compliance with a total leverage ratio test. In addition, our Senior Secured Credit Facilities require prepayment of the outstanding indebtedness thereunder if we have certain excess cash flow, as described therein. Finally, our Senior Secured Credit Facilities require the repayment in full of all amounts outstanding thereunder upon a change of control, as defined therein.

Despite our current indebtedness levels, we and our subsidiaries may still be able to incur substantially more debt, which could further exacerbate the risks associated with our substantial leverage.

We and our subsidiaries may be able to incur substantial additional indebtedness in the future, including secured indebtedness. Although the Amended Credit Agreement (as defined herein) governing our Senior

Secured Credit Facilities contains restrictions on the incurrence of additional indebtedness, these restrictions are subject to a number of significant qualifications and exceptions, and the indebtedness incurred in compliance with these restrictions could be substantial. If new debt is added to our or our subsidiaries' current debt levels, the related risks that we face would be increased.

To service our indebtedness, we will require a significant amount of cash. Our ability to generate cash depends on many factors beyond our control, and any failure to meet our debt service obligations could have a material adverse effect on our business, prospects, results of operations and financial condition.

Our ability to pay interest on and principal of our debt obligations principally depends upon our operating performance. As a result, prevailing economic conditions and financial, business and other factors, many of which are beyond our control, will affect our ability to make these payments.

In addition, we conduct our operations through our subsidiaries. Accordingly, repayment of our indebtedness is dependent on the generation of cash flow by our subsidiaries and their ability to make such cash available to us by dividend, debt repayment or otherwise. Our subsidiaries may not be able to, or may not be permitted to, make distributions to enable us to make payments in respect of our indebtedness. Each of our subsidiaries is a distinct legal entity and, under certain circumstances, legal and contractual restrictions may limit our ability to obtain cash from our subsidiaries. In particular, the constituent documents governing many of our non-wholly owned subsidiaries limit, under certain circumstances, our ability to access the cash generated by those subsidiaries in a timely manner.

If we do not generate sufficient cash flow from operations to satisfy our debt service obligations, we may have to undertake alternative financing plans, such as refinancing or restructuring our indebtedness, selling assets, reducing or delaying capital investments or capital expenditures or seeking to raise additional capital. Our ability to restructure or refinance our debt, if at all, will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. In addition, the terms of existing or future debt instruments may restrict us from adopting some of these alternatives. Our inability to generate sufficient cash flow to satisfy our debt service obligations, or to refinance our obligations at all or on commercially reasonable terms, could affect our ability to satisfy our debt obligations and have a material adverse effect on our business, prospects, results of operations and financial condition.

The terms of our Senior Secured Credit Facilities may restrict our current and future operations, particularly our ability to respond to changes in our business or to take certain actions.

Our Senior Secured Credit Facilities contain, and any future indebtedness of ours would likely contain, a number of restrictive covenants that impose significant operating restrictions, including restrictions on our ability to engage in acts that may be in our best long-term interests.

The Amended Credit Agreement governing our Senior Secured Credit Facilities includes covenants restricting, among other things, our ability to:

- incur liens;
- incur or assume additional debt or guarantees or issue or sell certain types of preferred stock;
- pay dividends or make redemptions and repurchases with respect to capital stock;
- prepay, or make redemptions and repurchases of, subordinated debt;
- make loans or investments; and
- engage in mergers, acquisitions, asset sales, sale/leaseback transactions and transactions with affiliates.

The operating restrictions and covenants in these debt agreements and any future financing agreements may adversely affect our ability to finance future operations or capital needs or to engage in other business activities. Our ability to comply with these covenants may be affected by events beyond our control, and any material deviations from our forecasts could require us to seek waivers or amendments of covenants, alternative sources of financing or reductions in expenditures. In addition, the outstanding indebtedness under our Senior Secured Credit Facilities is, subject to certain exceptions, secured by security interests in substantially all of our, SCA's and the other Guarantors' (as defined herein) assets. A breach of any of the restrictive covenants in the Amended Credit Agreement governing the Senior Secured Credit Facilities would result in a default, and our lenders may elect to declare all outstanding borrowings, together with accrued interest and other fees, to be immediately due and payable, or enforce and foreclose on their security interest and liquidate some or all of such pledged assets. The lenders under our Senior Secured Credit Facilities also have the right in these circumstances to terminate any commitments they have to provide further borrowings.

We are exposed to market risk related to interest rate changes.

We are exposed to market risk related to changes in interest rates as a result of the floating interest rates applicable to the outstanding debt under our Senior Secured Credit Facilities, including our $214.4 million Class B Term Loan due December 30, 2017 and our $388.1 million Class C Term Loan due June 30, 2018. The interest rate on the Class B Term Loan and the Class C Term Loan at December 31, 2013 was 4.25%. The weighted average interest rate for the outstanding debt under our Senior Secured Credit Facilities as of December 31, 2013 was 4.26%. Borrowings under each portion of the Senior Secured Credit Facilities bear interest at a base rate or at LIBOR, as elected by us, plus an applicable margin. The base rate is determined by reference to the higher of (i) the prime rate of JPMorgan Chase Bank, N.A. and (ii) the federal funds effective rate plus 0.50%. The LIBOR rate is determined by reference to the interest rate for dollar deposits in the London interbank market for the interest period relevant to such borrowings. There is no cap on the maximum interest rate for the Senior Secured Credit Facilities. As of December 31, 2013, we held forward starting interest rate swaps hedging interest rate risk on $240.0 million of our variable rate debt to manage our exposure to these fluctuations. These forward starting interest rate swaps, which are swaps that are entered into at a specified trade date but do not begin to accrue interest until a future start date, extend the interest rate swaps that we terminated in 2012 and 2013. These swaps are "receive floating/pay fixed" instruments, meaning we receive floating rate payments, which fluctuate based on LIBOR, from the counterparty and provide payments to the counterparty at a fixed rate, the result of which is to convert the interest rate of a portion of our floating rate debt into fixed rate debt in order to limit the variability of interest-related payments caused by changes in LIBOR. See Item 7A — "Quantitative and Qualitative Disclosures About Market Risk."

We make significant loans to the partnerships and LLCs that own and operate certain of our facilities.

For certain of our surgical facilities, indebtedness at the partnership or LLC level is funded through intercompany loans that we provide. Through many of these loans, which totaled approximately $27.6 million to 27 surgical facilities as of December 31, 2013, we have a security interest in the partnership's or LLC's assets. However, our business, prospects, financial condition and results of operations could be materially adversely affected if our surgical facilities are unable to repay these intercompany loans.

We are liable for certain debts and other obligations of the partnerships and limited liability companies that own and operate certain of our facilities.

In certain of the general partnerships, LPs, LLPs or LLCs in which one of our affiliates is the general partner or managing member, our affiliate is liable for some or all of the debts and other obligations of the entity. Our partners or co-members are often required to guarantee their pro rata share of any indebtedness or lease agreements to which the entity is a party in proportion to their ownership interest in the entity. As of December 31, 2013, we guaranteed a total of $37.6 million of debt, consisting of $35.1 million at consolidated facilities and $2.5 million in the aggregate at nonconsolidated and managed-only facilities. For more information regarding guarantees made to nonconsolidated or managed-only facilities, see "Management's Discussion and

Analysis of Financial Condition and Results of Operations — Liquidity and Capital Resources — Off-Balance Sheet Transactions." There can be no assurance that a third-party lender or lessor would seek performance of the guarantees rather than seek repayment from us of any obligation of the general partnership, LP, LLP or LLC if there is a default, or that the physician partners or co-members would have sufficient assets to satisfy their guarantee obligations.

We may recognize impairments on long-lived assets, including goodwill and other intangible assets, or recognize impairments on our equity method investments.

Our balance sheet at December 31, 2013 contained intangible assets, including goodwill, of $806.0 million. Future acquisitions that result in the recognition of additional long-lived and intangible assets would cause an increase in these types of assets. On an ongoing basis, we evaluate whether facts and circumstances indicate any potential impairment to the carrying value of these assets could exist. Estimates of the future cash flows associated with the assets are critical to the impairment assessments. Changes in estimates based on changed economic conditions or business strategies could result in material impairment charges and therefore have a material adverse impact on our business, prospects, results of operations and financial condition.

We recognize an impairment charge when the decline in the estimated fair value of our equity method investments in our nonconsolidated facilities below their book value are judged to be other-than-temporary. Significant judgment is used to identify events or circumstances that would likely have a significant adverse effect on the future prospects of an equity method investment. We consider various factors in determining whether an impairment is other-than-temporary, including the severity and duration of the impairment, forecasted recovery and the financial condition and near-term prospects of the facility. Our current evaluation of other-than-temporary impairments reflects our intent to maintain our equity method investments for a reasonable period of time sufficient for a forecasted recovery of fair value. However, our intent to hold certain of these investments may change in future periods as a result of facts and circumstances impacting the operations of the facility. If our intent changes and we do not expect the equity method investment to fully be recoverable, we will write down the investment to its fair value in the period that our intent changes.

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

Our operations depend significantly on effective information systems, which require continual maintenance, upgrading and enhancement to meet our operational needs. Any system failure that causes an interruption in service or availability of our systems could adversely affect operations or delay the collection of revenues. Moreover, our growth and acquisition strategy will require frequent transitions and integration of various information systems. If we are unable to properly integrate other information systems or expand our current information systems, we could suffer, among other things, operational disruptions, disruptions in cash flows and increases in administrative expenses.

Information security risks have generally increased in recent years because of the proliferation of new technologies and the increased sophistication and activities of perpetrators of cyber-attacks. A failure in or breach of our operational or information security systems as a result of cyber-attacks or information security breaches could disrupt our business, result in the disclosure or misuse of confidential or proprietary information, damage our reputation, increase our costs or lead to fines and financial losses. As a result, cyber security and the continued development and enhancement of the controls and processes designed to protect our systems, computers, software, data and networks from attack, damage or unauthorized access remain a priority for us. Although we believe that we have appropriate information security procedures and other safeguards in place, as cyber threats continue to evolve, we may be required to expend additional resources to continue to enhance our information security measures or to investigate and remediate any information security vulnerabilities.

We may not be able to fully realize the value of our net operating loss carryforwards.

As of December 31, 2013, we had unused federal net operating loss carryforwards ("NOLs") of approximately $263.7 million. Such losses expire in various amounts at varying times beginning in 2027. Unless

they expire, these NOLs may be used to offset future taxable income and thereby reduce our income taxes otherwise payable. While we believe we will be able to use a substantial portion of these tax benefits before they expire, no such assurances can be provided. For further discussion of our NOLs see Note 13, Income Taxes, to the accompanying consolidated financial statements.

As of December 31, 2013, we maintained a full valuation allowance of $166.1 million against our deferred tax assets. On a quarterly basis, we assess the likelihood of realization of our deferred tax assets considering all available evidence, both positive and negative. While we have concluded that a full valuation allowance continued to be appropriate as of December 31, 2013, we are continually monitoring actual and forecasted earnings. If there is a change in management's assessment of the amount of deferred income tax assets that is realizable, adjustments to the valuation allowance will be made in future periods.

If reversal of the valuation allowance does occur, we will need to continue to monitor results. If our expectations for future operating results on a consolidated basis or at the state jurisdiction level vary from actual results due to changes in healthcare regulations, general economic conditions, or other factors, we may need to adjust the valuation allowance, for all or a portion of our deferred tax assets. Our income tax expense in future periods will be reduced or increased to the extent of offsetting decreases or increases, respectively, in our valuation allowance in the period when the change in circumstances occurs. These changes could have a significant impact on our future earnings.

Section 382 ("Section 382") of the Internal Revenue Code of 1986, as amended (the "Code") imposes an annual limit on the ability of a corporation that undergoes an "ownership change" to use its NOLs to reduce its tax liability. An "ownership change" is generally defined as any change in ownership of more than 50% of a corporation's "stock" by its "5-percent shareholders" (as defined in Section 382) over a rolling three-year period based upon each of those shareholder's lowest percentage of stock owned during such period. It is possible that future transactions, not all of which would be within our control (including a possible sale by TPG or MTS of some or all of their respective shares of our common stock), could cause us to undergo an ownership change as defined in Section 382. In that event, we would not be able to use our pre-ownership-change NOLs in excess of the limitation imposed by Section 382. At this time, we do not believe these limitations will affect our ability to use any NOLs before they expire, but we cannot assure you that will be the case. If our ability to utilize our NOLs to offset taxable income generated in the future is subject to this limitation, it could have an adverse effect on our business, prospects, results of operations and financial condition.

Our facilities may be adversely impacted by weather and other factors beyond our control.

The financial results of our facilities may be adversely impacted by adverse weather conditions, such as tornadoes, earthquakes and hurricanes, or other factors beyond our control, such as wildfires. These weather conditions or other factors could disrupt patient scheduling, displace our patients, teammates and physician partners and force certain of our facilities to close temporarily or for an extended period of time. In certain markets, including Southern and Northern California, we have a large concentration of surgery centers that may be simultaneously affected by adverse weather conditions, earthquakes, wildfires or other events beyond our control.

Risks Related to Healthcare Regulation

We are currently unable to predict the impact of the Health Reform Law, which represents a significant change to the healthcare industry.

The Health Reform Law will change how healthcare services are covered, delivered and reimbursed through, among other things, expanded coverage of uninsured individuals, reduced growth in Medicare program spending and the establishment of programs where reimbursement is tied to quality. The Health Reform Law also reforms certain aspects of health insurance, expands existing efforts to tie Medicare and Medicaid payments to performance and quality and contains provisions intended to strengthen fraud and abuse enforcement. Due to the

complexity of the Health Reform Law, the many factors involved in its implementation and ongoing court challenges on certain issues, it is difficult to predict the full impact of the Health Reform Law on the healthcare industry.

The Health Reform Law was signed into law in March 2010; however, many of its measures do not take effect until 2014 or later and other measures have been delayed. For example, the date by which individuals must have obtained qualified health insurance coverage in order to avoid tax penalties has been delayed until March 31, 2014. In addition, the Health Reform Law's employer mandate, pursuant to which certain larger employers that do not offer health insurance benefits to their employees will be required to make "shared responsibility payments" if an employee obtains government-subsidized coverage through the Health Insurance Marketplace, will be delayed until January 1, 2015, for employers with 100 or more employees, and until January 1, 2016, for employers with 50 to 99 employees.

Further, it is unclear how many states will decline to implement the Medicaid expansion provisions of the Health Reform Law. In June 2012, the Supreme Court upheld the constitutionality of the individual mandate provisions of the Health Reform Law, but struck down provisions that would have allowed HHS to penalize states that do not implement the Medicaid expansion provisions of the law with the loss of existing Medicaid funding. As a result, some states may choose not to implement the Medicaid expansion, and fewer individuals will be covered by a state Medicaid program than would have been covered had the Supreme Court upheld the Health Reform Law in its entirety.

In addition, the potential impact of the Health Insurance Marketplace, the system of state and federal health insurance exchanges through which qualified health insurance coverage may be obtained, is uncertain. The purpose of the Health Insurance Marketplace is to provide consumers, including individuals that do not currently have health insurance, with a convenient and transparent marketplace through which individual health insurance products may be purchased. The Health Insurance Marketplace became operational on October 1, 2013, with insurance coverage purchased through the Marketplace taking effect as early as January 1, 2014. It is possible that rates payable to providers under health insurance policies purchased by an individual through the Health Insurance Marketplace will be lower than rates payable under policies purchased by an employer for a group. It is also possible that some employers will opt to cease providing group coverage and make "shared responsibility payments," leaving their employees to purchase individual policies through the Marketplace. The impact of the Health Insurance Marketplace on the market for individual policies, and the rates payable to providers under health insurance products offered through the Marketplace, is uncertain.

The Health Reform Law makes several significant changes to healthcare fraud and abuse laws, provides additional enforcement tools for the Federal government, increases cooperation between federal agencies by establishing mechanisms for the sharing of information and enhances criminal and administrative penalties for non-compliance. For example, the Health Reform Law: (i) provides $350 million in increased federal funding to fight healthcare fraud, waste and abuse; (ii) expands the scope of the Recovery Audit Contractor program to include both the Medicaid and Medicare Advantage plans; (iii) authorizes HHS, in consultation with the OIG, to suspend Medicare and Medicaid payments to a provider of services or a supplier "pending an investigation of a credible allegation of fraud;" (iv) provides Medicare contractors with additional flexibility to conduct random prepayment reviews; and (v) strengthens the rules for returning overpayments made by governmental health programs, including expanding liability under the FCA to extend to failures to timely repay identified overpayments. The Health Reform Law also places limitations on an exception to the Stark Law that allows physicians to invest in hospitals if the physicians' investments are in the entire hospital and not just a department of the hospital (the "whole hospital exception"). Among other things, the Health Reform Law prohibits hospitals from increasing the percentages of the total value of the ownership interests held in the hospital by physicians after March 23, 2010, and places restrictions on the ability of a hospital subject to the whole hospital exception to add operating rooms, procedure rooms and beds.

As a result of the Health Reform Law, we expect enhanced scrutiny of healthcare providers' compliance with state and federal regulations, increased enforcement of infection control standards and implementation of

other quality control measures. In addition, the Health Reform Law includes certain value-based purchasing initiatives, and we expect such initiatives, including programs that condition reimbursement on patient outcome measures, to become more common among governmental and commercial payors. Pursuant to the Health Reform Law, HHS has submitted a report to Congress outlining HHS's plan to implement a value-based purchasing program for ASCs that would tie Medicare payments to quality and efficient measures. In addition, CMS has promulgated three national coverage determinations that prevent Medicare from paying for certain serious, preventable medical errors that occur in a healthcare facility. Several commercial payors also do not reimburse providers for certain preventable adverse events. CMS has also established an ASC Quality Reporting Program. Failure to report quality data according to CMS requirements may result in a reduction of the Medicare payment rates in subsequent years. An increased emphasis by government and accreditation agencies on the accuracy of quality reporting, quality performance and more rigorous performance standards and oversight could result in a reduction of the payments and fees that we receive from Medicare.

In addition, the Health Reform Law mandates 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 2012. Further, additional cuts to Medicare and Medicaid payments may occur depending on government response to economic conditions.

Because of the many fluid and dynamic variables involved, we are currently unable to predict the net effect of the Health Reform Law and other associated changes within the healthcare industry on us or our operations. Further, it is unclear how efforts to repeal or revise the Health Reform Law will be resolved or what the impact, if any, would be of any resulting changes to the law. However, depending on how the Health Reform Law is ultimately interpreted, amended and implemented, it could have a material adverse effect on our business, prospects, results of operations and financial condition.

If we fail to comply with or otherwise incur liabilities under the numerous federal and state laws and regulations relating to the operation of our facilities, we could incur significant penalties or other costs 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 the markets in which we operate. These laws and regulations require that our facilities meet various licensing, certification and other requirements, including, but not limited to, those relating to:

- ownership and control of our facilities;
- qualification of medical and support persons;
- pricing of, billing for and coding of services and properly handling overpayments;
- the adequacy of medical care, equipment, personnel, operating policies and procedures;
- maintenance and preservation of medical records;
- financial arrangements between referral sources and our facilities;
- the protection of privacy, including patient and credit card information;
- provision of emergency services;
- antitrust;
- state licensing standards; and
- environmental protection, health and safety.

If we fail or have failed to comply with applicable laws and regulations, we could be subject to administrative, civil or criminal penalties, cease and desist orders, forfeiture of amounts owed and recoupment of amounts paid to us by governmental or commercial payors, loss of licenses necessary to operate and disqualification from Medicare, Medicaid and other government-sponsored healthcare programs.

We do not control compliance programs at certain of our nonconsolidated facilities; however, if there are failures in compliance or regulatory violations at those facilities, such failures or violations could have a material adverse effect on our business, prospects, results of operations and financial condition.

In pursuing our growth strategy, we may seek to expand our presence into states in which we do not currently operate. In new geographic areas, we may encounter laws and regulations that differ from those applicable to our current operations. If we are unwilling or unable to comply with these legal requirements in a cost-effective manner, we will not be able to expand into new states.

In addition, some of the governmental and regulatory bodies that regulate us are considering or may in the future consider enhanced or new regulatory requirements. These authorities may also seek to exercise their supervisory or enforcement authority in new or more robust ways. All of these possibilities, if they occurred, could detrimentally affect the way we conduct our business and manage our capital, either of which, in turn, could have a material adverse effect on our business, prospects, results of operations and financial condition.

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

Regulatory changes or changes in the interpretation of existing laws or regulations may obligate us to purchase all of the ownership interests of the physician investors in partnerships or LLCs that own and operate our facilities. Such changes would include those that:

- make illegal the referral of patients to our facilities by physician investors;
- create a substantial likelihood that cash distributions to physician investors from the partnerships or LLCs through which we operate our facilities would be illegal; or
- make illegal the ownership by the physician investors of interests in the partnerships or LLCs through which we own and operate our facilities.

In addition, some of our partnership and operating agreements with our physician partners and management agreements with our facilities require us to renegotiate such agreements upon the occurrence of various fundamental regulatory changes or changes in the interpretation of existing regulations and provide for termination of such agreements if such renegotiations are not successful.

We cannot control whether or when any of these regulatory events might occur. In the event we are required to purchase all of the physicians' ownership interests in our facilities, our existing capital resources would not be sufficient for us to meet this obligation. See "Management's Discussion and Analysis of Financial Condition and Results of Operations — Liquidity and Capital Resources." These obligations and the possible termination of our partnership, operating and management agreements would have a material adverse effect on our business, prospects, results of operations and financial condition.

The Medicare and Medicaid programs, which together provide a material portion of our net patient revenues, are particularly susceptible to legislative and regulatory changes that could adversely affect our revenues and profitability.

The Medicare and Medicaid programs are subject to statutory and regulatory changes, retroactive and prospective rate adjustments, spending freezes, federal and state funding reductions and administrative rulings and interpretations concerning, without limitation, patient eligibility requirements, funding levels and the method of calculating payments or reimbursements. Any of these factors could adversely affect the level and timing of payments to our surgical facilities. For the year-ended December 31, 2013, payments from Medicare and Medicaid represented approximately 20% and 3% of our net patient revenues, respectively.

In recent years, legislative and regulatory changes have resulted in limitations on and, in some cases, reductions in levels of payments to healthcare providers for certain services under the Medicare program. The Budget Control Act of 2011 (the "BCA") requires automatic spending reductions of $1.2 trillion for federal fiscal years 2013 through 2021, minus any deficit reductions enacted by Congress and debt service costs. The percentage reduction for Medicare may not be more than 2% for a fiscal year, with a uniform percentage reduction across all Medicare programs. The BCA-mandated spending reductions went into effect on March 1, 2013. We are unable to predict how these spending reductions will be structured, what other deficit reduction initiatives may be proposed by Congress or whether Congress will attempt to suspend or restructure the automatic budget cuts. These reductions will be in addition to reductions mandated by the Health Reform Law, which provides for material reductions in the growth of Medicare program spending.

Many states must operate with balanced budgets, and the Medicaid program is often the largest budget expenditure for many states. The current economic environment has increased the budgetary pressures on many states, and these budgetary pressures have resulted, and likely will continue to result, in decreased spending or decreased spending growth for Medicaid programs in many states. Some states that provide Medicaid supplemental payments are reviewing these programs or have filed waiver requests with CMS to replace these programs, which could result in Medicaid supplemental payments being reduced or eliminated.

We are unable to predict the effect of future government healthcare funding policy changes on our operations. If the rates paid by governmental payors are reduced or if the scope of services covered by governmental payors is limited there could be, in either case, a material adverse effect on our business, prospects, results of operations and financial condition.

Our surgical facilities do not satisfy the requirements for any of the safe harbors under the Anti-Kickback Statute. If we fail to comply with the Anti-Kickback Statute, we could be subject to criminal and civil penalties, loss of licenses and exclusion from governmental 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, purchasing or arranging for or recommending 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 broad in scope, and many of its provisions have not been uniformly or definitively interpreted by existing case law or regulations. Courts have found a violation of the Anti-Kickback Statute if just one purpose of the remuneration is to generate referrals, even if there are other lawful purposes. Violations of the Anti-Kickback Statute may result in substantial civil or criminal penalties, plus three times the remuneration involved or the amount claimed and exclusion from participation in the Medicare and Medicaid programs. Our exclusion from participation in such programs would have a material adverse effect on our business, prospects, results of operations and financial condition. 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, including the loss of a license to do business in the state.

In July 1991, HHS issued final regulations defining various "safe harbors" under 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. Two of the original safe harbors issued in 1991 apply to business arrangements similar to those used in connection with our surgical facilities. However, the structure of the entities operating our facilities generally does not satisfy all of the requirements of either such safe harbor.

In November 1999, HHS issued final regulations creating additional safe harbor provisions, including a safe harbor that applies to physician ownership of, or investment interests in, ASCs. However, our ASC arrangements do not comply with all of the requirements of the ASC safe harbor and, therefore, are not immune from government review or prosecution.

Further, we employ dedicated marketing personnel whose job functions include the recruitment of physicians to practice surgery at our centers. These teammates are paid a base salary plus a productivity bonus. We believe our employment arrangements with these teammates are consistent with a safe harbor provision designed to protect payments made to employees. However, a government agency or private party may assert a contrary position.

Although we believe that our business arrangements do not violate the Anti-Kickback Statute or similar state laws, a government agency or a private party may assert a contrary position. Additionally, new federal or state laws may be enacted that would cause our relationships with our physician partners to become illegal or result in the imposition of penalties against us or our facilities. If any of our business arrangements with physician partners were alleged or deemed to violate the Anti-Kickback Statute or similar laws, or if new federal or state laws were enacted rendering these arrangements illegal, it could have a material adverse effect on our business, prospects, results of operations and financial condition.

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 substantial monetary penalties and a significant loss of revenues.

The Stark Law prohibits a physician from making a referral to an entity for the furnishing of certain "designated health services" otherwise payable under Medicare or Medicaid if the physician or a member of the physician's immediate family has a financial relationship with the entity, such as an ownership interest or compensation arrangement, unless an exception applies. The Stark Law also prohibits entities that provide designated health services otherwise payable by Medicare or Medicaid from billing the Medicare and Medicaid programs for any items or services that result from a prohibited referral and requires the entities to refund amounts received for items or services provided pursuant to the prohibited referral. HHS, acting through CMS, has promulgated regulations implementing the Stark Law. These regulations exclude health services provided by an ASC from the definition of "designated health services" if the services are included in the facility's composite Medicare payment rate. Therefore, the Stark Law's self-referral prohibition generally does not apply to health services provided by an ASC. However, if the ASC is separately billing Medicare for designated health services that are not covered under the ASC's composite Medicare payment rate, or if either the ASC or an affiliated physician is performing (and billing Medicare) for procedures that involve designated health services that Medicare has not designated as an ASC service, the Stark Law's self-referral prohibition would apply and such services could implicate the Stark Law. We believe that our operations do not violate the Stark Law, as currently interpreted. All services provided by our ASCs that would otherwise constitute designated health services are reimbursed by Medicare as part of the composite payment rate and are thus subject to an exception from the Stark Law, with the exception of implants. The Stark Law provides for a special exception for implants, such as intraocular lenses and artificial joints, furnished in ASCs as long as certain regulatory requirements are met. These requirements provide that the implant must be implanted by the referring physician or a member of his or her group practice, that the implant be implanted during a surgical procedure reimbursed as an ASC procedure by Medicare, that the arrangement for the furnishing of the implant not violate the Anti-Kickback Statute and that the billing for the implant be conducted legally. In addition, we believe that physician ownership of ASCs is not prohibited by similar self-referral statutes enacted at the state level. However, the Stark Law and similar state statutes are subject to different interpretations with respect to many important provisions. Moreover, the Stark Law applies to our five surgical hospitals. Violations of these self-referral laws may result in substantial civil or criminal penalties, including large civil monetary penalties and exclusion from participation in the Medicare and Medicaid programs. If physician self-referral laws are interpreted differently or if other legislative restrictions are issued, we could incur significant sanctions and loss of revenues, or we could have to change our arrangements and operations in a way that could have a material adverse effect on our business, prospects, results of operations and financial condition.

Federal law restricts the ability of our surgical hospitals to expand surgical capacity.

The Stark Law includes an exception that permits physicians to refer Medicare and Medicaid patients to hospitals in which they have an ownership interest if certain requirements are met. However, the Health Reform Law dramatically curtailed this exception and prohibits physician ownership in hospitals that did not have a Medicare provider agreement by December 31, 2010. This prohibition does not apply to our five surgical hospitals, each of which had a Medicare provider agreement in place prior to December 31, 2010 and are therefore able to continue operating with their existing ownership structure. However, the Health Reform Law prohibits "grandfathered" hospitals from increasing their percentage of physician ownership, and it limits to a certain extent their ability to grow, because it prohibits such hospitals from increasing the aggregate number of inpatient beds, operating rooms and procedure rooms.

Companies within the healthcare industry continue to be the subject of federal and state audits and investigations, and we may be subject to such audits and investigations, including actions for false and other improper claims.

Federal and state government agencies, as well as commercial payors, have increased their auditing and administrative, civil and criminal enforcement efforts as part of numerous ongoing investigations of healthcare organizations. These audits and investigations relate to a wide variety of topics, including the following: cost reporting and billing practices; quality of care; financial reporting; financial relationships with referral sources; medical necessity of services provided; and classification of the level of care provided, including proper classification of inpatient admissions, observation services and outpatient care. In addition, the OIG and the DOJ have, from time to time, undertaken national enforcement initiatives that focus on specific billing practices or other suspected areas of abuse.

The Federal 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. Claims filed with private insurers can also lead to criminal and civil penalties. While the criminal statutes are generally reserved for instances of fraudulent intent, the Federal government is applying its criminal, civil and administrative penalty statutes in an ever-expanding range of circumstances, including claiming payment for unnecessary services if the claimant merely should have known the services were unnecessary and claiming payment for low-quality services if the claimant should have known that the care was substandard. In addition, a violation of the Stark Law or the Anti-Kickback Statute can result in liability under the FCA.

Over the past several years, the Federal government has accused an increasing number of healthcare providers of violating the FCA, which prohibits a person from knowingly presenting, or causing to be presented, a false or fraudulent claim to the Federal 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. Violators of the FCA are subject to severe financial penalties, including treble damages and per claim penalties in excess of $10,000. Because our facilities perform hundreds or thousands of similar procedures each year for which they are paid by Medicare, and since the statute of limitations for such claims extends for six years under normal circumstances (and possibly as long as ten years in the event of failure to discover material facts), a repetitive billing error or cost reporting error could result in significant, material repayments and civil or criminal penalties.

Under the "qui tam," or whistleblower, provisions of the FCA, private parties may bring actions on behalf of the Federal government. These private parties, often referred to as relators, are entitled to share in any amounts recovered by the government through trial or settlement. These qui tam cases are sealed by the court at the time of filing. The only parties privy to the information contained in the complaint are the relator, the Federal government and the presiding court. It is possible that qui tam lawsuits have been filed against us and that we are unaware of such filings. Both direct enforcement activity by the government and whistleblower lawsuits under the FCA have increased significantly in recent years; thus, the risk that we will have to defend a false claims action, pay significant fines or be excluded from the Medicare and Medicaid programs has increased. In addition,

under the Health Reform Law, if we receive an overpayment, we must report and refund the overpayment before the later of sixty days after the overpayment was identified or the date any corresponding cost report is due, if applicable. Any overpayment that is retained after this deadline is considered an obligation subject to an action under the FCA. 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 business, prospects, results of operations and financial condition.

We are also subject to various state laws and regulations, as well as contractual provisions with commercial payors that prohibit us from submitting inaccurate, incorrect or misleading claims. We believe that our surgical facilities are in material compliance with all such laws, regulations and contractual provisions regarding the submission of claims. We cannot be sure, however, that none of our surgical facilities' claims will ever be challenged. If we were found to be in violation of a state's laws or regulations, or of a commercial payor contract, we could be forced to discontinue the violative practice and be subject to recoupment actions, fines and criminal penalties, which could have a material adverse effect on our business, prospects, results of operations and financial condition.

All payors are increasingly conducting post-payment audits. For example, CMS has implemented the RAC program, involving Medicare claims audits nationwide. Under the program, CMS contracts with RACs on a contingency fee basis to conduct post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. The Health Reform Law expanded the RAC program's scope to include managed Medicare plans and to include Medicaid claims. In addition, CMS employs MICs to perform post-payment audits of Medicaid claims and identify overpayments. The Health Reform Law increases federal funding for the MIC program. In addition to RACs and MICs, the state Medicaid agencies and other contractors have increased their review activities. We are regularly subject to these external audits and we also perform internal audits and monitoring. Depending on the nature of the conduct found in such audits and whether the underlying conduct could be considered systemic, the resolution of these audits could have a material adverse effect on our business, prospects, results of operations and financial condition.

Failure to comply with Medicare's conditions for coverage and conditions of participation may result in loss of program payment or other governmental sanctions.

To participate in and receive payment from the Medicare program, our facilities must comply with regulations promulgated by CMS. These regulations, known as "conditions for coverage" for ASCs and "conditions of participation" for hospitals, set forth specific requirements with respect to the facility's physical plant, equipment, personnel and standards of medical care. All of our surgery centers and surgical hospitals are certified to participate in the Medicare program. As such, these facilities are subject to on-site, unannounced surveys by state survey agencies working on behalf of CMS. Under the ASC survey process, the surveyors are becoming more familiar with expanded interpretive guidance and the updated ASC conditions for coverage, which may lead to an increased number of deficiency citations requiring remedy with appropriate action plans. Failure to comply with Medicare's conditions for coverage and conditions of participation may result in loss of payment or other governmental sanctions, including termination from participation in the Medicare program. We have established ongoing quality assurance activities to monitor our facilities' compliance with these conditions and respond to surveys, but we cannot be sure that our facilities are or will always remain in full compliance with the requirements.

We are subject to federal privacy regulations enacted under HIPAA, and ensuring continued compliance with HIPAA could require us to expend significant resources and capital, impair our profitability and limit our ability to grow our business.

HIPAA mandates the adoption of privacy, security and integrity standards related to patient information and standardizes the method for identifying providers, employers, health plans and patients. Numerous federal regulations have been adopted under HIPAA. We have taken actions to comply with the HIPAA privacy

regulations and believe that we are in substantial compliance with those regulations. These actions include the establishment of policies and procedures, teammate training, identifying "business associates" with whom we need to enter into HIPAA-compliant contractual arrangements and various other measures. Ongoing implementation and oversight of these measures involves significant time, effort and expense.

Other federal regulations adopted under HIPAA require our surgical facilities to conduct certain standardized healthcare transactions, including billing and other claim transactions. We have undertaken significant efforts involving substantial time and expense to ensure that our surgical facilities and hospitals submit HIPAA-compliant transactions. We anticipate that continual time and expense will be required to submit HIPAA-compliant transactions and to ensure that any newly acquired facilities can submit HIPAA-compliant transactions.

In addition, compliance with the HIPAA security regulations requires ASCs, hospitals and other covered entities to implement reasonable technical, physical and administrative security measures to safeguard protected healthcare information maintained, used and disclosed in electronic form. We have taken actions in an effort to be in compliance with these regulations and believe that we are in substantial compliance with the HIPAA security regulations. A cyber-attack that bypasses our information security systems causing an information security breach, loss of protected health information or other data subject to privacy laws or a material disruption of our operational systems could result in a material adverse impact on our business, along with fines. Ongoing implementation and oversight of these security measures involves significant time, effort and expense. For additional information regarding the risks related to management and security of our information systems, see "Risks Related to Our Business — If we are unable to manage and secure our information systems effectively, our operations could be disrupted."

ARRA broadened the scope of the HIPAA privacy and security regulations. Among other things, ARRA extends the application of certain provisions of the security and privacy regulations to business associates (entities that handle identifiable health information on behalf of covered entities) and subjects business associates to civil and criminal penalties for violation of the regulations. ARRA and its implementing regulations also require covered entities to report breaches of unsecured protected health information to affected individuals without unreasonable delay and in no case later than 60 days after the discovery of the breach by the covered entity or its agents. Notification must also be made to HHS and, in certain situations involving large breaches, to the media. Pursuant to a rule issued to implement ARRA, HHS has created a presumption that all non-permitted uses or disclosures of unsecured protected health information are breaches unless the covered entity or business associate establishes that there is a low probability the information has been compromised. Violations of the HIPAA privacy and security regulations may result in civil and criminal penalties, and ARRA strengthened HIPAA's enforcement provisions. ARRA increased the amount of civil penalties, with penalties now ranging up to $50,000 per violation and a maximum civil penalty of $1.5 million in a calendar year for violations of the same requirement. In addition, ARRA authorized state attorneys general to bring civil actions seeking either an injunction or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents.

In addition, states may impose more protective privacy laws, and both state and federal laws are subject to modification or enhancement of privacy protection at any time. Our facilities will continue to remain subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These statutes vary and could impose additional requirements on us and more severe penalties for disclosures of confidential health information. If we fail to comply with HIPAA or similar state laws, we could incur substantial monetary penalties.

If we fail to effectively and timely implement electronic health record systems and transition to the ICD-10 coding system, our operations could be adversely affected.

As required by ARRA, the Secretary of HHS has developed and implemented an incentive payment program for eligible hospitals and healthcare professionals that adopt and meaningfully use certified electronic

health record ("EHR") technology. We have incurred and will continue to incur both capital costs and operating expenses in order to implement certified EHR technology and meet meaningful use requirements. We have incurred $3.5 million of operating expenses to implement our certified EHR technology and to meet meaningful use requirements. These expenses are ongoing and are projected to continue over all stages of implementation of meaningful use. The timing of expenses will not correlate with the receipt of the incentive payments and the recognition of incentive income. If our eligible hospitals are unable to meet the requirements for participation in the incentive payment program, we will not be eligible to receive incentive payments that could offset some of the costs of implementing EHR systems. In addition, although the ARRA incentive payment program does not apply to surgery centers, we have not yet determined an EHR solution for our surgery center facilities. A requirement that surgery centers adopt and meaningfully use EHR technology could cause us to incur significant additional capital costs and operating expenses. As physicians become more integrated with EHR in their practices, we could incur additional capital costs and operating expenses in connection with implementing new technologies at our surgery centers.

Health plans and providers, including our facilities, are required to transition to the new ICD-10 coding system, which greatly expands the number and detail of billing codes used for third-party claims. Use of the ICD-10 system is required beginning October 1, 2014. This transition requires significant investment in coding technology and software, and training of staff involved in the coding and billing process. In addition to these upfront costs of transitioning to ICD-10, our facilities could experience significant disruption or delays in payment due to technical or coding errors or other implementation issues involving either our systems, or the systems and implementation efforts of health plans and their business partners. Further, the extent to which the transition to the more detailed ICD-10 coding system could result in decreased reimbursement, because the use of ICD-10 codes results in conditions being reclassified to payment groupings with lower levels of reimbursement than assigned under the previous system, is unknown at this time.

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

Some states require us to apply for and receive prior approval, typically in the form of a CON, for the construction, relocation, acquisition, change of ownership or change of control of healthcare facilities or expansion of the number of operating or procedure rooms or services our facilities offer. In granting approval, these states consider the need for additional or expanded healthcare facilities or for additional or expanded services. Additionally, third parties, including our competitors, have the right to, and often do, object to our applications for a CON. In many of the states in which we currently operate, CONs must be obtained for capital expenditures exceeding a prescribed amount, changes in capacity or services offered and various other matters, including change of control or change of ownership. Other states in which we now or may in the future operate may adopt similar legislation. Our costs of obtaining a CON could be significant, and we cannot ensure that we will be able to obtain the CON or other required approvals for the addition, expansion or change of control or change of ownership of facilities or services in the future. If we are unable to obtain required approvals, we may not be able to acquire additional facilities, expand healthcare services we provide at our existing facilities or replace, expand or relocate our facilities.

If antitrust enforcement authorities conclude that our market share in any particular market is too concentrated, that our or our health system partners' commercial payor contract negotiating practices are illegal, or that we otherwise violate antitrust laws, we could be subject to enforcement actions that could have a material adverse effect on our business, prospects, results of operations and financial condition.

The Federal government and most states have enacted antitrust laws that prohibit certain types of conduct deemed to be anti-competitive. These laws prohibit price fixing, concerted refusal to deal, market monopolization, price discrimination, tying arrangements, acquisitions of competitors and other practices that have, or may have, an adverse effect on competition. Violations of federal or state antitrust laws can result in various sanctions, including criminal and civil penalties. Antitrust enforcement in the healthcare industry is

currently a priority of the FTC. We believe we are in compliance with federal and state antitrust laws, but courts or regulatory authorities may reach a determination in the future that could have a material adverse effect on our business, prospects, results of operations and financial condition.

The healthcare laws and regulations to which we are subject are constantly evolving and may change significantly in the future.

The laws and regulations applicable to our business and to the healthcare industry generally to which we are subject are constantly in a state of flux. While we believe that we have structured our agreements and operations in material compliance with applicable healthcare laws and regulations, there can be no assurance that we will be able to successfully address changes in the current regulatory environment. We believe that our business operations materially comply with applicable healthcare laws and regulations. However, some of the healthcare laws and regulations applicable to us are subject to limited or evolving interpretations, and a review of our business or operations by a court, law enforcement or a regulatory authority might result in a determination that could have a material adverse effect on us. Furthermore, the healthcare laws and regulations applicable to us may be amended or interpreted in a manner that could have a material adverse effect on our business, prospects, results of operations and financial condition.

Risks Related to Our Common Stock

We are a "controlled company" within the meaning of the NASDAQ Stock Market ("NASDAQ") listing rules and, as a result, qualify for, and rely on, exemptions from certain corporate governance requirements. You do not have the same protections afforded to stockholders of companies that are subject to such requirements.

TPG currently controls a majority of the voting power of our outstanding common stock. As a result, we are a "controlled company" within the meaning of NASDAQ listing rules. Under these standards, a company of which more than 50% of the voting power is held by an individual, group or another company is a "controlled company" and may elect not to comply with certain corporate governance requirements, including the requirements:

- that a majority of the board of directors consists of independent directors;
- that we have a nominating and corporate governance committee that is composed entirely of independent directors; and
- that we have a compensation committee that is composed entirely of independent directors.

We are currently utilizing certain of these exemptions. Although we currently have a majority of independent directors on our board of directors, our Nominating and Corporate Governance Committee and Compensation Committee do not consist entirely of independent directors. Accordingly, you do not have the same protections afforded to stockholders of companies that are subject to all of the NASDAQ corporate governance requirements.

In addition, on June 20, 2012, the SEC passed final rules implementing provisions of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (the "Dodd-Frank Act") pertaining to compensation committee independence and the role and disclosure of compensation consultants and other advisers to the compensation committee. The SEC's rules directed each of the national securities exchanges to develop listing standards requiring, among other things, that:

- compensation committees be composed of fully independent directors, as determined pursuant to new independence requirements;
- compensation committees be explicitly charged with hiring and overseeing compensation consultants, legal counsel and other committee advisors; and
- compensation committees be required to consider, when engaging compensation consultants, legal counsel or other advisors, certain independence factors, including factors that examine the relationship between the consultant or advisor's employer and us.

On January 11 and December 11, 2013, the SEC approved the proposed listing standards of the national securities exchanges, including NASDAQ, related to, among other items, compensation committee advisors and compensation committee independence. As a "controlled company," we are not subject to these compensation committee independence requirements, but we are subject to the other requirements.

If in the future we no longer qualify as a "controlled company" within the meaning of NASDAQ listing rules, we will no longer qualify for exemptions from certain corporate governance requirements.

We are listed on the NASDAQ Global Select Market and are therefore subject to NASDAQ's listing rules. If in the future, as a result of additional issuances of common stock or otherwise, TPG no longer holds more than 50% of our outstanding common stock, we will no longer be a "controlled company" within the meaning of NASDAQ's listing rules. Pursuant to the requirements of NASDAQ's listing rules, within one year after a loss in status as a controlled company, our Compensation Committee and Nominating and Corporate Governance Committee must be composed entirely of "independent directors" (as defined by NASDAQ's listing rules). During the phase-in period granted by NASDAQ's listing rules, our stockholders will not have the same protections afforded to stockholders of companies that are subject to all of NASDAQ's listing rules. If, within one year of a loss of controlled company status, we do not have additional independent directors on our Compensation Committee and Nominating and Corporate Governance Committee, we will not be in compliance with NASDAQ's listing rules and may be subject to enforcement actions by NASDAQ.

TPG has significant influence over us, including control over decisions that require the approval of stockholders, which could limit your ability to influence the outcome of key transactions, including a change of control, and which may result in conflicts with us or you in the future.

We are controlled by TPG, and they currently own approximately 62.6% of our common stock. Pursuant to the Stockholders' Agreement, dated November 4, 2013, among the Company, TPG and its affiliates, TPG currently has the right to designate a majority of the seats on our board of directors, and as a result Mr. Sisitsky, a TPG Partner, Mr. Rhodes, a TPG Principal, and Mr. Geiser and Dr. Mansukani, each of whom provide consulting services to TPG, have been appointed to our board of directors. As a result, TPG can exercise control over our affairs and policies, including the approval of certain actions such as amending our Certificate of Incorporation, commencing bankruptcy proceedings and taking certain actions (including, without limitation, incurring debt, issuing stock, selling assets and engaging in mergers and acquisitions), appointing members of our management and any transaction that requires stockholder approval regardless of whether others believe that such change or transaction is in our best interests. The interests of TPG may not be consistent with your interests as a stockholder. So long as TPG continues to hold a majority of our outstanding common stock, TPG will have the ability to control the vote in any election of directors, amend our Certificate of Incorporation or By-Laws or take other actions requiring the vote of our stockholders. Even if the amount owned by TPG is less than 50%, TPG will continue to be able to strongly influence or effectively control our decisions. So long as TPG collectively owns at least 50% of the shares of our common stock held by them at the closing of our initial public offering, they will be able to designate for nomination a majority of the seats on our board of directors. This control may also have the effect of deterring hostile takeovers, delaying or preventing changes of control or changes in management, or limiting the ability of our other stockholders to approve transactions that they may deem to be in the best interests of our company. In addition, although we have opted out of the provisions of Section 203 of the General Corporation Law of the State of Delaware (the "DGCL"), which regulates corporate takeovers, our Certificate of Incorporation contains similar provisions related to business combinations with interested stockholders and provides that TPG and any of its direct or indirect transferees and any group as to which such persons are a party do not constitute interested stockholders for purposes of this provision.

Additionally, TPG is in the business of making investments in companies and may currently hold, and may from time to time in the future acquire, controlling interests in businesses engaged in industries that complement or compete, directly or indirectly, with certain portions of our business. Further, if TPG pursues other acquisitions in our industry, those acquisitions may not be available to us. These rights of TPG are set forth in

our Certificate of Incorporation. So long as the TPG Funds (as defined in Part III, Item 10 herein) continue to indirectly own a significant amount of our equity, TPG will continue to be able to strongly influence or effectively control our decisions.

We are an "emerging growth company" under the Jumpstart Our Business Startups Act of 2012 (the "JOBS Act"), and we cannot be certain if the reduced disclosure requirements applicable to emerging growth companies will make our common stock less attractive to investors.

We are an "emerging growth company," under the JOBS Act, and we are permitted to, and currently intend to, take advantage of certain exemptions from certain disclosure requirements. We are an "emerging growth company" until the earliest of: (i) the last day of the fiscal year during which we had total annual gross revenues of $1.0 billion or more, (ii) the last day of the fiscal year following the fifth anniversary of the completion of our initial public offering, (iii) the date on which we have, during the previous three-year period, issued more than $1.0 billion in non-convertible debt or (iv) the date on which we are deemed a "large accelerated filer" as defined under the federal securities laws. We will be deemed a large accelerated filer in the fourth quarter of 2014 if our public float as of June 30, 2014 is $700 million or greater. Our public float as of March 20, 2014 was approximately $456 million.

For so long as we remain an "emerging growth company", we may take advantage of certain exemptions from various reporting requirements that are applicable to other public companies that are not "emerging growth companies" including, but not limited to, not being required to comply with the auditor attestation requirements of Section 404 of the Sarbanes-Oxley Act of 2002, as amended (the "Sarbanes-Oxley Act"), reduced disclosure obligations regarding executive compensation in our periodic reports and proxy statements and exemptions from the requirements of holding a nonbinding advisory vote on certain executive compensation matters, such as "say on pay" and "say on frequency." As a result, our stockholders may not have access to certain information that they may deem important. Although we currently intend to rely on the exemptions provided in the JOBS Act, the exact implications of the JOBS Act for us are still subject to interpretations and guidance by the SEC and other regulatory agencies.

In addition, Section 107 of the JOBS Act provides that an "emerging growth company" can take advantage of the extended transition period provided in Section 7(a)(2)(B) of the Securities Act for complying with new or revised financial accounting standards. An emerging growth company can therefore delay the adoption of certain accounting standards until those standards would otherwise apply to private companies. However, we have determined to opt out of such extended transition period and, as a result, we will comply with new or revised financial accounting standards on the relevant dates on which adoption of such standards is required for non-emerging growth companies. Section 107 of the JOBS Act provides that our decision to opt out of the extended transition period for complying with new or revised financial accounting standards is irrevocable.

We cannot predict if investors will find our common stock less attractive as a result of our taking advantage of these exemptions. If some investors find our common stock less attractive as a result of our choices, there may be a less active trading market for our common stock, and our stock price may be more volatile.

Some provisions of Delaware law and our governing documents could discourage a takeover that stockholders may consider favorable.

In addition to TPG's ownership of a controlling percentage of our common stock, Delaware law and provisions contained in our Certificate of Incorporation and By-Laws could have the effect of delaying, deferring or preventing a change of control of us. A change of control could be proposed in the form of a tender offer or takeover proposal that might result in a premium over the market price for our common stock. In addition, these provisions could make it more difficult to bring about a change in the composition of our board of directors, which could result in entrenchment of current management. For example, our Certificate of Incorporation and By-Laws:

- establish a classified board of directors so that not all members of our board of directors are elected at one time;

- require that the number of directors be determined, and any vacancy or new board seat be filled, only by the board of directors;
- do not permit stockholders to act by written consent once TPG ceases to beneficially own more than 50% of our outstanding shares entitled to vote generally in the election of directors;
- do not permit stockholders to call a special meeting, provided, however, at any time when TPG beneficially owns at least 50% of our outstanding shares entitled to vote generally in the election of directors, special meetings of our stockholders shall also be called by the board of directors or the chairman of the board of directors at the request of TPG;
- require a 66 2/3% vote of all outstanding shares entitled to vote generally in the election of directors in order to amend certain provisions in the Certificate of Incorporation and By-Laws;
- provide that our directors may be removed only for cause by the affirmative vote of at least 66 2/3% of our outstanding shares entitled to vote generally in the election of directors;
- establish advance notice requirements for nominations for elections to our board of directors or for proposing matters that can be acted upon by stockholders at stockholder meetings;
- authorize the issuance of undesignated preferred stock, or "blank check" preferred stock, by our board of directors without stockholder approval; and
- contain provisions similar to that of Section 203 of the DGCL related to business combinations with interested stockholders and provide that TPG and any of its direct or indirect transferees and any group as to which such persons are a party, do not constitute interested stockholders for purposes of this provision.

Many of our employment agreements, plans and equity arrangements with our executive officers also contain change of control provisions. Under the terms of these arrangements, the executive officers are entitled to receive (i) certain payments or benefits upon a termination without cause or for good reason and (ii) accelerated vesting of option awards if the executive is terminated without cause or for good cause within the two-year period following a change in control.

These and other provisions of our organizational documents and Delaware law may have the effect of delaying, deferring or preventing changes of control or changes in management, even if such transactions or changes would have significant benefits for our stockholders. As a result, these provisions could limit the price some investors might be willing to pay in the future for shares of our common stock.

Prior to our initial public offering, there was no prior public market for our common stock and an active, liquid trading market for our common stock may not develop or be sustained.

Prior to our initial public offering, there was no public market for our common stock. Although our common stock is listed on the NASDAQ Global Select Market, we do not know whether third parties will find our common stock to be attractive or whether firms will be interested in continuing to make a market in our common stock. If an active and liquid trading market does not develop or is not sustained, you may have difficulty selling any of our common stock that you have purchased at an attractive price, or at all. The market price of our common stock may decline below its initial offering price, and you may not be able to sell your shares of our common stock at or above the price you paid for them, or at all, and may suffer a loss on your investment.

You may incur further dilution in the net tangible book value of the shares you have purchased.

We have a large number of outstanding stock options to purchase common stock with exercise prices that are below the initial public offering price of our common stock. In addition, HealthSouth Corporation ("HealthSouth") holds an unvested option to purchase equity securities constituting 5% of the equity securities issued and outstanding as of the closing of our acquisition in 2007 on a fully diluted basis, which becomes exercisable upon certain customary liquidity events, including a public offering of shares of our common stock

that results in 30% or more of our common stock being listed or traded on a national securities exchange. Additionally, as of March 20, 2014, there were 215,770 shares issuable upon settlement of restricted stock units. To the extent that these stock options are exercised, the option held by HealthSouth to purchase common shares becomes vested and is exercised or restricted stock units are settled in shares of our common stock, you may experience further dilution in the net tangible book value of the shares of common stock you have purchased.

The market price of our common stock may fluctuate significantly, and you could lose all or part of your investment as a result.

There is no guarantee that our common stock will appreciate in value or maintain the price at which our stockholders have purchased their shares. The trading price of our common stock may be volatile and subject to wide price fluctuations in response to various factors, many of which are beyond our control, including the following:

- quarterly variations in our results of operations;
- results of operations that vary from the expectations of securities analysts and investors;
- results of operations that vary from those of our competitors;
- changes in expectations as to our future financial performance, including financial estimates by securities analysts and investors;
- strategic actions by us or our competitors;
- announcements by us, our competitors or our vendors of significant contracts, acquisitions, joint marketing relationships, joint ventures or capital commitments;
- changes in business or regulatory conditions;
- investor perceptions or the investment opportunity associated with our common stock relative to other investment alternatives;
- the public's response to press releases or other public announcements by us or third parties, including our filings with the SEC;
- guidance, if any, that we provide to the public, any changes in this guidance or our failure to meet this guidance;
- changes in accounting principles;
- announcements by third parties or governmental entities of significant claims or proceedings against us;
- new laws and governmental regulations applicable to the healthcare industry, including the Health Reform Law;
- a default under the agreements governing our indebtedness;
- future sales of our common stock by us, directors, executives and significant stockholders;
- changes in domestic and international economic and political conditions and regionally in our markets; and
- other events or factors, including those resulting from natural disasters, war, acts of terrorism or responses to these events.

Furthermore, the stock market has recently experienced extreme volatility that, in some cases, has been unrelated or disproportionate to the operating performance of particular companies. These broad market and industry fluctuations may adversely affect the market price of our common stock, regardless of our actual operating performance. As a result, our common stock may trade at a price significantly below the price at which any stockholder purchased his or her shares.

In the past, following periods of market volatility, stockholders have instituted securities class action litigation. If we were to become involved in securities litigation, it could have a substantial cost and divert resources and the attention of executive management from our business regardless of the outcome of such litigation.

Future offerings of debt or preferred equity securities, which would rank senior to our common stock, may adversely affect the market price of our common stock.

If, in the future, we decide to issue debt or preferred equity securities that may rank senior to our common stock, it is likely that such securities will be governed by an indenture or other instrument containing covenants restricting our operating flexibility. Additionally, any convertible or exchangeable securities that we issue in the future may have rights, preferences and privileges more favorable than those of our common stock and may result in dilution to owners of our common stock. We and, indirectly, our stockholders, will bear the cost of issuing and servicing such securities. Because our decision to issue debt or equity securities in any future offering will depend on market conditions and other factors beyond our control, we cannot predict or estimate the amount, timing or nature of our future offerings. Thus, holders of our common stock will bear the risk of our future offerings reducing the market price of our common stock and diluting the value of their stock holdings in us.

Fluctuations in our future operating results may negatively affect the market price of our common stock.

Our operating results have fluctuated in the past and can be expected to fluctuate from time to time in the future. Some of the factors that may cause these fluctuations include but are not limited to:

- the timing, volume and pricing of procedures at our facilities;
- the impact to the marketplace of competitive products and pricing;
- surgery-related supplies, implants and equipment availability and cost;
- changes in or announcements regarding potential changes to Medicare reimbursement rates; and
- shifts in our ownership percentage in our facilities.

If our operating results are below the expectations of securities analysts or investors, the market price of our common stock may fall abruptly and significantly.

If we or our existing investors sell additional shares of our common stock, the market price of our common stock could decline.

The market price of our common stock could decline as a result of sales of a large number of shares of common stock in the market, or the perception that such sales could occur. These sales, or the possibility that these sales may occur, also might make it more difficult for us to sell equity securities in the future at a time and at a price that we deem appropriate.

At the completion of our initial public offering, we had 38.1 million shares of common stock outstanding. Of these outstanding shares of common stock, all of the shares of common stock sold in the initial public offering are freely tradable in the public market. We believe 26.9 million shares are restricted securities as defined in Rule 144 under the Securities Act ("Rule 144") and may be sold by the holders into the public market from time to time in accordance with and subject to limitation on sales under Rule 144.

We, our directors, our executive officers, TPG and the selling stockholders agreed not to sell or transfer any common stock or securities convertible into, exchangeable for, exercisable for, or repayable with common stock, for 180 days beginning on October 29, 2013 without first obtaining the written consent of J.P. Morgan Securities LLC and Citigroup Global Markets Inc.

In connection with our initial public offering, we entered into a registration rights agreement with TPG and certain members of our management and our board of directors, which provides the signatories thereto the right, under certain circumstances, to require us to register their shares of common stock under the Securities Act for sale into the public markets.

Currently, we have approximately 2.0 million shares issuable upon the exercise of outstanding vested stock options under our equity incentive plans, approximately 1.1 million shares subject to outstanding unvested stock options under our equity incentive plans, and approximately 2.3 million shares reserved for future grant under our equity incentive plans. Shares acquired upon the exercise of vested options under our equity incentive plans may be sold by holders into the public market from time to time, in accordance with and subject to limitation on sales by affiliates under Rule 144. Sales of a substantial number of shares of our common stock following the vesting of outstanding stock options could cause the market price of our shares of common stock to decline.

Because we do not currently intend to pay cash dividends on our common stock for the foreseeable future, you may not receive any return on investment unless you sell your common stock for a price greater than that which you paid for it.

We currently intend to retain future earnings, if any, for future operation, expansion and debt repayment and do not intend to pay any cash dividends for the foreseeable future. Any decision to declare and pay dividends in the future will be made at the discretion of our board of directors and will depend on, among other things, our results of operations, financial condition, cash requirements, contractual restrictions, restrictions imposed by applicable law or the SEC and other factors that our board of directors may deem relevant. In addition, our ability to pay dividends may be limited by covenants of any existing and future outstanding indebtedness we or our subsidiaries incur, including our Senior Secured Credit Facilities. Accordingly, investors must be prepared to rely on sales of their common stock after price appreciation to earn an investment return, which may never occur. Investors seeking cash dividends should not purchase our common stock. As a result, you may not receive any return on an investment in our common stock unless you sell our common stock for a price greater than that which you paid for it.

We are a holding company with nominal net worth and no operations of our own, and we will depend on dividends and distributions from our subsidiaries to pay any dividends.

Surgical Care Affiliates, Inc. is a holding company with nominal net worth. We do not have any assets or conduct any business operations other than our investments in our subsidiaries. Our business operations are conducted primarily out of our direct operating subsidiary, SCA. As a result, our ability to pay dividends, if any, will be dependent upon cash dividends and distributions or other transfers from our subsidiaries, including from SCA. Payments to us by our subsidiaries will be contingent upon their respective earnings and subject to any limitations on the ability of such entities to make payments or other distributions to us. See "— Risks Related to our Business — The terms of our Senior Secured Credit Facilities may restrict our current and future operations, particularly our ability to respond to changes in our business or to take certain actions" for additional information regarding the limitations currently imposed by our Senior Secured Credit Facilities. In addition, our subsidiaries, including our direct operating subsidiary, SCA, are separate and distinct legal entities and have no obligation to make any funds available to us.

If we are unable to implement and maintain effective internal control over financial reporting in the future, investors may lose confidence in the accuracy and completeness of our financial reports and the trading price of our common stock may be negatively affected.

Pursuant to Section 404 of the Sarbanes-Oxley Act and related rules and regulations, and beginning with our Annual Report on Form 10-K for the year ending December 31, 2014, our management will be required to report on the effectiveness of our internal control over financial reporting. However, until such time as we cease to be an "emerging growth company" as more fully described in "Risks Related to Our Common Stock — We are an 'emerging growth company' under the JOBS Act, and we cannot be certain if the reduced disclosure

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requirements applicable to emerging growth companies will make our common stock less attractive to investors," our independent registered public accounting firm is not required to formally attest to the effectiveness of our internal control over financial reporting in compliance with Section 404(b) of the Sarbanes-Oxley Act.

The rules governing the standards that must be met for management to assess our internal control over financial reporting are complex and require significant documentation, testing and possible remediation. We are in the process of designing, implementing, and testing the internal control over financial reporting required to comply with this obligation, which process is time consuming, costly, and complicated. As we only recently became a public company following the completion of our initial public offering on November 4, 2013, we have limited accounting personnel and other resources with which to address our internal controls and procedures. If we identify material weaknesses in our internal control over financial reporting, if we are unable to comply with the requirements of Section 404 of the Sarbanes-Oxley Act in a timely manner or assert that our internal control over financial reporting is effective, or if our independent registered public accounting firm is unable to express an opinion as to the effectiveness of our internal control over financial reporting when required, investors may lose confidence in the accuracy and completeness of our financial reports and the market price of our common stock could be negatively affected. As a result, we could become subject to investigations by the NASDAQ Global Select Market, the SEC, or other regulatory authorities, which could require additional financial and management resources. Any such action could have a material adverse effect on our business, prospects, results of operations and financial condition.

The requirements of being a public company are expensive and time-consuming and may strain our resources and distract our management, which could make it difficult to manage our business, particularly after we are no longer an "emerging growth company" under the JOBS Act.

Since the completion of our initial public offering of common stock, we have been required to comply with various regulatory and reporting requirements, including those required by the SEC. Complying with these reporting and other regulatory requirements is time-consuming and has resulted, and will continue to result, in increased costs to us and could have a material adverse effect on our business, results of operations and financial condition.

As a public company, we are subject to the reporting requirements of the Exchange Act, and requirements of the Sarbanes-Oxley Act and the Dodd-Frank Act. These requirements may place a strain on our systems and resources. The Exchange Act requires that we file annual, quarterly and current reports with respect to our business and financial condition. The Sarbanes-Oxley Act requires that we maintain effective disclosure controls and procedures and internal control over financial reporting. To maintain and improve the effectiveness of our disclosure controls and procedures, we will need to commit significant resources, hire additional staff and provide additional management oversight. The Dodd-Frank Act introduced multiple executive compensation and corporate governance reforms, some of which are not yet in effect, but which will demand additional attention of management. We have implemented, and will continue to implement, additional procedures and processes for the purpose of addressing the standards and requirements applicable to public companies. Sustaining our growth also will require us to commit additional management, operational and financial resources to identify new professionals to join our firm and to maintain appropriate operational and financial systems to adequately support expansion. These activities may divert management's attention from other business concerns, which could have a material adverse effect on our business, financial condition, results of operations and cash flows.

As an "emerging growth company" under the JOBS Act, we are permitted to, and intend to, take advantage of certain exemptions from various reporting requirements that are applicable to other public companies that are not "emerging growth companies," including, but not limited to, not being required to comply with the auditor attestation requirements of Section 404 of the Sarbanes-Oxley Act and reduced disclosure obligations regarding executive compensation in our periodic reports and proxy statements.

When these exemptions cease to apply, we expect to incur additional expenses and devote increased management effort toward ensuring compliance with them. We will remain an "emerging growth company" for

up to five years, although we may cease to be an emerging growth company earlier under certain circumstances. See "Risks Related to our Common Stock — We are an 'emerging growth company' under the JOBS Act, and we cannot be certain if the reduced disclosure requirements applicable to emerging growth companies will make our common stock less attractive to investors" for additional information on when we may cease to be an emerging growth company. We cannot yet predict or estimate the amount of additional costs that we may incur as a result of being a public company or the timing of such costs.

If securities or industry analysts do not publish, cease publishing or publish inaccurate or unfavorable research or reports about us, our business, or our market, or if they adversely change their recommendations regarding our stock, our stock price and trading volume could decline.

The trading market for our common stock is influenced by the research and reports that industry or securities analysts may publish about us, our business, our market or our competitors. If industry or securities analysts do not establish and maintain adequate research coverage, or if any of the analysts who may cover us downgrade our common stock or publish inaccurate or unfavorable research about our business or provide relatively more favorable recommendations about our competitors, our stock price could decline. If any analyst who may cover us ceases coverage of us or fails to regularly publish reports on us, we could lose visibility in the financial markets and demand for our common stock could decrease, which in turn could cause our stock price or trading volume to decline.

Item 1B. Unresolved Staff Comments

Not applicable.

Item 2. Properties

Our corporate headquarters is located in Deerfield, Illinois at 520 Lake Cook Road, Suite 250, where we currently lease approximately 7,526 square feet of space. This lease expires in March 2017. In addition, certain of our corporate operational functions are located in Birmingham, Alabama at 3000 Riverchase Galleria, Suite 500, where we currently lease approximately 40,390 square feet of space. This lease expires in March 2015. The Company believes these spaces are sufficient and adequate for our needs at this time.

Item 3. Legal Proceedings

On May 5, 2006, Dr. Hansel DeBartolo filed a lawsuit captioned *DeBartolo, et al. v. HealthSouth Corporation et al*, in the United States District Court for the Northern District of Illinois, Eastern Division, against Joliet Surgery Center Limited Partnership (the "Partnership"), the general partner of that Partnership, Surgicare of Joliet, Inc., and its then-parent, HealthSouth, for a declaratory judgment and an injunction relating to the forced repurchase of his partnership interest (the "Federal Court Action"). We agreed to take responsibility from HealthSouth (our parent until SCA was purchased by ASC Acquisition LLC) regarding this matter. Dr. DeBartolo claimed that the partnership agreement's requirement that an investor in a surgical center perform one-third of his surgical procedures at the center violates the federal Anti-Kickback Statute and its underlying federal policy, and he sought an order prohibiting the repurchase of his partnership interest. After the trial court dismissed the case by holding that no private cause of action exists under the Anti-Kickback Statute, Dr. DeBartolo appealed to the Seventh Circuit Court of Appeals, which directed the trial court to dismiss the case because the Federal courts did not have jurisdiction over the subject matter involved. On February 8, 2010, Dr. DeBartolo filed a lawsuit in the Twelfth Judicial Circuit Court, Will County, Illinois making the same claim and seeking the same relief as he sought in the Federal Court Action. On February 5, 2014, the Circuit Court entered an Order granting summary judgment in favor of the Defendants. On March 4, 2014, Plaintiff filed a Notice of Appeal in the Appellate Court of Illinois Third District seeking reversal of the Circuit Court's Order.

From time to time, we are involved in routine litigation that arises in the ordinary course of business. Other than the matter described above, we are not currently involved in any litigation that we believe could reasonably be expected to have a material adverse effect on our business, financial condition or results of operations.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

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

Market for Surgical Care Affiliates Common Stock

Our common stock trades under the symbol "SCAI" on the NASDAQ Global Select Market. The initial public offering of our common stock occurred on October 30, 2013. The following table sets forth the high and low sales prices per share for the common stock from the date of the initial public offering through December 31, 2013, as reported on the NASDAQ Global Select Market:

	October 30 - December 31
2013:	
High	$35.80
Low	$25.50

As of March 20, 2014, there were 42 stockholders of record, which excludes stockholders whose shares were held in nominee or street name by brokers. The actual number of common stockholders is greater than the number of record holders, and includes stockholders who are beneficial owners, but whose shares are held in street name by brokers and other nominees. This number of holders of record also does not include stockholders whose shares may be held in trust by other entities. The last reported sales price of Surgical Care Affiliates' common stock as reported on the NASDAQ Global Select Market on March 20, 2014 was $32.32.

Dividends

Since our initial public offering we have not declared or paid a cash dividend on our common stock. We intend to retain our earnings to finance the growth and development of our business and do not expect to declare or pay any cash dividends in the foreseeable future. The declaration of dividends is within the discretion of our Board of Directors. Additionally, our ability to pay dividends in the future, if any, will be dependent upon cash dividends and distributions or other transfers from our subsidiaries.

Use of Proceeds from Our Initial Public Offering

On November 4, 2013, the Company completed an initial public offering of its common stock in which it issued and sold 7,857,143 shares of common stock and the selling shareholders offered and sold 3,387,301 shares of common stock, including 1,466,666 shares of common stock from certain of the selling stockholders pursuant to the exercise in full of the underwriters' option to purchase additional shares of common stock. The shares sold in the offering were registered under the Securities Act pursuant to the Company's Registration Statement on Form S-1 (Registration No. 333-190998), which was declared effective by the SEC on October 29, 2013. The proceeds to us, net of total expenses, were approximately $171.8 million. The Company did not receive any proceeds from shares sold by the selling shareholders.

We used the net proceeds received in the initial public offering to redeem in December 2013 all $150.0 million in aggregate principal amount of the Senior Subordinated Notes (as defined herein) at a redemption price of 103.333% of principal amount thereof, plus accrued and unpaid interest thereon. The remainder of the net proceeds was used for other general corporate purposes. This use of proceeds is consistent with the planned use of proceeds from our initial public offering as described in our final Prospectus filed with the SEC on October 30, 2013 pursuant to Rule 424(b).

Item 6. Selected Financial Data

	YEAR-ENDED DECEMBER 31,				
	2013	2012	2011	2010	2009
	(in millions, except facilities and per unit data in actual amounts)				
Net operating revenues:					
Net patient revenues	$ 746.6	$ 714.6	$ 692.9	$ 697.3	$ 678.7
Management fee revenues	40.5	17.8	11.3	6.7	4.0
Other revenues	14.9	12.4	10.0	6.3	3.8
Total net operating revenues	802.0	744.9	714.2	710.3	686.5
Equity in net income of nonconsolidated affiliates	23.4	16.8	22.2	15.3	10.5
Operating expenses:					
Salaries and benefits	277.7	241.8	221.8	216.6	218.4
Supplies	175.2	170.1	160.6	172.6	161.6
Other operating expenses	131.8	118.5	114.6	112.9	113.0
Depreciation and amortization	42.9	41.6	40.4	37.4	36.6
Occupancy costs	27.0	26.8	26.6	27.8	28.0
Provision for doubtful accounts	15.0	13.2	14.6	13.9	14.4
Impairment of intangible and long-lived assets	—	1.1	—	—	0.1
Loss (gain) on disposal of assets	0.1	(0.3)	(0.8)	0.4	(0.1)
Total operating expenses	669.8	612.7	577.9	581.5	572.0
Operating income	155.6	148.9	158.5	144.1	125.0
Interest expense	60.4	58.8	56.0	52.6	53.6
Loss from extinguishment of debt	10.3	—	—	—	—
Interest income	(0.2)	(0.3)	(0.4)	(1.6)	(1.3)
Loss on sale of investments	12.3	7.1	(3.9)	(2.1)	0.6
Income from continuing operations before income tax expense	72.7	83.3	106.8	95.2	72.1
Provision for income tax expense	12.6	8.9	20.3	14.5	12.6
Income from continuing operations [1]	60.1	74.4	86.5	80.7	59.5
(Loss) income from discontinued operations, net of income tax expense	(7.4)	(2.1)	(3.0)	(11.1)	(2.4)
Net income	52.7	72.3	83.5	69.6	57.1
Less: Net income attributable to noncontrolling interests	(104.0)	(92.3)	(93.2)	(84.5)	(82.6)
Net loss attributable to Surgical Care Affiliates	$ (51.3)	$ (20.0)	$ (9.7)	$ (14.9)	$ (25.5)
Basic and diluted net loss per share attributable to Surgical Care Affiliates:					
Continuing operations attributable to Surgical Care Affiliates	$ (1.39)	$ (.59)	$ (.23)	$ (.14)	$ (.82)
Discontinued operations attributable to Surgical Care Affiliates	$ (.23)	$ (.07)	$ (.10)	$ (.39)	$ (.09)
Net loss per share attributable to Surgical Care Affiliates	$ (1.62)	$ (.66)	$ (.33)	$ (.53)	$ (.91)
Basic and diluted weighted average shares outstanding (in thousands) [2]	31,688	30,340	29,347	28,144	28,129
Distribution paid per share on September 16, 2013	$ 2.47				
Facilities (at period end):					
Consolidated facilities	87	87	94	95	105
Equity method facilities	60	52	44	23	19
Managed-only facilities	30	8	4	5	1
Total facilities	177	147	142	123	125

	December 31,				
	2013	2012	2011	2010	2009
			(in millions)		
Balance Sheet Data (at period end):					
Cash and cash equivalents	$ 85.8	$ 118.7	$ 71.3	$ 33.6	$ 35.6
Total current assets	234.9	267.4	215.0	172.0	161.7
Total assets [3]	1,422.4	1,412.1	1,356.5	1,189.8	1,178.0
Current portion of long-term debt	23.2	15.2	16.2	7.5	6.7
Long-term debt, net of current portion	649.7	774.5	769.1	673.4	671.4
Total current liabilities	197.6	175.2	148.9	133.6	121.9
Total liabilities [3]	984.5	1,070.4	1,030.6	897.5	869.0
Noncontrolling interests — redeemable	21.9	21.7	20.2	20.6	25.9
Total Surgical Care Affiliates' equity	205.7	147.5	170.3	144.5	165.0
Noncontrolling interests — non-redeemable	210.3	172.5	135.4	127.2	118.1
Total equity	416.0	320.0	305.7	271.7	283.1

(1) Loss from continuing operations attributable to Surgical Care Affiliates, which is income from continuing operations less net income attributable to noncontrolling interests, was $43.9 million, $17.9 million, $6.7 million, $3.8 million and $23.1 for years-ended December 31, 2013, 2012, 2011, 2010 and 2009, respectively.

(2) Calculated based on number of shares of common stock and vested RSUs that would have been outstanding as of December 31, 2012, 2011, 2010 and 2009, assuming our conversion from a Delaware limited liability company to a Delaware corporation.

(3) Our consolidated assets as of December 31, 2013 and December 31, 2012 include total assets of a VIE of $49.5 million and $28.2 million, respectively, which can only be used to settle the obligations of the VIE. Our consolidated total liabilities as of December 31, 2013 and December 31, 2012 include total liabilities of the VIE of $12.2 million and $1.4 million, respectively, for which the creditors of the VIE have no recourse to us, with the exception of $4.0 million of debt guaranteed by us at December 31, 2013.

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

(Amounts in tables are in millions of U.S. dollars unless otherwise indicated)

This report contains certain forward-looking statements (all statements other than statements with respect to historical fact) within the meaning of the federal securities laws, which are intended to be covered by the safe harbors created thereby. Investors are cautioned that all forward-looking statements involve known and unknown risks and uncertainties including, without limitation, those described in Item 1A. Risk Factors, some of which are beyond our control. Although we believe that the assumptions underlying the forward-looking statements contained herein are reasonable, any of the assumptions could be inaccurate. Therefore, there can be no assurance that the forward-looking statements included in this report will prove to be accurate. Actual results could differ materially and adversely from those contemplated by any forward-looking statement. In light of the significant risks and uncertainties inherent in the forward-looking statements included herein, the inclusion of such information should not be regarded as a representation by us or any other person that our objectives and plans will be achieved. We undertake no obligation to publicly release any revisions to any forward-looking statements in this discussion to reflect events and circumstances occurring after the date hereof or to reflect unanticipated events. Forward-looking statements and our liquidity, financial condition and results of operations may be affected by the risks set forth in Item 1A. Risk Factors or by other unknown risks and uncertainties.

OVERVIEW

We are a leading provider of surgical solutions to health systems and payors, providing high quality, cost-effective surgical care. For a substantial portion of the periods covered by our financial statements in this Annual Report on Form 10-K, we were a Delaware limited liability company that was formed with a focus on developing and operating a network of multi-specialty ASCs and surgical hospitals in the United States. However, on October 30, 2013, we converted from a Delaware limited liability company, previously named ASC Acquisition LLC, to a Delaware corporation. As of December 31, 2013, we operated in 34 states and had an interest in and/or operated 171 freestanding ASCs, five surgical hospitals and one sleep center with 11 locations. Of these 177 facilities, we consolidated the operations of 87 affiliated facilities, had 60 nonconsolidated affiliated facilities and held no ownership in 30 affiliated facilities that contract with us to provide management services only. In addition, at December 31, 2013, we provided perioperative consulting services to 14 facilities, which are not included in the facility count.

With the exception of the managed-only facilities, the entities that own our facilities are structured as general partnerships, LPs, LLPs or LLCs in which either one of our subsidiaries or a joint venture is an owner and serves as the general partner, limited partner, managing member or member. Our partners or co-members in these entities are generally licensed physicians, hospitals or health systems.

EXECUTIVE SUMMARY

Our growth strategy continues to include growing the profits at our existing facilities, entering into strategic relationships with hospitals and health systems and making selective acquisitions of existing surgical facilities and groups of facilities.

We took several steps during 2013 to optimize our portfolio by:

- acquiring a controlling interest in four ASCs, which we consolidate;
- acquiring a noncontrolling interest in six ASCs and one surgical hospital that we hold as equity method investments;
- entering into agreements to manage 19 ASCs and one sleep center with 11 locations;
- placing two de novo facilities into operation, one that we consolidate and one that we hold as an equity method investment;

- closing two non-strategic consolidated ASCs;
- selling our interest in two consolidated ASCs and one nonconsolidated ASC;
- terminating a management agreement with an ASC; and
- increasing the number of relationships with not-for-profit health systems.

Our consolidated net patient revenues increased $32.0 million, or 4.5%, for the year-ended December 31, 2013 compared to the prior year. Factors which increased consolidated net patient revenues included improved rates paid under payor contracts, fee schedule increases and changes in case mix. Consolidated net patient revenues per case increased 6.1% as compared to the prior period.

We do not consolidate 60 of the facilities affiliated with us because we do not hold a controlling equity interest in the partnerships that own those facilities. To assist management in analyzing our results of operations, including at our nonconsolidated facilities, we prepare and disclose a "systemwide" case volume statistic and certain supplemental "systemwide" growth measures, each of which treats our equity method facilities as if they were consolidated. While the revenues earned at our equity method facilities are not recorded in our consolidated financial statements, we believe systemwide net operating revenues growth and systemwide net patient revenue per case growth are important to understand our financial performance because they are used by management to help interpret the sources of our growth and provide management with a growth metric incorporating the revenues earned by all of our affiliated facilities, regardless of the accounting treatment. "Systemwide" is a non-GAAP measure which includes the results of both our consolidated and nonconsolidated facilities (without adjustment based on our percentage of ownership). For more information, please see "Our Consolidated Results and Results of Nonconsolidated Affiliates" on page 84.

During the year-ended December 31, 2013, systemwide net operating revenues grew by 15.2% as compared to the prior year. Systemwide net patient revenues per case grew by 9.2% compared to the prior year. These increases are due to acquisitions of noncontrolling interests in ASCs since the prior period, coupled with improved rates paid under payor contracts, fee schedule increases and changes in case mix.

At December 31, 2013, we held ownership interests in consolidated and nonconsolidated facilities in partnership with 30 different health systems and managed facilities with an additional 13 health systems. Our health system relationships include local health systems, regional health systems and national health systems. We typically have co-development arrangements with our health system partners to jointly develop a network of outpatient surgery centers in a defined geographic area. These co-development arrangements are an important source of differentiation and potential growth of our business. We expect our co-development and acquisition activity to continue with a major focus on creating partnerships with not-for-profit health systems as we continue to position ourselves as a partner of choice to physician groups and health systems.

Our Consolidated Subsidiaries and Nonconsolidated Affiliates

At facilities where we serve as an owner and day-to-day manager, we have significant influence over the operations of such facilities. When we have control of the facility, we account for our investment in the facility as a consolidated subsidiary. When this influence does not represent control of the facility, but we have the ability to exercise significant influence over operating and financial policies, we account for our investment in the facility under the equity method, and treat the facility as a nonconsolidated affiliate. Our net earnings from a facility are the same under either method, but the classification of those earnings in our consolidated statements of operations differs.

For our consolidated subsidiaries, our financial statements reflect 100% of the revenues and expenses for these subsidiaries, after elimination of intercompany transactions and accounts. The net income attributable to owners of our consolidated subsidiaries, other than us, is classified within the line item *Net income attributable to noncontrolling interests.*

As of December 31, 2013, we consolidated six facilities into our financial results where we do not currently hold an equity ownership interest in the facility. All six facilities are majority-owned and controlled by a common parent company (the "future JV"). We hold a promissory note from the future JV that is convertible into equity of the future JV at our option upon the occurrence of the renegotiation of certain contractual arrangements. The promissory note has a fixed interest rate of 4% plus a variable component that is dependent on the earnings of the future JV. We are also party to management services agreements with the facilities controlled by the future JV. As a result of the financial interest in the earnings of the future JV held by us via the promissory note and the powers granted to us in the promissory note and the management services agreements, we have determined, under the Accounting Standards Codification Section 810, that the future JV is a VIE for which we are the primary beneficiary and as a result we consolidate these facilities into our financial results.

For our nonconsolidated affiliates, our consolidated statements of operations reflect our earnings from such facilities in two line items:

- *Equity in net income of nonconsolidated affiliates,* which represents our combined share of the net income of each equity method facility that is based on such equity method facility's net income and the percentage of such equity method facility's outstanding equity interests owned by us; and
- *Management fee revenues*, which represents our combined income from management fees that we earn from managing the day-to-day operations of the facilities that we do not consolidate for financial reporting purposes.

Our equity in net income of nonconsolidated affiliates is primarily a function of the performance of our nonconsolidated affiliates and our percentage of ownership interest in those affiliates. However, our net patient revenue and associated expense line items only contain the results from our consolidated facilities. As a result of this incongruity in our reported results, management uses a variety of supplemental information to analyze our results of operations, including:

- the results of operations of our consolidated subsidiaries and nonconsolidated affiliates;
- our ownership share in the facilities we operate; and
- facility operating indicators, such as systemwide net operating revenues growth, systemwide net patient revenues per case growth, same site systemwide net operating revenues growth and same site systemwide revenues per case growth.

While revenues of our nonconsolidated affiliates are not recorded in our net operating revenues, we believe this information is important in understanding our financial performance because these revenues are typically the basis for calculating the line item *Management fee revenues* and, together with the expenses of our nonconsolidated affiliates, are the basis for deriving the line item *Equity in net income of nonconsolidated affiliates*. As we execute on our strategy of partnering with health systems, we expect the number of our facilities that we account for as equity method facilities will increase relative to our total number of facilities.

KEY MEASURES

Facilities

Changes in our ownership of individual facilities and related changes in how we account for such facilities drive changes in our consolidated results from period to period in several ways, including:

- *Deconsolidations*. As a result of a deconsolidation transaction, an affiliated facility that was previously consolidated becomes a nonconsolidated facility. Any income we earn, based upon our ownership percentage in the facility, is reported on a net basis in the line item *Equity in net income of nonconsolidated affiliates*, whereas prior to a deconsolidation transaction, the affiliated facility's results were reported as part of our consolidated net operating revenues and the associated expense line items.

- *Consolidations.* As a result of a consolidation transaction, an affiliated facility that was previously nonconsolidated and accounted for on an equity method basis becomes a consolidated facility. After consolidation, revenues and expenses of the affiliated facility are included as part of our consolidated results.
- *De novos.* Where strategically appropriate, we invest, typically with a health system partner, in de novo facilities, which are newly developed ASCs. A de novo facility may be consolidated or nonconsolidated, depending on the circumstances.
- *Shifts in Ownership Percentage.* Our net income is driven in part by our ownership percentage in a facility since a portion of the net income earned by the facility is attributable to any noncontrolling owners in the facility, even if we consolidate such facility. As a result of our partnerships with physicians, our percentage of ownership in a facility may shift over time, which may result in an increase or a decrease in the net income we earn from such facility.

We took several steps during 2013 to optimize our facility portfolio by acquiring, deconsolidating, placing de novo facilities into operation and closing or selling certain facilities. On June 1, 2013, we completed the acquisition of Health Inventures, LLC ("HI") for a purchase price of $18.5 million. In the transaction, we acquired HI's ownership interests in four ASCs and one surgical hospital and management agreements with 19 facilities that together are affiliated with 11 different health systems.

The following table presents a breakdown of the changes in number of consolidated, nonconsolidated and managed-only facilities during the periods presented.

	During the Year-Ended December 31, 2013	During the Year-Ended December 31, 2012	During the Year-Ended December 31, 2011
Facilities at Beginning of Period			
Consolidated Facilities:	87	94	95
Equity Method Facilities:	52	44	23
Managed-only Facilities:	8	4	5
Total Facilities:	147	142	123
Strategic Activities Undertaken			
Acquisitions			
Consolidated Facilities acquired:	4	2	3
Noncontrolling interests acquired in facilities accounted for as equity method investments:	7	7	17
Management agreements entered into (Managed-only):	20	4	3
De novos			
Consolidated de novo facilities placed into operations:	1	—	—
De novo facilities accounted for as equity method investments placed into operations:	1	—	—
Consolidations / Deconsolidations			
Conversion transactions or contributions to joint ventures or other partnerships completed such that the facility is accounted for as a consolidated affiliate:	1	4	—
Conversion transactions or contributions to joint ventures or other partnerships completed such that the facility is accounted for as an equity method investment:	2	3	4
Changed to Managed-Only Facility			
Change to providing management services only:	3	—	—

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	During the Year-Ended December 31, 2013	During the Year-Ended December 31, 2012	During the Year-Ended December 31, 2011
Closures and Sales			
Consolidated Facilities sold:	—	3	—
Noncontrolling interests in facilities accounted for as equity method investments sold:	—	1	—
Consolidated Facilities closed:	2	3	—
Equity Method Facilities closed:	—	—	—
Management agreements exited from (Managed-only):	1	—	4
Facilities at End of Period			
Consolidated Facilities:	87	87	94
Equity Method Facilities:	60	52	44
Managed-only Facilities:	30	8	4
Total Facilities:	177	147	142
Average Ownership Interest			
Consolidated Facilities:	51.6%	54.8%	58.1%
Equity Method Facilities:	25.0%	27.7%	29.4%

Revenues

Our consolidated net operating revenues for the years-ended December 31, 2013, 2012 and 2011 were $802.0 million, $744.9 million and $714.2 million, respectively.

Given the significant increase in the number of our nonconsolidated facilities, driven by the success of our health system and physician partnership growth strategy, we review nonconsolidated facility revenues and also manage our facilities utilizing certain supplemental systemwide growth metrics.

The following table summarizes our systemwide net operating revenues growth, systemwide net patient revenues per case growth, same site systemwide revenue growth and same site systemwide net patient revenues per case growth.

	YEAR-ENDED DECEMBER 31,		
	2013	2012	2011
Systemwide net operating revenues growth [1]	15.2%	16.5%	17.0%
Systemwide net patient revenues per case growth [2]	9.2%	7.5%	9.4%
Same site systemwide net operating revenues growth [1][3]	8.8%	5.8%	5.5%
Same site systemwide net patient revenues per case growth [2][3]	6.0%	4.1%	6.6%

(1) The revenues and expenses of equity method facilities are not directly included in our consolidated GAAP results, rather only the net income earned from such facilities is reported on a net basis in the line item "*Equity in net income of nonconsolidated affiliates*." Because of this, management supplementally focuses on non-GAAP systemwide results, which measure results from all our facilities, including revenues from our consolidated facilities and our equity method facilities (without adjustment based on our percentage of ownership). We include management fee revenues from managed-only facilities in systemwide net operating revenues growth and same site net operating revenue growth, but not patient or other revenues from managed-only facilities (in which we hold no ownership interest).

(2) The revenues and expenses of equity method facilities are not directly included in our consolidated GAAP results; rather, only the net income earned from such facilities is reported on a net basis in the line item "*Equity in net income of nonconsolidated affiliates*." Because of this, management supplementally focuses on non-GAAP systemwide results, which measure results from all our facilities, including revenues from

our consolidated facilities and our equity method facilities (without adjustment based on our percentage of ownership). We do not include facilities at which we hold no ownership interest and provide only management services in systemwide net patient revenues per case growth or same site systemwide net patient revenues per case growth.

(3) Same site refers to facilities that were operational in both the current and prior periods.

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

Our consolidated net operating revenues increased by $57.1 million, or 7.7%, for the year-ended December 31, 2013 to $802.0 million from $744.9 million for the year-ended December 31, 2012. Consolidated net patient revenues per case increased by 6.1% to $1,710 per case during the year-ended December 31, 2013 from $1,612 per case during the year-ended December 31, 2012.

For the year-ended December 31, 2013, systemwide net operating revenues grew by 15.2% compared to the year-ended December 31, 2012. In addition, for the year-ended December 31, 2013, systemwide net patient revenues per case grew by 9.2% compared to the prior period.

The table below quantifies several significant items impacting our period-over-period net operating revenues growth and net operating revenues growth of our nonconsolidated affiliates.

	Year-Ended December 31, 2013	
	Surgical Care Affiliates as Reported Under GAAP	Nonconsolidated Affiliates
	(in millions)	
Total net operating revenues, year-ended December 31, 2012 [1][2]	$744.9	$477.5
Add: revenue from acquired facilities	31.4	79.1
revenue from consolidations	5.2	(5.2)
Less: revenue of disposed facilities	—	(30.7)
revenue from deconsolidated facilities	(26.9)	26.9
Adjusted base year total net operating revenues	754.6	547.6
Increase from operations	42.8	56.7
Non-facility based revenue	4.6	1.5
Total net operating revenues, year-ended December 31, 2013:	$802.0	$605.8

(1) $1.6 million in revenues have been reclassified from prior periods presented related to facilities accounted for as discontinued operations.

(2) Additions to revenue represent revenue from the acquisition or consolidation of facilities during the 12 months after the date of acquisition or consolidation, as applicable. Deductions from revenue represent revenue from disposition or deconsolidation of facilities that were owned or consolidated in a prior period but are not owned or consolidated at the end of the current period.

Year-Ended December 31, 2012 Compared to Year-Ended December 31, 2011

Our consolidated net operating revenues increased by $30.7 million, or 4.3%, for the year-ended December 31, 2012 to $744.9 million from $714.2 million for the year-ended December 31, 2011. Consolidated net patient revenues per case increased by 1.5% to $1,612 per case during 2012 from $1,589 per case during the prior period.

For the year-ended December 31, 2012, systemwide net operating revenues grew by 16.5% compared to the year-ended December 31, 2011. In addition, for the year-ended December 31, 2012, systemwide net patient revenues per case grew by 7.5% compared to the year-ended December 31, 2011.

The table below quantifies several significant items impacting our period-over-period net operating revenues growth and net operating revenues growth of our nonconsolidated affiliates.

	Year-Ended December 31, 2012	
	Surgical Care Affiliates as Reported Under GAAP	Nonconsolidated Affiliates
	(in millions)	
Total net operating revenues, year-ended December 31, 2011 [1][2]	$714.2	$334.8
Add: revenue from acquired facilities	4.5	106.6
revenue from consolidations	12.6	(12.6)
Less: revenue of disposed facilities	—	—
revenue from deconsolidated facilities	(22.1)	22.1
Adjusted base year total net operating revenues	709.2	450.9
Increase from operations	26.7	25.9
Non-facility based revenue	9.0	0.7
Total net operating revenues, year-ended December 31, 2012:	$744.9	$477.5

(1) $1.5 million in revenues have been reclassified from prior periods presented related to facilities accounted for as discontinued operations.

(2) Additions to revenue represent revenue from the acquisition or consolidation of facilities during the 12 months after the date of acquisition or consolidation, as applicable. Deductions from revenue represent revenue from disposition or deconsolidation of facilities that were owned or consolidated in a prior period but are not owned or consolidated at the end of the current period.

Summary of Key Line Items

Net Operating Revenues

The vast majority of our net operating revenues consist of net patient revenues from the facilities we consolidate for financial reporting purposes. Net patient revenues are derived from fees we collect from insurance companies, Medicare, state workers' compensation programs, patients and other payors in exchange for providing the facility and related services and supplies a physician requires to perform a surgical procedure. Our net operating revenues also includes the line item "*Management fee revenues,*" which includes fees we earn from managing the facilities that we do not consolidate for financial reporting purposes. The line item "*Other revenues*" is composed of other ancillary services and fees received for anesthesia services. The physicians who perform procedures at our facilities bill and collect from their patients and other payors directly for their professional services, and their revenues from such professional services are not included in our net operating revenues.

Net Patient Revenues

Net patient revenues are recorded during the period in which the healthcare services are provided, based upon the estimated amounts due from insurance companies, patients and other government and third-party payors, including federal and state agencies (under the Medicare and Medicaid programs), state workers' compensation programs and employers.

The following table presents a breakdown by payor source of the percentage of net patient revenues for the periods presented:

Consolidated Facilities

	YEAR-ENDED DECEMBER 31,		
	2013	2012	2011
Managed care and other discount plans	60%	61%	62%
Medicare	20	21	20
Workers' compensation	11	10	10
Patients and other third-party payors	6	5	4
Medicaid	3	3	4
Total	100%	100%	100%

Nonconsolidated Facilities

	YEAR-ENDED DECEMBER 31,		
	2013	2012	2011
Managed care and other discount plans	77%	73%	69%
Medicare	15	14	15
Workers' compensation	4	8	10
Patients and other third-party payors	2	2	3
Medicaid	2	3	3
Total	100%	100%	100%

The majority of our net patient revenues are related to patients with commercial health insurance coverage. The reimbursement rates we have been able to negotiate, on an average basis across our portfolio, have held relatively stable.

Medicare accounts for 20%, 21% and 20% of our net patient revenues for the years-ended December 31, 2013, 2012 and 2011, respectively. The Medicare program is subject to statutory and regulatory changes, possible retroactive and prospective rate adjustments, administrative rulings, freezes and funding reductions, all of which may adversely affect the level of payments to our facilities. Significant spending reductions mandated by the BCA impacting the Medicare program went into effect on March 1, 2013. Under the BCA, the percentage reduction for Medicare may not be more than 2% for a fiscal year, with a uniform percentage reduction across all providers. The impact from these spending reductions has not been material to our results.

For the year-ended December 31, 2013, our facilities located in North Carolina, California and Texas collectively represented approximately 14%, 14% and 12%, respectively, of our net patient revenues. Additionally, our facilities located in each of Alabama, Alaska, Connecticut, Florida and Idaho represented in excess of 5% of our net patient revenues for the year-ended December 31, 2013.

Of our 60 nonconsolidated facilities accounted for as equity method investments, as of December 31, 2013, 26 of these facilities were located in California and 12 of these facilities were located in Indiana.

Operating Expenses

Salaries and Benefits

Salaries and benefits represent the most significant cost to us and include all amounts paid to full and part-time teammates, including all related costs of benefits provided to such teammates. Salaries and benefits expense represented 34.6%, 32.5% and 31.1% of our net operating revenues for the years-ended December 31, 2013, 2012 and 2011, respectively.

Supplies

Supplies expense includes all costs associated with medical supplies used while providing patient care at our consolidated facilities. Our supply costs primarily include sterile disposables, pharmaceuticals, implants and other similar items. Supplies expense represented 21.8%, 22.8% and 22.5% of our net operating revenues for the years-ended December 31, 2013, 2012 and 2011, respectively, making it important for our facilities to appropriately manage these costs. Supplies expense is typically closely related not only to case volume but also to case mix, as an increase in the acuity of cases and the use of implants in those cases tends to drive supplies expense higher.

Other Operating Expenses

Other operating expenses consists primarily of expenses related to insurance premiums, contract services, legal fees, repairs and maintenance, professional and licensure dues, office supplies and miscellaneous expenses. Other operating expenses do not generally correlate with changes in net patient revenues.

Occupancy Costs

Occupancy costs include facility rent, utility and maintenance expense. Occupancy costs do not generally correlate with changes in net patient revenues.

Provision for Doubtful Accounts

We write off uncollectible accounts against the allowance for doubtful accounts after exhausting collection efforts and adding subsequent recoveries. Net accounts receivable include only those amounts we estimate we will collect. We perform an analysis of our historical cash collection patterns and consider the impact of any known material events in determining the allowance for doubtful accounts. In performing our analysis, we consider the impact of any adverse changes in general economic conditions, business office operations, aging of accounts receivable, payor mix or trends in Federal or state governmental healthcare coverage.

Provision for Income Tax Expense

Because we have a full valuation allowance booked against our net deferred tax assets, our tax expense is generated primarily from amortization of tax goodwill and write-offs of tax goodwill resulting from the syndication of partnership interests. Our tax expense therefore bears no relationship to pre-tax income, and our effective tax rate will fluctuate from period to period, depending upon the amount of tax expense from amortization and write-offs of goodwill. Since substantially all of our facilities are organized as general partnerships, limited partnerships, limited liability partnerships or limited liability companies, which are not taxed at the entity level for federal income tax purposes and are only taxed at the entity level in five states for state income tax purposes, substantially all of our tax expense is attributable to Surgical Care Affiliates.

Net Loss Attributable to Surgical Care Affiliates

Net loss attributable to Surgical Care Affiliates is derived by subtracting net income attributable to noncontrolling interests from net income. Net income includes certain revenues and expenses that are incurred

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only through our wholly owned subsidiaries and therefore do not impact net income attributable to noncontrolling interests. These revenues and expenses include management fee revenues, interest expense related to Surgical Care Affiliates' debt, losses or gains on sale of investments and provision for income taxes. In periods where net income is negatively affected by these non-shared revenues and expenses, the deduction of net income attributable to noncontrolling interests from net income can result in a net loss attributable to Surgical Care Affiliates in periods where net income is positive.

Summary Results of Operations

Year-Ended December 31, 2013 Compared to Year-Ended December 31, 2012 and December 31, 2011

Our Consolidated Results and Results of Nonconsolidated Affiliates

The following tables show our results of operations and the results of operations of our nonconsolidated affiliates for the years-ended December 31, 2013, 2012 and 2011.

	YEAR-ENDED DECEMBER 31,					
	2013		2012		2011	
	As Reported Under GAAP	Non-consolidated Affiliates[1]	As Reported Under GAAP	Non-consolidated Affiliates[1]	As Reported Under GAAP	Non-consolidated Affiliates[1]
	(in millions, except cases and facilities in actual amounts)					
Net operating revenues:						
Net patient revenues	$ 746.6	$600.6	$ 714.6	$474.4	$ 692.9	$332.6
Management fee revenues	40.5	—	17.8	—	11.3	—
Other revenues	14.9	5.2	12.4	3.2	10.0	2.2
Total net operating revenues	802.0	605.8	744.9	477.5	714.2	334.8
Equity in net income of nonconsolidated affiliates[2]	23.4	—	16.8	—	22.2	—
Operating expense:						
Salaries and benefits	277.7	128.9	241.8	108.8	221.8	80.5
Supplies	175.2	99.6	170.1	78.8	160.6	57.9
Other operating expenses	131.8	89.3	118.5	68.8	114.6	49.1
Depreciation and amortization	42.9	17.3	41.6	14.0	40.4	11.4
Occupancy costs	27.0	22.7	26.8	20.8	26.6	14.4
Provision for doubtful accounts	15.0	10.4	13.2	6.3	14.6	6.5
Impairment of intangible and long-lived assets	—	—	1.1	—	—	—
Loss (gain) on disposal of assets	0.1	0.3	(0.3)	0.1	(0.8)	(0.1)
Total operating expenses	669.8	368.5	612.7	297.6	577.9	219.6
Operating income	155.6	237.3	148.9	179.9	158.5	115.2
Interest expense	60.4	1.7	58.8	1.6	56.0	1.5
Loss from extinguishment debt	10.3	—	—	—	—	—
Interest income[3]	(0.2)	(0.1)	(0.3)	(0.1)	(0.4)	(0.1)
Loss (gain) on sale of investments	12.3	—	7.1	—	(3.9)	—
Income from continuing operations before income tax expense	72.7	235.6	83.3	178.4	106.8	113.8
Provision for income tax expense[4]	12.6	0.1	8.9	0.1	20.3	0.1
Income from continuing operations	60.1	235.5	74.4	178.4	86.5	113.8
Loss from discontinued operations, net of income tax expense	(7.4)	—	(2.1)	—	(3.0)	—
Net income	52.7	$235.5	72.3	$178.4	83.5	$113.8

	YEAR-ENDED DECEMBER 31,					
	2013		2012		2011	
	As Reported Under GAAP	Non-consolidated Affiliates (1)	As Reported Under GAAP	Non-consolidated Affiliates (1)	As Reported Under GAAP	Non-consolidated Affiliates (1)
	(in millions, except cases and facilities in actual amounts)					
Less: Net income attributable to noncontrolling interests	(104.0)		(92.3)		(93.2)	
Net loss attributable to Surgical Care Affiliates	$ (51.3)		$ (20.0)		$ (9.7)	
Equity in net income of nonconsolidated affiliates (2)		$ 23.4		$ 16.8		$ 22.2
Other Data (5)						
Cases — consolidated facilities (6)	436,560		443,361		436,207	
Cases — equity facilities (7)	258,942		226,860		184,860	
Consolidated facilities	87		87		94	
Equity method facilities	60		52		44	
Managed-only facilities	30		8		4	
Total facilities	177		147		142	

(1) The figures in this column, except within the line item *Equity in net income of nonconsolidated affiliates,* are non-GAAP presentations but management believes they provide further useful information about our equity method investments. The revenue, expense and operating income line items included in this column represent the results of our facilities that we account for as an equity method investment on a combined basis, without taking into account our percentage of ownership interest. The line item *Equity in net income of nonconsolidated affiliates* represents the total net income earned by us from our facilities accounted for as an equity method investment, which is computed as our percentage of ownership interest in the facility (which differs among facilities) multiplied by the net income earned by such facility, adjusted for basis differences such as amortization and other than temporary impairment charges, as described below.

(2) For the years-ended December 31, 2013, 2012 and 2011 we recorded amortization expense of $25.9 million, $20.3 million and $10.1 million, respectively, for definite-lived intangible assets attributable to equity method investments within *Equity in net income of nonconsolidated affiliates.* For the years-ended December 31, 2013 and 2012 we recorded other than temporary impairment charges of $6.1 million and $9.2 million, respectively, within the line item *Equity in net income of nonconsolidated affiliates.* There was no such impairment charge for the year-ended December 31, 2011.

(3) Interest income of nonconsolidated affiliates was $0.060 million, $0.090 million and $0.067 million for the years-ended December 31, 2013, 2012 and 2011, respectively.

(4) Provision for income tax expense for nonconsolidated affiliates was $0.071 million, $0.060 million and $0.060 million for the years-ended December 31, 2013, 2012 and 2011, respectively.

(5) Case data is presented for the years-ended December 31, 2013, 2012 and 2011, as applicable. Facilities data is presented as of December 31, 2013, 2012 and 2011, as applicable.

(6) Represents cases performed at consolidated facilities. The number of cases performed at our facilities is a key metric utilized by us to regularly evaluate performance.

(7) Represents cases performed at equity method facilities. The number of cases performed at our facilities is a key metric utilized by us to regularly evaluate performance.

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

Net Operating Revenues

Our consolidated net operating revenues increased $57.1 million, or 7.7%, for the year-ended December 31, 2013 to $802.0 million from $744.9 million for the year-ended December 31, 2012. The main factors that contributed to this increase were increased rates paid under certain payor contracts, revenues earned from a

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facility for which a consolidation transaction was completed during the second quarter of 2012, revenues earned from facilities acquired since December 31, 2012 and increases in acuity case mix. Consolidated net patient revenues per case grew by 6.1% to $1,710 per case for the year-ended December 31, 2013 from $1,612 per case during the prior period reflecting higher acuity case mix. During this same period, the number of cases at our consolidated facilities decreased to 436,560 cases during the year-ended December 31, 2013 from 443,361 cases during the year-ended December 31, 2012 and our number of consolidated facilities were 87 facilities as of December 31, 2013 and 2012.

For the year-ended December 31, 2013, systemwide net operating revenues grew by 15.2% compared to the year-ended December 31, 2012. The growth in systemwide net operating revenues is largely due to the acquisition of noncontrolling interests in seven facilities accounted for as equity method investments and four consolidated affiliates since the prior period and increased rates earned under certain payor contracts. The increase is also attributable to two de novo facilities, one of which is an equity method investment and the other one is a consolidated affiliate, which were placed into operations since December 31, 2012. These factors are partially offset by the sale of our interest in a nonconsolidated facility completed in 2012. In addition, for the year-ended December 31, 2013, systemwide net patient revenues per case grew by 9.2% compared to the year-ended December 31, 2012, which is due to similar factors as described above.

Equity in Net Income of Nonconsolidated Affiliates

Equity in net income of nonconsolidated affiliates increased $6.6 million, or 39.3%, to $23.4 million during the year-ended December 31, 2013 from $16.8 million during the year-ended December 31, 2012. This increase was primarily due to the acquisition of several noncontrolling interests in facilities since December 31, 2012 and the deconsolidation of two facilities completed during 2013 (i.e., the facilities became equity method facilities rather than consolidated facilities). After deconsolidation, the results of operations of the facilities were reported net in *Equity in net income of nonconsolidated affiliates*, whereas prior to deconsolidation, those results were reported within the consolidated revenue and expense line items. The increase was partially offset by $6.1 million of impairments related to five equity method facilities during 2013 and by the conversion of a facility that was previously accounted for as an equity method facility to a consolidated facility during the second quarter of 2012. After the date of conversion, the results of this facility were reported within our consolidated revenue and expense line items, whereas prior to the conversion, the results of operations at this facility were reported net in the line item *Equity in net income of nonconsolidated affiliates*. The $6.1 million of impairment recorded to our investments in nonconsolidated affiliates was due to a decline in the expected future cash flows of five nonconsolidated affiliates that we determined to be other than temporary. This impairment is included in *Equity in net income of nonconsolidated affiliates*. This decline in the expected future cash flows was caused by events specific to each impacted facility, as further described below. The impairments included:

- a $1.5 million impairment on our investment in Wausau Surgery Center, L.P. related to an offer received to purchase our interest in the facility;
- a $2.3 million impairment on our investment in Premier Surgery Center of Louisville, L.P. related to insufficient forecasted growth at the facility;
- a $0.9 million impairment on our investment in Kerlan-Jobe Surgery Center, LLC related to a buy-out agreement for the facility;
- a $0.8 million impairment on our investment in Surgery Center of Fort Collins, LLC related to insufficient forecasted growth at the facility; and
- a $0.6 million impairment on our investment in Surgery Center of Lexington, LLC related to insufficient forecasted growth at the facility.

Additionally, changes in our ownership amounts in equity method facilities and changes in the profitability of those equity method facilities also impacted *Equity in net income of nonconsolidated affiliates*.

During the year-ended December 31, 2013, we recorded $25.9 million of amortization expense for definite-lived intangible assets attributable to equity method investments. This expense was included in the line item *Equity in net income of nonconsolidated affiliates* in our consolidated financial statements. We recorded $20.3 million of amortization expense during the year-ended December 31, 2012.

Salaries and Benefits

Salaries and benefits expense increased $35.9 million, or 14.8%, to $277.7 million for the year-ended December 31, 2013 from $241.8 million for the year-ended December 31, 2012. The increase in salary and benefits expense is primarily due to the addition of new teammates in connection with acquisitions as well as the payment of a cash bonus to eligible holders of vested options and restricted equity units (the "2013 Special Cash Bonus Payment") of approximately $2.46 per vested option or restricted equity unit, as applicable, recorded during the third quarter of 2013, resulting in a total bonus payment of $4.6 million. Salaries and benefits also increased as a result of the addition of the expenses associated with existing teammates as a result of the consolidation of previously nonconsolidated affiliates.

Supplies

Supplies expense increased $5.1 million, or 3.0%, to $175.2 million for the year-ended December 31, 2013 from $170.1 million for the year-ended December 31, 2012. This increase in supplies expense is primarily attributable to changes in our case mix, in particular an increase in the number of orthopedic and ophthalmology cases performed at our facilities, which tend to require higher cost supplies and implants. Supplies expense per case increased by 4.6% during the year-ended December 31, 2013, as compared to the prior year, which is attributable to changes in our case mix as well as inflationary increases to supply costs.

Other Operating Expenses

Other operating expenses increased $13.3 million, or 11.2%, to $131.8 million for the year-ended December 31, 2013 from $118.5 million for the year-ended December 31, 2012. This increase is primarily attributable to the incurrence of certain additional overhead costs resulting from our organizational growth, partially offset by our efforts to manage and decrease existing overhead operating expenses.

Depreciation and Amortization

Depreciation and amortization expense increased $1.3 million, or 3.1%, to $42.9 million for the year-ended December 31, 2013 from $41.6 million for the year-ended December 31, 2012, primarily due to the addition of new capitalized assets during the year, partially offset by the conversion of two consolidated facilities to equity method investments.

Occupancy Costs

Occupancy costs remained relatively steady at $27.0 million during the year-ended December 31, 2013 as compared to $26.8 million during the year-ended December 31, 2012.

Provision for Doubtful Accounts

The provision for doubtful accounts increased $1.8 million, or 13.6%, to $15.0 million for the year-ended December 31, 2013 from $13.2 million during the year-ended December 31, 2012, however it remains consistent as a percentage of net patient revenues at approximately 2.0%.

Interest Expense

Interest expense increased $1.6 million, or 2.7%, to $60.4 million for the year-ended December 31, 2013 as compared to $58.8 million during the year-ended December 31, 2012 due to the de-designation of interest rate

swaps as cash flow hedges partially offset by interest savings from the refinancing of certain of our debt instruments in 2013, including the redemption of all of our outstanding senior notes and senior subordinated notes.

Loss (Gain) on Sale of Investments

We recognized a loss on sale of investments of $12.3 million for the year-ended December 31, 2013 and a loss on sale of investments of $7.1 million during the year-ended December 31, 2012. The loss during the year-ended December 31, 2013 was recorded in connection with the sale of two consolidated affiliates, a deconsolidation transaction and the consolidation of a previously nonconsolidated affiliate. The loss in 2012 was related to the divestiture of our interest in a nonconsolidated affiliate and the deconsolidation of a previously consolidated affiliate, which was partially offset by a gain from the consolidation of a previously nonconsolidated affiliate.

Provision for Income Tax Expense

For the year-ended December 31, 2013, income tax expense was $12.6 million, representing an effective tax rate of 17.4%, compared to an expense of $8.9 million, representing an effective tax rate of 10.6% for the year-ended December 31, 2012. The $12.6 million in expense for the year-ended December 31, 2013 includes $11.7 million attributable to the tax amortization of goodwill, an indefinite-lived intangible, $0.2 million of current federal income tax attributable to noncontrolling interests, and $0.7 million of state income taxes accrued by subsidiaries with separate state tax filing requirements, including $0.4 million attributable to noncontrolling interests. The $8.9 million in expense for the year-ended December 31, 2012 included $8.4 million attributable to the tax amortization of goodwill, an indefinite-lived intangible, and $0.5 million of state income taxes accrued by subsidiaries with separate state tax filing requirements, including $0.2 million attributable to noncontrolling interests.

Because we have a full valuation allowance booked against our net deferred tax assets, our tax expense is generated primarily from amortization of tax goodwill and write-offs of tax goodwill resulting from the syndication of partnership interests. Our tax expense therefore bears no relationship to pre-tax income, and our effective tax rate will fluctuate from period to period, depending upon the amount of tax expense from amortization and write-offs of goodwill.

On a quarterly basis, we assess the likelihood of realization of our deferred tax assets considering all available evidence, both positive and negative. Our most recent operating performance, the scheduled reversal of temporary differences and our forecast of taxable income in future periods are important considerations in our assessment. Management has considered all positive and negative evidence available at this time and has concluded that a full valuation allowance continues to be appropriate as of December 31, 2013. We continue to closely monitor actual and forecasted earnings and, if there is a change in management's assessment of the amount of deferred income tax assets that is realizable, adjustments to the valuation allowance will be made in future periods. As of December 31, 2013, our valuation allowance was $166.1 million. See "Risk Factors — Risks Related to Our Business — We may not be able to fully realize the value of our net operating loss carryforwards."

Net income attributable to noncontrolling interests

Net income attributable to noncontrolling interests increased $11.7 million, or 12.7%, to $104.0 million for the year-ended December 31, 2013 from $92.3 million for the year-ended December 31, 2012. The increase in our consolidated net operating revenues, as described above, drove an increase in consolidated facilities' net income. Most of our consolidated facilities include noncontrolling owners. An increase in the earnings of these facilities resulted in an increase in net income attributable to noncontrolling interests. This increase was partially offset by the deconsolidation of two facilities in 2013.

Net loss attributable to Surgical Care Affiliates

Net loss attributable to Surgical Care Affiliates increased $31.3 million to $51.3 million for the years-ended December 31, 2013 from $20.0 million for the year-ended December 31, 2012. While our facilities' revenue and operating income increased during the year-ended December 31, 2013, the increase in revenues and operating income was more than offset by increases in net income attributable to noncontrolling interests, loss from extinguishment of debt and increases in salaries and benefits.

Year-Ended December 31, 2012 Compared to Year-Ended December 31, 2011

Net Operating Revenues

Our consolidated net operating revenues increased by $30.7 million, or 4.3%, for the year-ended December 31, 2012 to $744.9 million from $714.2 million for the year-ended December 31, 2011. The main factors that contributed to this increase were revenues earned from a facility for which a consolidation transaction was completed during the second quarter of 2012, increased rates earned under certain payor contracts and a change in case mix. These factors were partially offset by the conversion of one facility from a consolidated facility to an equity method facility during 2012 and the conversion of one facility to an equity method facility during 2011. Consolidated net patient revenues per case increased by 1.5% to $1,612 per case for the year-ended December 31, 2012 from $1,588 per case during the prior period. During this same period, the number of cases at our consolidated facilities increased to 443,361 cases during the year-ended December 31, 2012 from 436,207 cases during the year-ended December 31, 2011, while our number of consolidated facilities decreased to 87 facilities as of December 31, 2012 from 94 facilities as of December 31, 2011. Our consolidated management fee revenues increased $6.5 million, or 57.5%, for the year-ended December 31, 2012 to $17.8 million from $11.3 million in the year-ended December 31, 2011. The increase in consolidated management fee revenues results primarily from the inclusion of a full year of management fee revenue from a nonconsolidated investment that was made in July 2011, whereas in 2011 only a half year of such revenues were included in our results, and an increase in our number of managed equity method facilities as compared to the prior year.

For the year-ended December 31, 2012, systemwide net operating revenues grew by 16.5% compared to the year-ended December 31, 2011. The growth in systemwide net patient revenues is due largely to the inclusion of a full year of revenue earned from acquisitions made in 2011 and from the acquisition of two consolidated facilities and noncontrolling interests in seven facilities accounted for as equity investments since the prior period, increased rates earned under certain payor contracts and changes in case mix. In addition, for the year-ended December 31, 2012, systemwide net patient revenues per case grew by 7.4% compared to the year-ended December 31, 2011, which is due to similar factors as described above.

Equity in Net Income of Nonconsolidated Affiliates

Equity in net income of nonconsolidated affiliates decreased by $5.4 million, or 24.3%, to $16.8 million for the year-ended December 31, 2012 from $22.2 million for the year-ended December 31, 2011. This decrease was primarily due to impairment charges totaling $9.2 million recorded during 2012 on our investments in nonconsolidated affiliates due to a decline in the expected future cash flows of five nonconsolidated affiliates that we determined to be other than temporary. This decline in the expected future cash flows was caused by events specific to each impacted facility, as further described below. We do not believe that the impairments at these facilities are indicative of any overall market trends or uncertainties in our business. The impairments included:

- a $1.1 million impairment on our investment in Pueblo Ambulatory Surgery Center LLC related to declining volumes and earnings at the facility;
- a $3.3 million impairment on our investment in Premier Surgery Center of Louisville, L.P. related to insufficient forecasted growth at the facility;
- a $1.7 million impairment on our investment in Endoscopy Center West, LLC related to a buy-out offer received for our interest in the facility;

- a $0.4 million impairment on our investment in Kerlan-Jobe Surgery Center, LLC related to a buy-out agreement for the facility; and
- a $2.7 million impairment on our investment in Surgical Center at Premier, LLC related to an estimated valuation obtained for the facility in connection with consideration of a new health system partner.

The fair value of our investments in nonconsolidated affiliates is determined using discounted cash flows or earnings, estimates or sales proceeds. No such impairment charges were recorded during the year-ended December 31, 2011.

Also contributing to the decrease in equity in net income of nonconsolidated affiliates was the conversion of a facility that was previously accounted for as an equity method investment to a consolidated facility during the second quarter of 2012. After the date of conversion, the results of such facility were reported in the our consolidated revenue and expense line items, whereas prior to the conversion, the results of operations at this facility were reported on a net basis in the line item *Equity in net income of nonconsolidated affiliates.*

These factors were partially offset by having a full year of equity income from certain large nonconsolidated affiliates acquired in 2011 and the acquisition of seven equity method facilities during 2012. Also, during the first quarter of 2012, we deconsolidated one previously consolidated facility to an equity method facility. After the deconsolidation, the results of operations for the affected facility are reported on a net basis in the line item *Equity in net income of nonconsolidated affiliates*, whereas prior to deconsolidation, the facility's results were reported in our consolidated net operating revenues and the associated expense line items.

Additionally, changes in our percentage of ownership in our equity method facilities and changes in the profitability of those equity method facilities also impacted *Equity in net income of nonconsolidated affiliates*.

During the year-ended December 31, 2012, we recorded $20.3 million of amortization expense for definite-lived intangible assets attributable to equity method investments. This expense was included in the line item *Equity in net income of nonconsolidated affiliates* in our consolidated financial statements. We recorded $10.1 million of amortization expense during the year-ended December 31, 2011.

Salaries and Benefits

Salaries and benefits expense increased $20.0 million, or 9.0%, to $241.8 million for the year-ended December 31, 2012 from $221.8 million for the year-ended December 31, 2011. The increase in salary and benefits expense is primarily a result of our adding teammates to support our new health system relationships and in connection with acquisitions of new facilities. In addition, this increase is also in part driven by an increase in total facility labor costs resulting largely from increased case volumes.

Supplies

Supplies expense increased $9.5 million, or 5.9%, to $170.1 million for the year-ended December 31, 2012 from $160.6 million for the year-ended December 31, 2011. The increase in supplies expense is primarily attributable to pharmaceutical shortages, a shift in case mix and inflation, which was partially offset by the positive impact of our various supply chain initiatives, designed to improve our purchasing power and negotiate more favorable pricing from key vendors. Supplies expense per case increased by 4.1% during the year-ended December 31, 2012, as compared to the prior year, which was also primarily due to similar factors.

Other Operating Expenses

Other operating expenses increased $3.9 million, or 3.4%, to $118.5 million for the year-ended December 31, 2012 from $114.6 million for the year-ended December 31, 2011. This increase is primarily

attributable to the incurrence of certain additional overhead costs resulting from our organizational growth, partially offset by our efforts to manage and decrease existing overhead operating expenses and the release of certain litigation and general and professional liability reserves.

Depreciation and Amortization

Depreciation and amortization expense increased $1.2 million, or 3.0%, to $41.6 million for the year-ended December 31, 2012 from $40.4 million for the year-ended December 31, 2011, primarily due to the addition of new capitalized assets during the year, partially offset by the conversion of one consolidated facility to an equity method investment.

Occupancy Costs

Occupancy costs remained relatively steady at $26.8 million during the year-ended December, 31, 2012 as compared to $26.6 million during the year-ended December, 31, 2011.

Provision for Doubtful Accounts

The provision for doubtful accounts decreased $1.4 million, or 9.6%, to $13.2 million for the year-ended December 31, 2012, from $14.6 million for the year-ended December 31, 2011, primarily as a result of improved collection of accounts receivables.

Impairment of Intangible and Long-Lived Assets

During 2012 and 2011, we examined our long-lived assets for impairment due to facility closings and facilities experiencing cash flows insufficient to recover the net book value of our long-lived assets. Based upon such review, we recorded $1.1 million of impairment charges during the year-ended December 31, 2012. No material impairment charges were recorded during the year-ended December 31, 2011.

Loss (Gain) on Sale of Investments

We recorded a loss on sale of investments of $7.1 million during 2012, compared to a gain of $3.9 million for 2011. The loss in 2012 was related to the divestiture of our interest in a nonconsolidated affiliate and the deconsolidation of a previously consolidated affiliate, which was partially offset by a gain from the consolidation of a previously nonconsolidated affiliate. The gain in 2011 was primarily related to deconsolidation transactions.

Provision for Income Tax Expense

For the year-ended December 31, 2012, income tax expense was $8.9 million, representing an effective tax rate of 10.6%, compared to an expense of $20.3 million, representing an effective tax rate of 19.0%, for the year-ended December 31, 2011. The $8.9 million in expense for the year-ended December 31, 2012 includes $8.4 million attributable to the tax amortization of goodwill, an indefinite-lived intangible, and $0.5 million of state income taxes accrued by subsidiaries with separate state tax filing requirements, including $0.2 million attributable to noncontrolling interests. The $20.3 million in expense for the year-ended December 31, 2011 included $19.9 million attributable to the tax amortization of goodwill, an indefinite-lived intangible, and $0.4 million of state income taxes accrued by subsidiaries with separate state tax filing requirements, including $0.2 million attributable to noncontrolling interests. See "Risk Factors — Risks Related to Our Business — We may not be able to fully realize the value of our net operating loss carryforwards."

Because we have a full valuation allowance booked against our net deferred tax assets, our tax expense is generated primarily from amortization of tax goodwill and write-offs of tax goodwill resulting from the syndication of partnership interests. Our tax expense therefore bears no relationship to pre-tax income, and our effective tax rate will fluctuate from period to period, depending upon the amount of tax expense from amortization and write-offs of goodwill.

On a quarterly basis, we assess the likelihood of realization of our deferred tax assets considering all available evidence, both positive and negative. Our most recent operating performance, the scheduled reversal of temporary differences and our forecast of taxable income in future periods are important considerations in our assessment. Management considers all positive and negative evidence available, and concluded that a full valuation allowance was appropriate as of December 31, 2012. As of December 31, 2012, our valuation allowance was $151.8 million. See "Risk Factors — Risks Related to Our Business — We may not be able to fully realize the value of our net operating loss carryforwards."

Net income attributable to noncontrolling interests

Net income attributable to noncontrolling interests decreased $0.9 million, or 1.0%, to $92.3 million for the year-ended December 31, 2012 from $93.2 million for the year-ended December 31, 2011. The increase in our consolidated net operating revenues, as described above, was more than offset by an increase in operating expenses. Most of our consolidated facilities include noncontrolling owners. A decrease in the earnings of these facilities resulted in a decrease in net income attributable to noncontrolling interests.

Net loss attributable to Surgical Care Affiliates

Net loss attributable to Surgical Care Affiliates increased $10.3 million, or 106.2%, to $20.0 million for the year-ended December 31, 2012 from $9.7 million for the year-ended December 31, 2011. While our facilities' revenue increased, lower equity in net income of nonconsolidated affiliates, higher operating expenses and higher loss on sale of investments drove the increase in net loss attributable to Surgical Care Affiliates.

Adjusted EBITDA-NCI and Adjusted Net Income Reconcilements

The following table represents the reconciliation of net income to Adjusted EBITDA-NCI and of net loss attributable to Surgical Care Affiliates to Adjusted Net Income for the periods indicated below:

	2013	2012	2011
Adjusted EBITDA-NCI:			
Net income	$ 52.7	$ 72.3	$ 83.5
Plus (minus):			
Interest expense, net	60.2	58.5	55.6
Provision for income tax expense	12.6	8.9	20.3
Depreciation and amortization	42.9	41.6	40.4
Loss from discontinued operations, net	7.4	2.1	3.0
Equity method amortization expense [a]	25.9	20.3	10.1
Loss (gain) on sale of investments	12.3	7.1	(3.9)
Loss on extinguishment of debt	10.3	—	—
Asset impairments	6.1	10.2	—
Loss (gain) on disposal of assets	0.1	(0.3)	(0.8)
IPO related expense [b]	9.1	—	—
Stock compensation expense [c]	7.3	1.7	1.7
Adjusted EBITDA	246.9	222.4	209.9
(Minus):			
Net income attributable to noncontrolling interests	(104.0)	(92.3)	(93.2)
Adjusted EBITDA-NCI	$ 142.9	$130.1	$116.7

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Adjusted Net Income:	2013	2012	2011
Net loss attributable to Surgical Care Affiliates	$ (51.3)	$ (20.0)	$ (9.7)
Plus (minus)			
Change in deferred income tax	15.4	7.4	22.2
Loss on extinguishment of debt	10.3	—	—
Asset impairments	6.1	10.2	—
Amortization expense	6.7	4.9	5.5
Loss from discontinued operations, net	7.4	2.1	3.0
Loss (gain) on sale of investments	12.3	7.1	(3.9)
Loss (gain) on disposal of assets	0.1	(0.3)	(0.8)
Equity method amortization expense [(a)]	25.9	20.3	10.1
IPO related expense [(b)]	9.1	—	—
Stock compensation expense [(c)]	7.3	1.7	1.7
Adjusted Net Income	$ 49.3	$ 33.4	$ 28.1

(a) For the years-ended December 31, 2013, December 31, 2012 and December 31, 2011, we recorded $25.9 million, $20.3 million and $10.1 million, respectively, of amortization expense for definite-lived intangible assets attributable to equity method investments. These expenses are included in *Equity in net income of nonconsolidated affiliates* in our consolidated financial statements.

(b) IPO related expense includes an $8.0 million fee paid to TPG Capital pursuant to the Management Services Agreement (as defined herein) at the closing of our initial public offering in November 2013. After the fee was paid, the Management Services Agreement was terminated. See "Certain Relationships and Related Party Transactions — Management Services Agreement" for additional information regarding the Management Services Agreement.

(c) Represents stock-based compensation expense comprised of $2.7 million non-cash expense and $4.6 million in a non-recurring cash bonus paid on vested awards in the fourth quarter of 2013.

Results of Discontinued Operations

We have closed or sold certain facilities that qualify for reporting as discontinued operations. The operating results of discontinued operations were as follows:

	YEAR-ENDED DECEMBER 31,		
	2013	2012	2011
Net operating revenues	$ 4.1	$ 16.6	$ 24.4
Costs and expenses	(5.4)	(17.9)	(26.6)
(Loss) gain on sale of investments or closures	(2.5)	(1.8)	1.6
(Loss) income from discontinued operations	(3.8)	(3.1)	(0.6)
Income tax (expense) benefit	(3.6)	1.0	(2.4)
Net loss from discontinued operations	$(7.4)	$ (2.1)	$ (3.0)

Both the decline in net operating revenues and the decline in costs and expenses in each period were due to the timing of the sale or closure of the facilities identified as discontinued operations. Tax expense for each year is attributable to the amortization and write-offs of tax goodwill. Thus, to the extent the sale or closure of a facility triggers a write-off of goodwill, tax expense is impacted accordingly. Given that the number of facilities sold or closed varies from year to year, tax expense will vary based on the number of discontinued facilities, and the amount of tax goodwill associated with those facilities. The net loss from our discontinued operations is included in the line item *Loss from discontinued operations, net of income tax expense* in our consolidated financial statements.

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Liquidity and Capital Resources

Our primary cash requirements are paying our operating expenses, servicing our existing debt, capital expenditures on our existing properties, financing acquisitions of ASCs and surgical hospitals (including as both consolidated and nonconsolidated affiliates), the purchase of equity interests in nonconsolidated affiliates and distributions to noncontrolling interests. These continuing liquidity requirements have been and will continue to be significant, primarily due to financing costs relating to our indebtedness. The following chart shows the cash flows provided by or used in operating, investing and financing activities of continuing and discontinued operations (in the aggregate) for the years-ended December 31, 2013, 2012 and 2011:

	YEAR-ENDED DECEMBER 31,		
	2013	2012	2011
Net cash provided by operating activities	$ 165.6	$ 171.2	$ 162.2
Net cash used in investing activities	(76.8)	(21.8)	(157.9)
Net cash (used in) provided by financing activities	(121.7)	(102.1)	33.3
(Decrease) increase in cash and cash equivalents	$ (32.9)	$ 47.3	$ 37.7

Cash Flows Provided by Operating Activities

Cash flows provided by operating activities is primarily derived from net income before deducting non-cash charges for depreciation and amortization.

	YEAR-ENDED DECEMBER 31,		
	2013	2012	2011
Net Income	$ 52.7	$ 72.3	$ 83.5
Depreciation and amortization	42.9	41.6	40.4
Distributions from nonconsolidated affiliates	50.5	38.7	27.1
Equity in income of nonconsolidated affiliates	(23.4)	(16.8)	(22.2)
Provision for doubtful accounts	15.0	13.2	14.6
Loss on de-designation and change in fair value of swap	8.3	—	—
Loss on extinguishment of debt	10.3	—	—
Payment of deferred interest	(14.8)	—	—
Debt call premium paid	(5.0)	—	—
Other operating cash flows, net	29.1	22.2	18.8
Net cash provided by operating activities	$165.6	$171.2	$162.2

During the year-ended December 31, 2013, we generated $165.6 million of cash flows provided by operating activities, as compared to $171.2 million during the year-ended December 31, 2012. Cash flows from operating activities decreased $5.6 million, or 3.3%, from the prior period, primarily due to the payment of $14.8 million of interest that had been deferred as a payment-in-kind for the Senior PIK-election Notes (as defined herein), as discussed in the "Debt" section below, and a debt call premium of $5.0 million, partially offset by an increase in distributions from nonconsolidated affiliates of $11.8 million.

During the year-ended December 31, 2012, we generated $171.2 million of cash flows provided by operating activities, as compared to $162.2 million during the year-ended December 31, 2011. Cash flows provided by operating activities increased $9.0 million, or 5.5%, from the prior period, primarily due to an $11.6 million increase in distributions from nonconsolidated affiliates, partially offset by a $5.8 million decrease in net income, excluding equity in income of nonconsolidated affiliates.

Cash Flows Used in Investing Activities

During the year-ended December 31, 2013, our net cash used in investing activities was $76.8 million, consisting primarily of $54.5 million for business acquisitions, net of cash acquired, $36.8 million of capital expenditures and $2.9 million of net settlements on interest rate swaps, partially offset by $5.9 million of proceeds from the disposal of assets, $4.6 million of proceeds from the sale of equity interests of nonconsolidated affiliates, $2.6 million of return of capital related to equity method investments and $2.1 million of proceeds from the sale of equity interests of consolidated affiliates in deconsolidation transactions.

During the year-ended December 31, 2012, our net cash used in investing activities was $21.8 million, consisting primarily of $28.4 million used in capital expenditures, $6.1 million used in net settlements on interest rate swaps and $14.5 million used in purchases of equity interests in nonconsolidated affiliates, partially offset by $4.3 million of proceeds received from the sale of equity interests of consolidated affiliates in deconsolidation transactions, $10.2 million of proceeds from the sale of businesses and $15.0 million of proceeds from the sale of equity interests of nonconsolidated affiliates.

During the year-ended December 31, 2011, our net cash used in investing activities was $157.9 million, consisting primarily of $131.4 million used for business acquisitions and purchase of equity interests in nonconsolidated affiliates, including $123.1 million used in the acquisition of 49% of the membership interests of IUH Surgery, $8.5 million used in net settlements on interest rate swaps and $32.9 million used in capital expenditures, partially offset by $9.0 million from the net change in restricted cash, $3.2 million in proceeds from the sale of equity interests of consolidated affiliates in deconsolidation transactions and $2.9 million in proceeds from the disposal of assets.

Cash Flows Used in Financing Activities

Net cash used in financing activities for the year-ended December 31, 2013 was $121.7 million, consisting primarily of $527.6 million for principal payments on long-term debt, $103.0 million of distributions to noncontrolling interests, which primarily related to existing facilities, $74.9 million of distributions to unit holders, and $5.7 million of payments of debt acquisition costs, partially offset by $417.7 million long-term debt borrowings and $171.9 million in proceeds from our initial public offering.

Net cash used in financing activities for the year-ended December 31, 2012 was $102.1 million, consisting primarily of $94.2 million in distributions to noncontrolling interests of consolidated affiliates, $8.9 million of repayments of long-term debt and $6.2 million of principal payments under capital lease obligations, partially offset by $7.6 million of proceeds from the sale of equity interests of consolidated affiliates.

Net cash provided by financing activities for the year-ended December 31, 2011 was $33.3 million, driven primarily by the funding of a $100.7 million senior secured incremental term loan facility, as well as $25.2 million of member equity contributions and $15.2 million of proceeds from the sale of equity interests of consolidated affiliates, partially offset by $84.7 million of distributions to noncontrolling interests, $6.4 million of repayments of long-term debt, $4.7 million of principal payments under capital lease obligations, $6.3 million of decreases in checks issued in excess of bank balance and $6.2 million of repurchases of equity interests of consolidated affiliates.

Cash and cash equivalents were $85.8 million at December 31, 2013 as compared to $118.7 million at December 31, 2012. Cash and cash equivalents consist of cash on hand, demand deposits with financial institutions, reduced by the amount of outstanding checks and drafts where the right of offset exists for such bank accounts, and short-term, highly liquid investments. We consider all highly liquid investments with original maturities of 90 days or less, such as certificates of deposit, money market funds and commercial paper, to be cash equivalents. Our overall working capital position at December 31, 2013 was $37.3 million, as compared to $92.3 million at December 31, 2012, a decrease of $55.0 million, or 59.6%. This decrease is primarily driven by a decrease in cash due to the net cash flows from investing and financing activities referenced above and an increase in amounts payable to nonconsolidated affiliates.

Based on our current level of operations, we believe cash flow from operations and available cash, together with available borrowings under our Class B Revolving Credit Facility, will be adequate to meet our short-term (12 months or less) liquidity needs.

Debt

Our primary sources of funding have been the issuance of debt and cash flows from operations. In the future, our primary sources of liquidity are expected to be cash flows from operations and additional funds available under the Class B Revolving Credit Facility.

The Credit Facility

Our senior secured credit facilities consist of a $132.3 million Class B Revolving Credit Facility, which will mature on June 30, 2016 (the "Class B Revolving Credit Facility"); a $214.4 million Class B Term Loan, which will mature on December 30, 2017 (the "Class B Term Loan"); and a $388.1 million Class C Term Loan, which will mature on June 30, 2018 (the "Class C Term Loan" and, together with the Class B Revolving Credit Facility and the Class B Term Loan, the "Senior Secured Credit Facilities").

We used the proceeds from our Class C Term Loan to repay in full our $118.7 million Class A Term Loan and $98.3 million Class A incremental Term Loan and to redeem our $164.8 million of Senior PIK-election Notes. On June 29, 2013, our $21.5 million Class A Revolving Credit Facility was terminated after we decided not to renew the revolving credit facility because we believe we have sufficient available borrowing capacity for our operations under our Class B Revolving Credit Facility.

The table below indicates the current maturity date for each of our credit facilities.

Facility	Maturity Date
Class B Revolving Credit Facility	June 30, 2016
Class B Term Loan	December 30, 2017
Class C Term Loan	June 30, 2018

As further shown in the table above, we believe that we do not currently face a substantial refinancing risk. However, upon the occurrence of certain events, such as a change of control or a violation of certain covenants in our Senior Secured Credit Facilities, we could be required to repay or refinance our indebtedness. See "Risk Factors — Risks Related to Our Business — We have a substantial amount of indebtedness, which may adversely affect our available cash flow and our ability to operate our business, remain in compliance with debt covenants and make payments on our indebtedness."

As of December 31, 2013, we had no outstanding balance under the Class B Revolving Credit Facility. At December 31, 2013, we had approximately $1.7 million in letters of credit outstanding under this facility. Utilization of the Class B Revolving Credit Facility is subject to compliance with a total leverage ratio test. No utilization of the Class B Revolving Credit Facility may be outstanding (other than issuances of up to an aggregate of $5.0 million of letters of credit) at the end of any fiscal quarter in which the total leverage ratio, which is the ratio of consolidated total debt to consolidated EBITDA (each as defined in our credit agreement (the "Amended Credit Agreement")), as of the last day of such fiscal quarter, is greater than the specified ratio level.

Borrowings under each portion of the Senior Secured Credit Facilities bear interest at a base rate or at LIBOR, as elected by us, plus an applicable margin. The base rate is determined by reference to the higher of (i) the prime rate of JPMorgan Chase Bank, N.A. and (ii) the federal funds effective rate plus 0.50% (the "base rate"). The LIBOR rate is determined by reference to the interest rate for dollar deposits in the London interbank market. The table below outlines the applicable margin for each credit facility.

	Applicable Margin (per annum)	
Facility	**Base Rate Borrowings**	**LIBOR Borrowings**
Class B Revolving Credit Facility	2.50%	3.50%
Class B Term Loan	3.00%	4.00%
Class C Term Loan	2.00% or 2.25% (with a base rate floor of 2.00%), depending upon the total leverage ratio	3.00% or 3.25% (with a LIBOR floor of 1.00%), depending upon the total leverage ratio

At December 31, 2013, the interest rate on the Class B Term Loan was 4.25%. At December 31, 2013, the interest rate on our Class C Term Loan was 4.25%. We must repay each of the Class B Term Loan and the Class C Term Loan in quarterly installments equal to 0.25% of the original principal amount of the respective loan. The remaining amount of each of the Class B Term Loan and the Class C Term Loan is due in full at maturity. We are also required to pay a commitment fee to the lenders under our Class B Revolving Credit Facility in respect of the unutilized commitments thereunder of either 0.375% or 0.50%, depending on the senior secured leverage ratio (as defined in the Amended Credit Agreement).

The Senior Secured Credit Facilities contain certain customary representations and warranties, affirmative covenants, events of default and various restrictive covenants, which are subject to certain significant exceptions. As of December 31, 2013, we believe we and SCA were in compliance with these covenants.

Senior Subordinated Notes

On June 29, 2007, SCA and Surgical Holdings, Inc. (the "Co-Issuer") issued $150.00 million in aggregate principal amount of 10% senior subordinated notes due July 15, 2017 (the "Senior Subordinated Notes"). On December 4, 2013, SCA and the Co-Issuer redeemed the Senior Subordinated Notes at a premium of 3.333%. The satisfaction, discharge and redemption of the Senior Subordinated Notes was funded with proceeds from our initial public offering. In conjunction with the redemption, we recognized a loss on extinguishment of $6.5 million.

Senior PIK-election Notes

On June 29, 2007, SCA and the Co-Issuer issued $150.0 million in aggregate principal amount of 8.875% / 9.625% Senior PIK-election Notes due July 15, 2015 (the "Senior PIK-election Notes"). On June 14, 2013, SCA and the Co-Issuer issued a notice of redemption for all of the outstanding Senior PIK-election Notes (which totaled $164.8 million as of June 14, 2013) and deposited sufficient funds with the trustee for the Senior PIK-election Notes to satisfy and discharge all of our and the Co-Issuer's obligations with respect to the Senior PIK-election Notes and the related indenture. The Senior PIK-election Notes were redeemed in full on July 15, 2013. This satisfaction, discharge and redemption of the Senior PIK-election Notes was funded with borrowings from the Class C Term Loan. In conjunction with the redemption, we recognized a loss on extinguishment of $3.8 million.

Contractual Obligations

The table below sets forth our future maturities of debt, interest on debt, capitalized lease obligations, operating lease obligations and other contractual obligations as of December 31, 2013:

	Total	Payments due by period Less than 1 year	1-3 years	3-5 years	More than 5 years
			(in millions)		
Debt obligations [1]	$646.5	$15.7	$ 27.3	$593.9	$ 9.6
Interest on debt obligations [2]	118.0	28.1	54.5	34.7	0.7
Capitalized lease obligations [3]	31.1	8.5	10.3	4.8	7.5
Operating lease obligations [4]	103.1	24.3	35.4	17.8	25.6
Other contractual obligations [5]	5.5	2.9	2.2	0.4	—
Total	$904.2	$79.5	$129.7	$651.6	$43.4

(1) As of December 31, 2013 and for purposes of this table, our indebtedness included (i) $214.4 million of Class B Term Loans, (ii) $388.1 million of Class C Term Loans, (iii) $132.3 million of Class B Revolving Credit Facility capacity and (iv) $44.0 million of notes payable to banks and others.

(2) Represents (i) interest expense on the debt obligations based on an assumed interest rate of the current 3-month LIBOR rate as of December 31, 2013 plus 175 basis points with respect to the Class B Term Loan and Class B Revolving Credit Facility, an interest rate of 3.25% with a LIBOR floor of 1.00%, (ii) quarterly commitment fees on unused borrowing capacity under the Class B Revolving Credit Facility and (iii) various fixed and variable rates on notes payable to banks and others.

(3) Capitalized lease obligations include real estate, medical equipment, computer equipment and other equipment utilized in operations (interest and principal).

(4) Operating lease obligations include land, buildings and equipment.

(5) Other contractual obligations are attributable to maintenance and service contracts.

Because their future cash outflows are uncertain, the following liabilities are excluded from the table above: deferred income taxes, professional liability reserves, workers' compensation reserves, redeemable noncontrolling interests and our estimated liability for unsettled litigation. Deferred rent is also excluded from the table above.

Repurchases of Equity from Physician Partners

We are obligated under the agreements governing certain of our partnerships and LLCs to repurchase all of the physicians' ownership interests upon the occurrence of certain regulatory events, including if it becomes illegal for physicians to own an interest in one of our facilities, refer patients to one of our facilities or receive cash distributions from a facility. The purchase price that we would be required to pay for these ownership interests is typically based on either a multiple of the applicable facility's EBITDA (Earnings Before Interest, Taxes, Depreciation and Amortization), or the fair market value of the ownership interests as determined by a third-party appraisal. In the event we are required to purchase all of the physicians' ownership interests in all of our facilities, our existing capital resources would not be sufficient for us to meet this obligation. See "Risk Factors — Risks Related to Healthcare Regulation — If laws or regulations governing physician ownership of our facilities change, we may be obligated to purchase some or all of the ownership interests of our physician partners or renegotiate some of our partnership and operating agreements with our physician partners and management agreements with our surgical facilities."

Capital Expenditures

Currently, we project our capital expenditures for fiscal year 2014 to be approximately $48 million, which we expect to finance primarily through internally generated funds and bank or manufacturer financing. Capital

expenditures totaled $36.8 million and $28.4 million for the years-ended December 31, 2013 and 2012. The capital expenditures made during 2013 consisted primarily of fixture improvements made at our leased facilities and our purchase of medical and other equipment. These capital expenditures were financed primarily through internally generated funds and bank or manufacturer financing. We believe that our capital expenditure program is adequate to improve and equip our existing facilities.

Capital Leases

We engage in a significant number of leasing transactions, including real estate, medical equipment, computer equipment and other equipment utilized in operations. Certain leases that meet the lease capitalization criteria in accordance with authoritative guidance for leases have been recorded as an asset and liability at the net present value of the minimum lease payments at the inception of the lease. Interest rates used in computing the net present value of the lease payments generally range from 2.3% to 12.2% based on our incremental borrowing rate at the inception of the lease.

Inflation

For the past three years, inflation has not significantly affected our operating results or the geographic areas in which we operate.

Off-Balance Sheet Transactions

As a result of our strategy of partnering with physicians and health systems, we do not own controlling interests in many of our facilities. At December 31, 2013, we accounted for 60 of our 177 facilities under the equity method. Similar to our consolidated facilities, our nonconsolidated facilities have debts, including capitalized lease obligations, that are generally non-recourse to us. With respect to our equity method facilities, these debts are not included in our consolidated financial statements. At December 31, 2013, the total debt on the balance sheets of our nonconsolidated affiliates was approximately $40.9 million. Our average percentage of ownership of these nonconsolidated affiliates, weighted based on the particular affiliate's amount of debt and our ownership of such affiliate, was approximately 22% at December 31, 2013. We or one of our wholly owned subsidiaries collectively guaranteed $2.5 million of the $40.9 million in total debt of our nonconsolidated affiliates as of December 31, 2013. Our guarantees related to operating leases of nonconsolidated affiliates were $4.0 million at December 31, 2013.

As described above, our nonconsolidated affiliates are structured as LPs, general partnerships, LLPs, or LLCs. None of these affiliates provide financing, liquidity, or market or credit risk support for us. They also do not engage in hedging or research and development services with us. Moreover, we do not believe that they expose us to any of their liabilities that are not otherwise reflected in our consolidated financial statements and related disclosures. Except as noted above with respect to guarantees, we are not obligated to fund losses or otherwise provide additional funding to these affiliates other than as we determine to be economically required in order to successfully implement our development plans.

Critical Accounting Policies

General

Our discussion and analysis of our financial condition, results of operations and liquidity and capital resources are based on our consolidated financial statements, which have been prepared in accordance with GAAP. The preparation of consolidated financial statements under GAAP requires our management to make certain estimates and assumptions that impact the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities as of the date of the consolidated financial statements. These estimates and assumptions also impact the reported amount of net earnings during any period. Estimates are based on information available as of the date financial statements are prepared. Accordingly, actual results could differ

from those estimates. Critical accounting policies and estimates are defined as those that are both most important to the portrayal of our financial condition and operating results and that require management's most subjective judgments. Our critical accounting policies and estimates include our policies and estimates regarding consolidation, variable interest entities, revenue recognition, accounts receivable, noncontrolling interests in consolidated affiliates, equity-based compensation, valuation of our common stock, income taxes, goodwill and impairment of long-lived assets and other intangible assets.

Principles of Consolidation

Our consolidated financial statements include the accounts of us, our subsidiaries and VIEs for which we are the primary beneficiary. All significant intercompany transactions and accounts have been eliminated.

We evaluate partially owned subsidiaries and joint ventures held in partnership form using authoritative guidance, which includes a framework for evaluating whether a general partner(s) or managing member(s) controls an affiliate and therefore should consolidate it. The framework includes the presumption that general partner or managing member control would be overcome only when the limited partners or members have certain rights. Such rights include the right to dissolve or liquidate the LP, LLP or LLC or otherwise remove the general partner or managing member "without cause," or the right to effectively participate in significant decisions made in the ordinary course of business of the LP, LLP or LLC. To the extent that any noncontrolling investor has rights that inhibit our ability to control the affiliate, including substantive veto rights, we do not consolidate the affiliate.

We use the equity method to account for our investments in affiliates with respect to which we do not have control rights but have the ability to exercise significant influence over operating and financial policies. Assets, liabilities, revenues and expenses are reported in the respective detailed line items on the consolidated financial statements for our consolidated affiliates. For our equity method affiliates, assets and liabilities are reported on a net basis in the line item *Investment in and advances to nonconsolidated affiliates* on the consolidated balance sheets, and revenues and expenses are reported on a net basis in the line item *Equity in net income of nonconsolidated affiliates* on the consolidated statements of operations.

Variable Interest Entities

Under Accounting Standards Codification Section 810, Consolidations, we include the assets, liabilities and activities of a VIE in our financial statements if we are the primary beneficiary of such VIE and the entity has one or more of the following characteristics: (a) the total equity investment at risk is not sufficient to permit the entity to finance its activities without additional subordinated financial support, (b) as a group the holders of the equity investment at risk lack (i) the ability to make decisions about an entity's activities through voting or similar rights, (ii) the obligation to absorb the expected losses of the entity or (iii) the right to receive the expected residual returns of the entity, or (c) the equity investors have voting rights that are not proportional to their economic interests and substantially all of the entity's activities either involve, or are conducted on behalf of, an investor that has disproportionately few voting rights. The primary beneficiary of a VIE is generally the entity that will receive a majority of the VIE's expected losses or receive a majority of a VIE's expected residual returns and has the power to direct the activities that most significantly impact the VIE's economic performance.

Determining the primary beneficiary of a VIE requires substantial judgment, including determining what activities most significantly impact the economic performance of the VIE and which entity or entities have control over those activities.

Revenue Recognition

Our revenues consist primarily of net patient revenues that are recorded based upon established billing rates less allowances for contractual adjustments. Revenues are recorded during the period the services are provided,

based upon the estimated amounts due from patients and third-party payors, including federal and state payors (primarily the Medicare and Medicaid programs), commercial health insurance companies, workers' compensation programs and employers. These estimates are complex and require significant judgement. Estimates of contractual allowances under third-party payor arrangements are based upon the payment terms specified in the related contractual agreements and payment history. Third-party payor contractual payment terms are generally based upon predetermined rates per procedure or discounted fee-for-service rates.

During the year-ended December 31, 2013, approximately 60% of our net patient revenues related to patients with commercial insurance coverage. Healthcare service providers are under increasing pressure to accept reduced reimbursement for services on these contracts. Continued reductions could have a material adverse impact on our financial position, results of operations and cash flows.

During the year-ended December 31, 2013, approximately 23% of our net patient revenues related to patients participating in the Medicare and Medicaid programs. Laws and regulations governing the Medicare and Medicaid programs are complex, subject to interpretation and are routinely modified for provider reimbursement. We are unable to predict if or when we may be subject to a suspension of payments by the Medicare and/or Medicaid programs, the possible length of the suspension period or the potential cash flow impact of a payment suspension. Any such suspension would adversely impact our financial position, results of operations and cash flows.

During the year-ended December 31, 2013, uninsured or self-pay revenues accounted for less than 6% of our net patient revenues.

Our facilities primarily perform surgery that is scheduled in advance by physicians who have already seen the patient. We verify benefits, obtain insurance authorization, calculate patient financial responsibility and notify the patient of their responsibility, usually prior to surgery.

Accounts Receivable

We report accounts receivable at estimated net realizable amounts from services rendered from federal and state payors (primarily the Medicare and Medicaid programs), commercial health insurance companies, workers' compensation programs, employers and patients. Our accounts receivable are geographically dispersed, but a significant portion of our accounts receivable are concentrated by type of payor.

Accounts receivable from government payors are significant to our operations, comprising 18% of net patient service accounts receivable at December 31, 2013. We do not believe there are significant credit risks associated with these government payors.

Accounts receivable related to workers' compensation are significant to our operations, comprising 14% of net patient service accounts receivable at December 31, 2013. We do not believe there are significant credit risks associated with workers' compensation payors and related receivables.

Accounts receivable from commercial health insurance payors were 63% of our net patient service accounts receivable at December 31, 2013. Because the category of commercial health insurance payors is composed of numerous individual payors which are geographically dispersed, our management does not believe there are any significant concentrations of revenues from any individual payor that would subject us to significant credit risks in the collection of our accounts receivable.

We perform an analysis of our historical cash collection patterns and consider the impact of any known material events in determining the allowance for doubtful accounts. In performing our analysis, we consider the impact of any adverse changes in general economic conditions, business office operations, payor mix or trends in federal or state governmental healthcare coverage. Due to the complexity of insurance reimbursements and

inherent limitations of insurance verification procedures, we expect we will continue to have write-offs of bad debt and provision for doubtful accounts. In 2013 our *"Provision for doubtful accounts"* was approximately 2% of net operating revenue. We reserve for doubtful accounts based principally upon the payor class and age of the receivable. We also write off accounts on an individual basis based on that information. We believe our policy allows us to accurately estimate our *"Provision for doubtful accounts."*

Noncontrolling Interest in Consolidated Affiliates

Our consolidated financial statements include all assets, liabilities, revenues and expenses of less-than-100%-owned affiliates that we control. Accordingly, we have recorded a noncontrolling interest in the earnings and equity of such affiliates. We record adjustments to noncontrolling interest for the allocable portion of income or loss to which the noncontrolling interest holders are entitled based upon the portion of the subsidiaries they own. Distributions to holders of noncontrolling interests reduce the respective noncontrolling interest holders' balance.

Equity-Based Compensation

We have one active equity-based compensation plan, the 2013 Omnibus Long-Term Incentive Plan, and two legacy equity-based compensation plans, the Management Equity Incentive Plan and the Directors and Consultants Equity Incentive Plan, under which we are no longer issuing new awards (together, the "Plans"). The Plans provide or have provided for the granting of options to purchase our stock as well as RSUs to key teammates, directors, service providers, consultants and affiliates.

Under the Plans, our key teammates, directors, service providers, consultants and affiliates are provided with what we believe to be appropriate incentives to encourage them to continue employment with us or providing service to us or any of our affiliates and to improve our growth and profitability.

Option awards are generally granted with an exercise price equal to at least the fair market value of the underlying share at the date of grant. Vesting in the option awards varies based upon time, attainment of certain performance conditions, or upon the occurrence of a Liquidity Event (as defined in the applicable Plan) in which the TPG Funds and/or any of its affiliates achieves a minimum cash return on its original investment. All existing RSU awards vest over time.

Income Taxes

We provide for income taxes using the asset and liability method. This approach recognizes the amount of federal, state and local taxes payable or refundable for the current year, as well as deferred tax assets and liabilities for the future tax consequence of events recognized in the consolidated financial statements and income tax returns. Deferred income tax assets and liabilities are adjusted to recognize the effects of changes in tax laws or enacted tax rates.

A valuation allowance is required when it is more-likely-than-not that some portion of the deferred tax assets will not be realized. Realization is dependent on generating sufficient future taxable income.

We file a consolidated federal income tax return. State income tax returns are filed on a separate, combined or consolidated basis in accordance with relevant state laws and regulations. LPs, LLPs, LLCs and other pass-through entities that we consolidate or account for using the equity method of accounting file separate federal and state income tax returns. We include the allocable portion of each pass-through entity's income or loss in our federal income tax return. We allocate the remaining income or loss of each pass-through entity to the other partners or members who are responsible for their portion of the taxes.

Goodwill

We test goodwill for impairment using a fair value approach at least annually, absent some triggering event that would require an interim impairment assessment. Absent any impairment indicators, we perform our goodwill impairment testing as of October 1st of each year.

We recognize an impairment charge for any amount by which the carrying amount of goodwill exceeds its implied fair value. We present a goodwill impairment charge as a separate line item within income from continuing operations in the consolidated statements of operations, unless the goodwill impairment is associated with a discontinued operation. In that case, we include the goodwill impairment charge, on a net-of-tax basis, within the results of discontinued operations.

When we dispose of a facility, the relative fair value of goodwill is allocated to the gain or loss on disposition.

The results of the first step of the annual impairment test performed as of October 1, 2013 indicated that the fair values of all operating segments substantially exceeded their carrying values.

Impairment of Long-Lived Assets and Other Intangible Assets

We assess the recoverability of long-lived assets (excluding goodwill) and identifiable acquired intangible assets with definite useful lives whenever events or changes in circumstances indicate we may not be able to recover the asset's carrying amount. We measure the recoverability of assets to be held and used by a comparison of the carrying amount of the asset to the expected net future cash flows to be generated by that asset, or, for identifiable intangibles with definite useful lives, by determining whether the amortization of the intangible asset balance over its remaining life can be recovered through undiscounted future cash flows. The amount of impairment of identifiable intangible assets with definite useful lives, if any, to be recognized is measured based on projected discounted future cash flows. We measure the amount of impairment of other long-lived assets (excluding goodwill) as the amount by which the carrying value of the asset exceeds the fair market value of the asset, which is generally determined based on projected discounted future cash flows or appraised values. We present an impairment charge as a separate line item within income from continuing operations in our consolidated statements of operations, unless the impairment is associated with a discontinued operation. In that case, we include the impairment charge, on a net-of-tax basis, within the results of discontinued operations. We classify long-lived assets to be disposed of other than by sale as held and used until they are disposed. We report long-lived assets to be disposed of by sale as held for sale and recognize those assets in the balance sheet at the lower of carrying amount or fair value less cost to sell, and cease depreciation.

Recent Revisions to Authoritative Accounting Guidance

Reclassification of Other Comprehensive Income

In February 2013, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2013-02, "*Comprehensive Income (Topic 220): Reporting of Amounts Reclassified Out of Accumulated Other Comprehensive Income.*" This update requires companies to include reclassification adjustments for items that are reclassified from other comprehensive income to net income in a single note or on the face of the financial statements. The amendment was effective for annual and interim reporting periods beginning after December 15, 2012. The adoption of this standard did not have a material impact on our consolidated financial statements.

We do not believe any other recently issued, but not yet effective, revisions to authoritative guidance will have a material effect on our consolidated financial position, results of operations or cash flows.

JOBS Act

The JOBS Act permits an "emerging growth company" such as us to take advantage of an extended transition period to comply with new or revised accounting standards applicable to public companies. However, we are choosing to "opt out" of this provision and, as a result, we will comply with new or revised accounting standards on the relevant dates on which adoption of such standards is required for non-emerging growth companies. Section 107 of the JOBS Act provides that our decision to opt out of the extended transition period for complying with new or revised accounting standards is irrevocable.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Our principal market risk is our exposure to variable interest rates. As of December 31, 2013, we had $645.7 million of indebtedness (excluding capital leases), of which $635.1 million is at variable interest rates and $10.6 million is at fixed interest rates. In seeking to reduce the risks and costs associated with such activities, we manage exposure to changes in interest rates primarily through the use of derivatives. We neither use financial instruments for trading or other speculative purposes, nor use leveraged financial instruments.

At December 31, 2013, we held interest rate swaps hedging interest rate risk on $240.0 million of our variable rate debt through three forward starting interest rate swaps with an aggregate notional amount of $240.0 million, which we entered into during 2011. These forward starting interest rate swaps, which are swaps that are entered into at a specified trade date but do not begin until a future start date, extend the interest rate swaps that we terminated in 2012 and on September 30, 2013. These swaps are "receive floating/pay fixed" instruments, meaning we receive floating rate payments, which fluctuate based upon LIBOR, from the counterparty and provide payments to the counterparty at a fixed rate, the result of which is to convert the interest rate of a portion of our floating rate debt into fixed rate debt in order to limit the variability of interest-related payments caused by changes in LIBOR. Forward starting interest rate swaps with an aggregate notional amount of $100.0 million were effective on September 30, 2012 and the remaining forward starting interest rate swap with a notional amount of $140.0 million was effective on September 30, 2013. A forward interest rate starting swap with a notional amount of $50.0 million will terminate on September 30, 2014. The remaining aggregate notional amount of $190.0 million in forward starting interest rate swaps will terminate on September 30, 2016. Assuming a 100 basis point increase in LIBOR on our un-hedged debt at December 31, 2013, our annual interest expense would increase by approximately $3.6 million.

Counterparties to the interest rate swaps discussed above expose us to credit risks to the extent of their potential non-performance. The credit ratings of the counterparties, which consist of investment banks, are monitored at least quarterly. We have completed a review of the financial strength of the counterparties using publicly available information, as well as qualitative inputs, as of December 31, 2013. Based on this review, we do not believe there is a significant counterparty credit risk associated with these interest rate swaps. However, we cannot assure you that these actions will protect us against or limit our exposure to all counterparty or market risks.

Item 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Report of Independent Auditors

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Surgical Care Affiliates, Inc.:

In our opinion, the accompanying consolidated balance sheets and the related consolidated statements of operations, comprehensive income (loss), changes in equity and cash flows present fairly, in all material respects, the financial position of Surgical Care Affiliates, Inc. and its subsidiaries at December 31, 2013 and 2012, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2013 in conformity with accounting principles generally accepted in the United States of America. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

/s/ PricewaterhouseCoopers LLP

Birmingham, Alabama

March 24, 2014

SURGICAL CARE AFFILIATES, INC.
CONSOLIDATED BALANCE SHEETS
(In thousands)

	DECEMBER 31, 2013	DECEMBER 31, 2012
Assets		
Current assets		
Cash and cash equivalents	$ 85,816	$ 118,725
Restricted cash	25,031	27,630
Accounts receivable, net of allowance for doubtful accounts (2013 — $11,918; 2012 — $5,928)	91,783	82,192
Receivable from nonconsolidated affiliates	12,331	22,883
Prepaids and other current assets	19,609	14,402
Current assets related to discontinued operations	297	1,578
Total current assets	234,867	267,410
Property and equipment, net of accumulated depreciation (2013 — $84,768; 2012 — $77,316)	199,872	179,863
Goodwill	744,096	706,495
Intangible assets, net of accumulated amortization (2013 — $26,124; 2012 — $20,963)	61,936	48,091
Deferred debt issue costs	8,321	11,131
Investment in and advances to nonconsolidated affiliates	168,824	194,299
Other long-term assets	2,140	2,268
Assets related to discontinued operations	2,361	2,556
Total assets[a]	$1,422,417	$1,412,113
Liabilities and Equity		
Current liabilities		
Current portion of long-term debt	$ 23,166	$ 15,220
Accounts payable	27,915	23,374
Accrued payroll	26,322	18,972
Accrued interest	446	13,709
Accrued distributions	27,601	24,805
Payable to nonconsolidated affiliates	68,455	58,926
Deferred income tax liability	477	580
Other current liabilities	23,021	18,972
Current liabilities related to discontinued operations	167	596
Total current liabilities	197,570	175,154
Long-term debt, net of current portion	649,722	774,516
Deferred income tax liability	116,221	100,708
Other long-term liabilities	20,651	19,618
Liabilities related to discontinued operations	380	397
Total liabilities[a]	984,544	1,070,393
Commitments and contingent liabilities (Note 16)		
Noncontrolling interests — redeemable (Note 9)	21,902	21,709
Equity		
Surgical Care Affiliates' equity		
Common stock, $0.01 par value, 180,000 shares authorized, 38,166 shares outstanding at December 31, 2013	382	—
Additional paid in capital	413,419	—
Contributed capital	—	313,153
Accumulated other comprehensive loss	—	(8,327)
Accumulated deficit	(208,115)	(157,309)
Total Surgical Care Affiliates' equity	205,686	147,517
Noncontrolling interests — non-redeemable (Note 9)	210,285	172,494
Total equity	415,971	320,011
Total liabilities and equity	$1,422,417	$1,412,113

(a) Our consolidated assets as of December 31, 2013 and December 31, 2012 include total assets of a variable interest entity ("VIE") of $49.5 million and $28.2 million, respectively, which can only be used to settle the obligations of the VIE. Our consolidated total liabilities as of December 31, 2013 and December 31, 2012 include total liabilities of the VIE of $12.2 million and $1.4 million, respectively, for which the creditors of the VIE have no recourse to us, with the exception of $4.0 million of debt guaranteed by us at December 31, 2013. See further description in Note 3, *Summary of Significant Accounting Policies*.

See Notes to Consolidated Financial Statements.

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SURGICAL CARE AFFILIATES, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS
(In thousands of U. S. dollars)

	YEAR-ENDED DECEMBER 31, 2013	2012	2011
Net operating revenues:			
Net patient revenues	$ 746,625	$714,629	$692,908
Management fee revenues	40,469	17,804	11,291
Other revenues	14,941	12,427	10,010
Total net operating revenues	802,035	744,860	714,209
Equity in net income of nonconsolidated affiliates	23,364	16,767	22,236
Operating expenses:			
Salaries and benefits	277,695	241,814	221,799
Supplies	175,199	170,051	160,649
Other operating expenses	131,767	118,460	114,616
Depreciation and amortization	42,941	41,628	40,417
Occupancy costs	27,012	26,768	26,642
Provision for doubtful accounts	15,033	13,200	14,599
Impairment of intangible and long-lived assets	—	1,086	—
Loss (gain) on disposal of assets	121	(308)	(764)
Total operating expenses	669,768	612,699	577,958
Operating income	155,631	148,928	158,487
Interest expense	60,438	58,842	56,040
Loss from extinguishment of debt	10,333	—	—
Interest income	(215)	(315)	(432)
Loss (gain) on sale of investments	12,330	7,100	(3,878)
Income from continuing operations before income tax expense	72,745	83,301	106,757
Provision for income tax expense	12,645	8,864	20,269
Income from continuing operations	60,100	74,437	86,488
Loss from discontinued operations, net of income tax expense	(7,392)	(2,090)	(2,984)
Net income	52,708	72,347	83,504
Less: Net income attributable to noncontrolling interests	(104,052)	(92,357)	(93,181)
Net loss attributable to Surgical Care Affiliates	$ (51,344)	$ (20,010)	$ (9,677)
Basic and diluted net loss per share attributable to Surgical Care Affiliates:			
Continuing operations attributable to Surgical Care Affiliates	$ (1.39)	$ (0.59)	$ (0.23)
Discontinued operations attributable to Surgical Care Affiliates	$ (0.23)	$ (0.07)	$ (0.10)
Net loss per share attributable to Surgical Care Affiliates	$ (1.62)	$ (0.66)	$ (0.33)
Basic and diluted weighted average shares outstanding (in thousands)	31,688	30,340	29,347

See Notes to Consolidated Financial Statements.

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SURGICAL CARE AFFILIATES, INC.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)
(In thousands of U.S. dollars)

	YEAR-ENDED DECEMBER 31, 2013	2012	2011
Net income	$ 52,708	$ 72,347	$ 83,504
Other comprehensive (loss) income:			
Unrealized income (loss) on interest rate swap	847	(5,177)	(4,594)
Amounts reclassified from accumulated other comprehensive loss	7,480	6,163	8,591
Total other comprehensive income (loss)	8,327	986	3,997
Comprehensive income	61,035	73,333	87,501
Comprehensive income attributable to noncontrolling interests	(104,052)	(92,357)	(93,181)
Comprehensive loss attributable to Surgical Care Affiliates	$ (43,017)	$(19,024)	$ (5,680)

See Notes to Consolidated Financial Statements.

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SURGICAL CARE AFFILIATES, INC.
CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
(In thousands of U. S. dollars)

	Common Stock Shares	Common Stock Amount	Additional Paid in Capital	Contributed Capital	Accumulated Other Comprehensive Loss	Accumulated Deficit	Total Surgical Care Affiliates Equity	Noncontrolling Interests-Non-redeemable	Total Equity
Balance at December 31, 2010	—	$—	$ —	$ 285,387	$(13,310)	$(127,622)	$144,455	$127,211	$271,666
Member contributions	—	—	—	25,205	—	—	25,205	—	25,205
Net (loss) income	—	—	—	—	—	(9,677)	(9,677)	68,374	58,697
Other comprehensive income	—	—	—	—	3,997	—	3,997	—	3,997
Stock compensation	—	—	—	1,680	—	—	1,680	—	1,680
Net change in equity related to amendments in agreements with noncontrolling interests (Note 9)	—	—	—	—	—	—	—	491	491
Net change in equity related to purchase/(sale) of ownership interests	—	—	—	4,643	—	—	4,643	2,029	6,672
Contributions from noncontrolling interests	—	—	—	—	—	—	—	272	272
Change in distribution accrual	—	—	—	—	—	—	—	(1,633)	(1,633)
Distributions to noncontrolling interests	—	—	—	—	—	—	—	(61,327)	(61,327)
Balance at December 31, 2011	—	$—	$ —	$ 316,915	$ (9,313)	$(137,299)	$170,303	$135,417	$305,720
Net (loss) income	—	—	—	—	—	(20,010)	(20,010)	67,741	47,731
Other comprehensive income	—	—	—	—	986	—	986	—	986
Stock compensation	—	—	—	1,719	—	—	1,719	—	1,719
Net change in equity related to purchase of ownership interests	—	—	—	(5,481)	—	—	(5,481)	39,748	34,267
Contributions from noncontrolling interests	—	—	—	—	—	—	—	22	22
Change in distribution accrual	—	—	—	—	—	—	—	(504)	(504)
Distributions to noncontrolling interests	—	—	—	—	—	—	—	(69,930)	(69,930)
Balance at December 31, 2012	—	$—	$ —	$ 313,153	$ (8,327)	$(157,309)	$147,517	$172,494	$320,011
Member distributions	—	—	—	(74,900)	—	—	(74,900)	—	(74,900)
Net (loss) income	—	—	—	—	—	(51,344)	(51,344)	79,913	28,569
Other comprehensive income	—	—	—	—	8,327	—	8,327	—	8,327
Conversion from LLC to INC (Note 1)	30,286	303	240,447	(240,750)	—	—	—	—	—
Issuance of stock from the initial public offering, net of offering costs	7,857	79	171,798	—	—	—	171,877	—	171,877
Stock options exercised	23	—	285	—	—	—	285	—	285
Stock compensation	—	—	421	2,303	—	—	2,724	—	2,724
Net change in equity related to amendments in agreements with noncontrolling interests (Note 9)	—	—	—	—	—	—	—	1,050	1,050
Net change in equity related to purchase of ownership interests	—	—	468	194	—	538	1,200	34,364	35,564
Contributions from noncontrolling interests	—	—	—	—	—	—	—	3,137	3,137
Change in distribution accrual	—	—	—	—	—	—	—	(2,363)	(2,363)
Distributions to noncontrolling interests	—	—	—	—	—	—	—	(78,310)	(78,310)
Balance at December 31, 2013	38,166	$382	$413,419	$ —	$ —	$(208,115)	$205,686	$210,285	$415,971

See Notes to Consolidated Financial Statements.

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SURGICAL CARE AFFILIATES, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands of U. S. dollars)

	YEAR-ENDED DECEMBER 31, 2013	2012	2011
Cash flows from operating activities			
Net income	$ 52,708	$ 72,347	$ 83,504
Loss from discontinued operations	7,392	2,090	2,984
Adjustments to reconcile net income to net cash provided by operating activities			
Provision for doubtful accounts	15,033	13,200	14,599
Depreciation and amortization	42,941	41,628	40,417
Amortization of deferred issuance costs	3,891	2,980	2,762
Impairment of long-lived assets	—	1,086	—
Realized loss (gain) on sale of investments	12,330	7,100	(3,878)
Loss (gain) on disposal of assets	121	(308)	(764)
Equity in net income of nonconsolidated affiliates	(23,364)	(16,767)	(22,236)
Distributions from nonconsolidated affiliates	50,505	38,652	27,067
Deferred income tax	15,410	7,385	22,238
Stock compensation	2,724	1,719	1,680
Loss on de-designation and change in fair value of interest rate swap	8,314	—	—
Loss on extinguishment of debt	10,333	—	—
Payment of deferred interest	(14,785)	—	—
Debt call premium paid	(5,000)	—	—
(Increase) decrease in assets, net of business combinations			
Accounts receivable	(23,409)	(5,863)	(25,138)
Other assets	6,719	(24,654)	(660)
(Decrease) increase in liabilities, net of business combinations			
Accounts payable	2,986	(773)	(240)
Accrued payroll	6,107	(1,178)	264
Accrued interest	(13,263)	(560)	112
Other liabilities	12,808	32,418	21,352
Other, net	(251)	251	(1,751)
Net cash (used in) provided by operating activities of discontinued operations	(4,666)	439	(118)
Net cash provided by operating activities	165,584	171,192	162,194
Cash flows from investing activities			
Capital expenditures	(36,838)	(28,445)	(32,936)
Proceeds from sale of business	1,276	10,198	—
Proceeds from sale of investment	—	4,335	—
Proceeds from disposal of assets	5,883	474	2,908
Proceeds from sale of equity interests of nonconsolidated affiliates	4,587	14,980	—
Proceeds from sale of equity interests of consolidated affiliates in deconsolidation transactions	2,069	4,251	3,216
Decrease in cash related to conversion of consolidated affiliates to equity interests	(116)	(1,034)	(706)
Net change in restricted cash	1,886	(3,936)	9,063
Net settlements on interest rate swap	(2,921)	(6,081)	(8,533)
Business acquisitions, net of cash acquired $6,131	(54,499)	(2,796)	(873)
Purchase of equity interests in nonconsolidated affiliates	(766)	(14,521)	(130,506)
Purchase of equity interests in deconsolidation transaction	—	(1,576)	—
Return of equity method investments in nonconsolidated affiliates	2,592	—	—
Net cash provided by investing activities of discontinued operations	13	2,347	513
Net cash used in investing activities	$ (76,834)	$ (21,804)	$(157,854)

See Notes to Consolidated Financial Statements.

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SURGICAL CARE AFFILIATES, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)
(In thousands of U. S. dollars)

	YEAR-ENDED DECEMBER 31, 2013	2012	2011
Cash flows from financing activities			
Checks issued in excess of bank balance	$ —	$ —	$ (6,342)
Member contributions	—	—	25,205
Borrowings under line of credit arrangements and long-term debt, net of issuance costs	417,678	4,010	100,656
Payment of debt acquisition costs	(5,700)	—	—
Proceeds from issuance of shares pursuant to IPO, net of offering costs	171,877	—	—
Principal payments on line of credit arrangements and long-term debt	(527,634)	(8,865)	(6,354)
Principal payments under capital lease obligations	(7,552)	(6,189)	(4,672)
Distributions to noncontrolling interests of consolidated affiliates	(102,975)	(94,163)	(84,700)
Contributions from noncontrolling interests of consolidated affiliates	4,758	22	37
Proceeds from sale of equity interests of consolidated affiliates	7,864	7,596	15,197
Repurchase of equity interests of consolidated affiliates	(5,612)	(6,500)	(6,186)
Distributions to unit holders	(74,900)	—	—
Proceeds from issuance of common stock upon exercise of stock options	453	—	—
Net cash provided by financing activities of discontinued operations	—	2,004	485
Net cash (used in) provided by financing activities	(121,743)	(102,085)	33,326
Change in cash and cash equivalents	(32,993)	47,303	37,666
Cash and cash equivalents at beginning of period	118,725	71,268	33,596
Cash and cash equivalents of discontinued operations at beginning of period	70	113	119
Less: Cash and cash equivalents of discontinued operations at end of period	14	41	(113)
Cash and cash equivalents at end of period	$ 85,816	$ 118,725	$ 71,268
Supplemental cash flow information			
Cash paid during the year for interest	$ 62,167	$ 56,848	$ 53,521
Supplemental schedule of noncash investing and financing activities			
Property and equipment acquired through capital leases and installment purchases	21,329	7,714	10,046
Goodwill attributable to sale of surgery centers	10,062	9,066	—
Net investment in consolidated affiliates that became equity method facilities	5,356	712	10,337
Noncontrolling interest associated with conversion of consolidated affiliates to equity method affiliates	747	3,019	3,466
Contributions (non-cash) from noncontrolling interests of consolidated affiliates	—	—	272
Conversion of equity method affiliate to consolidated affiliate financed through the issuance of debt	—	7,221	—
Equity interest purchase in nonconsolidated affiliates via withheld distributions	—	10,462	—
Debt to equity conversion of nonconsolidated affiliate	—	5,027	—

See Notes to Consolidated Financial Statements.

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Unless the context otherwise indicates or requires, the terms "Surgical Care Affiliates," "we," "us," "our" and "Company" refer to Surgical Care Affiliates, Inc. and its subsidiaries.

NOTE 1 — DESCRIPTION OF BUSINESS

Nature of Operations and Ownership of the Company

Surgical Care Affiliates, Inc., a Delaware corporation, was converted from a Delaware limited liability company, previously named ASC Acquisition LLC, to a Delaware corporation on October 30, 2013. Pursuant to the conversion, every 10.25 outstanding membership units of ASC Acquisition LLC were converted into one share of common stock of Surgical Care Affiliates, and options to purchase membership units of ASC Acquisition LLC were converted into options to purchase shares of common stock of Surgical Care Affiliates at a ratio of 10.25 membership units of ASC Acquisition LLC underlying such options to each one share of common stock of Surgical Care Affiliates underlying such converted options. In connection with the conversion, the exercise prices of such converted options were adjusted accordingly. Upon conversion, all outstanding restricted stock units of ASC Acquisition LLC were converted into one restricted share of Surgical Care Affiliates. All share and per share amounts have been adjusted to reflect these conversion amounts throughout these financial statements.

We were formed primarily to own and operate a network of multi-specialty ambulatory surgery centers ("ASCs") and surgical hospitals in the United States of America. We do this through our direct operating subsidiary, Surgical Care Affiliates, LLC ("SCA"). For the majority of the periods covered by our financial statements, the Company was a Delaware limited liability company named ASC Acquisition LLC. As of December 31, 2013, the Company operated in 34 states and had an interest in and/or operated 171 ASCs, five surgical hospitals and one sleep center with 11 locations, with a concentration of facilities in California, Indiana and Texas. Our ASCs and surgical hospitals primarily provide the facilities, equipment and medical support staff necessary for physicians to perform non-emergency surgical and other procedures in various specialties, including orthopedics, ophthalmology, gastroenterology, pain management, otolaryngology (ear, nose and throat, or "ENT"), urology and gynecology, as well as other general surgery procedures. At our ASCs, physicians perform same-day surgical procedures. At our surgical hospitals, physicians perform a broader range of surgical procedures, and patients may stay in the hospital for several days.

Business Structure

We operate our facilities through strategic relationships with approximately 2,000 physician partners and often with healthcare systems that have strong local market positions that we also believe have strong reputations for clinical excellence. The facilities in which we hold an ownership interest are owned by general partnerships, limited partnerships ("LP"), limited liability partnerships ("LLP") or limited liability companies ("LLC") in which the Company serves as the general partner, limited partner, managing member or member. We account for our 177 facilities as follows:

	AS OF DECEMBER 31, 2013
Consolidated facilities	87
Equity method facilities	60
Managed-only facilities	30
Total facilities	177

Basis of Presentation

The Company maintains its books and records on the accrual basis of accounting, and the accompanying consolidated financial statements have been prepared in accordance with accounting principles generally

accepted in the United States of America ("U.S. GAAP"). Such financial statements include the assets, liabilities, revenues and expenses of all wholly owned subsidiaries and majority-owned subsidiaries over which we exercise control and, when applicable, entities in which we have a controlling financial interest.

NOTE 2 — TRANSACTIONS, DECONSOLIDATIONS AND CLOSURES

Acquisitions

In April 2013, we invested in an ASC in McKinney, Texas for total consideration of $4.0 million. This ASC is consolidated (as part of the future JV, as further described in Note 3) as a VIE in which we are the primary beneficiary. The amounts recognized as of the acquisition date for each major class of assets and liabilities assumed are as follows:

Assets	
Property and equipment	$2,971
Goodwill	679
Intangible assets	350
Total assets	$4,000
Liabilities	
Total liabilities	$ —

In June 2013, we acquired 100% of the interest in Health Inventures, LLC ("HI"), a surgical and physician services company, for total consideration of $20.4 million. $9.6 million of the consideration was paid to the sellers in cash, $8.9 million was placed into escrow as contingent consideration, and $1.9 million was payable to certain individuals. The amount payable as contingent consideration depends upon the successful continuation and/or renewal of certain management agreement contracts held by HI and, in the case of renewals, will be determined by comparing the contract revenue prior to renewal against the expected contract revenue after renewal. The undiscounted range of amounts that could be paid as contingent consideration is zero to $8.9 million. As of the acquisition date and December 31, 2013, approximately $8.6 million of contingent consideration was recognized. In the transaction, we acquired HI's ownership interests in four ASCs and one surgical hospital and management agreements with 19 affiliated facilities.

The HI amounts recognized as of the acquisition date for each major class of assets and liabilities assumed are as follows:

Assets	
Current assets	
Cash and cash equivalents	$ 1,179
Accounts receivable	2,130
Other current assets	400
Total current assets	3,709
Property and equipment	584
Goodwill	4,203
Intangible assets	7,605
Investment in and advances to nonconsolidated affiliates	4,360
Total assets	$20,461
Liabilities	
Current liabilities	
Accounts payable and other current liabilities	$ 1,742
Total current liabilities	1,742
Total liabilities	$ 1,742

The HI goodwill and intangible assets are expected to be fully deductible for tax purposes. The HI purchase price allocation is preliminary and subject to adjustment. $18.8 million of *Net operating revenues* related to HI were included in our 2013 consolidated statement of operations. HI contributed $1.5 million to our *Income from continuing operations before income taxes* in the year ended December 31, 2013.

In October 2013, we acquired a controlling interest consisting of approximately 58% of the equity in an ASC in Melbourne, Florida for total consideration of $1.2 million. This ASC is consolidated. The amounts recognized as of the acquisition date for each major class of assets and liabilities assumed are as follows:

Assets	
Current assets	
Cash and cash equivalents	$ 67
Accounts receivable	119
Other current assets	60
Total current assets	246
Property and equipment	2,029
Goodwill	1,374
Intangible assets	460
Total assets	$4,109
Liabilities	
Current liabilities	
Accounts payable and other current liabilities	$ 931
Total current liabilities	931
Other long term liabilities	390
Total liabilities	$1,321

In December 2013, we invested in an ASC in Cleburne, Texas for total consideration of $3.1 million. This ASC is consolidated (as part of the future JV, as further described in Note 3) as a VIE in which we are the primary beneficiary. The amounts recognized as of the acquisition date for each major class of assets and liabilities assumed are as follows:

Assets	
Current assets	
Cash and cash equivalents	$ 130
Accounts receivable	447
Other current assets	206
Total current assets	783
Property and equipment	1,988
Goodwill	4,218
Intangible assets	788
Total assets	$7,777
Liabilities	
Current liabilities	
Accounts payable and other current liabilities	$ 883
Total current liabilities	883
Other long term liabilities	286
Total liabilities	$1,169

In December 2013, we acquired a controlling interest consisting of approximately 51% of the equity in an ASC in East Brunswick, New Jersey for total consideration of $25.4 million. This ASC is consolidated. The amounts recognized as of the acquisition date for each major class of assets and liabilities assumed are as follows:

Assets	
Current assets	
Cash and cash equivalents	$ 195
Accounts receivable	2,369
Other current assets	23
Total current assets	2,587
Property and equipment	860
Goodwill	35,944
Intangible assets	10,500
Total assets	$49,891
Liabilities	
Current liabilities	
Accounts payable and other current liabilities	$ 185
Total current liabilities	185
Total liabilities	$ 185

In December 2013, we purchased all the outstanding equity of a formerly nonconsolidated ASC in Thousand Oaks, California for $2.3 million. As a result of the transaction, we recognized a loss on the previous equity method investment of $2.8 million. The amounts recognized as of the acquisition date for each major class of assets and liabilities assumed are as follows:

Assets	
Current assets	
Cash and cash equivalents	$ 4
Accounts receivable	297
Other current assets	27
Total current assets	328
Property and equipment	429
Goodwill	3,079
Intangible assets	630
Total assets	$4,466
Liabilities	
Current liabilities	
Accounts payable and other current liabilities	$ 172
Total current liabilities	172
Other long term liabilities	1
Total liabilities	$ 173

Also during the year-ended December 31, 2013, we acquired a noncontrolling interest in a surgery center in Newport Beach, California, a noncontrolling interest in a surgery center in Redding, California and a management agreement with a surgery center in Fountain Valley, California for an immaterial amount of consideration.

The purchase price allocations attributable to Melbourne, Florida; Cleburne, Texas; East Brunswick, New Jersey; and Thousand Oaks, California are preliminary. When all relevant information is obtained, resulting changes, if any, to our provisional purchase price allocation will be retrospectively adjusted to reflect new information about the facts and circumstances that existed as of the respective acquisition dates that, if known, would have affected the measurement of the amounts recognized as of those dates. Management notes that the preliminary prices of these purchase price allocations related primarily to working capital balances.

In November 2012, we purchased a controlling interest in a multi-specialty surgery center located in Southern California ("New ASC") for $6.0 million and entered into a management services agreement with New ASC. In connection with that transaction, an existing consolidated facility ("existing ASC") contributed substantially all assets and liabilities to New ASC and ceased operations. Because New ASC and existing ASC were both under our control at the date of the transaction, we did not recognize any gains or losses relating the cessation of operations of existing ASC.

In December 2012, we completed a transaction whereby we contributed our interest in two consolidated facilities ("SCA facilities") and $1.6 million to a newly formed entity that is jointly owned by us and a California health system (the "JV"). Concurrently, the California health system contributed its controlling interest in a facility ("Health System facility") to the JV. We also entered into management services agreements with the facilities contributed to the JV. As a result of the transaction, the operations of one of the contributed SCA facilities were merged with and into the Health System facility; the Health System facility was the surviving entity. Accordingly, two facilities remain as a result of the transaction. We have a noncontrolling interest in the surviving facilities, which are presented under the equity method of accounting. The net effect of these contributions resulted in the Company recording a loss of approximately $3.3 million, related to the conversion of the two SCA facilities into an equity method investment. The loss on this transaction is recorded in *"Loss (gain) on sale of investments"* in the accompanying consolidated statement of operations.

During the year-ended December 31, 2012, we acquired noncontrolling interests in seven ASCs for aggregate consideration of $24.7 million. Additionally, we acquired a noncontrolling interest in a de novo ASC for consideration of $0.8 million. Also during the year-ended December 31, 2012, we acquired a controlling interest in an ASC that was previously accounted for as an equity method investment. This acquisition was financed through the issuance of a $7.2 million note payable.

Deconsolidations

During the year-ended December 31, 2013, we completed two separate deconsolidation transactions. In one of these transactions, we sold a controlling equity interest, and transferred certain control rights, to a health system. We retained a noncontrolling interest in this affiliate. We received cash proceeds of approximately $2.1 million and recorded a pre-tax loss of approximately $1.6 million, which was primarily related to the revaluation of our remaining investment in this affiliate to fair value. The loss on this transaction is recorded in *"Loss (gain) on sale of investments"* in the accompanying consolidated statements of operations. In the other transaction, we transferred certain control rights to partners in the entity. We retained a noncontrolling interest in this affiliate. We recorded a pre-tax loss of approximately $1.5 million, which was primarily related to the revaluation of our remaining investment in this affiliate to fair value. The loss on this transaction is recorded in *Equity in net income of nonconsolidated affiliates* in the accompanying consolidated statements of operations.

During the year-ended December 31, 2012, we completed one deconsolidation transaction. In the transaction, we sold a controlling equity interest in an ASC and transferred certain control rights to a health system. We retained a noncontrolling interest in this affiliate. We received cash proceeds of approximately $4.3 million and recorded a pre-tax gain of approximately $2.0 million, which was primarily related to the revaluation of our remaining investment in this affiliate to fair value. The gain on this transaction is recorded in *Gain on sale of investments* in the accompanying consolidated statements of operations.

During the year-ended December 31, 2011, we completed four separate deconsolidation transactions. In three of these transactions, we sold a controlling equity interest, and transferred certain control rights to a health

system. We retained a noncontrolling interest in these entities. In the other transaction, we transferred certain control rights to partners in the entity and retained a noncontrolling interest in this entity. In the aggregate, we received proceeds of approximately $3.2 million and recorded a pre-tax gain of approximately $3.9 million, which was primarily related to the revaluation of our remaining investment in these entities to fair value. The gain on these transactions is recorded in *Gain on sale of investments* in the accompanying consolidated statements of operations.

Fair values for the retained noncontrolling interests are primarily estimated based on third-party valuations we have obtained in connection with such transactions and/or the amount of proceeds received for the controlling equity interest sold. Our continuing involvement as an equity method investor and manager of the facilities precludes classification of these transactions as discontinued operations.

Closures and Sales

During the year-ended December 31, 2013, we closed two facilities. We recorded a pre-tax loss of approximately $1.4 million as a result of the closures. The loss on the transactions is recorded in the *"Loss from discontinued operations, net of income tax"* in the accompanying consolidated statements of operations.

During the year-ended December 31, 2012, we closed two facilities. We recorded a pre-tax loss of approximately $3.2 million as a result of the closures. The loss on these transactions is recorded in the *"Loss from discontinued operations, net of income tax"* in the accompanying consolidated statements of operations. We also wrote off approximately $2.2 million of goodwill related to one closure.

During the year-ended December 31, 2013, we sold all of our interest in two ASCs for aggregate consideration of $1.3 million. We recorded a pre-tax loss of approximately $8.4 million as a result of the sale. The loss on this transaction is recorded in the *"Loss (gain) on sale of investments"* in the accompanying consolidated statements of operations. Our continuing involvement as manager of these facilities precludes classification of these transactions as discontinued operations.

During the year-ended December 31, 2012, we sold all of our interest in one ASC. We recorded a pre-tax gain of approximately $1.5 million as a result of the sale. The gain on this transaction is recorded in the *"Loss from discontinued operations, net of income tax"* in the accompanying consolidated statements of operations.

Unaudited Pro Forma Financial Information

Summarized below are our consolidated results of operations for the years ended December 31, 2013 and 2012, on an unaudited pro forma basis as if the HI acquisition and the East Brunswick, New Jersey ASC acquisition had occurred at the beginning of the earliest period presented. The pro forma information is based on the Company's consolidated results of operations for the years ended December 31, 2013 and 2012, and on other available information. These pro forma amounts include historical financial statement amounts with the following adjustments: we converted the sellers' historical financial statements to GAAP and applied the Company's accounting policies and we adjusted for depreciation and amortization expense assuming the fair value adjustments to intangible assets had been applied beginning January 1, 2012. The pro forma financial information does not purport to be indicative of results of operations that would have occurred had the transaction occurred on the basis assumed above, nor are they indicative of results of the future operations of the combined enterprises.

In thousands	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012
Net operating revenues	$834,112	$795,659
Income from continuing operations before income tax expense	80,366	89,011

NOTE 3 — SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation

The consolidated financial statements include the accounts of the Company, its subsidiaries and VIEs for which we are the primary beneficiary. All significant intercompany transactions and accounts have been eliminated.

We evaluate partially owned subsidiaries and joint ventures held in partnership form using authoritative guidance, which includes a framework for evaluating whether a general partner(s) or managing member(s) controls an affiliate and therefore should consolidate it. The framework includes the presumption that general partner or managing member control would be overcome only when the limited partners or members have certain rights. Such rights include the right to dissolve or liquidate the LP, LLP or LLC or otherwise remove the general partner or managing member "without cause," or the right to effectively participate in significant decisions made in the ordinary course of business of the LP, LLP or LLC. To the extent that any noncontrolling investor has rights that inhibit our ability to control the affiliate, including substantive veto rights, we do not consolidate the affiliate.

We use the equity method to account for our investments in affiliates with respect to which we do not have control rights but have the ability to exercise significant influence over operating and financial policies. Assets, liabilities, revenues and expenses are reported in the respective detailed line items on the consolidated financial statements for our consolidated affiliates. For our equity method affiliates, assets and liabilities are reported on a net basis in *Investment in and advances to nonconsolidated affiliates* on the consolidated balance sheets, and revenues and expenses are reported on a net basis in *Equity in net income of nonconsolidated affiliates* on the consolidated statements of operations. This difference in accounting treatment of equity method affiliates impacts certain financial ratios of the Company.

Variable Interest Entities

In order to determine if we are the primary beneficiary of a VIE for financial reporting purposes, we consider whether we have the power to direct the activities of the VIE that most significantly impact the economic performance of the VIE and whether we have the obligation to absorb losses or the right to receive returns that would be significant to the VIE. We consolidate a VIE when we are the primary beneficiary.

In 2012, the Company entered into a transaction whereby we transferred our interest in two consolidated facilities and cash to an entity (the "future JV") wholly owned by a health system in exchange for a promissory note. Concurrently, the health system transferred its interest in a facility it controlled to the future JV. The promissory note, which eliminates upon consolidation, has a fixed interest rate plus a variable component dependent on the earnings of the future JV. The promissory note contains a conversion feature that allows us to convert the promissory note to a 49% equity interest in the future JV at our option upon the occurrence of the renegotiation of certain contractual arrangements. We also entered into management services agreements with the facilities controlled by the future JV. As a result of the financial interest in the earnings of the future JV held by us via the promissory note and the powers granted us in the promissory note and the management services agreements, we have determined that the future JV is a VIE for which we are the primary beneficiary. We consolidated the future JV as of October 1, 2012.

The carrying amounts and classifications of the assets and liabilities of the future JV, which are included in our December 31, 2013 and 2012 consolidated balance sheets, were as follows:

	DECEMBER 31, 2013	DECEMBER 31, 2012
Assets		
Current assets		
Accounts receivable, net	$ 5,362	$ 1,867
Other current assets	3,423	4,635
Total current assets	8,785	6,502
Property and equipment, net	14,674	3,663
Goodwill	21,154	12,265
Intangible assets	4,931	5,792
Total assets	$49,544	$28,222
Liabilities		
Current liabilities		
Accounts payable and other current liabilities	$ 6,172	$ 1,348
Total current liabilities	6,172	1,348
Other long-term liabilities	5,984	88
Total liabilities	$12,156	$ 1,436

The assets of the consolidated VIE can only be used to settle the obligations of the VIE. The creditors of the VIE have no recourse to us, with the exception of $4.0 million of debt guaranteed by us at December 31, 2013. There was no such guarantee at December 31, 2012.

Reclassifications and Revisions

Certain amounts in the consolidated financial statements for prior periods have been reclassified to conform to the current period presentation. Such reclassifications primarily relate to facilities we closed or sold, which qualify for reporting as discontinued operations.

We revised our consolidated statements of changes in equity and of cash flows for the year ended December 31, 2011, to adjust the classification of *Member contributions* that were inappropriately reflected in *Other long-term liabilities* in 2011. For the year ended December 31, 2011, this adjustment had the effect of decreasing *Other long-term liabilities* by $3.1 million with a corresponding increase to *Contributed capital* by $3.1 million, increasing *Member contributions* reported on the consolidated statement of changes in equity by $3.1 million, and decreasing cash flows from operating activities by $3.1 million with a corresponding increase to cash flows from financing activities. This revision resulted in an adjustment to our previously presented consolidated balance sheet at December 31, 2012 which had the effect of decreasing *Other long-term liabilities* by $3.1 million with a corresponding increase to *Contributed capital* by $3.1 million. These revisions are not material to the related financial statements for any prior periods and had no impact on our consolidated statements of operations. As prior period financial information is presented in future filings, we will similarly revise the applicable financial statements for comparative periods presented in future filings.

The 2012 balance sheet includes reclassifications totaling $2.9 million within *Accounts receivable, net, other current liabilities* and *Other long-term liabilities* to conform the 2012 presentation to the 2013 presentation for certain recovery audit program and Medicaid-related liabilities.

The 2012 statement of operations includes reclassifications totaling $3.7 million within the *Other revenues* and *Provision for doubtful accounts* lines to conform the 2012 presentation to the 2013 presentation.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements, as well as the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. The most significant estimates include, but are not limited to: (1) allowance for contractual revenue adjustments; (2) allowance for doubtful accounts; (3) asset impairments, including goodwill; (4) depreciable lives of assets; (5) useful lives of intangible assets; (6) economic lives and fair value of leased assets; (7) provision for income taxes, including valuation allowances; (8) reserves for contingent liabilities; and (9) reserves for losses in connection with unresolved legal matters. Future events and their effects cannot be predicted with certainty; accordingly, our accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of our consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained, and as our operating environment changes. We evaluate and update our assumptions and estimates on an ongoing basis and may employ outside experts to assist in our evaluation as considered necessary. Actual results could differ from those estimates.

Risks and Uncertainties

We operate in a highly regulated industry and are required to comply with extensive and complex laws and regulations at the federal, state and local government levels. These laws and regulations relate to, among other things:

- licensure, certification and accreditation;
- coding and billing for services;
- relationships with physicians and other referral sources, including physician self-referral and anti-kickback laws;
- quality of medical care;
- use and maintenance of medical supplies and equipment;
- maintenance and security of medical records;
- acquisition and dispensing of pharmaceuticals and controlled substances; and
- disposal of medical and hazardous waste.

Many of these laws and regulations are expansive, and we do not have the benefit of significant regulatory or judicial interpretation of them. In the future, different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our investment structure, facilities, equipment, personnel, services, capital expenditure programs, operating procedures and contractual arrangements.

If we fail to comply with applicable laws and regulations, we could be subjected to liabilities, including (1) criminal penalties, (2) civil penalties, including monetary penalties and the loss of our licenses to operate one or more of our ASCs and surgical hospitals and (3) exclusion or suspension of one or more of our ASCs and surgical hospitals from participation in Medicare, Medicaid and other federal and state healthcare programs.

Historically, the United States Congress and some state legislatures have periodically proposed significant changes in regulations governing the healthcare system. Many of these changes have resulted in limitations on and, in some cases, significant reductions in the levels of payments to healthcare providers for services under many government reimbursement programs. Because we receive a significant percentage of our revenues from Medicare, such proposed changes in legislation might have a material adverse effect on our financial position, results of operations and cash flows, if any such changes were to occur.

Certain of our operating agreements have termination dates by which the agreement expires by its terms. In these situations, if we wish to continue the business, we would attempt to negotiate an amendment to the agreement and if necessary, to renegotiate material terms of the agreement, to prevent such termination. None of our operating agreements have termination dates in 2014.

In addition, certain of our partnership and operating agreements contain provisions that give our partners or other members rights that include, but are not limited to, rights to purchase our interest, rights to require us to purchase the interests of our partners or other members or rights requiring the consent of our partners and other members prior to our transferring our ownership interest in a facility or prior to a change in control of us or certain of our subsidiaries.

Almost all of our partnership and operating agreements contain restrictions on actions that we can take, even though we may be the general partner or the managing member, including rights of our partners and other members to approve the sale of substantially all of the assets of the entity, to dissolve the partnership or LLC, and to amend the partnership or operating agreement. Many of our agreements also restrict our ability in certain instances to compete with our existing facilities or with our partners. Where we hold only a limited partner or a non-managing member interest, the general partner or managing member may take certain actions without our consent, although we typically have certain protective rights to approve major decisions, such as the sale of substantially all of the assets of the entity, the dissolution of the partnership or LLC, and the amendment of the partnership or operating agreement.

As discussed in Note 16, *Commitments and Contingent Liabilities*, we are a party to a number of lawsuits. We cannot predict the outcome of litigation filed against us. Substantial damages or other monetary remedies assessed against us could have a material adverse effect on our business, financial position, results of operations and cash flows.

Revenue Recognition

Our revenues consist primarily of net patient service revenues that are recorded based upon established billing rates less allowances for contractual adjustments. Revenues are recorded during the period the services are provided, based upon the estimated amounts due from patients and third-party payors, including federal and state payors (primarily, the Medicare and Medicaid programs), commercial health insurance companies, workers' compensation programs and employers. Estimates of contractual allowances under third-party payor arrangements are based upon the payment terms specified in the related contractual agreements and payment history. Third-party payor contractual payment terms are generally based upon predetermined rates per procedure or discounted fee-for-service rates.

During the years-ended December 31, 2013, 2012 and 2011, approximately 60%, 61% and 62%, respectively, of our net patient revenues related to patients with commercial insurance coverage. Healthcare services providers are under increasing pressure to accept reduced reimbursement for services on these contracts. Continued reductions could have a material adverse impact on our financial position, results of operations and cash flows.

During each of the years-ended December 31, 2013, 2012 and 2011, approximately 23%, 24% and 24%, respectively, of our net patient revenues related to patients participating in the Medicare and Medicaid programs. Laws and regulations governing the Medicare and Medicaid programs are complex, subject to interpretation and are routinely modified for provider reimbursement. The Centers for Medicare and Medicaid Services ("CMS") has been granted authority to suspend payments, in whole or in part, to Medicare providers if CMS possesses reliable information that an overpayment, fraud or willful misrepresentation exists. If CMS suspects that payments are being made as the result of fraud or misrepresentation, CMS may suspend payment at any time without providing us with prior notice. The initial suspension period is limited to 180 days. However, the payment suspension period can be extended almost indefinitely if the matter is under investigation by the United

States Department of Health & Human Services Office of Inspector General ("OIG") or the Department of Justice ("DOJ"). Therefore, we are unable to predict if or when we may be subject to a suspension of payments by the Medicare and/or Medicaid programs, the possible length of the suspension period or the potential cash flow impact of a payment suspension. Any such suspension would adversely impact our financial position, results of operations and cash flows.

Our revenues also include *Management fee revenues* representing fees we earn from managing the facilities that we do not consolidate for financial reporting purposes. Management fee revenues are determined as dictated by management agreements between SCA and the facility and the fee for management services is generally a defined percentage of the facility's net patient revenues.

Cash and Cash Equivalents

Cash and cash equivalents include all demand deposits reduced by the amount of outstanding checks and drafts where the right of offset exists for these bank accounts. As a result of the Company's cash management system, checks issued but not presented to banks for payment may create negative book cash balances. Such negative balances are included in current liabilities as "checks issued in excess of bank balance." There were no such balances at December 31, 2013 and 2012. The Company has deposits with certain financial institutions which exceed federally insured limits. The Company has not experienced any losses on such deposits.

Restricted Cash

As of December 31, 2013 and 2012, we had approximately $25.0 million and $27.6 million, respectively, of restricted cash in affiliate cash accounts maintained by partnerships in which we participate where one or more external partners requested, and we agreed, that the partnership's cash not be commingled with other Company cash and be used only to fund the operations of those partnerships.

Accounts Receivable

We report accounts receivable at estimated net realizable amounts from services rendered from federal and state payors (primarily the Medicare and Medicaid programs) commercial health insurance companies, workers' compensation programs, employers and patients. Our accounts receivable are geographically dispersed, but a significant portion of our accounts receivable are concentrated by type of payor. The concentration of net patient service accounts receivable by payor class, as a percentage of total net patient service accounts receivable, as of the end of each of the reporting periods, is as follows:

	AS OF DECEMBER 31	
	2013	2012
Commercial health insurance payors	63%	62%
Medicare	15	19
Workers' compensation	14	9
Medicaid	3	5
Patients and other third-party payors	5	5
Total	100%	100%

Revenues and accounts receivable from government payors are significant to our operations; however, we do not believe there are significant credit risks associated with these government agencies.

Revenue and accounts receivable from commercial health insurance payors are also significant to our operations. Because the category of commercial health insurance payors is composed of numerous individual payors which are geographically dispersed, our management does not believe there are any significant concentrations of revenues from any individual payor that would subject us to significant credit risks in the collection of our accounts receivable.

Additions to the allowance for doubtful accounts are made by means of the *Provision for doubtful accounts*. We write off uncollectible accounts against the allowance for doubtful accounts after exhausting collection efforts and adding subsequent recoveries. Net accounts receivable include only those amounts we estimate we will collect.

We perform an analysis of our historical cash collection patterns and consider the impact of any known material events in determining the allowance for doubtful accounts. In performing our analysis, we consider the impact of any adverse changes in general economic conditions, business office operations, payor mix or trends in federal or state governmental healthcare coverage.

Long-Lived Assets

We report land, buildings, improvements and equipment at cost, net of asset impairment. We report assets under capital lease obligations at the lower of fair value or the present value of the aggregate future minimum lease payments at the beginning of the lease term. We depreciate our assets using the straight-line method over the shorter of the estimated useful life of the assets or life of the lease term, excluding any lease renewals, unless the lease renewals are reasonably assured. Useful lives are as follows:

	YEARS
Buildings	15 to 30
Leasehold improvements	5 to 20
Furniture, fixtures and equipment	3 to 7
Assets under capital lease obligations:	
Real estate	15 to 25
Equipment	3 to 5

Maintenance and repairs of property and equipment are expensed as incurred. We capitalize replacements and improvements that increase the estimated useful life of an asset. We capitalize interest expense on major construction and development projects while in progress. Interest of approximately $0.1 million was capitalized for the year-ended December 31, 2012; no interest was capitalized during the years-ended December 31, 2013 and 2011.

We retain fully depreciated assets in property and accumulated depreciation accounts until we remove them from service. In the case of sale, retirement or disposal, the asset cost and related accumulated depreciation balance is removed from the respective account, and the resulting net amount, less any proceeds, is included as a component of income from continuing operations in the consolidated statements of operations. However, if the sale, retirement or disposal involves a discontinued operation, the resulting net amount, less any proceeds, is included in the results of discontinued operations.

For operating leases, we recognize escalated rents, including any rent holidays, on a straight-line basis over the term of the lease.

Goodwill

We test goodwill for impairment using a fair value approach at least annually, absent some triggering event that would require an interim impairment assessment. Absent any impairment indicators, we perform our goodwill impairment testing as of October 1st of each year.

In 2013, we changed from one operating segment to six operating segments, which are aggregated into one reportable segment. Our six operating segments are generally organized geographically. As a result of this change, we ascribed goodwill to each reporting unit (same as our operating segments) using a relative fair value approach. In 2013, we evaluated our reporting units for goodwill impairment using a two-step process.

The first step of the impairment test identifies potential impairment by comparing the fair value of a reporting unit to its carrying value, including goodwill. If the fair value of a reporting unit exceeds its carrying value, goodwill of the reporting unit is not considered impaired and the second step of the impairment test is not required. If the carrying value of a reporting unit exceeds its fair value, the second step of the impairment test is performed to measure the amount of impairment loss, if any.

The second step of the impairment test compares the implied fair value of the reporting unit goodwill with the carrying amount of that goodwill. The implied fair value of goodwill is determined by hypothetically allocating the fair value of the reporting unit to its identifiable assets and liabilities in a manner consistent with a business combination, with any excess fair value representing implied goodwill. If the carrying value of the reporting unit goodwill exceeds the implied fair value of that goodwill, an impairment loss is recognized in an amount equal to that excess.

The carrying value of each operating segment was determined by assigning assets and liabilities to those reporting units as of the measurement date. We estimated the fair values of the operating segments by considering the indicated fair values derived from an income approach, which involves discounting estimated future cash flows. We considered market factors when determining the assumptions and estimates used in our valuation models. To substantiate the fair values derived from these valuations, we reconciled the reporting unit fair values to our market capitalization.

For 2012 and 2011, in accordance with amended guidance for goodwill impairment testing, we performed a qualitative assessment because management estimated the fair value to significantly exceed the carrying value. In the qualitative assessments, we weighed the relative impact of factors that are specific to us as well as industry and macroeconomic factors. The factors specific to us that were considered included financial performance and changes to the carrying value since the most recent impairment test. We also considered growth projections from independent sources and significant developments within our industry. We determined that the impact of macroeconomic factors on the most recent impairment tests would not significantly affect the estimated fair value. Based on this qualitative assessment, considering the aggregation of these factors, we concluded that it is not more-likely-than-not that the fair value of the Company is less than its carrying amount and therefore performing the two-step impairment test was unnecessary.

We recognize an impairment charge for any amount by which the carrying amount of goodwill exceeds its implied fair value. We present a goodwill impairment charge as a separate line item within income from continuing operations in the consolidated statements of operations, unless the goodwill impairment is associated with a discontinued operation. In that case, we include the goodwill impairment charge, on a net-of-tax basis, within the results of discontinued operations.

When we dispose of a business, the relative fair value of goodwill is allocated to the carrying amount of the business disposed of in determining the gain or loss on disposition.

Impairment of Long-Lived Assets and Other Intangible Assets

We assess the recoverability of long-lived assets (excluding goodwill) and identifiable acquired intangible assets with definite useful lives whenever events or changes in circumstances indicate we may not be able to recover the asset's carrying amount. We measure the recoverability of assets to be held and used by a comparison of the carrying amount of the asset to the expected net future cash flows to be generated by that asset, or, for identifiable intangibles with definite useful lives, by determining whether the amortization of the intangible asset balance over its remaining life can be recovered through undiscounted future cash flows. The amount of impairment of identifiable intangible assets with definite useful lives, if any, to be recognized is measured based on projected discounted future cash flows. We measure the amount of impairment of other long-lived assets (excluding goodwill) as the amount by which the carrying value of the asset exceeds the fair market value of the asset, which is generally determined based on projected discounted future cash flows or appraised values. We

present an impairment charge as a separate line item within income from continuing operations in our consolidated statements of operations, unless the impairment is associated with a discontinued operation. In that case, we include the impairment charge, on a net-of-tax basis, within the results of discontinued operations. We classify long-lived assets to be disposed of other than by sale as held and used until they are disposed. We report long-lived assets to be disposed of by sale as held for sale and recognize those assets in the balance sheet at the lower of carrying amount or fair value less cost to sell, and cease depreciation.

We amortize the cost of intangible assets with definite useful lives over their respective estimated useful lives to their estimated residual value. As of December 31, 2013, none of our definite useful lived intangible assets have an estimated residual value. As of December 31, 2013, we do not have any intangible assets with indefinite useful lives. The range of estimated useful lives of our other intangible assets is as follows:

	YEARS
Certificates of need	10 to 30
Favorable contracts	4
Favorable lease obligations	5
Licenses	15 to 20
Management agreements	3 to 15
Noncompete agreements	2 to 15

For the years-ended December 31, 2013, 2012 and 2011, we recorded on our Consolidated Statement of Operations within *Equity in net income of nonconsolidated affiliates* amortization expense of $25.9 million, $20.3 million and $10.1 million, respectively, for definite-lived intangible assets attributable to equity method investments.

Investment in and Advances to Nonconsolidated Affiliates

Investments in entities we do not control, but in which we have the ability to exercise significant influence over the operating and financial policies of the investee, are accounted for under the equity method. Equity method investments are recorded at original cost and adjusted periodically to recognize our proportionate share of the investees' net income or losses after the date of investment, additional contributions made and distributions received, amortization of definite-lived intangible assets attributable to equity method investments and impairment losses resulting from adjustments to the carrying value of the investment. We record equity method losses in excess of the carrying amount of an investment when we guarantee obligations or we are otherwise committed to provide further financial support to the affiliate.

Management periodically assesses the recoverability of our equity method investments for impairment. We consider all available information, including the recoverability of the investment, the earnings and near-term prospects of the affiliate, factors related to the industry, conditions of the affiliate and our ability, if any, to influence the management of the affiliate. We assess fair value based on valuation methodologies, as appropriate, including discounted cash flows, estimates of sales proceeds and external appraisals, as appropriate. If an equity method investment's decline in value is other than temporary, we record an impairment in *Equity in net income of nonconsolidated affiliates*.

Financing Costs

We amortize financing costs using the effective interest method over the life of the related debt. The related expense is included in *Interest expense* in our consolidated statements of operations.

Fair Value of Financial Instruments

Our financial instruments consist mainly of cash and cash equivalents, restricted cash, accounts receivable, accounts payable, letters of credit, long-term debt and interest rate swap agreements. The carrying amounts of cash and cash equivalents, restricted cash, accounts receivable and accounts payable approximate fair value

because of the short-term maturity of these instruments. The fair value of our letters of credit is deemed to be the amount of payment guaranteed on our behalf by third-party financial institutions. We determine the fair value of our long-term debt based on various factors, including maturity schedules, call features and current market rates. We also use quoted market prices, when available, or discounted cash flows to determine fair values of long-term debt. The fair value of our interest rate swaps is determined using information provided by a third-party financial institution and discounted cash flows.

Derivative Instruments

All derivative instruments are recorded on the balance sheet at their fair value. Changes in the fair value of derivatives are recorded each period in current earnings or in other comprehensive income, depending on whether a derivative is designated as part of a hedging relationship and, if it is, depending on the type of hedging relationship.

As of December 31, 2013 and 2012, we held interest rate swaps to hedge the interest rate risk on a portion of our long-term debt. These swaps were historically designated as a cash flow hedge; however, in 2013 we de-designated these instruments. The de-designation resulted in the reclassification of all amounts related to the cash flow hedges in *Accumulated other comprehensive loss* to be reclassified to ***Interest expense***. Prior to de-designation, all changes in the fair value of these interest rate swaps were reported in other comprehensive income on the consolidated statement of changes in equity. Net cash settlements on our interest rate swaps are included in investing activities in our consolidated statements of cash flows. For additional information regarding these interest rate swaps, see Note 8, *Long-Term Debt.*

Noncontrolling Interest in Consolidated Affiliates

The consolidated financial statements include all assets, liabilities, revenues and expenses of less-than-100%-owned affiliates that we control. Accordingly, we have recorded a noncontrolling interest in the earnings and equity of such affiliates. We record adjustments to noncontrolling interest for the allocable portion of income or loss to which the noncontrolling interest holders are entitled based upon the portion of the subsidiaries they own. Distributions to holders of noncontrolling interests reduce the respective noncontrolling interest holders' balance.

Also, certain of the Company's noncontrolling interests have industry-specific redemption features, such as a change in law that would prohibit the noncontrolling interests' current form of ownership in ASCs, which are not solely within the control of the Company. We are not aware of events that would make a redemption probable. According to authoritative guidance, classification of these noncontrolling interests outside of permanent equity is required due to the redemption features.

Equity-Based Compensation

We have one active equity-based compensation plan, the 2013 Omnibus Long-Term Incentive Plan, and two legacy equity-based compensation plans, the Management Equity Incentive Plan and the Directors and Consultants Equity Incentive Plan, under which we are no longer issuing new awards (together, the "Plans"). The Plans provide or have provided for the granting of options to purchase our stock as well as RSUs to key teammates, directors, service providers, consultants and affiliates.

Under the Plans, our key teammates, directors, service providers, consultants and affiliates are provided with what we believe to be appropriate incentives to encourage them to continue employment with us or providing service to us or any of our affiliates and to improve our growth and profitability.

Option awards are generally granted with an exercise price equal to at least the fair market value of the underlying share at the date of grant. Vesting in the option awards varies based upon time, attainment of certain

performance conditions, or upon the occurrence of a Liquidity Event (as defined in the applicable Plan) in which the TPG Funds and/or any of its affiliates achieves a minimum cash return on its original investment. All existing RSU awards vest over time.

Income Taxes

We provide for income taxes using the asset and liability method. This approach recognizes the amount of federal, state and local taxes payable or refundable for the current year, as well as deferred tax assets and liabilities for the future tax consequence of events recognized in the consolidated financial statements and income tax returns. Deferred income tax assets and liabilities are adjusted to recognize the effects of changes in tax laws or enacted tax rates.

A valuation allowance is required when it is more-likely-than-not that some portion of the deferred tax assets will not be realized. Realization is dependent on generating sufficient future taxable income.

We file a consolidated federal income tax return. State income tax returns are filed on a separate, combined or consolidated basis in accordance with relevant state laws and regulations. LPs, LLPs, LLCs and other pass-through entities that we consolidate or account for using the equity method of accounting file separate federal and state income tax returns. We include the allocable portion of each pass-through entity's income or loss in our federal income tax return. We allocate the remaining income or loss of each pass-through entity to the other partners or members who are responsible for their portion of the taxes.

Assets Held for Sale and Results of Discontinued Operations

Components of an entity that have been disposed of or are classified as held for sale and have operations and cash flows that can be clearly distinguished from the rest of the entity are reported as assets held for sale and discontinued operations. In the period a component of an entity has been disposed of or classified as held for sale, we reclassify the results of operations for current and prior periods into a single caption titled *Loss from discontinued operations, net of income tax expense*. In addition, assets and liabilities associated with facilities that qualify for reporting as discontinued operations are reflected in the consolidated balance sheets as *Current assets related to discontinued operations, Assets related to discontinued operations, Current liabilities related to discontinued operations* and *Liabilities related to discontinued operations*. We also classify cash flows related to discontinued operations as one line item within each category of cash flows in our consolidated statements of cash flows.

Assessment of Loss Contingencies

We have legal and other contingencies that could result in significant losses upon the ultimate resolution of such contingencies. We record accruals for such contingencies to the extent we conclude it is probable that a liability has been incurred and the amount of loss can be reasonably estimated. A significant amount of judgment is involved in determining whether a loss is probable and reasonably estimable due to the uncertainty involved in determining the likelihood of future events and estimating the financial statement impact of such events. If further developments or resolution of a contingent matter are not consistent with our assumptions and judgments, we may need to recognize a significant charge in a future period related to an existing contingent matter. See Note 16, *Commitments and Contingent Liabilities*, for more information regarding these matters.

Earnings Per Share (EPS)

We report two earnings per share numbers, basic and diluted. These are computed by dividing net earnings by the weighted-average common shares outstanding (basic EPS) or weighted-average common shares outstanding assuming dilution (diluted EPS), as set forth below:

In thousands	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012	YEAR-ENDED DECEMBER 31 2011
Weighted average shares outstanding	31,688	30,340	29,347
Dilutive effect of equity-based compensation plans	—	—	—
Weighted-average shares outstanding, assuming dilution	31,688	30,340	29,347

The shares used reflect the conversion to a Delaware corporation discussed in Note 1 for all periods. All dilutive share equivalents are reflected in our earnings per share calculations. Antidilutive share equivalents are not included in our EPS calculations. In periods of loss, shares that otherwise would have been included in our diluted weighted-average shares outstanding computation are excluded. The excluded shares for the years-ended December 31 are as follows: 2013 — 216,682, 2012 — 98,439 and 2011 — 114,537.

Reportable Segments

We have six operating segments, which aggregate into one reportable segment. Our six operating segments are generally organized geographically. For reporting purposes, we have aggregated our operating segments into one reportable segment as the nature of the services are similar and the businesses exhibit similar economic characteristics, processes, types and classes of customers, methods of service delivery and distribution and regulatory environments.

Distribution

On September 16, 2013, we declared a cash distribution of approximately $0.24 per outstanding membership unit, resulting in a total distribution to our membership unit holders of $74.9 million. The distribution was payable promptly after the date it was declared. In addition, on September 16, 2013, the board of directors of the Company resolved to pay a cash bonus to eligible holders of vested options and restricted equity units of approximately $0.24 per vested option or restricted equity unit, as applicable, resulting in a total bonus payment of $4.6 million, and to reduce the exercise price of any such holder's unvested options by approximately $0.24 per unvested option. The cash bonus payment was recorded as compensation expense in the third quarter of 2013. We will record stock compensation expense over the remaining vesting periods related to the adjustment to unvested options.

Recent Revisions to Authoritative Guidance

In February 2013, the Financial Accounting Standards Board issued ASU No. 2013-02, Reporting of Amounts Reclassified Out of Accumulated Other Comprehensive Income. This update requires companies to include reclassification adjustments for items that are reclassified from other comprehensive income to net income in a single note or on the face of the financial statements. The amendment was effective for annual and interim reporting periods beginning after December 15, 2012. The adoption of this standard did not have a material impact on the consolidated financial statements of the Company.

We do not believe any other recently issued, but not yet effective, revisions to authoritative guidance will have a material effect on our consolidated financial position, results of operations or cash flows.

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NOTE 4 — ACCOUNTS RECEIVABLE

Accounts receivable consist of the following:

	AS OF DECEMBER 31 2013	2012
Accounts receivable	$103,701	$88,120
Less: Allowance for doubtful accounts	(11,918)	(5,928)
Accounts receivable, net	$ 91,783	$82,192

The following is the activity related to our allowance for doubtful accounts:

	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012	YEAR-ENDED DECEMBER 31 2011
Balance at beginning of period	$ 5,928	$ 9,414	$ 6,710
Provision for doubtful accounts	15,033	13,200	14,599
Deductions and accounts written off	(9,043)	(16,686)	(11,895)
Balance at end of period	$11,918	$ 5,928	$ 9,414

NOTE 5 — PROPERTY AND EQUIPMENT

Property and equipment consists of the following:

	AS OF DECEMBER 31 2013	2012
Land	$ 20,222	$ 21,205
Buildings	41,840	47,141
Leasehold improvements	43,493	31,800
Furniture, fixtures and equipment	162,533	141,143
	268,088	241,289
Less: Accumulated depreciation	(84,768)	(77,316)
	183,320	163,973
Construction in progress	16,552	15,890
Property and equipment, net	$199,872	$179,863

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The amount of depreciation expense, amortization expense and accumulated amortization relating to assets under capital lease obligations, and rent expense under operating leases is as follows:

	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012	YEAR-ENDED DECEMBER 31 2011
Depreciation expense	$ 29,831	$ 31,061	$ 30,088
Assets under capital lease obligations:			
Buildings	$ 17,062	$ 13,004	$ 14,917
Equipment	28,484	16,768	13,511
	45,546	29,772	28,428
Accumulated depreciation	(16,588)	(15,498)	(12,808)
Assets under capital lease obligations, net	$ 28,958	$ 14,274	$ 15,620
Amortization expense	$ 6,418	$ 5,698	$ 4,861
Rent Expense:			
Minimum rent payments	$ 22,288	$ 21,780	$ 21,736
Contingent and other rents	10,999	11,795	11,391
Total rent expense	$ 33,287	$ 33,575	$ 33,127

Leases

We lease certain land, buildings and equipment under non-cancelable operating leases expiring at various dates through 2031. We also lease certain buildings and equipment under capital leases expiring at various dates through 2023. Operating leases generally have 3 to 22 year terms, with one or more renewal options, with terms to be negotiated at the time of renewal. Various facility leases include provisions for rent escalation to recognize increased operating costs or require us to pay certain maintenance and utility costs. Contingent rents are included in rent expense in the year incurred. Some facilities are subleased to other parties. Rental income from subleases approximated $0.6 million, $0.9 million and $1.0 million for the years-ended December 31, 2013, 2012 and 2011, respectively. Certain leases contain annual escalation clauses based on changes in the Consumer Price Index while others have fixed escalation terms. The excess of cumulative rent expense (recognized on a straight-line basis) over cumulative rent payments made on leases with fixed escalation terms is recognized as straight-line rental accrual and is included in *Other long-term liabilities* in the accompanying consolidated balance sheets.

Our facilities lease land, buildings and equipment, with most leases being for terms of three to ten years. Additionally, the lease for our Birmingham, Alabama office, which commenced on March 1, 2008, had an initial term of five years. In 2012, it was extended for an additional two year period through March 31, 2015.

Future minimum lease payments at December 31, 2013 for those leases of the Company and its subsidiaries having an initial or remaining non-cancelable lease term of one year or more are as follows:

YEAR ENDING DECEMBER 31,	OPERATING LEASES	CAPITAL LEASE OBLIGATIONS	TOTAL
2014	$ 24,270	$ 8,541	$ 32,811
2015	20,188	6,048	26,236
2016	15,249	4,269	19,518
2017	10,043	2,759	12,802
2018	7,742	1,983	9,725
2019 and thereafter	25,613	7,476	33,089
	$103,105	31,076	$134,181
Less: interest portion		(3,906)	
Obligations under capital leases		$27,170	

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Obligations Under Lease Guarantees

In conjunction with the sale of certain facilities in prior years, the leases of certain properties were assigned to the purchasers and, as a condition of the lease, the Company is a guarantor on the lease. Should the purchaser fail to pay the rent due on these leases, the lessor would have contractual recourse against the Company.

We have not recorded a liability for these guarantees because we do not believe it is probable that we will have to perform under these agreements. If we are required to perform under these guarantees, we could potentially have recourse against the purchaser for recovery of any amounts paid. The amount remaining on these guarantees is not material to our financial statements. These guarantees are not secured by any assets under the leases. As of December 31, 2013, the Company has not been required to perform under any such lease guarantees.

Impairment of Long-Lived Assets

During 2013, 2012 and 2011, we examined our long-lived assets for impairment due to facility closings and facilities experiencing cash flow insufficient to recover the net book value of its long-lived assets. Based on this review, $1.1 million of impairment charges were recorded for the year-ended December 31, 2012. No material impairment charges were recorded for the years-ended December 31, 2013 and December 31, 2011. For all periods presented, the fair value of the impaired long-lived assets at our facilities was determined primarily based on the assets' estimated fair value using valuation techniques that included discounted future cash flows.

NOTE 6 — GOODWILL AND OTHER INTANGIBLE ASSETS

Goodwill represents the unallocated excess of purchase price over the fair value of identifiable assets and liabilities acquired in business combinations. Goodwill also includes the unallocated excess of purchase price plus the fair value of any noncontrolling interest in the acquiree at the acquisition date over the fair value of identifiable assets and liabilities acquired in business combinations. Other definite-lived intangibles consist primarily of certificates of need, licenses, noncompete agreements and management agreements. We have no accumulated impairment of goodwill for the periods ended December 31, 2013 or December 31, 2012.

The following tables show changes in the carrying amount of goodwill for the years-ended December 31, 2013 and December 31, 2012:

	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012
Balance at beginning of period	$706,495	$679,463
Acquisitions (Note 2)	48,346	17,156
Deconsolidations (Note 2)	(7,351)	(11,676)
Sales	(10,062)	(3,574)
Closure and other	(515)	(2,609)
VIE related (Note 3)	4,104	8,923
Conversion of equity method investment to consolidated	3,079	18,812
Balance at end of period	$744,096	$706,495

We performed impairment reviews as of October 1, 2013 and 2012, and concluded that no goodwill impairment existed.

The following table provides information regarding our other intangible assets:

	AS OF DECEMBER 31 2013	2012
Certificates of need		
Gross carrying amount	$ 20,097	$ 18,529
Accumulated amortization	(8,073)	(6,812)
Net	$ 12,024	$ 11,717
Management agreements		
Gross carrying amount	$ 49,978	$ 38,627
Accumulated amortization	(15,410)	(12,250)
Net	$ 34,568	$ 26,377
Licenses		
Gross carrying amount	$ 8,031	$ 8,575
Accumulated amortization	(1,612)	(1,306)
Net	$ 6,419	$ 7,269
Noncompete agreements		
Gross carrying amount	$ 9,954	$ 3,323
Accumulated amortization	(1,029)	(595)
Net	$ 8,925	$ 2,728
Total other intangible assets		
Gross carrying amount	$ 88,060	$ 69,054
Accumulated amortization	(26,124)	(20,963)
Net	$ 61,936	$ 48,091

During 2013, 2012 and 2011, we examined our intangible assets for impairment due to facility closings and facilities experiencing cash flow insufficient to recover the net book value of its long-lived assets. In all periods presented, no impairment charge was deemed necessary for intangible assets.

For the years-ended December 31, 2013, December 31, 2012 and December 31, 2011, we recorded $25.9 million, $20.3 million and $10.1 million, respectively, of amortization expense for definite-lived intangible assets attributable to equity method investments. These expenses are included in *Equity in net income of nonconsolidated affiliates* in our consolidated financial statements.

Amortization expense for other intangible assets is as follows:

	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012	YEAR-ENDED DECEMBER 31 2011
Amortization expense	$6,692	$4,869	$5,468

Total estimated amortization expense for our other intangible assets for the next five years is as follows:

YEAR ENDING DECEMBER 31	ESTIMATED AMORTIZATION EXPENSE
2014	$5,811
2015	5,418
2016	5,372
2017	5,369
2018	5,382

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NOTE 7 — RESULTS OF OPERATIONS OF NONCONSOLIDATED AFFILIATES

As of December 31, 2013, *Investment in and advances to nonconsolidated affiliates* represents Surgical Care Affiliates' investment in 60 partially owned entities, most of which are general partnerships, LPs, LLPs, LLCs or joint ventures in which SCA or one of our subsidiaries is a general or limited partner, managing member, member or venturer, as applicable. We do not control these affiliates but have the ability to exercise significant influence over the operating and financial policies of certain of these affiliates. Accordingly, we account for these affiliates using the equity method. Our ownership percentage in these affiliates generally ranged from 5% to 50% as of December 31, 2013. Our investment in these affiliates is an integral part of our operations.

During the year-ended December 31, 2013, we completed two separate deconsolidation transactions. In one of these transactions, we sold a controlling equity interest, and transferred certain control rights, to a health system. We retained a noncontrolling interest in this affiliate. We received cash proceeds of approximately $2.1 million and recorded a pre-tax loss of approximately $1.6 million, which was primarily related to the revaluation of our remaining investment in this affiliate to fair value. The loss on this transaction is recorded in *Loss (gain) on sale of investments* in the accompanying consolidated statements of operations. In the other transaction, we transferred certain control rights to partners in the entity. We retained a noncontrolling interest in this affiliate. We recorded a pre-tax loss of approximately $1.5 million, which was primarily related to the revaluation of our remaining investment in this affiliate to fair value. The loss on this transaction is recorded in *Equity in net income of nonconsolidated affiliates* in the accompanying consolidated statements of operations.

During 2012, we completed a deconsolidation transaction. In the transaction, we sold a controlling equity interest in an ASC and transferred certain control rights to a health system. We retained a noncontrolling interest in this affiliate. We received cash proceeds of approximately $4.3 million and recorded a pre-tax gain of approximately $2.0 million, which was primarily related to the revaluation of our remaining investment in this affiliate to fair value. The gain on this transaction is recorded in *Loss (gain) on sale of investments* in the accompanying consolidated statement of operations.

Also during 2012, the Company completed a transaction whereby we contributed our interest in two consolidated facilities ("Surgical Care Affiliates facilities") and $1.6 million to a newly formed entity that is jointly owned by us and a California health system (the "JV"). Concurrently, the California health system contributed its controlling interest in a facility ("Health System facility") to the JV. We also entered into management services agreements with the facilities contributed to the JV. As a result of the transaction, the operations of one of the contributed Surgical Care Affiliates facilities were merged with and into the Health System facility; the Health System facility was the surviving entity. Accordingly, two facilities remain as a result of the transaction. We have a noncontrolling interest in the surviving facilities, which are presented under the equity method of accounting. The net effect of these contributions resulted in the Company recording a loss of approximately $3.3 million, related to the conversion of the two Surgical Care Affiliates facilities into an equity method investment. The loss on this transaction is recorded in *Loss (gain) on sale of investments* in the accompanying consolidated statement of operations.

During 2011, we completed four separate deconsolidation transactions. In three of these transactions, we sold a controlling equity interest, and transferred certain control rights, to a health system. In the other transaction, we transferred certain control rights to partners in the entity and retained a noncontrolling interest in this entity. We retained a noncontrolling interest in these entities. In the aggregate, we received proceeds of approximately $3.2 million and recorded a pre-tax gain of approximately $3.9 million, which was primarily related to the revaluation of our remaining investment in these entities to fair value. The gain on these transactions is recorded in *Loss (gain) on sale of investments* in the accompanying consolidated statement of operations.

Fair values for the retained noncontrolling interests are primarily estimated based on third-party valuations we have obtained in connection with such transactions. Our continuing involvement as an equity method investor and manager of the facilities precludes classification of these transactions as discontinued operations.

During 2013, we recorded $6.1 million of impairment to our investments in nonconsolidated affiliates due to a decline in the expected future cash flows of five nonconsolidated affiliates that we determined to be other than temporary. This impairment is included in *Equity in net income of nonconsolidated affiliates*. This decline in the expected future cash flows was caused by events specific to each impacted facility, as further described below. The impairments included:

- a $1.5 million impairment on our investment in Wausau Surgery Center, L.P. related to an offer received to purchase our interest in the facility;
- a $2.3 million impairment on our investment in Premier Surgery Center of Louisville, L.P. related to insufficient forecasted growth at the facility;
- a $0.9 million impairment on our investment in Kerlan-Jobe Surgery Center, LLC related to a buy-out agreement for the facility;
- a $0.8 million impairment on our investment in Surgery Center of Fort Collins, LLC related to insufficient forecasted growth at the facility; and
- a $0.6 million impairment on our investment in Surgery Center of Lexington, LLC related to insufficient forecasted growth at the facility.

During 2012, we recorded $9.2 million of impairment to our investments in nonconsolidated affiliates due to a decline in the expected future cash flows of five nonconsolidated affiliates that we determined to be other than temporary. This impairment is included in *Equity in net income of nonconsolidated affiliates*. This decline in the expected future cash flows was caused by events specific to each impacted facility, as further described below. The impairments included:

- a $1.1 million impairment on our investment in Pueblo Ambulatory Surgery Center, LLC related to declining volumes and earnings at the facility;
- a $3.3 million impairment on our investment in Premier Surgery Center of Louisville, L.P. related to insufficient forecasted growth at the facility;
- a $1.7 million impairment on our investment in Endoscopy Center West, LLC related to a buy-out offer received for our interest in the facility;
- a $0.4 million impairment on our investment in Kerlan-Jobe Surgery Center, LLC related to a buy-out agreement for the facility; and
- a $2.7 million impairment on our investment in Surgical Center at Premier, LLC related to an estimated valuation obtained for the facility based upon our search for a new health system partner.

In determining whether an impairment charge is necessary on a particular investment, we consider all available information, including the recoverability of the investment, the earnings and near-term prospects of the affiliate, factors related to the industry, conditions of the affiliate and our ability, if any, to influence the management of the affiliate. We assess fair value based on valuation methodologies, including discounted cash flows, estimates of sales proceeds and external appraisals, as appropriate.

We account for investments in nonconsolidated affiliates primarily using the equity method of accounting. The difference between the carrying amount of the investment and the underlying equity in net assets was $76.9 million and $109.4 million at December 31, 2013 and 2012, respectively, and is primarily attributable to goodwill and other intangible assets. Our investments consist of the following:

INVESTMENT IN AND ADVANCES TO NONCONSOLIDATED AFFILIATES:	AS OF DECEMBER 31 2013	2012
Beginning balance	$194,299	$212,608
Share of income [1]	23,364	16,767
Share of distributions	(53,097)	(38,652)
Acquisitions	5,126	21,414
Conversion to/from investments in nonconsolidated affiliates	186	(2,717)
Sale/closure of investments in nonconsolidated affiliates	(2,133)	(20,880)
Other	1,079	5,759
Total investment in and advances to nonconsolidated affiliates	$168,824	$194,299

(1) Includes $6.1 million and $9.2 million of impairments at December 31, 2013 and 2012, respectively, as previously noted.

Included in the 2013 and 2012 *Share of income* amount above is amortization expense of $25.9 million and $20.3 million, respectively, for definite-lived intangible assets attributable to equity method investments.

The following summarizes the combined assets, liabilities and equity of our nonconsolidated affiliates (on a 100% basis):

	DECEMBER 31 2013	DECEMBER 31 2012
Assets		
Current	$191,765	$143,536
Noncurrent	138,238	97,682
Total assets	$330,003	$241,218
Liabilities		
Current	$ 45,523	$ 31,044
Noncurrent	38,665	18,803
Total liabilities	84,188	49,847
Partners' capital and shareholders' equity		
Surgical Care Affiliates	91,952	84,885
Outside parties	153,863	106,486
Total partners' capital and shareholders' equity	245,815	191,371
Total liabilities and partners' capital and shareholders' equity	$330,003	$241,218

The following summarizes the combined condensed results of operations of our nonconsolidated affiliates:

	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012	YEAR-ENDED DECEMBER 31 2011
Net operating revenues:			
Net patient revenues	$600,600	$474,354	$332,631
Other revenues	5,166	3,153	2,209
Total net operating revenues	605,766	477,507	334,840
Operating expenses:			
Salaries and benefits	128,892	108,803	80,538
Supplies	99,587	78,824	57,897
Other operating expenses	122,764	95,909	69,796
Depreciation and amortization	17,281	14,045	11,383
Total operating expenses	368,524	297,581	219,614
Operating income	237,242	179,926	115,226
Interest expense, net of interest income	1,627	1,501	1,410
Loss on sale of investments	22	—	—
Income from continuing operations before income tax expense	$235,593	$178,425	$113,816
Net income	$235,522	$178,365	$113,760

NOTE 8 — LONG-TERM DEBT

Our long-term debt outstanding consists of the following:

	As of December 31, 2013	As of December 31, 2012
Bonds payable		
Class B Term Loan due 2017	214,429	216,634
Class C Term Loan due 2018	388,050	—
Discount of Class C Term Loan	(784)	—
Class A Term Loan due 2014	—	118,970
Incremental Term Loan due 2018	—	98,500
Discount of Incremental Term Loan	—	(786)
10.0% Senior Subordinated Notes due 2017	—	150,000
8.875% Senior PIK-election Notes due 2015	—	164,785
Notes payable to banks and others	44,023	24,338
Capital lease obligations	27,170	17,295
	672,888	789,736
Less: Current portion	(23,166)	(15,220)
Long-term debt, net of current portion	$649,722	$774,516

The following chart shows scheduled principal payments due on long-term debt, including capital leases, for the next five years and thereafter:

Year Ending December 31	
2014	$ 23,166
2015	18,542
2016	17,162
2017	220,146
2018	377,603
Thereafter	16,269
Total	$672,888

The following table provides information regarding our total *Interest expense* presented in our consolidated statements of operations for both continuing and discontinued operations:

	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012	YEAR-ENDED DECEMBER 31 2011
Continuing operations:			
Interest expense	$56,547	$55,862	$53,278
Amortization of bond issue costs	3,891	2,980	2,762
Total interest expense and amortization of bond issue costs for continuing operations	60,438	58,842	56,040
Discontinued operations:			
Interest expense	178	242	331
Total interest expense for discontinued operations	178	242	331
Total interest expense and amortization of bond Issue costs	$60,616	$59,084	$56,371

Capital Lease Obligations

We engage in a significant number of leasing transactions, including real estate, medical equipment, computer equipment and other equipment utilized in operations. Certain leases that meet the lease capitalization criteria have been recorded as an asset and liability at the net present value of the minimum lease payments at the inception of the lease. Interest rates used in computing the net present value of the lease payments generally range from 2.3% to 12.2% based on the incremental borrowing rate at the inception of the lease. Our leasing transactions include arrangements for equipment with major equipment finance companies and manufacturers who retain ownership of the equipment during the term of the lease and with a variety of both small and large real estate owners.

Senior Subordinated Notes and Senior PIK-election Notes

In connection with the amendment to the Company's Senior Secured Credit Facility (the "Credit Facility") in the second quarter of 2013, on June 14, 2013 we extinguished the Senior PIK-election Notes at par, including a payment of accrued interest through July 15, 2015. Additionally, we redeemed the Senior Subordinated Notes at a premium of 3.333% on December 4, 2013. An aggregate loss on extinguishment of debt of $10.3 million was recorded in connection with these two redemptions.

Credit Facility

With respect to the Credit Facility, as of December 31, 2013, we had $602.5 million outstanding under the senior secured term loan facility consisting of the following:

- $214.4 million under the Class B Term Loan (as defined below) due December 30, 2017. The interest rate on the Class B Term Loan was 4.25% at December 31, 2013.
- $388.1 million under the Class C Term Loan (as defined below) due June 30, 2018. The interest rate on the Class C Term Loan was 4.25% at December 31, 2013.

We must repay the Class B Term Loan and the Class C Term Loan in quarterly installments equal to 0.25% of the original principal amount, with the remaining amount payable in full on the maturity date noted above.

Borrowings under each portion of the Credit Facility bear interest at a base rate or at the London interbank market for the interest period relevant to such borrowings ("LIBOR"), as elected by the Company, plus an applicable margin. The base rate is determined by reference to the higher of (i) the prime rate of JPMorgan Chase

Bank, N.A. and (ii) the federal funds effective rate plus 0.50%. The LIBOR rate is determined by reference to the interest rate for dollar deposits in the London interbank market for the interest period relevant to such borrowings. The below table outlines the applicable margin for each portion of the Credit Facility.

	Applicable Margin (per annum)	
Facility	Base Rate Borrowings	LIBOR Borrowings
Class B Revolving Credit Facility	2.50%	3.50%
Class B Term Loan	3.00%	4.00%
Class C Term Loan	2.00% or 2.25% (with a base rate floor of 2.00%) depending upon the total leverage ratio	3.00% or 3.25% (with a LIBOR floor of 1.00%) depending upon the total leverage ratio

There was no outstanding balance under the senior secured revolving credit facility (the "Class B Revolving Credit Facility") as of December 31, 2013 or December 31, 2012. As of December 31, 2013 the Revolver had a capacity of $132.3 million under the Class B revolver with a maturity date of June 30, 2016.

On June 29, 2013, our Class A Revolving Credit Facility was terminated after we decided not to renew such revolving credit facility.

Any utilization of the Class B Revolving Credit Facility (other than issuances of up to an aggregate of $5.0 million of letters of credit) will be subject to compliance with a total leverage ratio test. At December 31, 2013, we had approximately $1.7 million in such letters of credit outstanding.

2013 Amendment to the Credit Facility

In the second quarter of 2013, we amended our credit agreement (the "Amended Credit Agreement"). The Amended Credit Agreement provides for a Class C Term Loan Facility ("Class C Term Loan") of $388.1 million ($387.3 million, net of discount) as of December 31, 2013. The Class C Term Loan will mature on June 30, 2018. We utilized the proceeds of the Class C Term Loan plus $8.7 million in cash to extinguish the Senior PIK-election Notes, the Class A Term Loan and the Incremental Term Loan. The applicable margin for borrowings under the Class C Term Loan is (i) 2.25% with respect to base rate borrowings (with a base rate floor of 2.00%) and (ii) 3.25% with respect to LIBOR borrowings (with a LIBOR floor of 1.00%). The interest rate on the Class C Term Loan was 4.25% at December 31, 2013. Until maturity, quarterly amortization payments will be made in an amount equal to 0.25% of the original principal amount of the Class C Term Loan.

We incurred a loss on extinguishment of debt of $3.8 million in connection with the settlement of existing debt due to the closing of the Class C Term Loan.

The Credit Facility is guaranteed by the Company and certain of SCA's direct 100% owned domestic subsidiaries (the "Guarantors"), subject to certain exceptions, and borrowings under the Credit Facility are secured by a first priority security interest in all equity interests of SCA and of each 100% owned domestic subsidiary directly held by SCA or a Guarantor. The Credit Facility generally restricts SCA and SCA's restricted subsidiaries' ability to, among other things:

- incur liens;
- incur or assume additional debt or guarantees or issue or sell certain types of preferred stock;
- pay dividends or make redemptions and repurchases with respect to capital stock;
- prepay, or make redemptions and repurchases of, subordinated debt;
- make loans or investments; and
- engage in mergers, acquisitions, asset sales, sale/leaseback transactions and transactions with affiliates.

The Company believes it and SCA were in compliance with these covenants as of December 31, 2013. The Amended Credit Agreement contains a provision that could require prepayment of a portion of our indebtedness if SCA has excess cash flow, as defined by the Amended Credit Agreement. No such prepayment was required at December 31, 2013.

Interest Rate Swaps

We use an interest rate risk management strategy that incorporates the use of derivative financial instruments to limit its exposure to interest rate risk. The swaps are "receive floating/pay fixed" instruments that define a fixed rate of interest on the economically hedged debt that the Company will pay, meaning we receive floating rate payments, which fluctuate based on LIBOR, from the counterparty and pay at a fixed rate to the counterparty, the result of which is to convert the interest rate of a portion of our floating rate debt into fixed rate debt, or to limit the variability of interest related payments caused by changes in LIBOR. At December 31, 2013, interest rate swaps of $240.0 million remained outstanding. As a result of the amendment to the Credit Facility, we de-designated the cash flow hedging instruments. The de-designation resulted in the reclassification of all amounts related to the cash flow hedges in *Accumulated other comprehensive loss* to be reclassified to *Interest expense.*

The following table presents changes in the components of *Accumulated other comprehensive loss*, net of related income tax effects:

	YEAR-ENDED DECEMBER 31, 2013
Balance at Beginning of Period	$(8,327)
Other comprehensive income before reclassifications	847
Amounts reclassified from accumulated other comprehensive loss	7,480
Balance at End of Period	$ —

All derivative instruments are recognized on the balance sheet on a gross basis at fair value. The fair value of the interest rate swaps is recorded in the Company's consolidated balance sheets, either in *Other current liabilities* and *Other long-term liabilities* or *Prepaids and other current assets* and *Other long-term assets*, depending on the changes in the fair value of the swaps and the period remaining until the expiration of the swap, with an offsetting adjustment reported as *Interest expense* on the Company's consolidated statements of operation. At December 31, 2012, gross liabilities in the amount of $2.2 million were included in *Other current liabilities*, and $3.1 million and $3.9 million were included in *Other long-term liabilities* at December 31, 2013 and December 31, 2012, respectively, in the consolidated balance sheets based on the fair value of the derivative instruments. Although all our derivative instruments are subject to master netting arrangements, no amounts have been netted against the gross liabilities previously detailed and no collateral has been posted with counterparties. During the year-ended December 31, 2013, the liability related to the swaps decreased by $3.0 million. The decrease was due to swap settlements and the change in fair value resulting in a $2.2 million decrease in *Other current liabilities* and a $0.8 million decrease in *Other long-term liabilities*. During the year-ended December 31, 2013, the Company recorded losses of approximately $8.3 million within *Interest expense* due to the de-designation of interest rate swaps and subsequent changes in fair value of derivative instruments.

The accounting for changes in fair value of a derivative instrument depends on whether it has been designated and qualifies as part of a hedging relationship and, further, on the type of hedging relationship. For those derivative instruments that are designated and qualify as hedging instruments, a company must designate the hedging instrument, based upon the exposure being hedged, as a fair value hedge, cash flow hedge or a hedge related to foreign currency exposure. The Company previously designated its interest rate swaps as a cash flow hedge; however, as noted above, the interest rate swaps were de-designated as hedges in the second quarter of 2013.

Credit risk occurs when a counterparty to a derivative instrument fails to perform according to the terms of the agreement. Derivative instruments expose us to credit risk and could result in material changes from period to

period. The Company minimizes its credit risk by entering into transactions with highly rated counterparties. In addition, at least quarterly, we evaluate our exposure to counterparties who have experienced or may likely experience significant threats to their ability to perform according to the terms of the derivative agreements to which we are a party. We have completed this review of the financial strength of the counterparty to our interest rate swaps using publicly available information, as well as qualitative inputs, as of December 31, 2013. Based on this review, we do not believe there is a significant counterparty credit risk associated with these derivative instruments. However, no assurances can be provided regarding our potential exposure to counterparty credit risk in the future.

NOTE 9 — NONCONTROLLING INTERESTS

The following table shows the breakout of net loss attributable to Surgical Care Affiliates between continuing operations and discontinued operations:

	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012	YEAR-ENDED DECEMBER 31 2011
Net loss from continuing operations, net of tax, attributable to Surgical Care Affiliates	$(43,952)	$(17,920)	$(6,693)
Net loss from discontinued operations, net of tax, attributable to Surgical Care Affiliates	(7,392)	(2,090)	(2,984)
Net loss, net of tax, attributable to Surgical Care Affiliates	$(51,344)	$(20,010)	$(9,677)

The following table shows the effects of changes to Surgical Care Affiliates' ownership interest in its subsidiaries on Surgical Care Affiliates' equity:

	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012	YEAR-ENDED DECEMBER 31 2011
Net loss attributable to Surgical Care Affiliates	$(51,344)	$(20,010)	$(9,677)
Increase (decrease) in equity due to sales to noncontrolling interests	2,056	(4,243)	4,573
(Decrease) increase in equity due to purchases from noncontrolling interests	(1,394)	(1,738)	320
Change from net loss attributable to Surgical Care Affiliates and transfers to/from noncontrolling interests	$(50,682)	$(25,991)	$(4,784)

Certain of the Company's noncontrolling interests have industry-specific redemption features whereby the Company could be obligated, under the terms of certain of its operating subsidiaries' partnership and operating agreements, to purchase some or all of the noncontrolling interests of the consolidated subsidiaries. As a result, these noncontrolling interests are not included as part of the Company's equity and are carried as *Noncontrolling interests-redeemable* on the Company's consolidated balance sheets.

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The activity relating to the Company's noncontrolling interests — redeemable is summarized below:

	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012	YEAR-ENDED DECEMBER 31 2011
Balance at beginning of period	$ 21,709	$ 20,215	$ 20,594
Net income attributable to noncontrolling interests-redeemable	24,139	24,616	24,807
Net change in equity related to amendments in agreements with noncontrolling interests	(1,050)	—	(491)
Net change related to purchase/(sale) of ownership interests-redeemable	580	1,800	(1,928)
Contributions from noncontrolling interests	1,622	—	37
Change in distribution accrual	(433)	(689)	569
Distributions to noncontrolling interests-redeemable	(24,665)	(24,233)	(23,373)
Balance at end of period	$ 21,902	$ 21,709	$ 20,215

NOTE 10 — FAIR VALUE OF FINANCIAL INSTRUMENTS

We follow the provisions of the authoritative guidance for fair value measurements, which addresses how companies should measure fair value when they are required to use a fair value measure for recognition or disclosure purposes under generally accepted accounting principles.

The fair value of an asset or liability is the amount at which the instrument could be exchanged in an orderly transaction between market participants to sell the asset or transfer the liability. As a basis for considering assumptions, the authoritative guidance establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value as follows:

- Level 1 — Observable inputs such as quoted prices in active markets;
- Level 2 — Inputs, other than the quoted prices in active markets, that are observable either directly or indirectly; and
- Level 3 — Unobservable inputs in which there is little or no market data, which require the reporting entity to develop its own assumptions.

Assets and liabilities measured at fair value are based on one or more of three valuation techniques, as follows:

- Market approach — Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities;
- Cost approach — Amount that would be required to replace the service capacity of an asset (i.e., replacement cost); and
- Income approach — Techniques to convert future amounts to a single present amount based on market expectations (including present value techniques, option-pricing models, and lattice models).

The fair values of our assets and liabilities that are measured on a recurring basis are as follows (in millions):

	December 31, 2013				
	Fair Value Measurements Using			Total Assets/Liabilities at Fair Value	Valuation Technique[1]
	Level 1	Level 2	Level 3		
Assets					
Other long-term assets	$—	$—	$ 0.3	$ 0.3	I
Total assets	$—	$—	$ 0.3	$ 0.3	
Liabilities					
Other current liabilities	$—	$—	$—	$—	I
Other long-term liabilities	—	3.1	$—	3.1	I
Total liabilities	$—	$ 3.1	$—	$ 3.1	

	December 31, 2012				
	Fair Value Measurements Using				Valuation Technique[1]
	Level 1	Level 2	Level 3	Total	
Liabilities					
Other current liabilities	$—	$2.2	$—	$2.2	I
Other long-term liabilities	—	3.9	$—	3.9	I
Total liabilities	$—	$6.1	$—	$6.1	

1 As discussed above, the authoritative guidance identifies three valuation techniques: market approach (M), cost approach (C), and income approach (I).

Interest Rate Swaps

On a recurring basis, we measure our interest rate swaps at fair value. The fair value of our interest rate swaps is derived from models based upon well recognized financial principles and reasonable estimates about relevant future market conditions and calculations of the present value of future cash flows, discounted using market rates of interest. Further, included in the fair value is approximately $0.1 million related to non-performance risk associated with the interest rate swaps at December 31, 2013 and December 31, 2012.

Contingent Consideration

As further described in Note 2, $8.9 million of the HI consideration was placed into escrow as contingent consideration. The amount payable as contingent consideration depends upon the successful continuation and/or renewal of certain management agreement contracts held by HI and, in the case of renewals, will be determined by comparing the contract revenue prior to renewal against the expected contract revenue after renewal. As of the acquisition date and December 31, 2013, approximately $8.6 million of contingent consideration was recognized.

Level 3 Disclosures for Recurring Measurements

The following table provides quantitative information associated with the fair value measurement of our recurring Level 3 inputs (in millions):

Level 3 Contingent Consideration	Level 3 Assets as of December 31, 2013	Significant Unobservable Input	Range of Inputs	Weighted Average
Income Approach	$ 0.3	Probabilities of retention of management contracts [(a)]	75% - 100%	98%

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(a) The fair value of adjustment to the contingent consideration is based on a formula driven threshold contract value set at the time of the HI transaction. The threshold contract value is a function of revenue and probability of retention of each contract over 12 to 18 months from the transaction date. Significant increases or decreases in any of the probabilities of renewal would result in a significantly lower or higher fair value measurement, respectively.

The following table provides a roll-forward of the recurring fair value balance that used Level 3 inputs (in millions):

	Contingent Consideration
Beginning balance as of December 31, 2012	$ —
Addition of contingent consideration asset	0.3
Ending balance as of December 31, 2013	$ 0.3

Nonrecurring Measurements

Where applicable, on a nonrecurring basis, we measure property and equipment, goodwill, other intangible assets, investments in nonconsolidated affiliates and assets and liabilities of discontinued operations at fair value. The fair values of our property and equipment and other intangible assets are determined using discounted cash flows and significant unobservable inputs. The fair value of our investments in nonconsolidated affiliates is determined using discounted cash flows or earnings, or market multiples derived from a set of comparables. The fair value of our assets and liabilities of discontinued operations is determined using discounted cash flows and significant unobservable inputs unless there is an offer to purchase such assets and liabilities, which would be the basis for determining fair value. The fair value of our goodwill is determined using discounted cash flows, and, when available and as appropriate, we use comparative market multiples to corroborate discounted cash flow results. Goodwill is tested for impairment as of October 1 of each year, absent any interim impairment indicators.

An impairment charge of $1.5 million was recorded during 2013 for an investment in a nonconsolidated affiliate. In conjunction with the deconsolidation of this affiliate (as described in Note 2), we adjusted the investment to fair value. The fair value of the investment in the nonconsolidated affiliate was determined based on the estimated fair value using valuations techniques that included recent market transactions.

Also during 2013 we recorded $4.6 million of impairment to our investments in a nonconsolidated affiliates due to the decline of future cash flows of such nonconsolidated affiliates that we judged to be other than temporary. This impairment is included in *Equity in net income of nonconsolidated affiliates*.

During 2012 we recorded $9.2 million of impairment to our investments in nonconsolidated affiliates due to a decline in the expected future cash flows of three nonconsolidated affiliates that we judged to be other than temporary. This impairment is included in *Equity in net income of nonconsolidated affiliates*.

The investment in nonconsolidated affiliates measured at fair value on a nonrecurring basis is as follows (in millions of U.S. dollars):

		Fair Value Measurements Using			
December 31, 2013	Net Carrying Value as of:	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total Losses Year-ended:
Investment in nonconsolidated affiliate	$6.4	—	—	$6.4	$4.6

		Fair Value Measurements Using			
June 30, 2013	Net Carrying Value as of:	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total Losses Year-ended:
Investment in nonconsolidated affiliate	$2.9	—	—	$2.9	$1.5

		Fair Value Measurements Using			
December 31, 2012	Net Carrying Value as of:	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total Losses Year-ended:
Investment in nonconsolidated affiliate	$7.0	—	—	$7.0	$9.2

The inputs used by the Company in estimating the value of Level 3 *Investment in nonconsolidated affiliate* may include the weighted average cost of capital ("WACC"), revenue growth rates and exit price. Assumptions used by the Company due to the lack of observable inputs may significantly impact the resulting fair value and therefore the Company's results of operations. The following table includes information regarding the significant unobservable input used in the estimation of Level 3 fair value measurement.

Level 3 Investment in nonconsolidated affiliate	Level 3 Assets as of December 31, 2013	Significant Unobservable Inputs	Range of Inputs
Income Approach	$6.4	WACC	11.4% - 15%
		Revenue growth rates	0.0% - 3.0%

Level 3 Investment in nonconsolidated affiliate	Level 3 Assets as of June 30, 2013	Significant Unobservable Input	Range of Inputs
Market Approach	$2.9	Exit price[a]	$2.9

(a) The exit price was determined using the amount stated in a firm offer letter for the investment.

Level 3 Investments	Level 3 Assets as of December 31, 2012	Significant Unobservable Inputs	Range of Inputs	Weighted Average
Income Approach	$4.0	CAGR[a]	(2.8) - 8.8%	7.7%
		Discount rate[b]	11.4%	11.4%
Market Approach	$3.0	EBITDA multiple[c]	6.8x	6.8x

(a) "CAGR" is defined as cumulative average growth rate. The CAGR is determined utilizing probability weighted estimates of future cash flows.
(b) The discount rate utilized is an estimate of what would be used by a market participant.
(c) The EBITDA multiple is Earnings before Interest, Taxes, Depreciation and Amortization of the underlying affiliate times a multiple that would be used by a market participant.

During the three-month period ended March 31, 2012, we recorded an impairment charge of $0.4 million for an asset group consisting of property and equipment. During the fourth quarter of 2012, we recorded a separate

impairment charge of $0.7 million for an asset group consisting of property and equipment, resulting in an aggregate impairment charge of $1.1 million recorded for the year-ended December 31, 2012. No material impairment charges were recorded during the years-ended December 31, 2013 and December 31, 2011 for intangible and long-lived assets. Facilities experiencing declining trends of earnings from operations or triggering events, such as the loss of a physician partner or increased local competition, resulted in the impairment charges recorded in 2012. The fair value of the impaired long-lived assets was determined based on the assets' estimated fair value using valuation techniques that included third-party appraisals.

Property and equipment measured at fair value on a nonrecurring basis are as follows (in millions of U.S. dollars):

		Fair Value Measurements Using			
December 31, 2012	Net Carrying Value as of:	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total Losses Year-ended:
Property and equipment	$0.7	—	—	$0.7	$0.7
March 31, 2012					
Property and equipment	$0.9	—	—	$0.9	$0.4

The inputs we used in estimating the value of Level 3 *Property and equipment* include the replacement cost per square foot, depreciation percentage and market price per square foot. Based on available inputs with respect to the two separate events, we used the market approach for determining the fair value of assets for the March 31, 2012 impairment event and the cost approach for determining the fair value of assets for the December 31, 2012 event. Assumptions used by us due to the lack of observable inputs may significantly impact the resulting fair value and, consequently, the Company's results of operations. The following table includes information regarding significant unobservable inputs used in the estimation of Level 3 fair value measurements.

Level 3 Property and equipment	Level 3 Assets as of December 31, 2012	Significant Unobservable Input	Range of Inputs	Weighted Average
Cost Approach	$0.7	Cost per square foot[a]	$ 271	$ 271
		Depreciation[b]	92.5%	92.5%

Level 3 Property and equipment	Level 3 Assets as of March 31, 2012	Significant Unobservable Input	Range of Inputs	Weighted Average
Market Approach	$0.9	Price per square foot[a]	$109	$109

(a) Price per square foot is multiplied times the total square footage of a facility to determine the approximate market value.

The following table presents the carrying amounts and estimated fair values of our financial instruments that are classified as long-term liabilities in our consolidated balance sheets (in thousands). The carrying value equals fair value for our financial instruments that are classified as current in our consolidated balance sheets. The carrying amounts of a portion of our long-term debt approximate fair value due to various characteristics of those issues, including short-term maturities, call features and rates that are reflective of current market rates. For our long-term debt without such characteristics, we determined the fair market value by using quoted market prices, when available, or discounted cash flows to calculate their fair values. The fair values utilize inputs other than quoted prices in active markets, although the inputs are observable either directly or indirectly; accordingly, the fair values are in level 2 of the fair value hierarchy.

	As of December 31, 2013		As of December 31, 2012	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Interest rate swap agreements (includes short-term component)	$ 3,126	$ 3,126	$ 6,105	$ 6,105
Long-term debt:				
Advances under $132.3 million Class B Revolving Credit Facility	$ —	$ —	$ —	$ —
Class A Term Loan due 2014	—	—	118,970	118,673
Class B Term Loan due 2017	214,429	214,563	216,634	215,280
Class C Term Loan due 2018	388,050	389,020	—	—
Incremental Term Loan due 2018	—	—	98,500	98,500
8.875%/9.625% Senior PIK-Election Notes due 2015	—	—	164,785	167,119
10% Senior Subordinated Notes due 2017	—	—	150,000	157,313
Notes payable to banks and others	44,023	44,023	24,338	24,338
Financial commitments	$ —	$ —	$ —	$ —

NOTE 11 — EQUITY-BASED COMPENSATION

We have one active equity-based compensation plan, the 2013 Omnibus Long-Term Incentive Plan, and two legacy equity-based compensation plans, the Management Equity Incentive Plan and the Directors and Consultants Equity Incentive Plan, under which we are no longer issuing new awards (together, the "Plans"). The Plans provide or have provided for the granting of options to purchase our stock as well as RSUs to key teammates, directors, service providers, consultants and affiliates.

Option awards are generally granted with an exercise price equal to at least the fair market value of the underlying share at the date of grant. Vesting in the option awards varies based upon time, attainment of certain performance conditions, or upon the occurrence of a Liquidity Event (as defined in the applicable Plan) in which the TPG Funds and/or any of its affiliates achieves a minimum cash return on its original investment. All existing RSU awards vest over time.

At December 31, 2013, 3,007,121 stock-based awards were authorized for grant under the Plans and 2,330,099 stock-based awards were available for future equity grants.

In conjunction with our conversion to a Delaware corporation on October 30, 2013 (see Note 1), every 10.25 outstanding membership units of ASC Acquisition LLC were converted into one share of common stock of Surgical Care Affiliates, Inc., and options to purchase membership units of ASC Acquisition LLC were converted into options to purchase shares of common stock of Surgical Care Affiliates, Inc. at a ratio of 10.25 membership units of ASC Acquisition LLC underlying such options to each one share of common stock of Surgical Care Affiliates, Inc. underlying such converted options. In connection with the conversion, the exercise prices of such converted options were adjusted accordingly. In addition, every 10.25 outstanding restricted equity units of ASC Acquisition LLC were converted into one restricted equity share of Surgical Care Affiliates, Inc. All information in this footnote is presented giving effect to the conversion.

On September 16, 2013, our Board of Directors accelerated the vesting of all performance-based options. This modification was a "probable-to-probable" modification under the authoritative guidance. As a result of the acceleration, the Company recognized $0.8 million of additional stock-based compensation expense in the year-ended December 31, 2013. The additional expense represents the incremental fair value as a result of the modification. As a result of the acceleration, no unvested performance-based options existed at December 31, 2013.

Also on September 16, 2013, our Board of Directors resolved to pay a cash bonus of $2.46 per vested option and adjust downward the exercise price of all unvested options by approximately $2.46 per unvested option. As such, the Company recorded additional compensation expense of $4.6 million during the year-ended December 31, 2013. We will record stock-based compensation expense over the remaining vesting periods related to the adjustment to unvested options. This modification was a "probable-to-probable" modification under the authoritative guidance. We will record $1.5 million of additional stock-based compensation expense over remaining vesting periods of the modified options.

Information pertaining to equity-based compensation was as follows (in thousands):

	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012	YEAR-ENDED DECEMBER 31 2011
Equity-based compensation expense	$2,724	$1,719	$1,680
Cash received from option exercises	453	—	—

As of December 31, 2013, the Company had total unrecognized compensation cost of approximately $7,794 related to non-vested awards, which the Company expects to recognize through 2017 and over a weighted-average period of 2.2 years.

Option Awards

A summary of option activity under the Plans as of December 31, 2013, and changes during the year-ended December 31, 2013 are presented below:

	UNITS (IN 000'S)	WEIGHTED-AVERAGE EXERCISE PRICE	REMAINING CONTRACTUAL LIFE (YEARS)	AGGREGATE INTRINSIC VALUE
Outstanding, December 31, 2012	2,485	$10.52	2.6 –10.0	$56,779
Granted	612	$13.05	9.2 –10.0	$13,338
Exercised	(41)	$12.09		—
Forfeitures	(49)	$11.51	5.5 –9.5	—
Expirations	—	n/a		—
Outstanding, December 31, 2013	3,007	$19.96	0.6 –10.0	$70,117
Exercisable, December 31, 2013	1,974			

The weighted average grant-date fair value per option of all options granted during the year-ended December 31, 2013, was $6.68. The weighted average grant-date fair value per option of all options granted during the year-ended December 31, 2012, was $3.79. The weighted average grant-date fair value per option of all options granted during the year-ended December 31, 2011 was $3.38.

The fair value of each option award is estimated on the date of grant utilizing two methodologies. For the Time-Based Options, the Company estimates the fair value of the grant utilizing the Black-Scholes-Merton model that utilizes the assumptions shown in the table below. Expected volatilities are based on observed historical trends in the industry and other factors. The expected term of the options granted represents the period of time that options granted are expected to be outstanding. The risk-free interest rate was based on the time horizon of the expected term and is based on the U.S. Treasury yield curve in effect at the time of the grant.

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	YEAR-ENDED DECEMBER 31, 2013	YEAR-ENDED DECEMBER 31, 2012	YEAR-ENDED DECEMBER 31, 2011
Expected volatility	35% -40%	37% -39%	38%-39%
Risk-free interest rate	1.0% -1.35%	1.0% -1.35%	1.2% -3.1%
Expected term (years)	6.25	6.25	6.5
Dividend yield	0.00%	0.00%	0.00%

The fair value of the Performance-Based Options is based on the application of a Monte Carlo simulation model. Expected volatilities are based on observed historical trends in the industry and other factors. The expected term of the options granted is derived from the output of the option valuation model and represents the period of time that options granted are expected to be outstanding. The risk-free interest rate was based on the time horizon of the expected term and is based on the U.S. Treasury yield curve in effect at the time of the grant. On September 16, 2013, our Board of Directors accelerated the vesting of all performance-based options. This modification was a "probable-to-probable" modification under the authoritative guidance. As a result of the acceleration, the Company recognized $0.8 million of additional stock-based compensation expense. The additional expense represents the incremental fair value as a result of the modification.

For the expected volatility assumption, an emphasis was placed on identifying comparable public companies that operate ambulatory surgery centers. The Company utilized comparable public company volatility rates to estimate the expected volatility. The Company used the exponentially weighted moving average volatility of the public companies identified, adjusted for changes in the capital structure (as described by ASC 718), for the derived expected term for the Time-Based Options.

RSU Awards

A summary of activity associated with RSU awards during 2013 is presented below:

	UNITS (IN 000'S)	GRANT DATE FAIR VALUE PER UNIT
Nonvested RSUs at December 31, 2012	20	$11.64
Granted	77	$24.58
Vested	(17)	$11.64
Forfeited	0	n/a
Nonvested RSUs at December 31, 2013	80	$24.58

	UNITS (IN 000'S)	GRANT DATE FAIR VALUE PER UNIT
Total RSUs at December 31, 2012	74	$10.63
Granted	77	$24.58
Vested	—	$ n/a
Forfeited	—	n/a
Total RSUs at December 31, 2013	151	$17.71

NOTE 12 — EMPLOYEE BENEFIT PLANS

SCA has certain employee benefit plans, including the following:

- Company sponsored healthcare plans, including coverage for medical and dental benefits;
- The Retirement Investment Plan, which is a qualified 401(k) savings plan; and
- The Senior Management Bonus Program.

Substantially all teammates are eligible to enroll in the SCA's sponsored healthcare plans, including coverage for medical and dental benefits. Our primary healthcare plans are national plans administered by third-party administrators, for which we are self-insured. The cost associated with these plans, net of amounts paid by teammates, was approximately $21.0 million, $16.9 million and $14.0 million for the years-ended December 31, 2013, 2012 and 2011, respectively.

The Retirement Investment Plan is a qualified 401(k) savings plan. The plan allows eligible teammates to contribute up to 100% of their pay on a pre-tax basis into their individual retirement account in the plan, subject to the maximum annual limits set by the IRS. SCA's employer matching contribution is 50% of the first 4% of each participant's elective deferrals. All contributions to the plan are in the form of cash. Substantially all teammates who are at least 21 years of age are eligible to participate in the plan. Employer contributions vest over a six-year service period. Participants are immediately fully vested in their own contributions. Employer contributions made to the Retirement Investment Plan approximated $2.9 million, $2.8 million and $2.4 million during the years-ended December 31, 2013, 2012 and 2011, respectively.

SCA has a Senior Management Bonus Program designed to reward senior management for performance, based on a combination of corporate, regional and individual goals. The corporate goals are based upon the Company meeting a pre-determined financial goal. Similarly, regional goals, if any, are based upon a pre-determined set of financial goals for the applicable region. Individual goals are initially proposed by each participant in consultation with his or her immediate supervisor and, with respect to our executive officers, are then approved by our Compensation Committee. We recorded expense of approximately $8.5 million, $4.8 million and $5.4 million under the Senior Management Bonus Program for the years-ended December 31, 2013, 2012 and 2011, respectively.

NOTE 13 — INCOME TAXES

The Company is subject to U.S. federal, state and local income taxes. The *Income from continuing operations before income tax expense* is as follows:

	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012	YEAR-ENDED DECEMBER 31 2011
Income from continuing operations before income tax expense	$72,745	$83,301	$106,757

The significant components of the provision for income taxes related to continuing operations are as follows:

	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012	YEAR-ENDED DECEMBER 31 2011
Current:			
Federal	$ 200	$ —	$ —
State and local	661	497	393
Total current expense	861	497	393
Deferred:			
Federal	9,442	6,745	16,121
State and local	2,342	1,622	3,755
Total deferred expense	11,784	8,367	19,876
Total income tax expense related to continuing operations	$12,645	$8,864	$20,269

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A reconciliation of differences between the federal income tax at statutory rates and our actual income tax expense on income from continuing operations, which include federal, state and other income taxes, is as follows:

	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012	YEAR-ENDED DECEMBER 31 2011
Tax expense at statutory rate	35.0%	35.0%	35.0%
Increase (decrease) in tax rate resulting from:			
Federal income tax assumed by noncontrolling interests	(50.1)	(38.8)	(30.5)
Increase in valuation allowance	30.3	14.6	13.5
State income taxes, net of federal tax benefit	(2.0)	(0.5)	0.8
Non-deductible stock issuance costs	3.9	—	—
Other, net	0.3	0.3	0.2
Income tax expense	17.4%	10.6%	19.0%

The income tax expense at the statutory rate is the expected income tax expense resulting from the income from continuing operations. Income tax expense, subsequent to the removal of tax expense related to noncontrolling interest income, is greater than the statutory rate for the year-ended December 31, 2013, 2012 and 2011, due to a valuation allowance and goodwill amortization related to indefinite-lived intangible assets. After consideration of all evidence, both positive and negative, management concluded that it is more-likely-than-not that the Company will not realize its net deferred tax assets. Therefore, a full valuation allowance has been established on our net deferred tax assets. The deferred tax liability resulting from goodwill amortization is considered an indefinite-lived intangible and cannot be looked upon as a source of future taxable income to support the realization of deferred tax assets for purposes of establishing a valuation allowance.

Deferred income taxes recognize the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and amounts used for income tax purposes and the impact of available net operating loss ("NOL") carryforwards. The significant components of the Company's deferred tax assets and liabilities are as follows:

	AS OF DECEMBER 31 2013	2012
Current		
Deferred income tax assets:		
Allowance for doubtful accounts	$ 2,760	$ 1,108
Accrued liabilities	11,148	10,146
Valuation allowance	(12,824)	(10,656)
Deferred income tax liabilities:		
Prepaid expenses	(1,561)	(1,178)
Net current deferred income tax liability	(477)	(580)
Non-current		
Deferred income tax assets:		
Net operating loss	112,795	102,353
Capital loss	30,604	31,610
Investment in nonconsolidated affiliates	16,554	11,445
Other comprehensive income	—	3,350
Interest rate swaps	1,254	—
Other	6,843	257
Valuation allowance	(153,321)	(141,163)
Deferred income tax liabilities:		
Goodwill and other indefinite-lived intangibles	(116,698)	(101,288)
Property, net	(7,391)	(6,924)
Intangible assets	(6,861)	(348)
Net non-current deferred income tax liability	(116,221)	(100,708)
Total deferred income tax liability	$(116,698)	$(101,288)

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We reduce our deferred income tax assets by a valuation allowance if, based on the weight of the available evidence, it is more-likely-than-not that all or a portion of a deferred tax asset will not be realized. We assess the likelihood of realization of our deferred tax assets considering all available evidence, both positive and negative. Our most recent operating performance, the scheduled reversal of temporary differences and our forecast of taxable income in future periods are important considerations in our assessment. Management has considered all positive and negative evidence available at this time and continues to believe it is more-likely-than-not we will not realize a portion of our deferred tax assets. We have established a full valuation allowance against net deferred tax assets other than the deferred tax liability resulting from the goodwill amortization which is considered an indefinite-lived intangible. Based on these conclusions, a valuation allowance of $166.1 million, $151.8 million and $142.4 million is necessary as of December 31, 2013, 2012 and 2011, respectively. For the years-ended December 31, 2013, 2012 and 2011, the increases in the valuation allowance were $14.3 million, $9.4 million and $14.1 million, respectively. Adjustments to the valuation allowance may be made in future periods if there is a change in management's assessment of the amount of deferred income tax assets that is realizable.

At December 31, 2013, we had federal net operating loss carryforwards ("NOLs") of approximately $263.7 million. Such losses expire in various amounts at varying times beginning in 2027. These NOL carryforwards are subject to a valuation allowance. At December 31, 2012, we had federal NOL carryforwards of $243.4 million. At this time, we do not believe the limitations imposed by Internal Revenue Code Section 382 will restrict our ability to use any NOLs before they expire. However, we cannot assure you that will be the case.

The Company has no tax liability for uncertain tax positions as of December 31, 2013 or December 31, 2012.

NOTE 14 — DISCONTINUED OPERATIONS

The Company has closed or sold certain facilities that qualify for reporting as discontinued operations. The assets and liabilities associated with these facilities are reflected in the accompanying consolidated balance sheets as of December 31, 2013 and December 31, 2012 as *Current assets related to discontinued operations, Assets related to discontinued operations, Current liabilities related to discontinued operations* and *Liabilities related to discontinued operations*. Additionally, the accompanying consolidated statements of operations and cash flows reflect the loss, net of income tax expense, and the net cash (used in) provided by operating, investing and financing activities, respectively, associated with these facilities as discontinued operations.

The operating results of discontinued operations are as follows:

	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012	YEAR-ENDED DECEMBER 31 2011
Net operating revenues	$ 4,076	$ 16,654	$ 24,391
Costs and expenses	(5,363)	(17,911)	(26,524)
(Loss) gain on sale of investments	(2,493)	(1,773)	1,573
Impairments	—	(13)	(49)
Loss from discontinued operations	(3,780)	(3,043)	(609)
Income tax benefit (expense)	(3,612)	953	(2,375)
Net loss from discontinued operations	$(7,392)	$ (2,090)	$ (2,984)

The assets and liabilities related to discontinued operations consist of the following:

	DECEMBER 31, 2013	DECEMBER 31, 2012
Assets		
Current assets		
Accounts receivable, net	$ 198	$1,308
Other current assets	99	270
Total current assets	297	1,578
Property and equipment, net	2,136	2,322
Other long term assets	225	234
Total assets	$2,658	$4,134
Liabilities		
Current liabilities		
Accounts payable and other current liabilities	$ 167	$ 596
Total current liabilities	167	596
Other long-term liabilities	380	397
Total liabilities	$ 547	$ 993

NOTE 15 — RELATED PARTY TRANSACTIONS

The Company paid management fees to TPG Capital Management, L.P., an affiliate of TPG Global LLC and its affiliates ("TPG"), our majority owner, of $1.5 million during the year-ended December 31, 2013 and $2.0 million during each of the years-ended December 31, 2012 and 2011, respectively. In connection with the completion of our initial public offering (see Note 1), the Company no longer pays management fees to TPG and the related management services agreement has been terminated.

In conjunction with the completion of our initial public offering, TPG is entitled to a fee payable under our management services agreement in an amount equal to $8.0 million. This fee was paid during the fourth quarter of 2013 and recorded in *Other operating expenses* in the accompanying consolidated statement of operations.

Also in connection with the IPO, we entered into a registration rights agreement with the TPG Funds and certain members of our management and of our Board of Directors (the "Registration Rights Agreement"), which provides the TPG Funds with certain demand registration rights, including shelf registration rights, in respect of any shares of our common stock held by them, subject to certain conditions and limitations. The TPG Funds are entitled to an unlimited number of demand registrations, upon written notice.

In connection with the amendment of our Amended Credit Agreement on May 8, 2013, TPG Capital BD, LLC, an affiliate of TPG, served as an arranger for purposes of the amendment and was paid an arrangement fee in the amount of $0.5 million during the year-ended December 31, 2013. In addition, TPG Capital BD, LLC participated as an underwriter underwriting the shares of our common stock in connection with our initial public offering of common stock and was paid an underwriting discount of approximately $0.7 million by us and the selling stockholders.

Certain directors of the Company have received options to purchase shares of the Company under the Directors Plan as part of their compensation for service on the Company's Board and for consulting services provided to the Company. Total expense recognized by the Company related to these options was immaterial for the years-ended December 31, 2013, 2012 and 2011.

The law firm of Bradley Arant Boult Cummings LLP provided certain legal services to us. We paid approximately $1.8 million, $1.0 million and $0.9 million to this law firm in 2013, 2012 and 2011, respectively, for such legal services. The spouse of one of our executive officers, Richard Sharff, is a partner of this law firm.

NOTE 16 — COMMITMENTS AND CONTINGENT LIABILITIES

Legal Proceedings

The Company provides services in a highly regulated industry and is subject to various legal actions and regulatory and other governmental and internal audits and investigations from time to time. As a result, we expect that various lawsuits, claims and legal and regulatory proceedings may be instituted or asserted against us, including, without limitation, employment-related claims and medical negligence claims. Additionally, governmental agencies often possess a great deal of discretion to assess a wide range of monetary penalties and fines. We record accruals for contingencies to the extent that we conclude it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. No estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made at this time regarding the matters specifically described below because the inherently unpredictable nature of legal proceedings may be exacerbated by various factors, including, but not limited to: (i) the damages sought in the proceedings are unsubstantiated or indeterminate; (ii) discovery is not complete; (iii) the proceeding is in its early stages; (iv) the matters present legal uncertainties; (v) there are significant facts in dispute; (vi) there are a large number of parties (including where it is uncertain how liability, if any, will be shared among multiple defendants); or (vii) there is a wide range of potential outcomes. The outcome of any current or future litigation or governmental or internal investigations, cannot be accurately predicted, nor can we predict any resulting penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities. Nevertheless, it is reasonably possible that any such penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position and cash flows and may affect our reputation.

Litigation

On May 5, 2006, Dr. Hansel DeBartolo filed a lawsuit captioned *DeBartolo, et al. v. HealthSouth Corporation et al,* in the United States District Court for the Northern District of Illinois, Eastern Division, against Joliet Surgery Center Limited Partnership (the "Partnership"), the general partner of that Partnership, Surgicare of Joliet, Inc., and its then-parent, HealthSouth Corporation, for a declaratory judgment and an injunction relating to the forced repurchase of his partnership interest (the "Federal Court Action"). We agreed to take responsibility from HealthSouth Corporation (our parent until SCA was purchased by ASC Acquisition LLC) regarding this matter. Dr. DeBartolo claimed that the partnership agreement's requirement that an investor in a surgical center perform one-third of his surgical procedures at the center violates the federal Anti-Kickback Statute and its underlying federal policy, and he sought an order prohibiting the repurchase of his partnership interest. After the trial court dismissed the case by holding that no private cause of action exists under the Anti-Kickback Statute, Dr. DeBartolo appealed to the Seventh Circuit Court of Appeals, which directed the trial court to dismiss the case because the Federal courts did not have jurisdiction over the subject matter involved. On February 8, 2010, Dr. DeBartolo filed a lawsuit in the Twelfth Judicial Circuit Court, Will County, Illinois making the same claim and seeking the same relief as he sought in the Federal Court Action. On February 5, 2014, the Circuit Court entered an Order granting summary judgment in favor of the Defendants. On March 4, 2014, Plaintiff filed a Notice of Appeal in the Appellate Court of Illinois Third District seeking reversal of the Circuit Court's Order.

Risk Insurance

Risk insurance for SCA and most of our facilities is provided through SCA's risk insurance program. We insure our professional liability, general liability and workers' compensation risks through commercial insurance plans placed with unrelated carriers.

Provisions for these risks are based upon market driven premiums and actuarially determined estimates for incurred but not reported exposure under claims made policies. Provisions for losses within the policy deductibles represent the estimated ultimate net cost of all reported and unreported losses incurred through the consolidated balance sheet dates. Those estimates are subject to the effects of trends in loss severity and frequency. While we believe the provisions for losses are adequate, we cannot be sure the ultimate costs will not exceed our estimates.

Reserves for incurred but not reported professional and general liability risks were approximately $6.3 million and $5.5 million at December 31, 2013 and December 31, 2012, and are included in *Other long-term liabilities* in the consolidated balance sheets. Expenses related to professional and general liability risks were $4.6 million, $3.4 million and $3.8 million for the years-ended December 31, 2013, 2012 and 2011, respectively, and are classified in *Other operating expenses* in our consolidated statements of operations. Expenses associated with workers' compensation were $2.1 million, $2.2 million and $1.7 million for the years-ended December 31, 2013, 2012 and 2011, respectively, and are classified in *Salaries and benefits* in our consolidated statements of operations.

Leases

We lease certain land, buildings and equipment under non-cancelable operating leases expiring at various dates through 2031. We also lease certain buildings and equipment under capital leases expiring at various dates through 2023. Operating leases generally have 3 to 22 year terms with one or more renewal options and with terms to be negotiated at the time of renewal.

NOTE 17 — SUBSEQUENT EVENTS

Effective January 1, 2014, a partner in our Fort Walton, FL ASC, which was a consolidated affiliate as of December 31, 2013, purchased SCA's controlling equity interest in the facility for $2.4 million pursuant to the partner exercising a contractual right to repurchase our equity interest in the facility as described in "Operations—*Facility Level Ownership.*" SCA, through an indirect wholly owned subsidiary, retains a noncontrolling interest in the facility.

Effective January 1, 2014, the owners and operators of a non-SCA affiliated ASC located in Riverside, CA (the "contributed facility") contributed substantially all of the contributed facility's assets to a current SCA facility located in Riverside, CA ("Riverside facility"), which is a consolidated affiliate, in exchange for a limited partnership interest in the Riverside facility. Operations of the two facilities were consolidated into the Riverside facility location, and the contributed facility location ceased operations.

Effective January 1, 2014, an indirect wholly owned subsidiary of SCA purchased for $2.5 million a noncontrolling interest in a joint venture entity that owns and operates an ASC in Fishers, IN.

Effective February 1, 2014, the owners and operators of a non-SCA affiliated ASC located in Sartell, MN ("Sartell facility") contributed 100% of their ownership interests in the Sartell facility to a current SCA facility located in St. Cloud, MN ("St. Cloud facility"), which is a consolidated affiliate, in exchange for a limited partnership interest in the St. Cloud facility as well as cash in the amount of $1.7 million. In addition, we acquired newly issued units of the St. Cloud facility for $1.7 million in cash. The Sartell and St. Cloud facilities continue to operate in separate locations. The operations of the Sartell location will be consolidated into the St. Cloud location at a later date, and the Sartell location will cease operations.

Effective February 28, 2014, an indirect wholly owned subsidiary of SCA exercised its right to repurchase our partner's entire noncontrolling interest in our Houston, TX surgical hospital for $0.3 million.

NOTE 18 — CONDENSED FINANCIAL INFORMATION OF PARENT COMPANY

Surgical Care Affiliates has no material assets or standalone operations other than its ownership in SCA and its subsidiaries.

There are significant restrictions on the Surgical Care Affiliates' ability to obtain funds from any of its subsidiaries through dividends, loans or advances. Accordingly, these condensed financial statements have been presented on a "Parent-only" basis. Under a Parent-only presentation, the Company's investments in its consolidated subsidiaries are presented under the equity method of accounting. These Parent-only financial statements should be read in conjunction with the Company's Consolidated Financial Statements.

The following tables present the financial position of Surgical Care Affiliates as of December 31, 2013 and 2012 and the results of its operations and cash flows for the years-ended December 31, 2013, 2012 and 2011.

Surgical Care Affiliates, Inc.
Condensed Balance Sheets
(In thousands of U.S. dollars)

	DECEMBER 31, 2013	DECEMBER 31, 2012
Assets		
Cash and cash equivalents	$ 16,193	$ 200
Investment in SCA	205,686	147,517
Total assets	$ 221,879	$ 147,717
Liabilities		
Due to SCA	$ 16,193	$ 200
Total liabilities	16,193	200
Equity		
Common stock	382	—
Additional paid in capital	413,419	—
Contributed capital	—	304,826
Accumulated deficit	(208,115)	(157,309)
Total equity	205,686	147,517
Total liabilities and equity	$ 221,879	$ 147,717

Surgical Care Affiliates, Inc.
Condensed Statements of Comprehensive Income
(In thousands, except per share data)

	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012	YEAR-ENDED DECEMBER 31 2011
Equity in net loss of SCA	$(48,620)	$(18,291)	$ (7,997)
Stock compensation expense	2,724	1,719	1,680
Loss before income taxes	(51,344)	(20,010)	(9,677)
Provision for income taxes	—	—	—
Net loss	(51,344)	(20,010)	(9,677)
Equity in comprehensive income of SCA	8,327	986	3,997
Comprehensive loss	$(43,017)	$(19,024)	$ (5,680)
Basic and diluted loss per share	$ (1.62)	$ (0.66)	$ (0.33)
Basic and diluted average shares outstanding	31,688	30,340	29,347

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Surgical Care Affiliates, Inc.
Condensed Statements of Cash Flows
(In thousands of U.S. dollars)

	YEAR-ENDED DECEMBER 31 2013	YEAR-ENDED DECEMBER 31 2012	YEAR-ENDED DECEMBER 31 2011
Net loss	$ (51,344)	$(20,010)	$ (9,677)
Adjustment to reconcile net loss to net cash from operating activities			
Equity in net loss of SCA	48,620	18,291	7,997
Stock compensation expense	2,724	1,719	1,680
Net cash from operating activities	—	—	—
Investing activities:			
Investment in SCA	(160,793)	—	(28,134)
Distributions from SCA	74,900	—	—
Net cash used in investing activities	(85,893)	—	(28,134)
Financing activities:			
Member contributions	—	—	25,205
Proceeds from issuance of shares pursuant to IPO	176,786	—	—
Distributions to unitholders	(74,900)	—	—
Net cash provided by financing activities	101,886	—	25,205
Net change in cash and cash equivalents	15,993	—	(2,929)
Cash and cash equivalents at beginning of period	200	200	3,129
Cash and cash equivalents at end of period	$ 16,193	$ 200	$ 200
Supplemental schedule of noncash investing and financing activities			
IPO fees paid by SCA	$ 4,909	—	—

Quarterly Statement of Earnings Data (Unaudited)

The following table presents certain quarterly statement of earnings data for the years ended December 31, 2013 and 2012. The quarterly statement of earnings data set forth below was derived from our unaudited financial statements and includes all adjustments, consisting of normal recurring adjustments, which we consider necessary for a fair presentation thereof. Results of operations for any particular quarter are not necessarily indicative of results of operations for a full year or predictive of future periods.

	2013				2012			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	(In thousands, except per share data)							
Net operating revenues	$191,991	$197,417	$195,080	$217,547	$179,750	$187,331	$180,213	$197,566
Income from continuing operations before income taxes	31,031	19,516	14,840	7,358	22,965	23,248	22,018	15,070
Income from continuing operations	27,661	18,439	9,130	4,870	19,909	21,115	18,050	15,363
(Loss) gain from discontinued operations, net of income tax	(1,426)	(2,434)	(397)	(3,135)	(624)	(3,935)	1,076	1,393
Net income	26,235	16,005	8,733	1,735	19,285	17,180	19,126	16,756
Less: Net income attributable to noncontrolling interests	(27,671)	(25,768)	(21,441)	(29,172)	(22,750)	(23,972)	(22,118)	(23,517)
Net loss attributable to Surgical Care Affiliates	$ (1,436)	$ (9,763)	$ (12,708)	$ (27,437)	$ (3,465)	$ (6,792)	$ (2,992)	$ (6,761)
Basic and diluted net earnings (loss) from continuing operations per common share	$ 0.00	$ (.24)	$ (.41)	$ (.68)	$ (.08)	$ (.09)	$ (.14)	$ (.27)
Basic and diluted net loss per common share	$ (.05)	$ (.32)	$ (.42)	$ (.77)	$ (.12)	$ (.22)	$ (.10)	$ (.22)

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Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure

Not applicable.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

The Company has carried out an evaluation under the supervision and with the participation of management, including the Company's Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of the Company's disclosure controls and procedures. There are inherent limitations to the effectiveness of any system of disclosure controls and procedures, including the possibility of human error and the circumvention or overriding of the controls and procedures. Accordingly, even effective disclosure controls and procedures can only provide reasonable assurance of achieving their control objectives. Based upon this evaluation, our Chief Executive Officer and Chief Financial Officer have concluded that, as of December 31, 2013, the Company's disclosure controls and procedures are effective in ensuring that material information relating to the Company required to be disclosed in reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported within the requisite time periods and is accumulated and communicated to our management, including our Chief Executive Officer and our Chief Financial Officer, as appropriate to allow timely decisions regarding disclosure.

Management's Annual Report on Internal Control Over Financial Reporting

Report of Independent Registered Public Accounting Firm on Internal Control Over Financial Reporting

This Annual Report on Form 10-K does not include a report of management's assessment regarding internal control over financial reporting or an attestation report of the Company's registered public accounting firm due to a transition period established by rules of the SEC for newly public companies.

Changes in Internal Control Over Financial Reporting

There has been no change in the Company's internal control over financial reporting during the Company's fourth quarter ended December 31, 2013, that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information

Not applicable.

PART III

Item 10. Directors, Executive Officers and Corporate Governance

Our Board of Directors

Our Certificate of Incorporation provides that our Board of Directors will consist of at least five directors but no more than 11 directors, with the exact number of directors to be fixed from time to time by resolution of our Board of Directors. We currently have seven directors. The Board of Directors is divided into three classes, as follows:

- Class I, which currently consists of Todd B. Sisitsky, Sharad Mansukani, M.D. and Jeffrey K. Rhodes, whose terms expire at our 2014 annual meeting of stockholders;
- Class II, which currently consists of Thomas C. Geiser and Curtis S. Lane, whose terms expire at our annual meeting of stockholders to be held in 2015; and
- Class III, which currently consists of Andrew P. Hayek and Frederick A. Hessler, whose terms expire at our annual meeting of stockholders to be held in 2016.

Upon the expiration of the initial term of office for each class of directors, each director in such class shall be elected for a term of three years and serve until a successor is duly elected and qualified or until his or her earlier death, resignation or removal. Any additional directorships resulting from an increase in the number of directors or a vacancy may be filled by the directors then in office.

In connection with the closing of our initial public offering on November 4, 2013 (the "IPO"), we entered into a stockholders' agreement (the "Stockholders' Agreement") with TPG FOF V-A, L.P., TPG FOF V-B, L.P., and TPG Partners V, L.P. (collectively, the "TPG Funds") that provides that, so long as the Stockholders' Agreement remains in effect, the TPG Funds will have certain nomination rights to designate for nomination candidates for our Board of Directors. We are required to use our reasonable best efforts to cause our Board of Directors and the Nominating and Corporate Governance Committee to include such persons designated by the TPG Funds in the slate of nominees recommended by the Board of Directors for election by the stockholders.

As set forth in the Stockholders' Agreement, for so long as the TPG Funds collectively own at least 50% of the shares of our common stock held by them at the closing of the IPO, they are entitled to designate for nomination a majority of the seats on our Board of Directors. When the TPG Funds collectively own less than 50% of the shares of our common stock held by them as of the closing of the IPO, but collectively own at least 30% of the shares of our common stock held by them as of the closing of the IPO, the TPG Funds will be entitled to designate for nomination three directors. When the TPG Funds collectively own less than 30% of the shares of our common stock held by them as of the closing of the IPO, but collectively own at least 10% of the shares of our common stock held by them as of the closing of the IPO, the TPG Funds will be entitled to designate for nomination two directors. Thereafter, the TPG Funds will be entitled to designate for nomination one director so long as they own at least 3% of the shares of our common stock held by them as of the closing of the IPO.

However, if on or before November 4, 2014 (the first anniversary of the IPO), our Board of Directors is increased to nine members, and at such time the TPG Funds collectively own at least 50% of the shares of our common stock held by them as of the closing of the IPO, the number of seats on our Board of Directors that the TPG Funds will be entitled to designate for nomination, as described above, will be increased by one seat, so long as the TPG Funds collectively own at least 20% of the shares of our common stock held by them as of the closing of the IPO. When the TPG Funds collectively own less than 20% of the shares of our common stock held by them as of the closing of the IPO, but collectively own at least 10% of the shares of our common stock held by them as of the closing of the IPO, the TPG Funds will be entitled to designate for nomination two directors. Thereafter, the TPG Funds will be entitled to designate for nomination one director so long as they own at least 3% of the shares of our common stock held by them as of the closing of the IPO.

In the event that the size of our Board of Directors is otherwise increased or decreased in size at any time, the nomination rights afforded to the TPG Funds will be proportionately adjusted as well, rounded up to the nearest whole person.

As our Board of Directors currently consists of seven members and the TPG Funds continue to collectively own at least 50% of the shares of our common stock held by them at the closing of the IPO, the TPG Funds have the right to designate for nomination four directors to our Board of Directors. In accordance with the Stockholders' Agreement, the TPG Funds designated Thomas C. Geiser, Sharad Mansukani, M.D., Todd B. Sisitsky and Jeffrey K. Rhodes as nominees of the TPG Funds to serve on our Board of Directors.

Our Certificate of Incorporation does not provide for cumulative voting in the election of directors, which means that the holders of a majority of the outstanding shares of common stock can elect all of the directors standing for election, and the holders of the remaining shares are not able to elect any directors, subject to our obligations under our Stockholders' Agreement.

Information about the Directors

Set forth below are the biographies of each of our directors, including their names, their ages, their offices in the Company, if any, their principal occupations or employment for at least the past five years, the length of their tenure as directors, and the names of other public companies in which such persons hold or have held directorships during the past five years. Additionally, information about the specific experience, qualifications, attributes or skills that led to the conclusion that each person listed below should serve as a director is set forth below.

Name	Age	Position(s) with the Company
Andrew P. Hayek	40	Director, President and Chief Executive Officer
Todd B. Sisitsky	42	Director and Chairman of the Board of Directors
Thomas C. Geiser	63	Director
Curtis S. Lane	56	Director
Sharad Mansukani, M.D.	44	Director
Jeffrey K. Rhodes	39	Director
Frederick A. Hessler	65	Director

Andrew P. Hayek was appointed to our Board of Directors on October 30, 2013 and the board of directors of SCA, our direct operating subsidiary, in 2008. He has also served as our President and Chief Executive Officer since 2008. Prior to joining the Company, Mr. Hayek served as the President of VillageHealth, a division of renal dialysis provider DaVita Inc. ("DaVita"), from 2007 to 2008 and as President and Chief Operating Officer of Alliance Healthcare Services Inc., a diagnostic imaging and radiation therapy provider, from 2003 to 2006. Mr. Hayek also previously worked at KKR Capstone, an affiliate of private equity firm Kohlberg Kravis Roberts & Co. and at The Boston Consulting Group, a strategy consulting firm. He currently serves on the board of advisors of Sg2, a healthcare analytics and consulting firm. Mr. Hayek earned his bachelor's degree *summa cum laude* from Yale University. We believe that Mr. Hayek's knowledge of the healthcare industry and his leadership experience make him a valuable asset to our management and the Board of Directors.

Todd B. Sisitsky was appointed to our Board of Directors on October 30, 2013 and the board of directors of SCA in 2007. Mr. Sisitsky is a Partner of TPG where he leads TPG's investment activities in the healthcare sector globally. Mr. Sisitsky serves on the board of directors of Aptalis Pharma, Inc., formerly Axcan Pharma, IASIS Healthcare Corp., HealthScope Ltd., Immucor Inc., IMS Health Holdings, Inc. and Par Pharmaceuticals Companies, Inc. and previously served on the boards of Biomet Inc. and Fenwal Inc. He also serves on the board of the Campaign for Tobacco Free Kids, a global not-for-profit organization, and the Dartmouth Medical School Board of Overseers. Prior to joining TPG in 2003, Mr. Sisitsky worked at Forstmann Little & Company and Oak Hill Capital Partners. Mr. Sisitsky earned an M.B.A. from the Stanford Graduate School of Business, where he was an Arjay Miller Scholar, and earned his undergraduate degree from Dartmouth College, where he graduated *summa cum laude*. We believe that Mr. Sisitsky's financial expertise and experience leading investments in numerous healthcare companies make him a valuable asset to the Board of Directors.

Thomas C. Geiser was appointed to our Board of Directors on October 30, 2013 and the board of directors of SCA in 2007. Mr. Geiser has served as a Senior Advisor of TPG Global, LLC since 2006 and served as the

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Executive Vice President and General Counsel of WellPoint Health Networks Inc. ("WellPoint") from its inception in 1993 to 2005. Mr. Geiser was responsible for WellPoint's legal, legislative and regulatory affairs in fifty states and served as its principal contact with state and federal regulators. Prior to joining WellPoint, Mr. Geiser worked as an attorney in private law practice, coming to WellPoint from Brobeck, Phleger & Harrison LLP in San Francisco. He currently serves on the board of directors for Novasom, Inc., IASIS Healthcare Corp., the Library Foundation of Los Angeles and Saint John's Health Center. Mr. Geiser earned his J.D. from the University of California, Hastings College of Law and earned his undergraduate degree in English from the University of Redlands. Mr. Geiser has extensive expertise and experience providing leadership in legal, legislative, regulatory and compliance affairs to both public and private companies in the healthcare industry, which we believe makes him a valuable asset to the Board of Directors.

Curtis S. Lane was appointed to our Board of Directors on October 30, 2013 and the board of directors of SCA in 2007. Mr. Lane is a Senior Managing Director of MTS Health Partners, L.P., a merchant banking firm focused on healthcare advisory and investment opportunities. Prior to forming MTS Health Partners, L.P. in 2000, Mr. Lane founded and managed the healthcare investment banking group at Bear, Stearns & Co. Inc. from its inception in 1986 until 1998. Mr. Lane serves on the board of directors for Alliance Healthcare Services, Loving Care Agency and ProVen Pharmaceuticals, LLC and serves as a board of directors observer for DDC — DNA Diagnostic Center and Senior Home Care, Inc. Mr. Lane serves on the board of America's Camp, which was formed to provide services to children that lost parents on September 11th, and is an emeritus board member of the University of Pennsylvania Health System. Mr. Lane earned his M.B.A. from the Wharton School of the University of Pennsylvania and also earned his bachelor's degree from the Wharton School of the University of Pennsylvania. We believe that Mr. Lane's financial and healthcare advisory experience and experience serving on numerous boards of directors make him a valuable asset to the Board of Directors.

Sharad Mansukani, M.D. was appointed to our Board of Directors on October 30, 2013 and the board of directors of SCA in 2007. Dr. Mansukani has served as a Senior Advisor of TPG Global, LLC since 2005. He serves on the board of directors of IASIS Healthcare Corp., Immucor Inc., IMS Health Holdings, Inc. and Par Pharmaceuticals Companies, Inc. Dr. Mansukani serves as Strategic Advisor to the board of directors of CIGNA and previously served as Vice Chairman of HealthSpring Inc. Dr. Mansukani also serves on the board of directors of the Children's Hospital of Philadelphia and on the editorial boards of the *American Journal of Medical Quality*, *Managed Care*, *Biotechnology Healthcare* and *American Health & Drug Benefits*. Dr. Mansukani was appointed to Medicare's Payment Advisory and Oversight Committee, and he was previously Senior Advisor to CMS and a member of the Medicare Reform Executive Committee. Dr. Mansukani previously served on the faculty at the University of Pennsylvania and at Temple University School of Medicine. Dr. Mansukani completed his residency and fellowship in ophthalmology at the University of Pennsylvania School of Medicine and a fellowship in quality management and managed care at the Wharton School of the University of Pennsylvania. Dr. Mansukani has substantial experience in the healthcare industry and has a deep understanding of the medical community and the dynamic regulatory and reimbursement environment, which we believe makes him a valuable asset to the Board of Directors.

Jeffrey K. Rhodes was appointed to our Board of Directors on October 30, 2013 and the board of directors of SCA in 2010. Mr. Rhodes is a Principal of TPG, where he is a leader of the firm's investment activities in the healthcare services and pharmaceutical/medical device sectors. Mr. Rhodes serves on the board of directors of Biomet Inc., EnvisionRx, IMS Health Holdings, Inc., Immucor Inc., and Par Pharmaceuticals Companies, Inc. Prior to joining TPG in 2005, Mr. Rhodes worked at McKinsey & Company and Article 27 LTD, a software company. Mr. Rhodes earned his M.B.A. from the Harvard Business School, where he was a Baker Scholar, and earned his undergraduate degree in Economics from Williams College, where he graduated *summa cum laude*. We believe that Mr. Rhodes' financial expertise and experience overseeing investments in numerous healthcare companies make him a valuable asset to the Board of Directors.

Frederick A. Hessler was appointed to our Board of Directors and the board of directors of SCA on October 30, 2013. Mr. Hessler is a retired Managing Director of Citigroup Global Markets Inc., where he headed

the Not-for-Profit Health Care Investment Banking Group from 1990 to 2013. Prior to joining Citigroup Global Markets Inc. in 1985, Mr. Hessler was a Partner and Regional Director for healthcare at Ernst & Young LLP, where he was responsible for conducting audits and performing feasibility, corporate reorganization and strategic planning studies for healthcare clients. Mr. Hessler serves on the Operations Committee and chairs the Investment Committee for the American Hospital Association and is a board member of The Center for Health Design, LHP Hospital Group, Inc., the National Center for Healthcare Leadership and the Public Health Institute and is a member of the senior advisory board of MedAssets, Inc. Mr. Hessler also previously served as chair of the Board of Trustees of the Health Research and Education Trust and the Health Insights Foundation and was a member of The Center for Healthcare Governance's Blue Ribbon Panel on Trustee Core Competencies and the Healthcare Executives Study Society. Mr. Hessler earned his bachelor's degree in accounting from Wayne State University and is a Certified Public Accountant (inactive status). We believe that Mr. Hessler's financial and accounting expertise and his substantial investment banking and advisory experience in the healthcare industry make him a valuable asset to the Board of Directors.

There are no family relationships between or among any of our directors or nominees. The principal occupation and employment during the past five years of each of our directors and nominees was carried on, in each case except as specifically identified above, with a corporation or organization that is not a parent, subsidiary or other affiliate of us. Except as described above in connection with the Stockholders' Agreement, there is no arrangement or understanding between any of our directors or nominees and any other person or persons pursuant to which he or she was or is to be selected as a director or nominee.

There are no legal proceedings to which any of our directors is a party adverse to us or any of our subsidiaries or in which any such person has a material interest adverse to us or any of our subsidiaries.

The stock ownership with respect to each director is set forth in the table entitled "Security Ownership of Certain Beneficial Owners and Management" under Item 12 below.

Executive Officers

The following table sets forth certain information regarding our executive officers who are not also directors. As described below under Item 11 below, we have employment agreements with each of our executive officers.

Name	Age	Position
Peter J. Clemens	49	Executive Vice President and Chief Financial Officer
Michael A. Rucker	44	Executive Vice President and Chief Operating Officer
Joseph T. Clark	57	Executive Vice President and Chief Development Officer
Richard L. Sharff, Jr.	45	Executive Vice President, General Counsel and Corporate Secretary

Peter J. Clemens is our Executive Vice President and Chief Financial Officer and has served in such capacity since 2011. Prior to joining SCA, Mr. Clemens held various positions at Caremark Rx, Inc. and CVS Caremark Corporation from 1995 until 2010, including most recently as Executive Vice President and Chief Financial Officer of Caremark, the pharmacy services division of CVS Caremark Corporation. Mr. Clemens has also held various positions in corporate banking with Wachovia Bank and Regions Bank. Mr. Clemens earned his M.B.A. from The Owen School at Vanderbilt University and earned his bachelor's degree from Samford University.

Michael A. Rucker is our Executive Vice President and Chief Operating Officer and has served in such capacity since 2009. Prior to joining SCA, Mr. Rucker served in a number of capacities at DaVita and its predecessor companies from 1995 to 2008, including most recently as Divisional Vice President of Operations. Mr. Rucker also served as an associate in the healthcare group of Houlihan, Lokey, Howard & Zukin Inc. and worked in public accounting as a CPA. Mr. Rucker earned his M.B.A. from the Wharton School of the University of Pennsylvania and his bachelor's degree from Miami University.

Joseph T. Clark is our Executive Vice President and Chief Development Officer and has served in such capacity since 2007. Prior to joining SCA, Mr. Clark served as President of the Surgery Division of HealthSouth

from 2005 to 2007. Mr. Clark also served as the President and Chief Executive Officer of HealthMark Partners, Inc., an owner, operator and developer of ASCs and specialty hospitals and in various senior management roles, including Chief Executive Officer of Response Oncology, Inc., a provider of cancer treatment services. He earned a bachelor's degree from Dartmouth College.

Richard L. Sharff, Jr. is our Executive Vice President, General Counsel and Corporate Secretary and has served in such capacity since 2007. Prior to joining SCA, Mr. Sharff practiced law from 1994 to 2007 at Bradley Arant Rose and White LLP (now Bradley Arant Boult Cummings LLP ("Bradley Arant")), where he represented a variety of clients in the healthcare industry. Mr. Sharff earned his J.D. from the University of Virginia and earned his bachelor's degree from the University of Virginia. He is a member of the bars in Alabama and California (inactive status).

There are no family relationships between or among any of our executive officers. The principal occupation and employment during the past five years of each of our executive officers was carried on, in each case except as specifically identified above, with a corporation or organization that is not a parent, subsidiary or other affiliate of us. There is no arrangement or understanding between any of our executive officers and any other person or persons pursuant to which he was or is to be selected as an executive officer.

There are no legal proceedings to which any of our executive officers is a party adverse to us or any of our subsidiaries or in which any such person has a material interest adverse to us or any of our subsidiaries.

The stock ownership with respect to each of our executive officers is set forth in the table entitled "Security Ownership of Certain Beneficial Owners and Management" under Item 12 below.

Section 16(a) Beneficial Ownership Reporting Compliance

Section 16(a) of the Exchange Act requires our directors and officers, and persons who own more than ten percent (10%) of our common stock, to file reports of ownership and changes in ownership of Company common stock held by them with the SEC. Copies of these reports must also be provided to the Company. Based on our review of these reports, we believe that, during the year ended December 31, 2013, all reports required to be filed during such year were filed on a timely basis.

Committees of the Board of Directors

Standing Committees

The Board of Directors has established five standing committees to assist it in carrying out its responsibilities: the Audit Committee, the Nominating and Corporate Governance Committee, the Compensation Committee, the Compliance Committee and the Acquisition Committee. Each of the committees operates under its own written charter adopted by the Board of Directors, each of which is available on the Company's Investor Relations Web site at http://investor.scasurgery.com under "Corporate Governance." In addition, special committees may be established under the direction of our Board of Directors when necessary to address specific issues. The membership and functions of each of the standing committees are described below.

Audit Committee

The Audit Committee is responsible for, among other things:

- appointing the independent auditor, reviewing the quality of its work annually, monitoring its independence and replacing it as necessary; pre-approving all the audit and non-audit services; reviewing with the auditor the scope and plan of the annual audit; reviewing with the auditor any review of the quarterly financial statements that the committee may direct the auditor to perform;
- reviewing with the senior internal audit services executive the results of the audit work at least annually and more frequently as provided in the policy for reporting financial accounting and auditing concerns, as approved by the committee; at least annually reviewing the experience and qualifications of the senior members of the internal audit services team;

- discussing with management and the auditor the annual audited financial statements, the financial information to be included in our annual and quarterly reports to be filed with the SEC and the adequacy of the internal controls over financial reporting;
- discussing with management and the auditor significant financial reporting issues and judgments made in connection with the preparation of our financial statements, including any significant changes in our selection or application of accounting principles, any significant issues (material weaknesses or significant deficiencies as such terms are defined in the Sarbanes-Oxley Act) as to the adequacy of our accounting controls;
- reviewing the adequacy of disclosure controls and procedures with the Chief Executive Officer, the Chief Financial Officer and the General Counsel at least quarterly;
- overseeing company policies and practices with respect to financial risk assessment and risk management;
- reviewing related party transactions;
- approving guidelines for the hiring of former employees of the independent auditor;
- establishing and publishing procedures for the receipt, retention and treatment of complaints received by us regarding accounting, internal accounting controls or auditing matters and the confidential, anonymous submission by employees of concerns regarding questionable accounting or auditing matters, referred to as "whistleblowing" procedures;
- reviewing with management, including the General Counsel, the implementation and effectiveness of the compliance and ethics program, including the "whistleblowing" procedures;
- meeting separately and periodically with management and the auditor; and
- regularly reporting its work to the Board of Directors.

The current members of the Audit Committee are Frederick A. Hessler (Chairman), Curtis S. Lane and Jeffrey K. Rhodes. Our Board of Directors has determined that (i) Messrs. Hessler, Lane and Rhodes are each "independent directors" under the NASDAQ listing rules, (ii) Messrs. Hessler and Lane each satisfy the heightened independence requirements of Rule 10A-3 under the Exchange Act, (iii) each member of the Audit Committee is financially literate and (iv) Mr. Hessler qualifies as an "audit committee financial expert" under the criteria set forth in the rules and regulations of the SEC.

Nominating and Corporate Governance Committee

The Nominating and Corporate Governance Committee is responsible for, among other things:

- establishing the criteria for selecting new directors;
- recommending to the Board of Directors corporate governance guidelines and reviewing such guidelines at least annually;
- reviewing the performance of our Board of Directors;
- making recommendations to the Board of Directors regarding the selection of candidates, qualification and competency requirements for service on the Board of Directors and the suitability of proposed nominees as directors;
- reviewing and making recommendations to the Board of Directors regarding the charters, structure and operations of the committees of the Board of Directors, including membership of these committees; and
- reviewing succession planning for the Chief Executive Officer and other senior executives, and making recommendations on such matters to the Board of Directors; and
- regularly reporting its activities to the Board of Directors.

The members of the Nominating and Corporate Governance Committee are Jeffrey K. Rhodes (Chairman), Thomas C. Geiser and Todd B. Sisitsky. Because we are a "controlled company" under the NASDAQ listing rules, our Nominating and Corporate Governance Committee is not required to be fully independent, although if such rules change in the future or we no longer meet the definition of a "controlled company" under the current rules, we will adjust the composition of the Nominating and Corporate Governance Committee accordingly in order to comply with such rules.

Compensation Committee

The Compensation Committee is responsible for, among other things:

- reviewing and approving corporate goals and objectives relevant to compensation of our executive officers, including the balance between short-term compensation and long-term incentives;
- conducting the evaluation process for our executive officers in light of these goals and objectives;
- determining and approving or recommending to the Board of Directors for approval the total compensation package of the executive officers;
- making recommendations to the Board of Directors with respect to the establishment and terms of incentive-compensation and equity-based plans for our executive officers; granting awards under and otherwise administering these plans and approving and administering any other compensation plan in which our executive officers participate;
- periodically establishing and reviewing policies with respect to management perquisites;
- advising the Board of Directors with respect to proposed changes in the compensation of the Board of Directors or the Compensation Committee;
- reviewing annually any stock ownership guidelines applicable to our directors and senior management and recommending to the Board of Directors revisions to such guidelines as appropriate;
- retaining compensation consultants and approving the compensation consultants' fees and other terms and conditions of retention, after considering all relevant factors, including any business or personal relationship of the consultant or consultant's employer with any of our executive officers;
- reviewing and discussing with management, prior to the filing of the proxy statement, the disclosure prepared regarding executive compensation; and
- regularly reporting its work to the Board of Directors.

Pursuant to the Compensation Committee's charter, the Compensation Committee may delegate any of its responsibilities to a subcommittee comprised of one or more members of the committee. The current members of the Compensation Committee are Todd B. Sisitsky (Chairman), Thomas C. Geiser and Sharad Mansukani, M.D. Because we are a "controlled company" under the NASDAQ listing rules, our Compensation Committee is not required to be fully independent, although if such rules change in the future or we no longer meet the definition of a controlled company under the current rules, we will adjust the composition of the Compensation Committee accordingly in order to comply with such rules.

Compliance Committee

The Compliance Committee is responsible for, among other things:

- overseeing, monitoring and evaluating our compliance with our federal, state and local regulatory obligations, with the exception of obligations relating to compliance with tax and securities-related laws, rules and regulations (which are the responsibility of the Audit Committee);
- ensuring the establishment, maintenance and oversight of an effective regulatory compliance program to prevent and detect violations of law; reviewing and approving the annual regulatory compliance program and the implementation and effectiveness of such program;

- establishing the qualifications, authority and responsibilities of the compliance officer and assisting with and overseeing the activities of the compliance officer; performing an annual evaluation of the compliance officer in carrying out an effective compliance program;
- monitoring our compliance with any corporate integrity agreement or similar undertaking, with the OIG, HHS or any other government agency;
- receiving and reviewing periodic reports from the compliance officer, including an annual report summarizing compliance-related activities undertaken by us during the year and the results of all regulatory compliance audits conducted during the year;
- establishing and publishing appropriate mechanisms for receipt, retention and treatment of complaints regarding potential violations of our compliance policies and applicable laws and regulations, and reviewing such complaints;
- discussing with management our major compliance risks and steps management has taken to monitor and control such risk, including any policies and procedures with respect to risk assessment and risk management; and
- recommending such actions or measures to be adopted by the Board of Directors that it deems appropriate to improve the effectiveness of the regulatory compliance program.

The members of the Compliance Committee are Thomas C. Geiser (Chair), Sharad Mansukani, M.D. and Curtis S. Lane.

Acquisition Committee

The Acquisition Committee is responsible for, among other things:

- reviewing our acquisition strategies in connection with our management;
- investigating acquisition candidates;
- authorizing and approving acquisitions valued in an amount not to exceed $5.0 million in cash, stock or a combination thereof; and
- recommending acquisition strategies and acquisition candidates valued in an amount above $5.0 million to our Board of Directors.

The members of the Acquisition Committee are Thomas C. Geiser (Chairman) and Jeffrey K. Rhodes.

Meetings and Executive Sessions

Under our Corporate Governance Guidelines, directors are expected to use their reasonable best efforts to attend all or substantially all Board meetings and meetings of the committees of the Board on which they serve, as well as annual meetings of stockholders. Executive sessions of the independent directors of the Board must be held at least two times a year and otherwise as needed. These sessions are chaired by an independent director selected by a majority of the independent directors participating in the executive session.

Process for Stockholders to Recommend Director Candidates

Stockholders who wish to recommend candidates for the Nominating and Corporate Governance Committee's consideration must submit a written recommendation to the Secretary of the Company at 520 Lake Cook Road, Suite 250, Deerfield, IL 60015. Recommendations must be sent by certified or registered mail and received by November 15th for consideration at the following year's annual meeting of stockholders. Recommendations must include the following:

- The recommending stockholder's name, number of shares owned, length of period held, and proof of ownership;
- The candidate's name, address, phone number, e-mail address and age;

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- A resume describing, at a minimum, the candidate's educational background, occupation, employment history, and material outside commitments (e.g., memberships on other boards and committees, charitable foundations, etc.);
- A supporting statement which describes the stockholder's and candidate's reasons for nomination to the Board and documents the candidate's ability to satisfy the director qualifications described above;
- The candidate's consent to a background investigation;
- The candidate's written consent to stand for election if nominated by the Board and to serve if elected by the stockholders; and
- Any other information that will assist the Nominating and Corporate Governance Committee in evaluating the candidate in accordance with this procedure.

The Corporate Secretary will promptly forward these materials to the Chairman of the Nominating and Corporate Governance Committee and the Board Chairperson. The Nominating and Corporate Governance Committee may contact recommended candidates to request additional information necessary for its evaluation or for disclosure under applicable SEC rules, including without limitation information relating to such candidate that is required to be disclosed in solicitations of proxies for election of directors pursuant to Regulation 14A under the Exchange Act.

Code of Business Conduct and Ethics

We are committed to having sound corporate governance principles. Having such principles is essential to running our business efficiently and to maintaining our integrity in the marketplace. We have adopted a document known as the Standards of Legal and Regulatory Conduct that is applicable to all of our directors and teammates ("Code of Business Conduct"). We have also adopted a Code of Ethical Conduct for Financial Leaders that applies to our Chief Executive Officer, Chief Financial Officer and other senior financial officers at the corporate level (the "Senior Officers Code"). Both the Code of Business Conduct and the Senior Officers Code are available on our website at www.scasurgery.com in the "Investors" section under "Corporate Governance." Any future changes or amendments to the Senior Officers Code or the Code of Business Conduct, and any waiver of the Senior Officers Code or the Code of Business Conduct that applies to our Chief Executive Officer, Chief Financial Officer or Principal Accounting Officer will be posted to our website at the above location.

Item 11. Executive Compensation

Overview

The following discussion relates to the compensation of our President and Chief Executive Officer, Andrew P. Hayek, and our two most highly compensated executive officers in 2013 (other than our Chief Executive Officer), Joseph T. Clark, our Executive Vice President and Chief Development Officer, and Michael A. Rucker, our Executive Vice President and Chief Operating Officer (Messrs. Hayek, Clark and Rucker are collectively referred to herein as our "Named Executive Officers"). Our Named Executive Officers' compensation is determined by our Compensation Committee and is generally reviewed annually. Our executive compensation program is designed to attract, motivate and retain high-quality leadership and incentivize our executive officers and other key teammates to achieve company and individual performance goals over the short- and long-term. Our pay-for-performance approach to executive compensation places an emphasis on both short- and long-term incentives, which serves to align the interests of our executive officers with those of our stockholders.

On October 30, 2013, prior to the closing of the IPO, we converted from a Delaware limited liability company, ASC Acquisition LLC, to a Delaware corporation. Pursuant to the conversion, options to purchase membership units of ASC Acquisition were converted into options to purchase shares of common stock of Surgical Care Affiliates at a ratio of 10.25 membership units underlying such options to each one share of common stock underlying such converted options. In connection with the conversion, the exercise prices of such converted options

were adjusted accordingly. In addition, every 10.25 outstanding Restricted Equity Units ("REUs") of ASC Acquisition LLC were converted into one RSU of Surgical Care Affiliates. The vesting and other terms of the options and REUs generally remained the same.

Elements of Executive Compensation

The compensation of our Named Executive Officers consists of base salary, annual cash bonuses, equity awards and employee benefits, as described below. Our Named Executive Officers are also entitled to certain compensation and benefits upon qualifying terminations of employment pursuant to their employment agreements.

Base Salaries. Base salaries for our Named Executive Officers are determined based on each officer's responsibilities and his experience and contributions to our business. Base salaries for our Named Executive Officers are reviewed periodically by our Compensation Committee. When reviewing base salaries for potential increase, our Compensation Committee considers each officer's experience and individual performance, our performance, and general industry conditions.

Annual Cash Bonuses. Our Named Executive Officers are eligible to participate in our Senior Management Bonus Program, which was established to promote and reward the achievement of corporate, regional and individual performance goals. Corporate goals are based upon Surgical Care Affiliates meeting pre-determined financial goals. Similarly, regional goals, if any, are based upon a pre-determined set of financial goals for the applicable region. Individual goals are initially proposed by each participant in consultation with his or her immediate supervisor and are then approved by the Compensation Committee. The target and maximum amounts of any annual bonus that may be earned by an executive officer are expressed as a percentage of the executive's annual base salary in effect with respect to the applicable year.

For fiscal year 2013, Mr. Hayek had a target annual bonus of 100% of base salary, up to a maximum of 200% of base salary. Mr. Clark had a target annual bonus of 70% of base salary, up to a maximum of 140% of base salary. Mr. Rucker had a target annual bonus of 75% of base salary, up to a maximum of 150% of base salary. The bonuses paid to each of our Named Executive Officers for fiscal year 2013 are set forth in the Summary Compensation Table below.

Equity Awards. Our Named Executive Officers participate in the Management Equity Incentive Plan adopted on November 16, 2007, as amended (the "2007 Equity Plan"). See "2007 Equity Plan" beginning on page 172 below for additional details about our 2007 Equity Plan. Grants under the 2007 Equity Plan, including those made to our Named Executive Officers, have consisted of option awards, which provide our executive officers with appropriate incentives to continue in our employ and to improve our growth and profitability, and which serve to align the interests of our Named Executive Officers with our stockholders. A portion of the option awards granted to each Named Executive Officer are subject to time-based vesting and a portion were subject to performance-based vesting, subject to the Named Executive Officer continuing to be employed on the applicable vesting date. Approximately 24% of Mr. Hayek's outstanding awards are subject to time-based vesting and approximately 76% were subject to performance-based vesting. Approximately 29% of Mr. Clark's outstanding awards are subject to time-based vesting and approximately 71% were subject to performance-based vesting. Approximately 49% of Mr. Rucker's outstanding awards are subject to time-based vesting and approximately 51% were subject to performance-based vesting. As of September 16, 2013, all of the performance-based options were deemed to be fully vested. The vesting of the time-based option awards is generally in four or five equal annual installments of 25% or 20% per year, respectively, following the grant, and accelerates upon certain qualifying terminations, as described below.

Our Named Executive Officers are also eligible to participate in the 2013 Omnibus Long-Term Incentive Plan adopted on October 29, 2013 (the "2013 Omnibus Plan"); however, no awards have been made to the Named Executive Officers to date under the 2013 Omnibus Plan. See "2013 Omnibus Plan" beginning on page 173 below for a description of our 2013 Omnibus Plan.

On July 24, 2008, Mr. Hayek was granted 700,000 REUs (or 68,292 RSUs after giving effect to our conversion from a Delaware limited liability company to a Delaware corporation on October 30, 2013), which were subject to time-based vesting over a period of five years from the date of grant and as of July 24, 2013 were fully vested. Mr. Hayek's RSUs will be settled for shares of common stock (or, in the Board of Directors' discretion, cash) upon the earlier of (i) the termination of Mr. Hayek's employment or (ii) a qualifying change in control of the Company or SCA.

Special Cash Bonus. In September 2013, we paid a cash distribution of $0.241279 per outstanding membership unit of ASC Acquisition LLC (or approximately $2.46 per share of our common stock after giving effect to our conversion to a corporation) (the "2013 Distribution"). In connection with the 2013 Distribution, in September 2013, SCA paid the 2013 Special Cash Bonus Payment to holders of vested options and REUs who remained employed by SCA as of the date of payment, including our Named Executive Officers, equal to $0.241279 per vested option or REU (or $2.46 per option or RSU after giving effect to our conversion to a corporation). In connection with the 2013 Distribution and the 2013 Special Cash Bonus Payment, the Company also reduced the exercise price of unvested options by the same amount. Holders of unvested REUs did not receive a cash payment or any adjustment with respect to their unvested REUs. To the extent teammates, including our Named Executive Officers, owned membership units of ASC Acquisition LLC outright, such teammates also received a payment in respect of such membership units as part of the 2013 Distribution.

Benefits and Perquisites. We provide the following benefits to our Named Executive Officers on the same basis as all other eligible executives:

- Company sponsored healthcare plans, including coverage for medical and dental benefits.
- A qualified 401(k) savings plan with a matching contribution.
- Payment of life insurance premiums.
- Payment of long-term disability insurance premiums.
- With respect to Mr. Hayek, dues and expenses for his memberships in the Young Presidents Organization ("YPO") and the YPO-WPO International in the amount of approximately $8,830 in 2013.

Employment Agreements. We have entered into employment agreements with each of our Named Executive Officers, which include severance and restrictive covenant provisions. We believe that reasonable severance benefits are necessary in order to attract and retain high-quality, talented executive officers.

Role of Executive Officers in Decisions Relating to Executive Officer and Director Compensation

Our Chief Executive Officer makes recommendations to the Compensation Committee regarding base salaries, bonuses and equity compensation grants for the remainder of our executives. However, the Chief Executive Officer is not present during deliberations or voting relating to his own compensation. The Compensation Committee has discretion to approve, disapprove or modify recommendations made by the Chief Executive Officer.

Role of Compensation Consultant

The Compensation Committee has engaged a compensation consultant, Deloitte Consulting LLP ("Deloitte"), to review, assess and provide recommendations with respect to certain aspects of our compensation program for executive officers and directors. Deloitte was previously engaged, beginning in July 2013, by the compensation committee of the board of directors of SCA to assist with executive compensation matters in connection with the possibility of either us or SCA transitioning to become a public company. In its role as compensation consultant, Deloitte has rendered services to the compensation committee of SCA, and since the IPO, to our Compensation Committee, including examining the overall pay mix for our executives, conducting a competitive assessment of our executive compensation program and making recommendations and advising on compensation design and

levels. Deloitte has also provided advice on structuring annual and long-term incentive arrangements for executives. In addition, Deloitte has provided and is expected to continue to provide advice to the Compensation Committee on the compensation elements and levels for non-employee directors.

In addition to the compensation consulting services provided by Deloitte to the Compensation Committee, Deloitte affiliates have provided certain services to us and SCA, at the request of management, consisting of internal audit support services and business valuation services. Deloitte's fees for executive and director compensation services in 2013 were $106,953. For the additional services provided by affiliates of Deloitte, as described above, the aggregate fees in 2013 were $242,037.

The Compensation Committee believes that, given the nature and scope of these projects, these additional services did not raise a conflict of interest and did not impair Deloitte's ability to provide independent advice to the Compensation Committee concerning executive and director compensation matters. In making this determination, the Compensation Committee has considered, among other things, the following factors: (i) the types of non-compensation services provided by the affiliates of Deloitte, (ii) the amount of fees for such non-compensation services, noting in particular that such fees are negligible when considered in the context of the aggregate total revenues of Deloitte and its affiliates for the period, (iii) Deloitte's policies and procedures concerning conflicts of interest, (iv) the fact that Deloitte representatives who advise the Compensation Committee do not provide any non-compensation related services to us or SCA, (v) the fact that there are no other business or personal relationships between our management or members of the Compensation Committee, on the one hand, and any Deloitte representatives who provide compensation services to us, on the other hand, and (vi) the fact that neither Deloitte nor any of the Deloitte representatives who provide compensation services to the Compensation Committee owns any of our common stock.

Summary Compensation Table

The table below summarizes the total compensation paid to or earned by each of the Company's Named Executive Officers for the fiscal years ended December 31, 2013 and December 31, 2012.

Name and Principal Position	Year	Salary ($)	Bonus ($)	Stock Awards ($)	Option Awards ($)[1]	Non-Equity Incentive Plan Compensation ($)[2]	Nonqualified Deferred Compensation Earnings ($)	All Other Compensation ($)[3]	Total ($)
Andrew P. Hayek	2013	595,327	1,871,032[4]	-0-	1,743,524	579,898	-0-	9,110	4,798,891
President and Chief Executive Officer	2012	582,000	31,440[5]	-0-	-0-	196,211	-0-	9,000	818,651
Michael A. Rucker	2013	424,338	433,906[6]	-0-	887,121	315,909	-0-	9,056	2,070,330
Executive Vice President and Chief Operating Officer	2012	415,000	20,375[7]	-0-	369,000	110,536	-0-	9,000	923,911
Joseph T. Clark	2013	458,559	497,638[8]	-0-	515,588	320,991	-0-	9,080	1,801,856
Executive Vice President and Chief Development Officer	2012	448,000	33,904[9]	-0-	95,000	97,883	-0-	9,000	683,787

(1) The amounts presented in this column represent the fair value of the options granted to purchase membership units of ASC Acquisition LLC (or, since October 30, 2013, shares of our common stock) on the date of grant in accordance with FASB ASC Topic 718. Further detail surrounding the options awarded, the method of valuation and the assumptions made are set forth in the "Management's Discussion and Analysis of Financial Conditions and Results of Operations" section, under "Critical Accounting Policies." For 2013, in addition to the grant date fair value of the option awards granted to the Named Executive Officers in fiscal year 2013, the amounts reported include (i) the incremental fair value of the performance-based options that were accelerated on September 16, 2013, computed as of the acceleration date in accordance with ASC Topic 718, or $174,635 for Mr. Hayek, $130,809 for Mr. Rucker and $52,562 for Mr. Clark and (ii) the incremental fair value recognized for the reduction on September 16, 2013 of the exercise price of previously granted options that were unvested as of such date, computed in accordance with ASC Topic 718, or $368,894 for Mr. Hayek, $276,317 for Mr. Rucker and $111,030 for Mr. Clark.

(2) The amounts presented in this column represent the portion of the cash bonuses earned by the executive officers under our Senior Management Bonus Program for the applicable year that were attributable to the attainment of pre-established corporate and/or individual performance goals for such year. Any discretionary bonuses, whether paid under the Senior Management Bonus Program or otherwise, are reported under the "Bonus" column rather than the "Non-Equity Incentive Plan Compensation" column.
(3) The amounts presented in this column represent 401(k) matching contributions and life insurance premiums paid on behalf of the Named Executive Officers by the Company.
(4) $1,495,930 of this amount represents the amount of a one-time cash bonus paid to Mr. Hayek in September 2013 in respect of vested options and REUs, as described above under "Elements of Executive Compensation — Special Cash Bonus," and $375,102 represents an additional special cash bonus paid to Mr. Hayek in connection with the successful completion of the Company's initial public offering.
(5) Represents the discretionary portion of the bonus paid to Mr. Hayek under our Senior Management Bonus Program for 2012.
(6) Represents the amount of a one-time cash bonus paid to Mr. Rucker in September 2013 in respect of vested options, as described above under "Elements of Executive Compensation — Special Cash Bonus."
(7) Represents the discretionary portion of the bonus paid to Mr. Rucker under our Senior Management Bonus Program for 2012.
(8) Represents the amount of a one-time cash bonus paid to Mr. Clark in September 2013 in respect of vested options, as described above under "Elements of Executive Compensation — Special Cash Bonus."
(9) Represents the discretionary portion of the bonus paid to Mr. Clark under our Senior Management Bonus Program for 2012.

Outstanding Equity Awards at 2013 Fiscal Year-End

The following table sets forth information regarding equity awards held by our Named Executive Officers as of December 31, 2013 and reflects our conversion from a Delaware limited liability company to a Delaware corporation on October 30, 2013.

		Option Awards					Stock Awards			
Name	Vesting Start Date	Number of Securities Underlying Unexercised Options (#) Exercisable	Number of Securities Underlying Unexercised Options (#) Unexercisable	Equity Incentive Plan Awards: Number of Securities Underlying Unexercised Unearned Options (#)	Option Exercise Price ($)	Option Expiration Date	Number of Shares or Units of Stock That Have Not Vested (#)	Market Value of Shares or Units of Stock That Have Not Vested ($)	Equity Incentive Plan Awards: Number of Unearned Shares, Units or Other Rights That Have Not Vested (#)	Equity Incentive Plan Awards: Market or Payout Value of Unearned Shares, Units or Other Rights That Have Not Vested ($)
(a)		(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)
Andrew Hayek	4/21/2008	360,975(1)	— (1)	—	10.25	4/21/2018	—	—		
	3/24/2010	175,610(1)	— (1)	—	11.18	3/24/2020	—	—		
	3/24/2010	21,951(1)	21,951(1)	—	8.72(4)	3/24/2020	—	—		
	5/06/2013	—	182,926(2)	—	12.41(4)	5/06/2023	—	—		
Michael A. Rucker	9/15/2008	53,500(1)	— (1)	—	12.10	9/15/2018	—	—		
	7/23/2009	37,765(1)	— (1)	—	12.10	7/23/2019	—	—		
	7/23/2009	— (1)	4,196(1)	—	9.64(4)	7/23/2019	—	—		
	3/24/2010	46,829(1)	— (1)	—	11.18	3/24/2020	—	—		
	3/24/2010	5,854(1)	5,853(1)	—	8.72(4)	3/24/2020	—	—		
	2/8/2011	13,659(1)	— (1)	—	11.18	2/8/2021	—	—		
	2/8/2011	1,951(1)	3,902(1)	—	8.72(4)	2/8/2021	—	—		
	3/6/2012	23,696(2)	— (2)	—	13.94	3/6/2022	—	—		
	3/6/2012	23,695(2)	47,390(2)	—	11.48(4)	3/6/2022	—	—		
	5/6/2013	— (2)	73,170(2)	—	12.41(4)	5/6/2023	—	—		
Joseph T. Clark	6/29/2007	195,121(1)(3)	—	—	10.25	6/29/2014	—	—		
	3/6/2012	6,098(2)	— (2)	—	13.94	3/6/2022	—	—		
	3/6/2012	6,097(2)	12,195(2)	—	11.48(4)	3/6/2022	—	—		
	5/6/2013	— (2)	53,658(2)	—	12.41(4)	5/6/2023	—	—		

(1) Half of these option awards are subject to time-based vesting, with 20% vesting on each of the first, second, third, fourth and fifth anniversaries of the date of grant, and half were subject to performance-based vesting, which half were deemed vested as of September 16, 2013.
(2) These option awards are subject to time-based vesting, with 25% vesting on each of the first, second, third and fourth anniversaries of the date of grant.
(3) On January 15, 2014, Mr. Clark exercised all of these options pursuant to an Option Net-Settlement Exercise Agreement, dated October 8, 2013, between the Company and Mr. Clark, which agreement granted Mr. Clark the ability to exercise, on a net-settlement basis, these options beginning on January 1, 2014.
(4) Reflects a $2.46 per share reduction in the exercise price of these options on September 26, 2013 in connection with the IPO.

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Employment Agreements

On October 30, 2013, we entered into employment agreements with each of our Named Executive Officers (collectively, the "Employment Agreements"). The initial term of the Employment Agreements is three years, in each case with automatic renewals for successive one-year terms unless either party to the agreement provides notice of non-renewal at least 90 days prior to the expiration of the initial term or the applicable renewal term.

The Employment Agreements establish a base salary for each of our Named Executive Officers, subject to possible annual increases as determined by the Board of Directors or the Compensation Committee. The annual base salaries currently in effect for Messrs. Hayek, Clark and Rucker are $780,000, $469,000, and $439,000, respectively.

Additionally, the Employment Agreements provide that the Named Executive Officers are eligible to participate in our Senior Management Bonus Program, under which they may earn a cash bonus each year, subject to the achievement of company and individual performance objectives established by the Compensation Committee. The target and maximum amounts of any annual bonus that may be earned by an executive are expressed as a percentage of the executive's annual base salary in effect with respect to such year. The Employment Agreements also provide that each Named Executive Officer is entitled to participate in all savings and retirement plans and welfare benefits provided by us which are generally made available to other executives.

The Employment Agreements contain standard ongoing confidentiality, non-solicitation and non-competition restrictions. The non-solicitation restrictions remain in place for 18 months for Messrs. Clark and Rucker, and two years for Mr. Hayek, in each case following termination of employment, and the non-competition restrictions remain in place for 18 months for Messrs. Clark, Rucker and Hayek, following termination of employment.

Each of the Employment Agreements provides that if a Named Executive Officer is terminated for cause, or if he terminates his employment without good reason (as such terms are defined in the applicable Employment Agreement), he will be entitled to any earned and unpaid base salary through the date of his termination. If a Named Executive Officer is terminated without cause, if he terminates his employment for good reason or if the Company delivers a notice of non-renewal, in each case other than in connection with a change in control, he will be entitled to the following payments and benefits: (i) continued base salary payments for 18 months (24 months for Mr. Hayek) following the date of termination of employment, (ii) health insurance benefits for 18 months following the date of termination of employment or until he becomes re-employed with another employer and is eligible to receive health insurance benefits under another employer-provided plan, whichever comes earlier, and (iii) a pro rata portion of his annual bonus based upon the achievement of the applicable performance objectives payable in a lump sum at the same time as the annual bonuses are otherwise paid to other employees.

In addition, each of the Employment Agreements provides that if a Named Executive Officer's employment terminates as a result of his death or disability, he will be entitled to any earned and unpaid base salary through the date of his termination, as well as a pro rata portion of his annual bonus based upon the achievement of the applicable performance objectives. In the event a Named Executive Officer's employment is terminated without cause, for good reason or if the Company delivers a notice of non-renewal, in each case within the three months prior to the consummation of, or within the twenty-four month period following, a change in control, in addition to any earned and unpaid base salary through the date of termination, he will be entitled to (i) an amount equal to 1.5 times (two times in the case of Mr. Hayek) the sum of the Named Executive Officer's then-current base salary and his target annual bonus, payable in a lump sum within forty days following the date of such termination, (ii) health insurance benefits for 18 months following the date of termination of employment or until he becomes re-employed with another employer and is eligible to receive health insurance benefits under another employer-provided plan, whichever comes earlier and (iii) a pro rata portion of his annual bonus based upon the achievement of the applicable performance objectives payable in a lump sum at the same time as the annual bonuses are otherwise paid to other employees.

Payments of severance and other benefits are conditioned upon the Named Executive Officer executing a release of claims, and such release becoming effective, and compliance with restrictive covenants.

Retirement Benefits

We maintain the SCA Retirement Investment Plan, a tax-qualified 401(k) savings plan (the "401(k) Plan"), in which our Named Executives participate. The 401(k) Plan allows participants to contribute up to 100% of their pay on a pre-tax basis into individual retirement accounts, subject to the maximum annual limits set by the IRS. SCA makes a matching employer contribution in an amount equal to 50% of the first 4% of each plan participant's elective deferrals. All contributions to the 401(k) Plan are in the form of cash. Employer contributions vest over a six-year service period. Participants are immediately fully vested in their own contributions to the 401(k) Plan.

Potential Payments Upon Termination or a Change in Control

The Employment Agreements contain severance provisions pursuant to which the Named Executive Officers are entitled to certain payments or benefits upon a termination without cause or for good reason. Please refer to the "Employment Agreements" section above for further information about such payments and benefits.

In addition, the 2007 Equity Plan provides for accelerated vesting of the outstanding option awards subject to time-based vesting if the executive is terminated without cause or for good reason within the two-year period following a change in control.

For any change in control consummated on or before January 1, 2015, Mr. Hayek has the right to receive a "gross-up" for any excise tax imposed by Section 4999 of the Code, or any federal, state or local income tax under the terms of his Employment Agreement in the event the amount of the "parachute payments" he is entitled to receive exceeds the safe harbor limit under Section 280G of the Code by more than 10%. Any amounts below that 10% limit would be reduced to fall within the safe harbor limit. For any change in control consummated after January 1, 2015, Mr. Hayek is not entitled to a gross up.

2007 Equity Plan

The 2007 Equity Plan, which became effective on November 16, 2007, provides for the grant of options to purchase our membership units to our and our affiliates' key teammates, directors, service providers and consultants. The summary of the 2007 Equity Plan contained in this proxy statement is not a complete description of all provisions of the 2007 Equity Plan and is qualified in its entirety by reference to the 2007 Equity Plan, which is filed as an exhibit to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013 and incorporated into this Annual Report on Form 10-K by reference.

The 2007 Equity Plan is administered by our Compensation Committee, which has authority to select award recipients and to determine the terms of all awards, including the time or times at which awards vest or become exercisable. Unless otherwise provided by our Compensation Committee in a participant's grant agreement or other agreement, a participant's unvested options will immediately expire on the date such participant's employment is terminated for any reason, and vested options will remain outstanding for one year following the participant's death or disability and for 90 days following termination of employment for any other reason (or, in each case, until the award's expiration date, if earlier). If a participant's employment is terminated for cause (as defined in the 2007 Equity Plan), all awards then held by the participant will be forfeited immediately, whether or not vested. Options granted after 2010 expire 10 years from the date of grant. The 2007 Equity Plan provides that if an individual's employment is terminated within a certain period following a change in control, either by the company without cause or by the individual for good reason, all unvested time-based options shall become fully vested.

Prior to 2010, with the exception of options granted to Mr. Hayek, all options granted to participants expired seven years from the date of grant (Mr. Hayek's options granted prior to 2010 expire 10 years from the date of grant). In 2011, we offered to cancel all of the outstanding options under the 2007 Equity Plan that had seven year terms and replace such options with a larger number of options with similar terms and with an expiration date of 10 years from the original date of grant (rather than seven years).

2013 Omnibus Plan

Prior to the IPO, we adopted the 2013 Omnibus Plan. All equity-based awards subsequent to the IPO have been and will be granted under the 2013 Omnibus Plan. No awards have been made to date to the Named Executive Officers under the 2013 Omnibus Plan. This summary of the 2013 Omnibus Plan is not a complete description of all provisions of the 2013 Omnibus Plan and is qualified in its entirety by reference to the 2013 Omnibus Plan, which is filed as an exhibit to this Annual Report on Form 10-K.

Purpose. The purpose of the 2013 Omnibus Plan is to advance our interests by providing for the grant to participants of equity-based awards.

Plan Administration. The 2013 Omnibus Plan is administered by our Compensation Committee. Our Compensation Committee has the authority to, among other things, interpret the 2013 Omnibus Plan, determine eligibility for, grant and determine the terms of awards under the 2013 Omnibus Plan, and to do all things necessary to carry out the purposes of the 2013 Omnibus Plan. Our Compensation Committee's determinations under the 2013 Omnibus Plan are conclusive and binding. Our Compensation Committee selects participants from among our key teammates, directors, and consultants who are in a position to make a significant contribution to our success. Eligibility for options intended to be incentive stock options is limited to our teammates or employees.

Authorized Shares. Subject to adjustment, the maximum number of shares of our common stock that may be delivered in satisfaction of awards under the 2013 Omnibus Plan is 2,220,000. Shares of common stock to be issued under the 2013 Omnibus Plan may be authorized but unissued shares of common stock or previously-issued shares acquired by us. Any shares of common stock underlying awards that are settled in cash or otherwise expire, terminate, are not delivered or are forfeited prior to the issuance of common stock will again be treated as not issued under the 2013 Omnibus Plan.

Individual Limits. The maximum number of shares for which equity-based awards may be granted to any person in any calendar year is 450,000 shares. The maximum amount that may be paid to any person in any calendar year with respect to cash awards is $3,500,000.

Types of Awards. The 2013 Omnibus Plan provides for grants of options, stock appreciation rights, restricted and unrestricted stock and stock units, performance awards, cash awards, and other awards convertible into or otherwise based on shares of our stock. Dividend equivalents may also be provided in connection with an award under the 2013 Omnibus Plan.

Performance Criteria. The 2013 Omnibus Plan provides that our Compensation Committee may grant incentive awards that are based upon, and subject to achievement of, objective business criteria and that qualify as performance-based compensation under Section 162(m) of the Code. The 2013 Omnibus Plan provides that performance measures may relate to the performance of the plan participant, us, one of our subsidiaries, any business group, any of our business units or other subdivisions, or any combination of the foregoing, as our Compensation Committee deems appropriate, and may be expressed as an amount, as an increase or decrease over a specified period, as a relative comparison to the performance of a group of comparator companies or a published or special index, or any other measure of the selected performance criteria, as our Compensation Committee deems appropriate.

Adjustments. In the event of certain corporate transactions (including a stock dividend or split, recapitalization, merger, consolidation combination or exchange of shares or similar corporate change), our Compensation Committee will appropriately adjust the maximum aggregate number of shares that may be delivered under and the individual limits included in the 2013 Omnibus Plan, and will also make appropriate adjustments to the number and type of shares of shares subject to awards, the exercise price of such awards or any other terms of such awards as our Compensation Committee deems appropriate.

Amendment and Termination. Our Compensation Committee may amend or suspend the 2013 Omnibus Plan or outstanding awards, or terminate the 2013 Omnibus Plan as to future grants of awards, except that our Compensation Committee will not be able to alter the terms of an award if it would affect adversely a participant's rights under the award without the participant's consent (unless expressly provided in the 2013 Omnibus Plan). Stockholder approval will be required for any amendment to the 2013 Omnibus Plan to the extent such approval is required by law, including the Code or applicable NASDAQ listing rules.

Director Compensation

The following table sets forth information concerning the compensation earned by our directors during 2013.

Name[1]	Fees Earned or Paid in Cash ($)	Stock Awards ($)(2)(3)	Option Awards ($)(4)	Non-Equity Incentive Plan Compensation ($)	Nonqualified Deferred Compensation Earnings ($)	All Other Compensation ($)(5)	Total ($)
Todd B. Sisitsky	—	—	—	—	—	—	—
Thomas C. Geiser	50,000	30,000	—	—	—	363,496	443,496
Curtis S. Lane	50,000	30,000	—	—	—	136,846	216,846
Sharad Mansukani, M.D.	50,000	30,000	—	—	—	198,882	278,882
Jeffrey K. Rhodes	—	—	—	—	—	—	—
Frederick A. Hessler	16,250	30,000	—	—	—	—	46,250

(1) Andrew P. Hayek, the Company's President and Chief Executive Officer, is not included in this table as he is, and at all times during 2013 was, an employee of the Company and thus received no compensation for his service as director. The compensation received by Mr. Hayek as an employee of the Company is shown in the Summary Compensation Table on page 169.

(2) The amounts presented in this column represent the fair value of the REUs granted (or, since October 30, 2013, RSUs granted) on the date of grant in accordance with FASB ASC Topic 718. Further detail surrounding the REUs awarded, the method of valuation and the assumptions made are set forth in the "Management's Discussion and Analysis of Financial Conditions and Results of Operations" section, under "Critical Accounting Policies."

(3) At the end of fiscal year 2013, the aggregate number of RSUs outstanding for each director was as follows: (i) for Mr. Geiser, 4,036, (ii) for Mr. Lane, 4,036, (iii) for Dr. Mansukani, 4,036, and (iv) for Mr. Hessler, 1,324.

(4) At the end of fiscal year 2013, the aggregate number of option awards outstanding (all of which have vested) for each director was as follows: (i) for Mr. Geiser, 146,976, (ii) for Mr. Lane, 55,331, and (iii) for Dr. Mansukani, 80,417.

(5) Represents the amount of the one-time cash bonus paid in September 2013 in respect of vested options and REUs held by then current teammates and directors.

Under our current director compensation program, certain members of our Board of Directors who are not employees of the Company are eligible to receive cash compensation for their services as a director as follows: Mr. Geiser, Mr. Lane, Mr. Hessler and Dr. Mansukani each receive $12,500 in cash fees in arrears each quarter.

Additionally, commencing January 1, 2014, Mr. Geiser receives an additional annual cash retainer of $15,000 (payable quarterly in arrears), representing two individual retainers of $7,500 each, for serving as the Chair of the Compliance Committee and the Chair of the Acquisition Committee. Additionally, commencing October 1, 2013, Mr. Hessler receives an additional annual cash retainer (payable quarterly in arrears) of $15,000 for serving as Chair of the Audit Committee.

Starting in 2012, the Company elected to make annual grants of REUs pursuant to Restricted Equity Unit Grant Agreements with each of our non-employee directors, generally in an aggregate amount equal to $30,000.

Upon the conversion of the Company from a Delaware limited liability company to a Delaware corporation on October 30, 2013, the REUs became RSUs that may be settled in shares of common stock (or, in the discretion of the Board of Directors, cash). The RSUs are subject to time-based vesting, with 50% of such RSUs vesting on each of the first two anniversaries of the date of grant, subject to the grantee continuing to serve as a director on each vesting date. In 2013, the Company granted 20,690 REUs (or 2,018 RSUs after giving effect to our conversion to a Delaware corporation on October 30, 2013) to each of Messrs. Geiser and Lane and Dr. Mansukani, and the Company granted 1,324 RSUs to Mr. Hessler, whose RSUs were granted under the 2013 Omnibus Plan. 50% of the RSUs granted to these directors vest on the first anniversary of the date of grant and the other 50% vest on the second anniversary of the date of grant. Vested RSUs are settled for shares of common stock or cash, at the Board's discretion, upon the earlier of (i) the director ceasing to provide services as a director of the Company or (ii) a qualifying change in control of the Company. Any portion of the RSUs that remain unvested on the date that the director ceases to be a director for any reason will be forfeited, and the director will cease to have any rights with respect thereto.

Pursuant to our Director and Consultant Equity Incentive Plan, adopted June 24, 2008, as amended September 9, 2008 (the "Director Equity Plan"), directors are eligible to receive grants of options subject to time-based vesting that become exercisable only upon the occurrence of a Liquidity Event (as defined in the Director Equity Plan) in which TPG achieves a minimum cash return on its original investment. The options granted pursuant to the Director Equity Plan may also accelerate vesting but not exercisability in the event of certain qualifying terminations (as defined in the Director Equity Plan).

In September 2013, the Company paid a cash bonus to holders of vested options and REUs who continued to provide services to us on the date of payment, including Messrs. Geiser and Lane and Dr. Mansukani, equal to $0.241279 per vested option or REU (or $2.46 per option or RSU after giving effect to our conversion to a Delaware corporation). The Board of Directors resolved to adjust downward the exercise price of any unvested options by the same amount. Holders of unvested REUs did not receive a cash payment or any adjustment with respect to their unvested REUs. To the extent non-employee directors owned membership units outright, they also received a payment in respect of such membership units as a result of this distribution.

Compensation Committee Interlocks and Insider Participation

From the date of designation of our Compensation Committee on October 30, 2013, the Compensation Committee has been comprised of Messrs. Sisitsky and Geiser and Dr. Mansukani. We did not have a compensation committee prior to October 30, 2013; however, these individuals comprised the compensation committee of SCA from January 1, 2013 until October 30, 2013. No member of the Compensation Committee has at any time been an officer or employee of ours or an executive officer of another entity whose executive officers served on our Compensation Committee. None of our executive officers serves as a member of the board of directors or compensation committee of another entity that has one or more executive officers serving as a member of our Board of Directors or Compensation Committee.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

Securities Authorized for Issuance under Equity Compensation Plans

The following table provides certain information as of December 31, 2013 about common stock that may be issued under all of the Company's existing equity compensation plans:

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights	Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in the First Column)
Equity Compensation Plans Approved by Security Holders	3,167,761[1]	$11.41[2]	2,256,181[3]
Equity Compensation Plans Not Approved by Security Holders	—	—	—
Total	3,167,761[1]	$11.41[2]	2,256,181[3]

(1) Consists of (i) options to purchase 2,538,203 shares of common stock granted under our 2007 Equity Plan, (ii) options to purchase 457,898 shares of common stock granted under our Director Equity Plan, (iii) options to purchase 20,776 shares of common stock granted under our 2013 Omnibus Plan, (iv) RSUs for 70,484 shares of common stock granted under our 2013 Omnibus Plan and (v) RSUs for 80,400 shares of common stock which were not granted pursuant to an equity incentive plan. Excludes the option held by HealthSouth to purchase shares of our common stock.

(2) Does not take into account RSUs, which have no exercise price.

(3) Consists of (i) 97,535 shares available under our 2007 Equity Plan, (ii) 29,906 shares available under our Director Equity Plan and (iii) 2,128,740 shares available under our 2013 Omnibus Plan. We do not intend to use the 2007 Equity Plan or the Director Equity Plan to make any future grants of equity awards.

Security Ownership of Certain Beneficial Owners and Management

The following table sets forth certain information regarding the beneficial ownership of our common stock as of March 20, 2014, by:

(i) each of our directors and director nominees;

(ii) each executive officer of the Company, including the Named Executive Officers listed in the Summary Compensation Table on page 169;

(iii) all of our current directors and executive officers as a group; and

(iv) each stockholder known by us to beneficially own more than 5% of our common stock.

Beneficial ownership is determined in accordance with the rules of the SEC and includes voting or investment power with respect to the securities. Shares of common stock that may be acquired by an individual or group within 60 days of March 20, 2014, pursuant to derivative securities, such as options or RSUs, are deemed to be outstanding for the purpose of computing the percentage ownership of such individual or group, but are not deemed to be outstanding for the purpose of computing the percentage ownership of any other person shown in the table. Percentage of ownership is based on an aggregate of 38,261,138 shares of common stock outstanding as of March 20, 2014.

Except as indicated in footnotes to this table, we believe that the stockholders named in this table have sole voting and investment power with respect to all shares of common stock shown to be beneficially owned by them, based on information provided to us by such stockholders. Unless otherwise indicated, the address for each director and executive officer is: c/o Surgical Care Affiliates, Inc., 520 Lake Cook Road, Suite 250, Deerfield, Illinois 60015.

Beneficial Owner	Number of Shares of Common Stock Beneficially Owned	Percentage of Common Stock Beneficially Owned
Five Percent Stockholders		
TPG Funds (1)	23,940,916	62.6%
MTS-SCA Acquisition LLC (2)	2,328,027	6.1%
FMR LLC (3)	2,332,250	6.1%
Directors and Executive Officers		
Andrew P. Hayek (4)	721,568	1.9%
Todd B. Sisitsky (5)	—	—
Thomas C. Geiser (6)	245,545	*
Frederick A. Hessler	5,000	*
Curtis S. Lane (7)	56,340	*
Sharad Mansukani, M.D. (8)	81,426	*
Jeffrey K. Rhodes (9)	—	—
Joseph T. Clark (10)	132,077	*
Peter J. Clemens (11)	127,927	*
Michael A. Rucker (12)	256,176	*
Richard L. Sharff, Jr. (13)	132,417	*
All Current Executive Officers and Directors as a Group (14)	1,758,476	4.4%

* Represents beneficial ownership of less than 1% of the shares of common stock.

(1) The "TPG Funds" refers collectively to TPG Partners V, L.P., a Delaware limited partnership ("TPG Partners V"), TPG FOF V-A, L.P., a Delaware limited partnership ("FOF V-A"), and TPG FOF V-B, L.P., a Delaware limited partnership ("FOF V-B"). The TPG Funds directly hold an aggregate of 23,940,916 shares of common stock (the "TPG Shares"), consisting of: (a) 23,828,317 shares of common stock held by

TPG Partners V, (b) 62,335 shares of common stock held by FOF V-A, and (c) 50,264 shares of common stock held by FOF V-B. The general partner of each of TPG Partners V, FOF V-A and FOF V-B is TPG GenPar V, L.P., a Delaware limited partnership, whose general partner is TPG GenPar V Advisors, LLC, a Delaware limited liability company, whose sole member is TPG Holdings I, L.P., a Delaware limited partnership, whose general partner is TPG Holdings I-A, LLC, a Delaware limited liability company, whose sole member is TPG Group Holdings (SBS), L.P., a Delaware limited partnership, whose general partner is TPG Group Holdings (SBS) Advisors, Inc., a Delaware corporation ("Group Advisors"). Because of Group Advisors' relationship to the TPG Funds, Group Advisors may be deemed to beneficially own the TPG Shares. David Bonderman and James G. Coulter are officers and sole shareholders of Group Advisors and may therefore also be deemed to be the beneficial owners of the TPG Shares. Messrs. Bonderman and Coulter disclaim beneficial ownership of the TPG Shares except to the extent of their pecuniary interest therein. The address of each of Group Advisors and Messrs. Bonderman and Coulter is c/o TPG Global, LLC, 301 Commerce Street, Suite 3300, Fort Worth, TX 76102. This information is based upon our review of a Schedule 13G filed jointly by Group Advisors and Messrs. Bonderman and Coulter on February 13, 2014, reporting beneficial ownership as of December 31, 2013.

(2) Consists of shares of common stock held directly by MTS-SCA Acquisition LLC. OCM Principal Opportunities Fund IV, L.P., the managing member and holder of a majority of interest in MTS-SCA Acquisition LLC, OCM Principal Opportunities Fund IV GP, L.P., the general partner of OCM Principal Opportunities Fund IV, L.P., OCM Principal Opportunities Fund IV GP Ltd., the general partner of OCM Principal Opportunities Fund IV GP, L.P., Oaktree Fund GP I, L.P., the sole shareholder and general partner of OCM Principal Opportunities Fund IV GP Ltd., Oaktree Capital I, L.P., the general partner of Oaktree Fund GP I, L.P., OCM Holdings I, LLC, the general partner of Oaktree Capital I, L.P., Oaktree Holdings, LLC, the managing member of OCM Holdings I, LLC, Oaktree Capital Group, LLC, the managing member of Oaktree Holdings, LLC and the sole shareholder of Oaktree Holdings, Inc., Oaktree Capital Group Holdings GP, LLC, the manager of Oaktree Capital Group, LLC, Oaktree Capital Management, L.P., the investment manager of OCM Principal Opportunities Fund IV, L.P., and Oaktree Holdings, Inc., the general partner of Oaktree Capital Management, L.P. (collectively, the "Oaktree Entities"), may be deemed to share beneficial ownership of the shares held directly by MTS-SCA Acquisition LLC. Each of the Oaktree Entities disclaims beneficial ownership of such shares except to the extent of their respective pecuniary interests therein. The principal business address of the Oaktree Entities is c/o Oaktree Capital Management, L.P., 333 South Grand Avenue, 28th Floor, Los Angeles, CA 90071. This information is based upon our review of a Schedule 13G filed by MTS-SCA Acquisition LLC with the SEC on February 14, 2014, reporting beneficial ownership as of December 31, 2013.

(3) Based on a Schedule 13G filed with the SEC on February 14, 2014. As of December 31, 2013, FMR LLC, a parent holding company, and Edward C. Johnson 3d, may be deemed the beneficial owners of 2,332,250 shares of common stock. FMR has sole voting power of 208,750 shares, no shared voting power, sole investment power of 2,332,250 shares and no shared investment power. No one person's interest relates to more than 5% of the outstanding shares of common stock. The address of FMR LLC is 245 Summer Street, Boston, MA 02210.

(4) Includes 68,292 shares of common stock underlying Restricted Stock Units and 604,268 shares of common stock underlying options, each that are currently exercisable or exercisable within 60 days of March 20, 2014 for shares of common stock. All of the shares of common stock, Restricted Stock Units and options are owned by the Andrew Hayek 2008 Living Trust (of which Mr. Hayek is the sole trustee).

(5) Todd B. Sisitsky, who is one of our directors, is a Partner of TPG Global, LLC. Mr. Sisitsky has no voting or investment power over and disclaims beneficial ownership of the TPG Shares. Mr. Sisitsky's address is c/o TPG Global, LLC, 301 Commerce Street, Suite 3300, Fort Worth, TX 76102.

(6) Includes (a) 1,009 shares of common stock underlying Restricted Stock Units and 146,976 shares of common stock underlying options, each that are currently exercisable or exercisable within 60 days of March 20, 2014 for shares of common stock and (b) 97,560 shares of common stock owned by TDK Properties, L.P., which is a California limited partnership whose general partner and owner of 1% of its limited partnership interests is TDK Management Company, LLC, a California limited liability company whose sole member is The Geiser Schweers Family Trust u/a/d 6/8/98, as amended, and whose trustees are

Thomas C. Geiser and Donna L. Schweers. 99% of the limited partnership interests of TDK Properties, L.P. are held by The Geiser Schweers 2006 Irrevocable Insurance Trust dated August 14, 2006, whose trustee is Kim T. Schoknecht.

(7) Includes 1,009 shares of common stock underlying Restricted Stock Units and 55,331 shares of common stock underlying options, each that are currently exercisable or exercisable within 60 days of March 20, 2014 for shares of common stock. The address for Mr. Lane is c/o MTS Health Partners, L.P., 623 Fifth Avenue, 14th Floor, New York, NY 10022.

(8) Includes 1,009 shares of common stock underlying Restricted Stock Units and 80,417 shares of common stock underlying options, each that are currently exercisable or exercisable within 60 days of March 20, 2014 for shares of common stock.

(9) Jeffrey K. Rhodes, who is one of our directors, is a Principal of TPG Global, LLC. Mr. Rhodes has no voting or investment power over and disclaims beneficial ownership of the TPG Shares. The address of Mr. Rhodes is c/o TPG Global, LLC, 301 Commerce Street, Suite 3300, Fort Worth, TX 76102.

(10) Includes 125,610 shares of common stock underlying options that are currently exercisable or exercisable within 60 days of March 20, 2014 for shares of common stock.

(11) Includes 107,927 shares of common stock underlying options that are currently exercisable or exercisable within 60 days of March 20, 2014 for shares of common stock.

(12) Includes 225,242 shares of common stock underlying options that are currently exercisable or exercisable within 60 days of March 20, 2014 for shares of common stock.

(13) Includes 115,224 shares of common stock underlying options that are currently exercisable or exercisable within 60 days of March 20, 2014 for shares of common stock.

(14) Includes Restricted Stock Units and options, each that are exercisable for shares of common stock as described in footnotes (4)-(13).

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

Policy for the Review and Approval of Related Person Transactions

Under SEC rules, a "related person" is an officer, director, nominee for director or beneficial holder of more than 5% of any class of our voting securities since the beginning of the last fiscal year or an immediate family member of any of the foregoing. Pursuant to our related party transaction written policy, directors (including director nominees), executive officers and employees are required to report any transactions or circumstances that may create or appear to create a conflict between the personal interests of the individual and our interests, regardless of the amount involved. The Audit Committee of the Board of Directors is responsible for evaluating each related party transaction and making a recommendation to the disinterested members of the Board of Directors as to whether the transaction at issue is fair, reasonable and within our policy and whether it should be ratified and approved. The Audit Committee, in making its recommendation, considers various factors, including the benefit of the transaction to us, the terms of the transaction and whether they are at arm's-length and in the ordinary course of our business, the direct or indirect nature of the related person's interest in the transaction, the size and expected term of the transaction and other facts and circumstances that bear on the materiality of the related party transaction under applicable law and listing standards. The Audit Committee reviews, at least annually, a summary of our transactions with our directors and officers and with firms that employ our directors, as well as any other related person transactions.

Related Person Transactions Entered into by the Company

Other than compensation agreements and other arrangements which are described under "Executive Compensation" and the transactions described below, since January 1, 2011, there has not been, and there is not currently proposed, any transaction or series of similar transactions to which we were or will be a party in which the amount involved exceeded or will exceed $120,000 and in which any related person had or will have a direct or indirect material interest.

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Operating Agreement Providing for Certain Purchase Rights

On August 22, 2007, we, the TPG Funds, MTS and certain other co-investors, including members of our management, entered into the Second Amended and Restated Limited Liability Company Operating Agreement of ASC Acquisition LLC (the "Operating Agreement"). The Operating Agreement contained agreements among the parties including with respect to tag-along rights, drag-along rights, rights of first refusal, transfer restrictions and other corporate governance provisions. Pursuant to the Operating Agreement, certain of our existing stockholders (who were members of ASC Acquisition LLC prior to our conversion to a corporation) purchased additional membership units of ASC Acquisition LLC on June 28, 2011, August 12, 2011 and September 23, 2011. The Operating Agreement terminated in connection with our conversion from a Delaware limited liability company to a Delaware corporation on October 30, 2013.

Management Unit Holders' Agreement

On August 22, 2007, we and certain investors that are members of our management entered into the management unit holders' agreement (the "Management Unit Holders' Agreement"), which contains certain arrangements among the parties including with respect to restrictions on transfer of interests in us, call rights in certain specified situations, drag-along rights and tag-along rights. In addition, all parties to the Management Unit Holders' Agreement are subject to a contractual lock-up provision during the 180 day period following the date of our IPO in October 2013. Except for this lock-up provision, the Management Unit Holders' Agreement terminated by its terms on the date of our IPO.

Stockholders' Agreement with the TPG Funds

In connection with the IPO, we entered into a stockholders' agreement with the TPG Funds, dated November 4, 2013 (the "Stockholders' Agreement"), that provides that, so long as the Stockholders' Agreement remains in effect, the TPG Funds will have certain rights to designate for nomination candidates for our Board of Directors. We are required to use our reasonable best efforts to cause the Board of Directors and the Nominating and Corporate Governance committee to include such persons designated by the TPG Funds in the slate of nominees recommended by the Board of Directors for election by the stockholders.

As set forth in the Stockholders' Agreement, for so long as the TPG Funds collectively own at least 50% of the shares of our common stock held by them at the closing of the IPO, they will be entitled to designate for nomination a majority of the seats on our Board of Directors. When the TPG Funds collectively own less than 50%, but at least 30%, of the shares of our common stock held by them as of the closing of the IPO, the TPG Funds will be entitled to designate for nomination three directors. When the TPG Funds collectively own less than 30%, but at least 10%, of the shares of our common stock held by them as of the closing of the IPO, the TPG Funds will be entitled to designate for nomination two directors. Thereafter, the TPG Funds will be entitled to designate for nomination one director so long as they own at least 3% of the shares of our common stock held by them as of the closing of the IPO.

However, if on or before the first anniversary of the IPO, our Board of Directors is increased to nine members, and at such time the TPG Funds collectively own at least 50% of the shares of our common stock held by them as of the closing of the IPO, the number of seats on our Board of Directors that the TPG Funds will be entitled to designate for nomination, as described above, will be increased by one seat, so long as the TPG Funds collectively own at least 20% of the shares of our common stock held by them as of the closing of the IPO. When the TPG Funds collectively own less than 20%, but at least 10%, of the shares of our common stock held by them as of the closing of the IPO, the TPG Funds will be entitled to designate for nomination two directors. Thereafter, the TPG Funds will be entitled to designate for nomination one director so long as they own at least 3% of the shares of our common stock held by them as of the closing of the IPO.

In the event that the size of our Board of Directors is otherwise increased or decreased in size at any time, the nomination rights afforded to the TPG Funds will be proportionately adjusted as well, rounded up to the nearest whole person.

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As our Board of Directors currently consists of seven members, in accordance with the Stockholders' Agreement, the TPG Funds have designated Thomas Geiser, Sharad Mansukani, M.D., Todd Sisitsky and Jeffrey Rhodes as nominees of the TPG Funds to serve on our Board of Directors.

Registration Rights Agreement

In connection with the IPO, we entered into a registration rights agreement with the TPG Funds and certain members of our management and of our Board of Directors (the "Registration Rights Agreement"), which provides the TPG Funds with certain demand registration rights, including shelf registration rights, in respect of any shares of our common stock held by them, subject to certain conditions and limitations. The TPG Funds are entitled to an unlimited number of demand registrations. In addition, in the event that we register additional shares of common stock for sale to the public following the completion of the IPO, we are required to give notice of such registration to the TPG Funds, certain members of management and our Board of Directors party to the Registration Rights Agreement of our intention to effect such a registration, and, subject to certain limitations, include any shares of common stock requested to be included in such registration held by them. Upon request from the TPG Funds following the one year anniversary of the IPO, we will undertake to file a shelf registration statement, and to use reasonable best efforts to have the shelf registration statement declared effective promptly and to remain effective until, subject to certain limitations, the earlier of the date on which all of the TPG Funds' shares of common stock have been sold pursuant to a registration statement and the date no shares of common stock are held by the TPG Funds. We are required to bear the registration expenses, other than underwriting discounts and commissions and transfer taxes, associated with any registration of shares of common stock pursuant to the Registration Rights Agreement. The Registration Rights Agreement includes customary indemnification provisions in favor of the TPG Funds and the members of management and our Board of Directors party to the agreement, any person who is or might be deemed a control person (within the meaning of the Securities Act or the Exchange Act) and related parties, including, without limitation, officers, directors and employees, against certain losses and liabilities (including reasonable costs of investigation and legal expenses) resulting from any untrue statement or omission of material fact in any registration statement or prospectus pursuant to which such selling stockholder sells shares of our common stock, unless such liability arose from the applicable selling stockholder's misstatement or omission and the applicable selling stockholder has agreed to indemnify us against losses caused by its misstatements or omissions, subject to certain limitations.

Management Services Agreement

Until October 2013, we were party to a management services agreement with TPG Capital, L.P. (now TPG Capital Management) ("TPG Capital"), an affiliate of TPG, pursuant to which TPG Capital provided us with management, advisory and consulting services (the "Management Services Agreement"). In connection with our acquisition by TPG in 2007, SCA paid a transaction fee to TPG Capital of $10.0 million for services rendered in connection with the acquisition and for certain operating advice. Under the Management Services Agreement, TPG Capital received an annual management fee of $2.0 million, payable quarterly in advance on or before the start of each calendar quarter. TPG Capital was entitled to an additional fee in connection with any financing, acquisition, disposition, spin-off, split-off or change of control transactions involving us or any of our subsidiaries equal to customary fees charged by internationally-recognized investment banks for serving as financial advisor in similar transactions. In conjunction with our IPO, TPG Capital was entitled under the Management Services Agreement to receive a fee in an amount equal to $8.0 million, which we paid in the fourth quarter of 2013. In addition, TPG Capital was entitled to reimbursement for out-of-pocket expenses incurred in connection with the provision of services under the Management Services Agreement. The Management Services Agreement was terminated in connection with the IPO.

Pursuant to certain consulting arrangements, two of our current directors, Mr. Geiser and Dr. Mansukani, and one of our former directors, Leonard Schaeffer, provided certain consulting services to us. As compensation for such services, each individual was paid a percentage of the annual management fee paid by us to TPG Capital. Mr. Geiser received $243,750 in 2013 and $325,000 in each of 2012 and 2011, respectively.

Dr. Mansukani received $250,000 in each of 2013, 2012 and 2011, respectively. Until Mr. Schaeffer's resignation from SCA's Board of Directors in September 2011, he had received $318,750 during the nine-months ended September 30, 2011. These consulting arrangements terminated in connection with the completion of the IPO, and no further payments are expected to be made by TPG Capital pursuant to these arrangements.

Indemnification Agreements

We have entered into indemnification agreements with each of our current directors and employment agreements containing indemnification provisions with each of our current executive officers. It is anticipated that future directors and officers will enter into indemnification arrangements with us in substantially similar form. The indemnification and employment agreements generally provide, among other things, that we will indemnify and hold harmless each person subject to such agreement (each, an "indemnitee") to the fullest extent permitted by applicable law from and against all expenses, losses, damages, judgments, fines, and other specified costs that may result or arise in connection with such indemnitee serving in his or her capacity as a director of ours or serving at our direction as a director, officer, employee or agent of another entity. These agreements further provide that, upon an indemnitee's request and subject to certain conditions, we will advance expenses to the indemnitee to the fullest extent permitted by applicable law. Pursuant to the indemnification agreements, an indemnitee is presumed to be entitled to indemnification and we have the burden of proving otherwise. The indemnification agreements also require us to maintain in full force and effect directors' liability insurance on the terms described in the indemnification agreement. The foregoing is only a brief description of the indemnification and employment agreements, does not purport to be complete and is qualified in its entirety by reference to the Company's form of indemnification agreement, filed as Exhibit 10.30 to its Annual Report on Form 10-K for the year ended December 31, 2013, and employment agreements with its executives, filed as Exhibits to such Annual Report on Form 10-K.

Certain Relationships

During 2011, 2012 and 2013, and continuing into 2014, Bradley Arant has provided certain legal services to us. We paid approximately $1.8 million, $1.0 million, and $865,000 in 2013, 2012 and 2011, respectively, and paid approximately $105,000 during the month ended January 31, 2014, to Bradley Arant for the provision of legal services. The spouse of one of our executive officers, Mr. Sharff, is a partner at Bradley Arant.

In connection with the amendment of our Amended Credit Agreement on May 8, 2013, TPG Capital BD, LLC, an affiliate of TPG Global, LLC, served as an arranger for purposes of the amendment and was paid an arrangement fee in the amount of $486,750. In addition, TPG Capital BD, LLC participated in the underwriting of the shares of our common stock that were offered and sold in the IPO.

From time to time, we do business with other companies affiliated with TPG Global, LLC. We believe that all such arrangements have been entered into in the ordinary course of business and have been conducted on an arms-length basis.

Director Independence

NASDAQ listing standards generally require that listed companies have a majority of independent directors, that compensation committees of listed companies be comprised entirely of independent directors and that nominating committees, if any, of listed companies be comprised entirely of independent directors. Under NASDAQ rules, however, a "controlled company" (which is a listed company of which more than 50% of the voting power for the election of directors is held by an individual, a group or another company) may elect not to comply with these three independence requirements. Because the TPG Funds own a majority of our outstanding common stock, we currently are a "controlled company" under the NASDAQ rules, and we have availed ourselves of the exemption from the independence requirements described above as a result of that status. In the

event that we are no longer considered a "controlled company" under the NASDAQ rules, then (i) a majority of our Board must be independent within one year of the date of our loss of "controlled company" status and (ii) at least one member of each of our Compensation Committee and our Nominating and Corporate Governance Committee must be independent as of the date of our loss of "controlled company" status, a majority of the members of each of these committees must be independent within 90 days of the date of the change in status, and all members of these committees must be independent within one year of the date of the change in status.

Even as a "controlled company," we must comply with the rules applicable to audit committees set forth in NASDAQ and SEC rules. However, as result of the phase-in of certain SEC rules applicable to audit committees of newly public companies, only a majority of the members of our Audit Committee are required to satisfy the heightened independence standards imposed by Rule 10A-3 under the Exchange Act until the first anniversary of the date of effectiveness of the Company's Registration Statement on Form S-1 filed with the SEC in connection with the IPO, or October 29, 2014, at which time all of the members of our Audit Committee must be independent.

Our Board of Directors has reviewed the materiality of any relationship that each of our directors has with Surgical Care Affiliates, either or directly or indirectly. Based upon this review, our Board has determined that Frederick A. Hessler, Curtis S. Lane, Jeffrey K. Rhodes and Todd B. Sisitsky are "independent directors" within the meaning of the NASDAQ rules. Additionally, our Board has determined that Frederick A. Hessler and Curtis S. Lane satisfy the heightened independence requirements of Rule 10A-3 under the Exchange Act for purposes of Audit Committee membership.

Item 14. Principal Accountant Fees and Services

Fees Paid to PricewaterhouseCoopers LLP

The following table presents fees for professional services rendered by PricewaterhouseCoopers LLP ("PwC") for the audit of the Company's annual financial statements for the years ended December 31, 2013 and December 31, 2012, and fees billed for other services rendered by PwC during those periods.

	2013	2012
Audit Fees	$2,365,633	$1,160,000
Audit-Related Fees	$ 350,974	$ 50,000
Tax Fees	$ 0	$ 0
All Other Fees	$ 0	$ 0
TOTAL	$2,716,607	$1,210,000

Audit Fees. Audit Fees for the last two years were for professional services rendered by the independent registered public accountants in connection with (i) the audits of the Company's annual financial statements and (ii) the review of the Company's quarterly financial statements. Audit fees for 2013 were also for services related to the Company's initial public offering, acquisitions, debt refinancing transactions and consents related to the Company's SEC filings.

Audit-Related Fees. Audit-Related Fees for 2013 and 2012 were for services related to audits of significant subsidiaries (as defined under Rule 3-05 of Regulation S-X), internal controls optimization and agreed-upon procedures. All audit-related services were pre-approved by the Company's Audit Committee.

Tax Fees. There were no Tax Fees for 2013 or 2012.

All Other Fees. All Other Fees encompasses any services provided by the independent registered public accountants other than the services reported in the other above categories. There were no such fees in 2013 or 2012.

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Pre-Approval Policy

Prior to March 4, 2014, the Audit Committee's policy was to specifically pre-approve all audit and non-audit services to be rendered by the independent registered public accountants. Through this policy, the Audit Committee has been able to effectively monitor the costs of services and ensure that the provision of such services does not impair the registered accountants' independence.

As of March 4, 2014, the Audit Committee has adopted policies and procedures for the pre-approval of audit and non-audit services performed by the independent registered public accountants pursuant to which the Audit Committee generally is required to pre-approve the audit and permissible non-audit services performed by the independent registered public accountants in order to assure that the provision of such services does not impair the registered accountants' independence. Unless a type of service to be provided by the independent registered public accountants has received general pre-approval, the service will require specific pre-approval by the Audit Committee. Any proposed services exceeding pre-approved cost levels will require specific pre-approval by the Audit Committee. On an annual basis, the Audit Committee may pre-approve specific services that are expected to be provided to the Company by the independent registered public accountants during the following twelve months. The Audit Committee may delegate pre-approval authority to one or more of its members. The member or members to whom such authority is delegated must report any pre-approval decisions to the Audit Committee at its next scheduled meeting.

PART IV

Item 15. Exhibits and Financial Statement Schedules

(a)(3) and (b) — Exhibits.

The exhibits listed on the Exhibit Index beginning on page 211 of this Form 10-K are filed herewith or are incorporated herein by reference.

(a)(1) and (c) — Financial Statements

Financial Statements: The Financial Statements and related Financial Statements Schedule of Surgical Care Affiliates are included herein in Part II, Item 8.

The following audited and unaudited consolidated financial statements of ASC Operators, LLC are presented pursuant to Rule 3-09 of Regulation S-X:

ASC Operators, LLC
Unaudited Consolidated Financial Statements
December 31, 2013

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Unaudited Consolidated Financial Statements

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ASC Operators, LLC
Unaudited Consolidated Balance Sheet
(In thousands of U.S. dollars)

	DECEMBER 31 2013
Assets	
Current assets	
Cash and cash equivalents	$ 7,361
Accounts receivable, net of allowance for doubtful accounts ($210)	9,011
Due from related party	871
Prepaids and other current assets	295
Total current assets	17,538
Property and equipment, net of accumulated depreciation ($12,185)	11,030
Goodwill	26,534
Intangible assets, net of accumulated amortization ($643)	1,254
Total assets	$56,356
Liabilities and Equity	
Current liabilities	
Current portion of long-term debt	$ 5,863
Accounts payable	1,689
Accrued payroll	273
Other current liabilities	936
Due to related party	1,735
Total current liabilities	10,496
Long-term debt, net of current portion	459
Other long-term liabilities	13
Total liabilities	10,968
Commitments and contingent liabilities	
Equity	
Members' equity	29,117
Noncontrolling interests	16,271
Total equity	45,388
Total liabilities and equity	$56,356

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

ASC Operators, LLC
Unaudited Consolidated Statement of Operations
(In thousands of U.S. dollars)

	Year Ended December 31 2013
Net operating revenues:	
Net patient revenues	$ 58,309
Other revenues	100
Total net operating revenues	58,409
Operating expenses:	
Salaries and benefits	15,257
Supplies	10,066
Professional and contractual services	3,454
Other operating expenses	3,796
Depreciation and amortization	1,966
Occupancy costs	1,738
Provision for doubtful accounts	1,183
Loss on sale of property and equipment	86
Total operating expenses	37,546
Operating income	20,863
Interest expense	42
Net income	20,821
Less: Net income attributable to noncontrolling interests	(10,232)
Net income attributable to ASC Operators	$ 10,589

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

ASC Operators, LLC
Unaudited Consolidated Statement of Changes in Equity
(In thousands of U.S. dollars)

	SCA	Sutter	Total Members Equity	Noncontrolling Interests	Total Equity
Balance at December 31, 2012	$16,367	$18,418	$ 34,785	$ 15,953	$ 50,738
Net income	5,189	5,400	10,589	10,232	20,821
Distributions to members	(8,883)	(9,245)	(18,128)	—	(18,128)
Contributions from members	915	952	1,867	621	2,488
Distributions to noncontrolling interests	—	—	—	(10,531)	(10,531)
Balance at December 31, 2013	$13,588	$15,525	$ 29,117	$ 16,271	$ 45,388

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

ASC Operators, LLC
Unaudited Consolidated Statement of Cash Flows
(In thousands of U.S. dollars)

	Year Ended December 31 2013
Cash flows from operating activities	
Net income	$ 20,821
Adjustments to reconcile net income to net cash provided by operating activities	
Provision for doubtful accounts	1,183
Depreciation and amortization	1,966
Loss on disposal of assets	86
Increase in assets	
Accounts receivable	(2,071)
Other assets	(119)
Increase in liabilities	
Accounts payable	388
Accrued payroll	3
Accrued interest	1
Other liabilities	758
Net cash provided by operating activities	23,016
Cash flows from investing activities	
Capital expenditures	(7,935)
Proceeds from disposal of assets	7
Changes in due to/from related party	(1,295)
Net cash provided used in investing activities	(9,223)
Cash flows from financing activities	
Borrowings under construction loan and long-term debt	6,094
Principal payments on long-term debt	(151)
Principal payments under capital lease obligations	(367)
Capital contributions	1,867
Contributions from noncontrolling interests of consolidated affiliates	621
Distributions to members	(18,128)
Distributions to noncontrolling interests of consolidated affiliates	(10,531)
Net cash used in financing activities	(20,595)
Change in cash and cash equivalents	(6,802)
Cash and cash equivalents at beginning of period	14,163
Cash and cash equivalents at end of period	$ 7,361
Supplemental cash flow information:	
Cash paid during the year for interest	$ 24

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

ASC Operators, LLC
Notes to Unaudited Consolidated Financial Statements
(Amounts in tables are in thousands of U. S. dollars unless otherwise indicated)

1. DESCRIPTION OF THE BUSINESS

Nature of Operations

ASC Operators, LLC ("ASC Operators," the "Company" or "we"), a California limited liability company, was formed on May 2, 2007, primarily to own and operate a network of multi-specialty ambulatory surgery centers ("ASCs") in the Sacramento, California, metropolitan area. ASC Operators is a 51% owned subsidiary of Sutter Health. Surgery Centers – West Holdings, LLC, a California limited liability company and a subsidiary of Surgical Care Affiliates, LLC (SCA), owns 49% of ASC Operators. As of December 31, 2013, the Company had an interest in and/or operated six ASCs in the Sacramento, California, metropolitan area. Our ASCs primarily provide the facilities, equipment and medical support staff necessary for physicians to perform non-emergency surgical and other procedures in various specialties, including orthopedics, ophthalmology, gastroenterology, pain management, otolaryngology (ear, nose and throat, or "ENT"), urology and gynecology, as well as other general surgery procedures. At our ASCs, physicians perform same-day surgical procedures.

Basis of Presentation

The Company maintains its books and records on the accrual basis of accounting, and the accompanying consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("U.S. GAAP"). Such financial statements include the assets, liabilities, revenues, and expenses of all majority-owned subsidiaries over which we exercise control and, when applicable, entities in which we have a controlling financial interest.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation

The consolidated financial statements include the accounts of the Company and its subsidiaries for which we are the primary beneficiary. All significant intercompany transactions and accounts have been eliminated.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements, as well as the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. The most significant estimates include, but are not limited to: (1) allowance for contractual revenue adjustments; (2) allowance for doubtful accounts; (3) asset impairments, including goodwill; (4) depreciable lives of assets; (5) useful lives of intangible assets; and (6) economic lives and fair value of leased assets. Future events and their effects cannot be predicted with certainty; accordingly, our accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of our consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained, and as our operating environment changes. We evaluate and update our assumptions and estimates on an ongoing basis and may employ outside experts to assist in our evaluation as considered necessary. Actual results could differ from those estimates.

Revenue Recognition

Revenues consist primarily of net patient service revenues that are recorded based upon established billing rates less allowances for contractual adjustments. Revenues are recorded during the period the healthcare services are provided, based upon the estimated amounts due from patients and third-party payors, including federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies and employers. Estimates of contractual allowances under third-party payor arrangements are based upon the payment terms specified in the related contractual agreements and payment history. Third-party payor contractual payment terms are generally based upon predetermined rates per procedure or discounted fee-for-service rates.

Cash and Cash Equivalents

Cash and cash equivalents include all demand deposits reduced by the amount of outstanding checks and drafts where the right of offset exists for these bank accounts. The Company has deposits with certain financial institutions which exceed federally insured limits. The Company has not experienced any losses on such deposits.

Accounts Receivable

We report accounts receivable at estimated net realizable amounts from services rendered from federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies, workers' compensation, employers and patients. Our accounts receivable are geographically dispersed, but a significant portion of our accounts receivable are concentrated by type of payors. The concentration of net patient service accounts receivable by payor class, as a percentage of total net patient service accounts receivable, as of the end of each of the reporting periods, is as follows:

	AS OF DECEMBER 31 2013
Managed care and other discount plans	53%
Medicare	40
Workers' compensation	6
Patients and other third-party payors	1
Total	100%

We recognize that revenues and accounts receivable from government agencies are significant to our operations; however, we do not believe there are significant credit risks associated with these government agencies.

We also recognize that revenue and accounts receivable from managed care and other discount plans are significant to our operations. Because the category of managed care and other discount plans is composed of numerous individual payors which are geographically dispersed, our management does not believe there are any significant concentrations of revenues from any individual payor that would subject us to significant credit risks in the collection of our accounts receivable.

Property and Equipment

We report improvements and equipment at cost, net of asset impairment. We report assets under capital lease obligations at the lower of fair value or the present value of the aggregate future minimum lease payments at the beginning of the lease term. We depreciate our assets using the straight-line method over the shorter of the estimated useful life of the assets or life of the lease term, excluding any lease renewals, unless the lease renewals are reasonably assured. Useful lives are as follows:

	Years
Leasehold improvements	5 to 20
Furniture, fixtures, and equipment	3 to 10
Assets under capital lease obligations:	
Equipment	3 to 5

Maintenance and repairs of property and equipment are expensed as incurred. We capitalize replacements and improvements that increase the estimated useful life of an asset. We capitalize interest expense on major construction and development projects while in progress. Capitalized interest for the year ended December 31, 2013 was approximately $19,000.

We retain fully depreciated assets in property and accumulated depreciation accounts until we remove them from service. In the case of sale, retirement or disposal, the asset cost and related accumulated depreciation balance is removed from the respective account, and the resulting net amount, less any proceeds, is included as a component of income from continuing operations in the consolidated statements of operations.

For operating leases, we recognize escalated rents, including any rent holidays, on a straight-line basis over the term of the lease.

Goodwill

Goodwill represents the unallocated excess of purchase price over the fair value of identifiable assets and liabilities acquired in business combinations. Goodwill also includes the unallocated excess of purchase price plus the fair value of any noncontrolling interest in the acquiree at the acquisition date over the fair value of identifiable assets and liabilities acquired in business combinations.

We test goodwill for impairment using a fair value approach at least annually, absent some triggering event that would require an interim impairment assessment. Absent any impairment indicators, we perform our goodwill impairment testing each year. We have no accumulated impairment of goodwill for the year ended December 31, 2013.

Fair Value of Financial Instruments

Our financial instruments consist mainly of cash and cash equivalents, accounts receivable, accounts payable, and long-term debt. The carrying amounts of cash and cash equivalents, accounts receivable and accounts payable approximate fair value because of the short-term maturity of these instruments. We determine the fair value of our long-term debt based on various factors, including maturity schedules, call features and current market rates.

Noncontrolling Interest in Consolidated Affiliates

The consolidated financial statements include all assets, liabilities, revenues and expenses of less-than-100%-owned affiliates that we control. Accordingly, we have recorded a noncontrolling interest in the earnings and equity of such affiliates. We record adjustments to noncontrolling interest for the allocable

portion of income or loss to which the noncontrolling interest holders are entitled based upon the portion of the subsidiaries they own. Distributions to holders of noncontrolling interests reduce the respective noncontrolling interest holders' balance.

Newly Issued Authoritative Guidance

We do not believe any recently issued, but not yet effective, revisions to authoritative guidance will have a material effect on our consolidated financial position, results of operations or cash flows.

3. PROPERTY AND EQUIPMENT

Property and equipment consists of the following:

	AS OF DECEMBER 31 2013
Leasehold improvements	$ 4,363
Furniture, fixtures and equipment	12,144
	16,507
Less: Accumulated depreciation and amortization	(12,185)
	4,322
Construction in progress	6,708
Property and equipment, net	$ 11,030

Depreciation expense for the year ended December 31, 2013, was approximately $1.7 million and is included in the consolidated statement of income as a component of operating expenses.

The amount of amortization expense and accumulated amortization relating to assets under capital lease obligations and rent expense under operating leases is as follows:

	YEAR ENDED DECEMBER 31 2013
Assets under capital lease obligations:	
Equipment	$1,099
Accumulated amortization	(796)
Assets under capital lease obligations, net	$ 303
Amortization expense	$ 350
Rent Expense:	
Minimum rent payments	$1,602
Contingent and other rents	206
Total rent expense	$1,808

Leases

Future minimum lease payments at December 31, 2013 for those leases of ASC Operators, LLC and its subsidiaries having an initial or remaining non-cancelable lease term of one year or more are as follows:

Year Ending December 31	
2014	$ 1,645
2015	1,619
2016	1,583
2017	1,620
2018	1,153
2019 and thereafter	4,565
	$12,185

4. GOODWILL

Goodwill represents the unallocated excess of purchase price over the fair value of identifiable assets and liabilities acquired in business combinations. Goodwill also includes the unallocated excess of purchase price plus the fair value of any noncontrolling interest in the acquiree at the acquisition date over the fair value of identifiable assets and liabilities acquired in business combinations. We have no accumulated impairment of goodwill for the period ended December 31, 2013. There was no change in goodwill for the year ended December 31, 2013.

We performed impairment reviews and concluded that no goodwill impairment existed.

5. LONG-TERM DEBT

Our long-term debt outstanding consists of the following:

	AS OF DECEMBER 31 2013
Notes payable	$ 6,322
Less: Current portion	(5,863)
Long-term debt, net of current portion	$ 459

$5.7 million of the Notes payable balance relates to a no-interest construction loan classified in the current portion of long-term debt. We expect to refinance the construction loan after completion of the construction activity.

The following chart shows scheduled principal payments due on long-term debt for the next five years:

Year Ending December 31	
2014	$5,863
2015	189
2016	159
2017	90
2018	21
Total	$6,322

6. NONCONTROLLING INTERESTS

The following table shows the effects of changes to ASC Operators, LLC ownership interest in its subsidiaries on ASC Operators, LLC equity:

	Year Ended December 31 2013
Net income attributable to ASC Operators	$10,589
(Decrease) increase in equity due to sales to noncontrolling interests	—
Decrease in equity due to purchases from noncontrolling interests	—
Change from net income attributable to ASC Operators	$10,589

7. RELATED PARTY TRANSACTIONS

The Company was involved in various transactions with affiliated companies. The surgery centers were owed $0.9 million from Surgical Care Affiliates, LLC and related affiliates for services at December 31, 2013, and such amounts are classified as *due from related party* in the accompanying consolidated balance sheets. The surgery centers owed Sutter Health and related entities $1.7 million for services at December 31, 2013, and such amounts were classified as *due to related party* in the accompanying consolidated balance sheets.

8. SUBSEQUENT EVENTS

The Company's management has evaluated subsequent events through March 24, 2014, and concluded that there were no material subsequent events.

ASC Operators, LLC
Audited Consolidated Financial Statements
December 31, 2012 and 2011

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Independent Auditor's Report

To Board of Directors and Members of
ASC Operators, LLC:

We have audited the accompanying consolidated financial statements of ASC Operators, LLC and its subsidiaries ("the Company"), which comprise the consolidated balance sheets as of December 31, 2012, and December 31, 2011, and the related consolidated statements of operations, changes in equity, and cash flows for each of the two years in the period ended December 31, 2012.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of ASC Operators, LLC and its subsidiaries at December 31, 2012 and December 31, 2011, and the results of their operations and their cash flows for the two years in the period ended December 31, 2012 in accordance with accounting principles generally accepted in the United States of America.

/s/ PricewaterhouseCoopers LLP
Birmingham, AL
March 24, 2014

ASC Operators, LLC
Consolidated Balance Sheets
(In thousands of U.S. dollars)

	December 31 2012	December 31 2011
Assets		
Current assets		
Cash and cash equivalents	$14,163	$ 3,292
Accounts receivable, net of allowance for doubtful accounts (2012 - $241; 2011 - $377)	8,124	6,810
Due from related party	882	5,788
Prepaids and other current assets	175	763
Total current assets	23,344	16,653
Property and equipment, net of accumulated depreciation (2012 - $11,852; 2011 - $10,400)	4,909	4,257
Goodwill	26,534	22,848
Intangible assets, net of accumulated amortization (2012 - $398; 2011 - $119)	1,499	269
Total assets	$56,286	$44,027
Liabilities and Equity		
Current liabilities		
Current portion of long-term debt	$ 460	$ 420
Accounts payable	1,302	1,064
Accrued payroll	270	731
Other current liabilities	167	997
Due to related party	3,041	—
Total current liabilities	5,240	3,212
Long-term debt, net of current portion	287	285
Other long-term liabilities	21	13
Total liabilities	5,548	3,510
Commitments and contingent liabilities		
Equity		
Members' equity	34,785	27,238
Noncontrolling interests	15,953	13,279
Total equity	50,738	40,517
Total liabilities and equity	$56,286	$44,027

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

ASC Operators, LLC
Consolidated Statements of Operations
(In thousands of U.S. dollars)

	Year Ended December 31 2012	Year Ended December 31 2011
Net operating revenues:		
Net patient revenues	$ 60,591	$ 58,639
Other revenues	65	67
Total net operating revenues	60,656	58,706
Operating expenses:		
Salaries and benefits	15,173	12,158
Supplies	8,960	7,708
Other operating expenses	6,940	7,951
Depreciation and amortization	1,861	1,277
Occupancy costs	1,600	1,480
Provision for doubtful accounts	1,067	817
Loss (gain) on disposal of assets	2	(29)
Total operating expenses	35,603	31,362
Operating income	25,053	27,344
Interest expense	35	6
Interest income	(1)	(1)
Net income	25,019	27,339
Less: Net income attributable to noncontrolling interests	(11,048)	(11,208)
Net income attributable to ASC Operators	$ 13,971	$ 16,131

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

ASC Operators, LLC
Consolidated Statements of Changes in Equity
(In thousands of U.S. dollars)

	SCA	Sutter	Total Members Equity	Noncontrolling Interests	Total Equity
Balance at December 31, 2010	$13,802	$14,503	$ 28,305	$ 9,715	$ 38,020
Net income	7,292	8,839	16,131	11,208	27,339
Distributions to members	(7,806)	(8,125)	(15,931)	—	(15,931)
Net change in equity related to purchase/(sale) of ownership interests	(619)	(648)	(1,267)	4,147	2,880
Distributions to noncontrolling interests	—	—	—	(11,791)	(11,791)
Balance at December 31, 2011	$12,669	$14,569	$ 27,238	$ 13,279	$ 40,517
Net income	6,846	7,125	13,971	11,048	25,019
Distributions to members	(3,148)	(3,276)	(6,424)	—	(6,424)
Contributions from members	—	—	—	—	—
Net change in equity related to purchase/(sale) of ownership interests	—	—	—	2,176	2,176
Distributions to noncontrolling interests	—	—	—	(10,550)	(10,550)
Balance at December 31, 2012	$16,367	$18,418	$ 34,785	$ 15,953	$ 50,738

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

ASC Operators, LLC
Consolidated Statements of Cash Flows
(In thousands of U.S. dollars)

	Year Ended December 31 2012	Year Ended December 31 2011
Cash flows from operating activities		
Net income	$ 25,019	$ 27,339
Adjustments to reconcile net income to net cash provided by operating activities		
Provision for doubtful accounts	1,067	817
Depreciation and amortization	1,861	1,277
Loss (gain) on disposal of assets	2	(29)
(Increase) decrease in assets, net of business combinations		
Accounts receivable	(2,040)	(796)
Other assets	594	(121)
Increase (decrease) in liabilities, net of business combinations		
Accounts payable	(89)	38
Accrued payroll	(462)	(5)
Other liabilities	(824)	(22)
Other, net	(54)	—
Net cash provided by operating activities	25,074	28,498
Cash flows from investing activities		
Capital expenditures	(1,586)	(912)
Proceeds from disposal of assets	268	259
Business acquisitions, net of cash acquired of 2012 - $169; 2011 - $211	(3,281)	(3,934)
Changes in due to/from related party	7,947	1,511
Net cash provided by (used in) investing activities	3,348	(3,076)
Cash flows from financing activities		
Principal payments on long-term debt	(65)	—
Principal payments under capital lease obligations	(512)	(138)
Distributions to members	(6,424)	(15,931)
Distributions to noncontrolling interests of consolidated affiliates	(10,550)	(11,791)
Repurchase of equity interests of consolidated affiliates	—	(758)
Other	—	—
Net cash used in financing activities	(17,551)	(28,618)
Change in cash and cash equivalents	10,871	(3,196)
Cash and cash equivalents at beginning of period	3,292	6,488
Cash and cash equivalents at end of period	$ 14,163	$ 3,292
Supplemental cash flow information:		
Cash paid during the year for interest	$ 14	$ 6
Supplemental schedule of noncash investing and financing activities		
Property and equipment acquired through capital leases and installment purchases	202	843
Repurchase of equity interests in consolidated affiliates	—	(509)

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

ASC Operators, LLC
Notes to Consolidated Financial Statements
(Amounts in tables are in thousands of U. S. dollars unless otherwise indicated)

1. DESCRIPTION OF THE BUSINESS

Nature of Operations

ASC Operators, LLC ("ASC Operators," the "Company" or "we"), a California limited liability company, was formed on May 2, 2007, primarily to own and operate a network of multi-specialty ambulatory surgery centers ("ASCs") in the Sacramento, California, metropolitan area. ASC Operators is a 51% owned subsidiary of Sutter Health. Surgery Centers — West Holdings, LLC, a California limited liability company and a subsidiary of Surgical Care Affiliates, LLC (SCA), owns 49% of ASC Operators. As of December 31, 2012, the Company had an interest in and/or operated six ASCs in the Sacramento, California, metropolitan area. Our ASCs primarily provide the facilities, equipment and medical support staff necessary for physicians to perform non-emergency surgical and other procedures in various specialties, including orthopedics, ophthalmology, gastroenterology, pain management, otolaryngology (ear, nose and throat, or "ENT"), urology and gynecology, as well as other general surgery procedures. At our ASCs, physicians perform same-day surgical procedures.

Basis of Presentation

The Company maintains its books and records on the accrual basis of accounting, and the accompanying consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("U.S. GAAP"). Such financial statements include the assets, liabilities, revenues, and expenses of all majority-owned subsidiaries over which we exercise control and, when applicable, entities in which we have a controlling financial interest.

2. ACQUISITIONS

Effective May 1, 2012, we purchased a controlling interest in a multi-specialty surgery center located in Roseville, California for $3.5 million and entered into a management services agreement with the facility.

The fair values of assets and liabilities assumed May 1, 2012 are as follows:

Cash	$ 169
Accounts receivable	341
Fixed assets	716
Other assets	6
Noncompete agreements	198
Certificates of need	126
Management agreements	1,185
Goodwill	3,686
Noncontrolling interests	(2,176)
Accounts payable and other liabilities	(801)
Net assets acquired	$ 3,450

Effective January 1, 2011, we purchased a controlling interest in a multi-specialty surgery center located in Sacramento, California for $4.1 million in cash and entered into a management services agreement with the facility.

The fair values of assets and liabilities assumed January 1, 2011 are as follows:

Cash	$ 211
Accounts receivable	265
Fixed assets	769
Noncompete agreements	237
Licenses	151
Goodwill	6,675
Noncontrolling interests	(3,928)
Accounts payable and other liabilities	(235)
Net assets acquired	$ 4,145

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation

The consolidated financial statements include the accounts of the Company and its subsidiaries for which we are the primary beneficiary. All significant intercompany transactions and accounts have been eliminated.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements, as well as the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. The most significant estimates include, but are not limited to: (1) allowance for contractual revenue adjustments; (2) allowance for doubtful accounts; (3) asset impairments, including goodwill; (4) depreciable lives of assets; (5) useful lives of intangible assets; and (6) economic lives and fair value of leased assets. Future events and their effects cannot be predicted with certainty; accordingly, our accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of our consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained, and as our operating environment changes. We evaluate and update our assumptions and estimates on an ongoing basis and may employ outside experts to assist in our evaluation as considered necessary. Actual results could differ from those estimates.

Revenue Recognition

Revenues consist primarily of net patient service revenues that are recorded based upon established billing rates less allowances for contractual adjustments. Revenues are recorded during the period the healthcare services are provided, based upon the estimated amounts due from patients and third-party payors, including federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies and employers. Estimates of contractual allowances under third-party payor arrangements are based upon the payment terms specified in the related contractual agreements and payment history. Third-party payor contractual payment terms are generally based upon predetermined rates per procedure or discounted fee-for-service rates.

Cash and Cash Equivalents

Cash and cash equivalents include all demand deposits reduced by the amount of outstanding checks and drafts where the right of offset exists for these bank accounts. The Company has deposits with certain financial institutions which exceed federally insured limits. The Company has not experienced any losses on such deposits.

Accounts Receivable

We report accounts receivable at estimated net realizable amounts from services rendered from federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies, workers' compensation, employers and patients. Our accounts receivable are geographically dispersed, but a significant portion of our accounts receivable are concentrated by type of payors. The concentration of net patient service accounts receivable by payor class, as a percentage of total net patient service accounts receivable, as of the end of each of the reporting periods, is as follows:

	As of December 31	
	2012	2011
Managed care and other discount plans	52%	56%
Medicare	16	14
Workers' compensation	22	24
Medicaid	5	6
Patients and other third-party payors	5	—
Total	100%	100%

We recognize that revenues and accounts receivable from government agencies are significant to our operations; however, we do not believe there are significant credit risks associated with these government agencies.

We also recognize that revenue and accounts receivable from managed care and other discount plans are significant to our operations. Because the category of managed care and other discount plans is composed of numerous individual payors which are geographically dispersed, our management does not believe there are any significant concentrations of revenues from any individual payor that would subject us to significant credit risks in the collection of our accounts receivable.

Property and Equipment

We report improvements and equipment at cost, net of asset impairment. We report assets under capital lease obligations at the lower of fair value or the present value of the aggregate future minimum lease payments at the beginning of the lease term. We depreciate our assets using the straight-line method over the shorter of the estimated useful life of the assets or life of the lease term, excluding any lease renewals, unless the lease renewals are reasonably assured. Useful lives are as follows:

	Years
Leasehold improvements	5 to 20
Furniture, fixtures, and equipment	3 to 10
Assets under capital lease obligations: Equipment	3 to 5

Maintenance and repairs of property and equipment are expensed as incurred. We capitalize replacements and improvements that increase the estimated useful life of an asset. We capitalize interest expense on major construction and development projects while in progress. No interest was capitalized during the years ended December 31, 2012 and 2011.

We retain fully depreciated assets in property and accumulated depreciation accounts until we remove them from service. In the case of sale, retirement or disposal, the asset cost and related accumulated depreciation balance is removed from the respective account, and the resulting net amount, less any proceeds, is included as a component of income from continuing operations in the consolidated statements of operations.

For operating leases, we recognize escalated rents, including any rent holidays, on a straight-line basis over the term of the lease.

Goodwill

Goodwill represents the unallocated excess of purchase price over the fair value of identifiable assets and liabilities acquired in business combinations. Goodwill also includes the unallocated excess of purchase price plus the fair value of any noncontrolling interest in the acquiree at the acquisition date over the fair value of identifiable assets and liabilities acquired in business combinations.

We test goodwill for impairment using a fair value approach at least annually, absent some triggering event that would require an interim impairment assessment. Absent any impairment indicators, we perform our goodwill impairment testing as of October 1st of each year. We have no accumulated impairment of goodwill for the periods ended December 31, 2012 and 2011.

Fair Value of Financial Instruments

Our financial instruments consist mainly of cash and cash equivalents, accounts receivable, accounts payable, and long-term debt. The carrying amounts of cash and cash equivalents, accounts receivable and accounts payable approximate fair value because of the short-term maturity of these instruments. We determine the fair value of our long-term debt based on various factors, including maturity schedules, call features and current market rates.

Noncontrolling Interest in Consolidated Affiliates

The consolidated financial statements include all assets, liabilities, revenues and expenses of less-than-100%-owned affiliates that we control. Accordingly, we have recorded a noncontrolling interest in the earnings and equity of such affiliates. We record adjustments to noncontrolling interest for the allocable portion of income or loss to which the noncontrolling interest holders are entitled based upon the portion of the subsidiaries they own. Distributions to holders of noncontrolling interests reduce the respective noncontrolling interest holders' balance.

Newly Issued Authoritative Guidance

Goodwill Impairment Testing. In September 2011, the FASB issued accounting guidance related to goodwill impairment testing. The guidance allows an entity to elect to first perform a qualitative assessment to determine whether it is more-likely-than-not that the fair value of a reporting unit is less than its carrying amount. If an entity believes, as a result of its qualitative assessment, that it is more-likely-than-not that the fair value of a reporting unit is less than its carrying amount, the quantitative impairment test is required. Otherwise, no further impairment testing is required. The guidance refers to several factors to consider when performing the qualitative analysis, including macroeconomic factors, industry factors and entity-specific factors. The guidance is effective for annual and interim goodwill impairment tests performed for fiscal years beginning after December 15, 2011. Early adoption is permitted provided that the entity has not yet performed its annual impairment test for goodwill. The Company performs its annual impairment test for goodwill as of October 1 of each year. The adoption of this new accounting guidance did not have a material impact on the Company's financial statements.

We do not believe any other recently issued, but not yet effective, revisions to authoritative guidance will have a material effect on our consolidated financial position, results of operations or cash flows.

4. PROPERTY AND EQUIPMENT

Property and equipment consists of the following:

	As of December 31 2012	2011
Leasehold improvements	$ 4,222	$ 3,781
Furniture, fixtures and equipment	12,052	10,824
	16,274	14,605
Less: Accumulated depreciation and amortization	(11,852)	(10,400)
	4,422	4,205
Construction in progress	487	52
Property and equipment, net	$ 4,909	$ 4,257

Depreciation expense for the years ended December 31, 2012 and 2011 was approximately $1.6 million and $1.2 million, respectively, and is included in the consolidated statements of income as a component of operating expenses.

The amount of amortization expense and accumulated amortization relating to assets under capital lease obligations and rent expense under operating leases is as follows:

	YEAR ENDED DECEMBER 31 2012	YEAR ENDED DECEMBER 31 2011
Assets under capital lease obligations:		
Equipment	$1,045	$ 843
Accumulated amortization	(447)	(94)
Assets under capital lease obligations, net	$ 598	$ 749
Amortization expense	$ 268	$ 94
Rent Expense:		
Minimum rent payments	$1,589	$1,325
Contingent and other rents	223	384
Total rent expense	$1,812	$1,709

Leases

Future minimum lease payments at December 31, 2012 for those leases of ASC Operators, LLC and its subsidiaries having an initial or remaining non-cancelable lease term of one year or more are as follows:

Year ending December 31,	Operating Leases	Capital Lease Obligations	Total
2013	$ 955	$368	$1,323
2014	734	2	736
2015	508	1	509
2016	305	1	306
2017	35	—	35
2018 and thereafter	327	—	327
	$2,864	372	$3,236
Less: interest portion		(4)	
Obligations under capital leases		$368	

5. GOODWILL

Goodwill represents the unallocated excess of purchase price over the fair value of identifiable assets and liabilities acquired in business combinations. Goodwill also includes the unallocated excess of purchase price plus the fair value of any noncontrolling interest in the acquiree at the acquisition date over the fair value of identifiable assets and liabilities acquired in business combinations. We have no accumulated impairment of goodwill for the periods ended December 31, 2012 and 2011.

The following table shows changes in the carrying amount of goodwill for the years ended December 31, 2012 and 2011:

	YEAR ENDED DECEMBER 31 2012	YEAR ENDED DECEMBER 31 2011
Balance at beginning of period	$22,848	$16,463
Acquisitions (Note 2)	3,686	6,675
Other	—	(290)
Balance at end of period	$26,534	$22,848

We performed impairment reviews and concluded that no goodwill impairment existed.

6. LONG-TERM DEBT

Our long-term debt outstanding consists of the following:

	As of December 31	
	2012	2011
Capital lease obligations	$ 368	$ 705
Notes payable	379	—
	747	705
Less: Current portion	(460)	(420)
Long-term debt, net of current portion	$ 287	$ 285

The following chart shows scheduled principal payments due on long-term debt for the next five years and thereafter:

Year Ending December 31	
2013	$460
2014	103
2015	109
2016	75
2017	—
Thereafter	—
Total	$747

7. NONCONTROLLING INTERESTS

The following table shows the effects of changes to ASC Operators, LLC ownership interest in its subsidiaries on ASC Operators, LLC equity:

	YEAR ENDED DECEMBER 31 2012	YEAR ENDED DECEMBER 31 2011
Net income attributable to ASC Operators	$13,971	$16,131
(Decrease) increase in equity due to sales to noncontrolling interests	—	(271)
Decrease in equity due to purchases from noncontrolling interests	—	(996)
Change from net loss attributable to ASC Operators and transfers to/from noncontrolling interests	$13,971	$14,864

8. RELATED PARTY TRANSACTIONS

The Company was involved in various transactions with affiliated companies. The surgery centers were owed $0.9 million and $5.8 million from Surgical Care Affiliates, LLC and related affiliates for services at December 31, 2012 and 2011, respectively, and such amounts are classified as *due from related party* in the accompanying consolidated balance sheets. The surgery centers owed Sutter Health and related entities $3.0 million for services at December 31, 2012, and such amounts were classified as *due to related party* in the accompanying consolidated balance sheets.

9. SUBSEQUENT EVENTS

The Company's management has evaluated subsequent events through March 24, 2014, and concluded that there were no material subsequent events.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on this the 24th day of March, 2014.

SURGICAL CARE AFFILIATES, INC.

By: /s/ Andrew P. Hayek
Andrew P. Hayek
President and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Name	Title	Date
/s/ Andrew P. Hayek Andrew P. Hayek	President, Chief Executive Officer and Director (principal executive officer)	March 24, 2014
/s/ Peter J. Clemens Peter J. Clemens	Executive Vice President and Chief Financial Officer (principal financial officer and principal accounting officer)	March 24, 2014
* Thomas C. Geiser	Director	March 24, 2014
* Sharad Mansukani, M.D.	Director	March 24, 2014
* Todd B. Sisitsky	Director	March 24, 2014
* Jeffrey K. Rhodes	Director	March 24, 2014
* Curtis S. Lane	Director	March 24, 2014
* Frederick A. Hessler	Director	March 24, 2014

* Richard L. Sharff, Jr., by signing his name hereto, does sign this document on behalf of each of the persons indicated above pursuant to powers of attorney executed by such persons and filed with the Securities and Exchange Commission.

By: /s/ Richard L. Sharff, Jr.
Richard L. Sharff, Jr.
Attorney in fact

EXHIBIT INDEX

Exhibit Number	Description
2.1	Plan of Conversion of ASC Acquisition LLC
3.1	Certificate of Incorporation of Surgical Care Affiliates, Inc. (incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed with the SEC on November 4, 2013)
3.2	By-Laws of Surgical Care Affiliates, Inc. (incorporated by reference to Exhibit 3.2 to the Company's Current Report on Form 8-K filed with the SEC on November 4, 2013)
4.1	Registration Rights Agreement by and among Surgical Care Affiliates, Inc. and certain stockholders (incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed with the SEC on November 4, 2013)
10.1	Amendment and Restatement Agreement dated as of June 30, 2011, among Surgical Care Affiliates, LLC, ASC Acquisition LLC, the Lenders party thereto, and JPMorgan Chase Bank, N.A., as Administrative Agent, Swing Line Lender and L/C Issuer, under the Credit Agreement dated as of June 29, 2007, as amended, among Surgical Care Affiliates, LLC, ASC Acquisition LLC, the lenders party thereto and JPMorgan Chase Bank, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.1 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)
10.2	Incremental Amendment dated as of May 8, 2013, among ASC Acquisition LLC, Surgical Care Affiliates, LLC, the Incremental Lenders and JPMorgan Chase Bank, N.A., as administrative agent, to the Amended and Restated Credit Agreement dated as of June 29, 2007, as amended and restated (incorporated by reference to Exhibit 10.2 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)
10.3	Pledge and Security Agreement dated as of June 29, 2007, among Surgical Care Affiliates LLC, ASC Acquisition LLC, certain subsidiaries of Surgical Care Affiliates, LLC identified therein and JPMorgan Chase Bank, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.3 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)
10.4	Supplement No. 1 dated as of December 16, 2010, to the Pledge and Security Agreement dated as of June 29, 2007 (incorporated by reference to Exhibit 10.4 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)
10.5	Guaranty dated as of June 29, 2007, among ASC Acquisition LLC, Surgical Care Affiliates, LLC, certain subsidiaries of Surgical Care Affiliates, LLC and JPMorgan Chase Bank, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.5 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)
10.6	Supplement No. 1 dated as of December 16, 2010, to the Guaranty dated as of June 29, 2007 (incorporated by reference to Exhibit 10.6 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)
10.7	Reaffirmation Agreement dated as of June 30, 2011, among Surgical Care Affiliates, LLC, ASC Acquisition LLC, certain subsidiaries of Surgical Care Affiliates, LLC and JPMorgan Chase Bank, N.A., as Administrative Agent, Swing Line Lender and L/C Issuer for the Lenders (incorporated by reference to Exhibit 10.7 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)
10.8*	Conformed copy of Surgical Care Affiliates, Inc. Management Equity Incentive Plan, adopted November 16, 2007, reflecting amendments through May 6, 2013 (incorporated by reference to Exhibit 10.8 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)

Exhibit Number	Description
10.9*	Form of Time-Based Option Award Under the Management Equity Incentive Plan (incorporated by reference to Exhibit 10.9 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)
10.10*	Conformed copy of Surgical Care Affiliates, Inc. Directors and Consultants Equity Incentive Plan, adopted June 24, 2008, reflecting amendments through February 8, 2011 (incorporated by reference to Exhibit 10.10 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)
10.11*	Form of Option Award to Directors Under the Director and Consultant Equity Incentive Plan (incorporated by reference to Exhibit 10.11 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)
10.12*	Restricted Equity Unit Grant Agreement dated July 24, 2008, between Surgical Care Affiliates LLC, ASC Acquisition LLC and Andrew Hayek (incorporated by reference to Exhibit 10.12 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)
10.13*	Form of Restricted Equity Unit Grant Agreement (incorporated by reference to Exhibit 10.13 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)
10.14*	Surgical Care Affiliates, Inc. 2013 Omnibus Long-Term Incentive Plan
10.15*	Employment Agreement, dated as of October 30, 2013, by and among Surgical Care Affiliates, Inc., Surgical Care Affiliates LLC and Andrew P. Hayek (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed with the SEC on November 4, 2013)
10.16*	Employment Agreement, dated as of October 30, 2013, by and among Surgical Care Affiliates, Inc., Surgical Care Affiliates LLC and Joseph T. Clark (incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K filed with the SEC on November 4, 2013)
10.17*	Employment Agreement, dated as of October 30, 2013, by and among Surgical Care Affiliates, Inc., Surgical Care Affiliates LLC and Michael A. Rucker (incorporated by reference to Exhibit 10.4 to the Company's Current Report on Form 8-K filed with the SEC on November 4, 2013)
10.18*	Employment Agreement, dated as of October 30, 2013, by and among Surgical Care Affiliates, Inc., Surgical Care Affiliates LLC and Peter J. Clemens (incorporated by reference to Exhibit 10.5 to the Company's Current Report on Form 8-K filed with the SEC on November 4, 2013)
10.19*	Employment Agreement, dated as of October 30, 2013, by and among Surgical Care Affiliates, Inc., Surgical Care Affiliates LLC and Richard L. Sharff, Jr. (incorporated by reference to Exhibit 10.6 to the Company's Current Report on Form 8-K filed with the SEC on November 4, 2013)
10.20	Lease Agreement, dated as of October 31, 2007, by and between Riverchase Tower, LLC and Surgical Care Affiliates, LLC (incorporated by reference to Exhibit 10.20 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)
10.21	Lease Amendment Agreement No. 1, dated as of June 20, 2012, by and between Surgical Care Affiliates, LLC and Riverchase Office, LLC (incorporated by reference to Exhibit 10.21 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)
10.22	Standard Office Lease, dated as of May 10, 2010, by and between Long Ride Office Portfolio, L.P. and Surgical Care Affiliates, LLC (incorporated by reference to Exhibit 10.22 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)
10.23	First Amendment to Lease (Corporate 500 Centre), dated as of April 13, 2011, by and between Long Ridge Office Portfolio, L.P. and Surgical Care Affiliates, LLC (incorporated by reference to Exhibit 10.23 to the Company's Registration Statement on Form S-1 filed with the SEC on September 5, 2013)

Exhibit Number	Description
10.24	Stockholders Agreement by and among Surgical Care Affiliates, Inc. and the stockholders party thereto (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed with the SEC on November 4, 2013)
10.25*	Option Net-Settlement Exercise Agreement, dated October 8, 2013, among ASC Acquisition LLC, Surgical Care Affiliates, LLC and Joseph T. Clark (incorporated by reference to Exhibit 10.25 to Amendment No. 2 to the Company's Registration Statement on Form S-1 filed with the SEC on October 16, 2013)
10.26*	Letter Agreement between Surgical Care Affiliates, Inc. and Thomas C. Geiser, dated December 7, 2012
10.26A*	Letter Agreement between Surgical Care Affiliates, Inc. and Thomas C. Geiser, dated January 23, 2014
10.27*	Letter Agreement between Surgical Care Affiliates, Inc. and Frederick A. Hessler, dated October 1, 2013
10.28*	Letter Agreement between Surgical Care Affiliates, Inc. and Curtis S. Lane, dated December 7, 2012
10.29*	Letter Agreement between Surgical Care Affiliates, Inc. and Sharad Mansukani, dated December 7, 2012
10.30*	Form of Surgical Care Affiliates, Inc. Indemnity Agreement
10.31*	Form of Restricted Stock Unit Award Agreement under 2013 Omnibus Long-Term Incentive Plan (Directors Grants)
10.32*	Form of Restricted Stock Unit Award Agreement under 2013 Omnibus Long-Term Incentive Plan (Employee Grants)
10.33*	Form of Non-qualified Stock Option Agreement under 2013 Omnibus Long-Term Incentive Plan
21.1	List of subsidiaries of Surgical Care Affiliates, Inc.
23.1	Consent of PricewaterhouseCoopers LLP, Independent Registered Public Accounting Firm
23.2	Consent of PricewaterhouseCoopers LLP, Independent Registered Public Accounting Firm
24.1	Powers of Attorney
31.1	Certification of Chief Executive Officer pursuant to Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as amended
31.2	Certification of Chief Financial Officer pursuant to Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as amended
32.1	Certification by Chief Executive Officer pursuant to 18 U.S.C. Section 1350
32.2	Certification of Chief Financial Officer Pursuant to 18 U.S.C. Section 1350
101.INS	XBRL Instance Document
101.SCH	XBRL Taxonomy Extension Schema Document
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	XBRL Taxonomy Extension Label Linkbase Document
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

* Management compensation plan or arrangement

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Exhibit 2.1

PLAN OF CONVERSION

This PLAN OF CONVERSION, dated as of October 29, 2013 (including all of the Exhibits attached hereto, this "Plan of Conversion"), is hereby adopted by TPG Partners V, L.P., the managing member (the "Managing Member") of ASC Acquisition LLC, a Delaware limited liability company (the "LLC"), in order to set forth the terms, conditions and procedures governing the conversion of the LLC from a Delaware limited liability company to a Delaware corporation to be named "Surgical Care Affiliates, Inc." (the "Corporation") pursuant to Section 18-216 of the Delaware Limited Liability Company Act (the "LLC Act") and Section 265 of the General Corporation Law of the State of Delaware (the "DGCL").

WITNESSETH

WHEREAS, the LLC was formed on March 23, 2007 and has been operating under the Second Amended and Restated Limited Liability Company Operating Agreement of the LLC, dated as of August 22, 2007, as amended (the "LLC Agreement");

WHEREAS, upon the terms and subject to the conditions of this Plan of Conversion and in accordance with the LLC Act and the DGCL, the LLC will be converted to a Delaware corporation pursuant to and in accordance with Section 18-216 of the LLC Act and Section 265 of the DGCL (the "Conversion");

WHEREAS, the Managing Member, pursuant to Section 12.13 of the LLC Agreement (i) has determined that in order to facilitate a public offering of the securities of the Corporation (the "IPO"), the Conversion is advisable and in the best interests of the LLC and its members (the "Members") and (ii) hereby approves and adopts this Plan of Conversion, the Conversion, and the other documents and transactions contemplated by this Plan of Conversion;

WHEREAS, in connection with the Conversion, every 10.25 outstanding Membership Units (as defined in the LLC Agreement) of the LLC shall be converted into one (1) share of common stock, par value $0.01 per share (the "Common Stock") of the Corporation as provided in this Plan of Conversion;

WHEREAS, the Managing Member, pursuant to the Written Consent of the Managing Member dated July 15, 2013, has established a Pricing Committee (the "Pricing Committee"), with authority to act for and in the name of the Managing Member, to approve the specific terms and conditions of the IPO, including, without limitation, the offering price of shares of Common Stock to be sold in the IPO (the "Offering Price"); and

NOW, THEREFORE, in accordance with the LLC Act and the DGCL, upon the Effective Time (as defined below), the LLC shall be converted to the Corporation. The mode of carrying the Conversion into effect shall be as described in this Plan of Conversion.

ARTICLE I

THE CONVERSION

SECTION 1.01 The Conversion. At the Effective Time (as defined below), the LLC shall be converted to the Corporation and, for all purposes of the laws of the State of Delaware, the Conversion shall be deemed a continuation of the existence of the LLC in the form of a Delaware corporation. The Conversion shall not require the LLC to wind up its affairs under Section 18-803 of the LLC Act or pay its liabilities and distribute its assets under Section 18-804 of the LLC Act, and the Conversion shall not constitute a dissolution of the LLC. At the Effective Time, for all purposes of the laws of the State of Delaware, all of the rights, privileges and powers of the LLC, and all property, real, personal and mixed, and all debts due to the LLC, as well as all other things and causes of action belonging to the LLC, shall remain vested in the Corporation and shall be the property of the Corporation, and the title to any real property vested by deed or otherwise in the LLC shall not revert or be in any way impaired by reason of any provision of the LLC Act; but all rights of creditors and all liens upon any property of the LLC shall be preserved unimpaired, and all debts, liabilities and duties of the LLC shall remain attached to the Corporation, and may be enforced against it to the same extent as if said debts, liabilities and duties had originally been incurred or contracted by it in its capacity as a corporation. The rights, privileges, powers and interests in property of the LLC, as well as the debts, liabilities and duties of the LLC, shall not be deemed, as a consequence of the Conversion, to have been transferred to the Corporation for any purpose of the laws of the State of Delaware.

SECTION 1.02 Effective Time. The Conversion shall become effective upon the filing of the Certificate of Conversion in the form attached hereto as Exhibit A (the "Certificate of Conversion") and the Certificate of Incorporation of the Corporation in the form attached hereto as Exhibit B (the "Certificate of Incorporation") with the Secretary of State of the State of Delaware (the "Secretary of State") pursuant to Section 265 of the DGCL (such time of effectiveness, the "Effective Time"). Notwithstanding the foregoing, each of the Certificate of Conversion and the Certificate of Incorporation may provide for the same post-filing effective time as permitted by the LLC Act and the DGCL, in which case the Effective Time shall be the post-filing effective time stated in the Certificate of Conversion and Certificate of Incorporation. The LLC, and the Managing Member or Andrew Hayek or Peter Clemens (such persons, the "Authorized Officers") on behalf of the LLC, acting singly, shall execute, deliver and file the Certificate of Conversion, and Richard L. Sharff, Jr. shall act as incorporator and execute, deliver and file the Certificate of Incorporation.

SECTION 1.03 Certificate of Incorporation and Bylaws of the Corporation. At and after the Effective Time, the Certificate of Incorporation and By-Laws of the Corporation (the "By-Laws") shall be in the forms attached hereto as Exhibit B and Exhibit C, respectively, until amended in accordance with their terms and the DGCL.

SECTION 1.04 Directors and Officers. The initial directors of the Corporation shall be Thomas C. Geiser, Andrew Hayek, Frederick A. Hessler, Curtis S. Lane, Sharad Mansukani, Jeffrey K. Rhodes and Todd B. Sisitsky, each of whom shall be named to the initial Board of Directors of the Corporation. The initial chairman of the Board of Directors shall be Todd B. Sisitsky. The Board of Directors of the Corporation shall be divided into three classes, the term of each of which shall terminate on the date of the annual meeting of stockholders held in the year indicated in parenthesis below, each designated as Class I, Class II and Class III as follows:

Class I (2014)

Sharad Mansukani
Jeffrey K. Rhodes
Todd B. Sisitsky

Class II (2015)

Thomas C. Geiser
Curtis S. Lane

Class III (2016)

Andrew Hayek
Frederick A. Hessler

The initial officers of the Corporation shall be determined by the Board of Directors of the Corporation, promptly following the Conversion, in each case until their respective successors are duly elected or appointed and qualified.

SECTION 1.05 Termination. This Plan of Conversion may be terminated and the Conversion abandoned by action of the Managing Member at any time prior to the Effective Time (a "Termination"). Upon a Termination, if the Certificate of Conversion and the Certificate of Incorporation have been filed with the Secretary of State, but have not become effective, any person or entity that was authorized to execute, deliver and file such certificates, including an Authorized Officer, may execute, deliver and file a Certificate of Termination of such certificates.

ARTICLE II

CONVERSION; CERTIFICATES

SECTION 2.01 Conversion of Membership Units. At the Effective Time, by virtue of the Conversion and without any action on the part of the LLC, the Corporation or the Members, every 10.25 outstanding Membership Units shall be converted into one (1) share of Common Stock and the number of options underlying the right to purchase 10.25 Membership Units shall be converted into an option to purchase one (1) share of Common Stock; provided, however, no fractional shares of Common Stock shall result from the Conversion. If a fractional share of Common Stock would result from the Conversion, the Member otherwise entitled to such fractional share shall receive, in lieu of any fraction of a share of Common Stock (after aggregating all fractional shares of Common Stock such Member would otherwise be entitled to receive), an amount of cash equal to such fraction of Common Stock multiplied by the Offering Price.

SECTION 2.02 Effect of Conversion on Employee Benefit, Incentive Compensation or Other Similar Plans. Upon the terms and subject to the conditions of this Plan of Conversion, at the Effective Time, by virtue of the Conversion and without any further action on the part of the LLC or its Members, each employee benefit plan, incentive compensation plan

or other similar plan to which the LLC is a party shall continue to be a plan of the Corporation. To the extent that any such plan provides for the issuance of Membership Units, upon the Effective Time, such plan shall be deemed to provide for the issuance of Common Stock. A number of shares of the Common Stock shall be reserved for issuance under such plan or plans equal to the number of Membership Units so reserved immediately prior to the Effective Time divided by 10.25.

SECTION 2.03. Registration of Shares.

(a) Registration in Book-Entry. Shares of Common Stock issued in connection with the Conversion shall be uncertificated, and the Corporation shall register, or cause to be registered, such shares of Common Stock into which each outstanding Membership Unit shall have been converted as a result of the Conversion in book-entry form.

(b) No Further Rights in Membership Units. The shares of Common Stock issued upon the conversion of the outstanding Membership Units in accordance with the terms hereof shall be deemed to have been issued in full satisfaction of all rights pertaining to such Membership Units, and shall, when issued, be duly authorized, validly issued, fully paid and nonassessable shares of Common Stock, as applicable.

SECTION 2.04 Governing Law. This Plan of Conversion shall be governed by, and construed in accordance with, the internal laws of the State of Delaware, without regard to the laws of any other jurisdiction that might be applied because of the conflicts of laws principles of the State of Delaware.

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IN WITNESS WHEREOF, the Managing Member has caused this Plan of Conversion to be duly executed as of the date first above written.

TPG PARTNERS V, L.P.

By: TPG GenPar V, L.P.,
its general partner
By: TPG GenPar V Advisors, LLC,
its general partner

By: /s/ Ronald Cami
Name: Ronald Cami
Title: Vice President

EXHIBIT A

Certificate of Conversion

EXHIBIT B

Certificate of Incorporation

EXHIBIT C

By-Laws

Exhibit 10.14

SURGICAL CARE AFFILIATES, INC.
2013 OMNIBUS LONG-TERM INCENTIVE PLAN
(Dated of as October 24, 2013)

1. Purpose of the Plan

This Plan is intended to promote the interests of the Company and its shareholders by providing employees, directors and consultants of the Company and its Subsidiaries, who are largely responsible for the management, growth and protection of the business of the Company and its Subsidiaries, with appropriate incentives and rewards to encourage them to continue in the service of the Company and its Subsidiaries.

2. Definitions

As used in the Plan or in any instrument governing the terms of any Incentive Award, the following definitions apply to the terms indicated below:

(a) "Affiliate" means, with respect to a specified person, a person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the specified person.

(b) "Award Agreement" means a written agreement, in a form determined by the Committee from time to time, entered into by each Participant and the Company, evidencing the grant of an Incentive Award under the Plan.

(c) "Board of Directors" means the Board of Directors of the Company.

(d) "Cash Incentive Award" means an award granted to a Participant pursuant to Section 8 of the Plan.

(e) "Change in Control" means (i) any one person, or more than one person acting as a group (as defined under Treasury Regulation § 1.409A-3(i)(5)(v)(B)), other than the Company, TPG or any employee benefit plan sponsored by the Company, acquires ownership of stock of the Company that, together with stock held by such person or group, constitutes more than fifty percent (50%) of the total fair market value or total Voting Power of the stock of the Company; or (ii) any one person, or more than one person acting as a group (as defined under Treasury Regulation § 1.409A-3(i)(5)(v)(B)), other than the Company or any employee benefit plan sponsored by the Company, acquires (or has acquired during the twelve (12) month period ending on the date of the most recent acquisition by such person or persons) ownership of stock of the Company possessing fifty percent (50%) or more of the total Voting Power of the stock of the Company; or (iii) a majority of members of the Board of Directors is replaced during any twelve (12) month period by directors whose appointment or election is not endorsed by a majority of the members of the Board of Directors before the date of each appointment or election; or (iv) any one person, or more than one person acting as a group (as defined in Treasury Regulation § 1.409A-3(i)(5)(v)(B)) acquires (or has acquired during the twelve (12)

month period ending on the date of the most recent acquisition by such person or persons) assets from the Company that have a total gross fair market value equal to or more than 40 percent of the total gross fair market value of all of the assets of the Company immediately before such acquisition or acquisitions. For purposes of subsection (iv), gross fair market value means the value of the assets of the Company, or the value of the assets being disposed of, determined without regard to any liabilities associated with such assets. The foregoing subsections (i) through (iv) shall be interpreted in a manner that is consistent with the Treasury Regulations promulgated pursuant to Section 409A of the Code so that all, and only, such transactions or events that could qualify as a "change in control event" within the meaning of Treasury Regulation §1.409A-3(i)(5)(i) will be deemed to be a Change in Control for purposes of this Plan.

(f) "Code" means the Internal Revenue Code of 1986, as amended from time to time, and all regulations, interpretations and administrative guidance issued thereunder.

(g) "Committee" means the Compensation Committee of the Board of Directors or such other committee as the Board of Directors shall appoint from time to time to administer the Plan and to otherwise exercise and perform the authority and functions assigned to the Committee under the terms of the Plan.

(h) "Common Stock" means the Company's common stock, $0.01 par value per share, or any other security into which the common stock shall be changed pursuant to the adjustment provisions of Section 10 of the Plan.

(i) "Company" means Surgical Care Affiliates, Inc., a Delaware corporation and any successors thereto.

(j) "Covered Employee" means each Participant who is an executive officer (within the meaning of Rule 3b-7 under the Exchange Act) of the Company.

(k) "Deferred Compensation Plan" means any plan, agreement or arrangement maintained by the Company from time to time that provides opportunities for deferral of compensation.

(l) "Effective Date" means the date the Plan is adopted.

(m) "Employment" means the period during which an individual is classified or treated by the Company as an employee or other service provider of the Company, as applicable.

(n) "Exchange Act" means the Securities Exchange Act of 1934, as amended.

(o) "Fair Market Value" means, with respect to a share of Common Stock, as of the applicable date of determination or if the market is not open for trading on such date, the immediately preceding day on which the market is open for trading, (i) the average of the high and low sales prices as reported on the date of determination on the principal securities exchange

on which shares of Common Stock are then listed or admitted to trading or (ii) if not so reported, the average volume-weighted trading price as reported on NYSE on the date of determination. In the event that the price of a share of Common Stock shall not be so reported, the Fair Market Value of a share of Common Stock shall be determined by the Committee in its sole discretion.

(p) "Incentive Award" means one or more Stock Incentive Awards and/or Cash Incentive Awards, collectively.

(q) "Option" means a stock option to purchase shares of Common Stock granted to a Participant pursuant to Section 6.

(r) "Other Stock-Based Award" means an award granted to a Participant pursuant to Section 7.

(s) "Participant" means an employee, consultant or director of the Company or one of its Subsidiaries who is eligible to participate in the Plan and to whom one or more Incentive Awards have been granted pursuant to the Plan and have not been fully settled or cancelled and, following the death of any such Person, his successors, heirs, executors and administrators, as the case may be.

(t) "Performance-Based Award" means any Incentive Award pursuant to which any compensation paid is intended to be Performance-Based Compensation.

(u) "Performance-Based Compensation" means compensation that satisfies the requirements of Section 162(m) of the Code for deductibility of "qualified performance-based compensation."

(v) "Performance Measures" means such measures as are described in Section 9 on which performance goals are based in order to qualify certain awards granted hereunder as Performance-Based Compensation.

(w) "Performance Percentage" means the factor determined pursuant to a Performance Schedule that is to be applied to a Target Award and that reflects actual performance compared to the Performance Target.

(x) "Performance Period" means the period of time during which the performance goals must be met in order to determine the degree of payout and/or vesting with respect to an Incentive Award that is intended to qualify as Performance-Based Compensation. Performance Periods may be overlapping.

(y) "Performance Schedule" means a schedule or other objective method for determining the applicable Performance Percentage to be applied to each Target Award.

(z) "Performance Target" means performance goals and objectives with respect to a Performance Period.

(aa) "Person" means a "person" as such term is used in Section 13(d) and 14(d) of the Exchange Act, including any "group" within the meaning of Section 13(d)(3) under the Exchange Act.

(bb) "Plan" means this 2013 Omnibus Long-Term Incentive Plan, as it may be amended from time to time.

(cc) "Securities Act" means the Securities Act of 1933, as amended.

(dd) "Stock Incentive Award" means an Option or Other Stock-Based Award granted pursuant to the terms of the Plan.

(ee) "Subsidiary" means any "subsidiary" within the meaning of Rule 405 under the Securities Act.

(ff) "Target Award" means target payout amount for an Incentive Award.

(gg) "TPG" means TPG Partners V, L.P., TPG FOF V-A, L.P., TPG FOF V-B, L.P. and their respective Affiliates.

(hh) "Voting Power" means the number of votes available to be cast (determined by reference to the maximum number of votes entitled to be cast by the holders of Voting Securities, or by the holders of any Voting Securities for which other Voting Securities may be convertible, exercisable or exchangeable, upon any matter submitted to stockholders where the holders of all Voting Securities vote together as a single class) by the holders of Voting Securities.

(ii) "Voting Securities" means any securities or other ownership interests of an entity entitled, or which may be entitled, to matters submitted to Persons holding such securities or other ownership interests in such entity generally (whether or not entitled to vote in the general election of directors), or securities or other ownership interests which are convertible into, or exercisable in exchange for, such Voting Securities, whether or not subject to the passage of time or any contingency.

3. Stock Subject to the Plan and Limitations on Cash Incentive Awards

(a) Stock Subject to the Plan

(i) The maximum number of shares of Common Stock that may be covered by Incentive Awards granted under the Plan shall not exceed 2,220,000 shares of Common Stock in the aggregate. Out of such aggregate, the maximum number of shares of Common Stock that may be covered by Options that are designated as "incentive stock options" within the meaning of Section 422 of the Code shall not exceed 2,220,000 shares of Common Stock. The maximum number of shares referred to in the preceding sentences of this Section 3(a)(i) shall in each case be subject to adjustment as provided in Section 10 and the following

provisions of this Section 3. Of the shares described, one hundred percent (100%) may be delivered in connection with "full-value Awards," meaning Awards other than Options, SARs, or Awards for which the Participant pays the intrinsic value either directly or in exchange for (or by foregoing) a right to receive a cash payment from the Company equal to the intrinsic value of the Award. Shares of Common Stock issued under the Plan may be either authorized and unissued shares, treasury shares, shares purchased by the Company in the open market, or any combination of the preceding categories as the Committee determines in its sole discretion.

(ii) For purposes of Section 3(a)(i), shares of Common Stock covered by Incentive Awards shall only be counted as used to the extent they are actually issued and delivered to a Participant (or such Participant's permitted transferees as described in the Plan) pursuant to the Plan. In addition, if shares of Common Stock are issued subject to conditions which may result in the forfeiture, cancellation or return of such shares to the Company, any portion of the shares forfeited, cancelled or returned shall be treated as not issued pursuant to the Plan. In addition, if shares of Common Stock owned by a Participant (or such Participant's permitted transferees as described in the Plan) are tendered (either actually or through attestation) to the Company in payment of any obligation in connection with an Incentive Award, the number of shares tendered shall be added to the number of shares of Common Stock that are available for delivery under the Plan. Shares of Common Stock covered by Incentive Awards granted pursuant to the Plan in connection with the assumption, replacement, conversion or adjustment of outstanding equity-based awards in the context of a corporate acquisition or merger (within the meaning of NASDAQ Listing Rule 5635) shall not count as used under the Plan for purposes of this Section 3.

(b) Individual Award Limits

Subject to adjustment as provided in Section 10, the maximum number of shares of Common Stock that may be covered by Incentive Awards granted under the Plan to any Covered Employee in any calendar year shall not exceed 450,000 shares. The amount payable to any Covered Employee with respect to any calendar year for all Cash Incentive Awards shall not exceed $3,500,000. For purposes of the preceding sentences, the phrase "amount payable with respect to any calendar year" means the amount of cash, or value of other property, required to be paid based on the achievement of applicable Performance Measures during a Performance Period that ends in such calendar year, disregarding any deferral pursuant to the terms of a Deferred Compensation Plan unless the terms of the deferral are intended to comply with the requirements for qualified performance-based compensation under Section 162 (m) of the Code.

4. Administration of the Plan

(a) The Plan shall be administered by a Committee of the Board of Directors consisting of two or more persons, each of whom, solely to the extent required by applicable law,

qualifies as a "non-employee director" (within the meaning of Rule 16b-3 promulgated under Section 16 of the Exchange Act), an "outside director" within the meaning of Treasury Regulation Section 1.162-27(e)(3) and as "independent" as required by NASDAQ or any security exchange on which the Common Stock is listed. From time to time, the Board may increase or decrease the size of the Committee, add additional members to, remove members (with or without cause) from, appoint new members in substitution therefor, and fill vacancies, however caused, in the Committee. The Committee shall, consistent with the terms of the Plan, from time to time designate those individuals who shall be granted Incentive Awards under the Plan and the amount, type and other terms and conditions of such Incentive Awards. All of the powers and responsibilities of the Committee under the Plan may be delegated by the Committee, in writing, to any subcommittee thereof, in which case the acts of such subcommittee shall be deemed to be acts of the Committee hereunder. The Committee may also from time to time authorize a subcommittee consisting of one or more members of the Board of Directors (including members who are employees of the Company or one of its Subsidiaries) or employees of the Company or one of its Subsidiaries to grant Incentive Awards to persons who are not "executive officers" of the Company (within the meaning of Rule 16a-1 under the Exchange Act), subject to such restrictions and limitations as the Committee may specify and to the requirements of Section 157 of the Delaware General Corporation Law.

(b) The Committee shall have full discretionary authority to administer the Plan, including discretionary authority to interpret and construe any and all provisions of the Plan and any Award Agreement thereunder, and to adopt, amend and rescind from time to time such rules and regulations for the administration of the Plan, including rules and regulations related to sub-plans established for the purpose of satisfying applicable foreign laws and/or qualifying for preferred tax treatment under applicable foreign tax laws, as the Committee may deem necessary or appropriate. Decisions of the Committee shall be final, binding and conclusive on all parties. For the avoidance of doubt, the Committee may exercise all discretion granted to it under the Plan in a non-uniform manner among Participants.

(c) The Committee may delegate the administration of the Plan to one or more officers or employees of the Company or one of its Subsidiaries, and such administrator(s) may have the authority to execute and distribute Award Agreements, to maintain records relating to Incentive Awards, to process or oversee the issuance of Common Stock under Incentive Awards, to interpret and administer the terms of Incentive Awards, and to take such other actions as may be necessary or appropriate for the administration of the Plan and of Incentive Awards under the Plan, provided that in no case shall any such administrator be authorized (i) to grant Incentive Awards under the Plan (except in connection with any delegation made by the Committee pursuant to Section 4(a)), (ii) to take any action that would cause Incentive Awards intended to qualify as Performance-Based Compensation to fail to so qualify, (iii) to take any action inconsistent with Section 409A of the Code or (iv) to take any action inconsistent with applicable provisions of the Delaware General Corporation Law. Any action by any such administrator within the scope of its delegation shall be deemed for all purposes to have been taken by the Committee and, except as otherwise specifically provided, references in this Plan to the Committee shall include any such administrator. The Committee and, to the extent it so provides,

any subcommittee, shall have sole authority to determine whether to review any actions and/or interpretations of any such administrator, and if the Committee shall decide to conduct such a review, any such actions and/or interpretations of any such administrator shall be subject to approval, disapproval, or modification by the Committee.

(d) On or after the date of grant of an Incentive Award under the Plan, the Committee may (i) accelerate the date on which any such Incentive Award becomes vested, exercisable or transferable, as the case may be, (ii) extend the term of any such Incentive Award, including, without limitation, extending the period following a termination of a Participant's Employment during which any such Incentive Award may remain outstanding, (iii) waive any conditions to the vesting, exercisability or transferability, as the case may be, of any such Incentive Award or (iv) provide for the payment of dividends or dividend equivalents with respect to any such Incentive Award; provided, that the Committee shall not have any such authority to the extent that the grant of such authority would cause any tax to become due under Section 409A of the Code. Notwithstanding anything herein to the contrary, the Company shall not reprice any stock option (within the meaning of NASDAQ Listing Rule 5635(c) and any other formal or informal guidance issued by NASDAQ) without the approval of the shareholders of the Company.

(e) The Company shall pay any amount payable with respect to an Incentive Award in accordance with the terms of such Incentive Award, provided that the Committee may, in its discretion, defer the payment of amounts payable with respect to an Incentive Award subject to and in accordance with the terms of a Deferred Compensation Plan.

(f) No member of the Committee shall be liable for any action, omission, or determination relating to the Plan, and the Company shall indemnify and hold harmless each member of the Committee and each other director or employee of the Company to whom any duty or power relating to the administration or interpretation of the Plan has been delegated, against any cost or expense (including counsel fees) or liability (including any sum paid in settlement of a claim with the approval of the Committee) arising out of any action, omission or determination relating to the Plan, unless, in either case, such action, omission or determination was taken or made by such member, director or employee in bad faith and without reasonable belief that it was in the best interests of the Company.

5. Eligibility

The Persons who shall be eligible to receive Incentive Awards pursuant to the Plan shall be those employees, consultants and directors of the Company or one of its Subsidiaries whom the Committee shall select from time to time, including officers of the Company or one of its Subsidiaries, whether or not they are directors. Each Incentive Award granted under the Plan shall be evidenced by an Award Agreement.

6. Options

The Committee may from time to time grant Options on such terms as it shall determine, subject to the terms and conditions set forth in the Plan. The Award Agreement shall clearly identify such Option as either an "incentive stock option" within the meaning of Section 422 of the Code or as a non-qualified stock option.

(a) Exercise Price

The exercise price per share of Common Stock covered by any Option shall be not less than one hundred percent (100%) of the Fair Market Value of a share of Common Stock on the date on which such Option is granted.

(b) Term and Exercise of Options

(i) Each Option shall become vested and exercisable on such date or dates, during such period and for such number of shares of Common Stock as shall be determined by the Committee on or after the date such Option is granted; provided, however that no Option shall be exercisable after the expiration of ten (10) years from the date such Option is granted; and, provided, further, that each Option shall be subject to earlier termination, expiration or cancellation as provided in the Plan or the Award Agreement.

(ii) Each Option shall be exercisable in whole or in part; provided, however that no partial exercise of a Option shall be for an aggregate exercise price of less than $1,000. The partial exercise of an Option shall not cause the expiration, termination or cancellation of the remaining portion thereof.

(iii) An Option shall be exercised by such methods and procedures as the Committee determines from time to time, including without limitation through net physical settlement or other method of cashless exercise.

(c) Special Rules for Incentive Stock Options

(i) The aggregate Fair Market Value of shares of Common Stock with respect to which "incentive stock options" (within the meaning of Section 422 of the Code) are exercisable for the first time by a Participant during any calendar year under the Plan and any other stock option plan of the Company or any of its "subsidiaries" (within the meaning of Section 424 of the Code) shall not exceed $100,000. Such Fair Market Value shall be determined as of the date on which each such incentive stock option is granted. In the event that the aggregate Fair Market Value of shares of Common Stock with respect to such incentive stock options exceeds $100,000, then incentive stock options granted hereunder to such Participant shall, to the extent and in the order required by regulations promulgated under the Code (or any other authority having the force of regulations), automatically be deemed to be non-qualified stock options, but all

other terms and provisions of such incentive stock options shall remain unchanged. In the absence of such regulations (and authority), or in the event such regulations (or authority) require or permit a designation of the Options which shall cease to constitute incentive stock options, incentive stock options granted hereunder shall, to the extent of such excess and in the order in which they were granted, automatically be deemed to be non-qualified stock options, but all other terms and provisions of such incentive stock options shall remain unchanged.

(ii) Incentive stock options may only be granted to individuals who are employees of the Company or its "subsidiaries" (within the meaning of Section 424 of the Code). No incentive stock option may be granted to an individual if, at the time of the proposed grant, such individual owns stock possessing more than ten percent of the total combined Voting Power of all classes of stock of the Company or any of its "subsidiaries" (within the meaning of Section 424 of the Code), unless (A) the exercise price of such incentive stock option is at least one hundred and ten percent (110%) of the Fair Market Value of a share of Common Stock at the time such incentive stock option is granted and (B) such incentive stock option is not exercisable after the expiration of five (5) years from the date such incentive stock option is granted.

7. Other Stock-Based Awards

The Committee may from time to time grant equity-based or equity-related awards not otherwise described herein in such amounts and on such terms as it shall determine, subject to the terms and conditions set forth in the Plan. Without limiting the generality of the preceding sentence, each such Other Stock-Based Award may (i) involve the transfer of actual shares of Common Stock to Participants, either at the time of grant or thereafter, or payment in cash or otherwise of amounts based on the value of shares of Common Stock, (ii) be subject to performance-based and/or service-based conditions, (iii) be in the form of stock appreciation rights, phantom stock, restricted stock, restricted stock units, performance shares, deferred share units or share-denominated performance units, (iv) be designed to comply with applicable laws, including jurisdictions other than the United States and (v) be designed to qualify as Performance-Based Compensation; provided, that each Other Stock-Based Award shall be denominated in, or shall have a value determined by reference to, a number of shares of Common Stock that is specified at the time of the grant of such Incentive Award; and provided, further, that the exercise price applicable to stock appreciation rights shall not be less than one hundred percent (100%) of the Fair Market Value of a share of Common Stock on the date on which such Other Stock-Based Award is granted.

8. Cash Incentive Awards

The Committee may from time to time grant Cash Incentive Awards on such terms as it shall determine, subject to the terms and conditions set forth in the Plan. Cash Incentive Awards may be settled in cash or in other property, including shares of Common Stock, provided that the term "Cash Incentive Award" shall exclude any Option or Other Stock-Based Award.

9. Performance-Based Compensation

(a) Calculation

The amount payable with respect to an Incentive Award that is intended to qualify as Performance-Based Compensation shall be determined in any manner permitted by Section 162(m) of the Code.

(b) Discretionary Reduction

Unless otherwise specified in the Award Agreement, the Committee may, in its discretion, reduce or eliminate the amount payable to any Participant with respect to the Incentive Award, based on such factors as the Committee may deem relevant, but the Committee may not increase any such amount above the amount established in accordance with the relevant Performance Schedule. For purposes of clarity, the Committee may exercise the discretion provided for by the foregoing sentence in a non-uniform manner among Participants.

(c) Performance Measures

(i) The performance goals upon which the payment or vesting of any Incentive Award (other than Options and stock appreciation rights) that is intended to qualify as Performance-Based Compensation depends shall (A) be objective business criteria and shall otherwise meet the requirements of Section 162(m) of the Code, including the requirement that the level or levels of performance targeted by the Committee result in the achievement of performance goals being "substantially uncertain," and (B) relate to one or more of the following Performance Measures: market price of Common Stock, earnings per share of Common Stock, adjusted earnings per share of Common Stock, adjusted cash earnings per share of Common Stock, income, net income or profit (before or after taxes), economic profit, operating income, return on equity or stockholder equity, total shareholder return, market capitalization, enterprise value, cash flow (including but not limited to operating cash flow and free cash flow), cash position, return on assets or net assets, return on capital, return on invested capital, stockholder returns, economic value added, cash value added, earnings or net earnings (before or after interest, taxes, depreciation and/or amortization and allowing for the inclusion or exclusion of non-controlling interest expense), earnings from continuing operations, operating earnings, controllable profits, net patient revenues or net operating revenues, revenues, revenues growth, capital or

investment, ratio of debt to debt plus equity, ratio of operating earnings to capital spending, new product or service line innovation, market share, cost reduction goals, inventory or supply chain management initiatives, budget comparisons, implementation or completion of specified projects or processes, objective measures of customer, physician or employee satisfaction, productivity, expense, margins, operating efficiency, working capital, the formation of joint ventures, research or development collaborations, the completion of other transactions, any other measure of financial performance that can be determined pursuant to United States generally accepted accounting principles, or any combination of any of the foregoing.

(ii) A Performance Measure (A) may relate to the performance of the Participant, the Company, a Subsidiary, any business group, business unit or other subdivision of the Company, or any combination of the foregoing, as the Committee deems appropriate and (B) may be expressed as an amount, as an increase or decrease over a specified period, as a relative comparison to the performance of a group of comparator companies or a published or special index, or any other measure of the selected performance criteria, as the Committee deems appropriate. Unless otherwise determined by the Committee during the period referred to in Section 9(d), the Committee shall retain the ability to use negative discretion to reduce the amount of an Incentive Award or to exclude any adverse impact and include the positive impact of unusual, nonrecurring or extraordinary items or expenses; items relating to financing activities; charges for restructurings; other non-operating items; discontinued operations; items related to the disposal of a business or segment of a business; the cumulative effect of changes in accounting treatment; items related to a change in accounting principle; items related to changes in applicable laws or business conditions; any impact of changes in foreign exchange rates and other changes in currency; any impact of impairment of tangible or intangible assets; any impact of the issuance or repurchase of equity securities or other changes in the number of outstanding shares of any class of Company equity securities; any gain, loss, income or expense attributable to acquisitions or dispositions of stock or assets; items attributable to the business operations of any entity acquired by the Company during a Performance Period; stock-based compensation expense; in-process research and development expense; gain or loss from all or certain claims and/or litigation and insurance recoveries; and any other items, each determined by the Committee according to Section 9(d) in accordance with generally accepted accounting principles and as identified in the Company's audited financial statements, including the notes thereto.

(d) Performance Schedules

Within ninety (90) days after the beginning of a Performance Period, and in any case before twenty-five (25%) of the Performance Period has elapsed, the Committee shall establish (i) Performance Targets for such Performance Period, (ii) Target Awards for each Participant, and (iii) Performance Schedules for such Performance Period.

(e) Committee Discretion

Nothing in this Plan is intended to limit the Committee's discretion to adopt conditions with respect to any Incentive Award that is not intended to qualify as Performance-Based Compensation that relate to performance other than the Performance Measures. Furthermore, nothing in this Plan shall be construed to require the Committee to grant any Award intended to qualify as Performance-Based Compensation. The Committee may, subject to the terms of the Plan, amend previously granted Incentive Awards in a way that disqualifies them as Performance-Based Compensation.

10. Adjustment Upon Certain Changes

Subject to any action by the shareholders of the Company required by law, applicable tax rules or the rules of any exchange on which shares of common stock of the Company are listed for trading:

(a) Shares Available for Grants

In the event of any change in the number of shares of Common Stock outstanding by reason of any stock dividend or split, recapitalization, merger, consolidation, combination or exchange of shares or similar corporate change, the maximum aggregate number of shares of Common Stock with respect to which the Committee may grant Incentive Awards and the maximum aggregate number of shares of Common Stock with respect to which the Committee may grant Incentive Awards to any individual Participant in any year shall be appropriately adjusted or substituted by the Committee. In the event of any change in the number of shares of common stock of the Company outstanding by reason of any other event or transaction, the Committee shall, to the extent deemed appropriate by the Committee, make such adjustments to the type or number of shares of Common Stock with respect to which Incentive Awards may be granted.

(b) Increase or Decrease in Issued Shares Without Consideration

In the event of any increase or decrease in the number of issued shares of Common Stock resulting from a subdivision or consolidation of shares of Common Stock or the payment of a stock dividend (but only on the shares of Common Stock), or any other increase or decrease in the number of such shares effected without receipt or payment of consideration by the Company, the Committee shall, to the extent deemed appropriate by the Committee, adjust the type or number of shares of Common Stock subject to each outstanding Incentive Award and the exercise price per share of Common Stock of each such Incentive Award.

(c) Certain Mergers and Other Transactions

(i) In the event of any merger, consolidation or similar transaction as a result of which the holders of shares of Common Stock receive consideration consisting exclusively of securities of the surviving corporation in such transaction, the Committee shall, to the extent deemed appropriate by the Committee, adjust each Incentive Award outstanding on the date of such merger or consolidation so that it pertains and applies to the securities which a holder of the number of shares of Common Stock subject to such Incentive Award would have received in such merger or consolidation.

(ii) In the event of (A) a dissolution or liquidation of the Company, (B) a sale of all or substantially all of the Company's assets (on a consolidated basis), (C) a merger, consolidation or similar transaction involving the Company in which the holders of shares of Common Stock receive securities and/or other property, including cash, other than shares of the surviving corporation in such transaction, the Committee shall, to the extent deemed appropriate by the Committee, have the power to: (1) cancel, effective immediately prior to the occurrence of such event, each Incentive Award (whether or not then exercisable or vested), and, in full consideration of such cancellation, pay to the Participant to whom such Incentive Award was granted an amount in cash, for each share of Common Stock subject to such Incentive Award, equal to the value, as determined by the Committee, of such Incentive Award, provided that with respect to any outstanding Option such value shall be equal to the excess of (x) the value, as determined by the Committee, of the property (including cash) received by the holder of a share of Common Stock as a result of such event over (y) the exercise price of such Option; or (2) provide for the exchange of each Incentive Award (whether or not then exercisable or vested) for an Incentive Award with respect to (x) some or all of the property which a holder of the number of shares of Common Stock subject to such Incentive Award would have received in such transaction or (y) securities of the acquiror or surviving entity and, incident thereto, make an equitable adjustment as determined by the Committee in the exercise price of the Incentive Award, or the number of shares or amount of property subject to the Incentive Award or provide for a payment (in cash or other property) to the Participant to whom such Incentive Award was granted in partial consideration for the exchange of the Incentive Award.

(e) Other Changes

In the event of any change in the capitalization of the Company or corporate change other than those specifically referred to in Sections 10(b), (c) or (d), the Committee shall, to the extent deemed appropriate by the Committee, make such adjustments in the number and class of shares subject to Incentive Awards outstanding on the date on which such change occurs and in such other terms of such Incentive Awards as the Committee may consider appropriate.

(f) Cash Incentive Awards

In the event of any transaction or event described in this Section 10, including without limitation any corporate change referred to in paragraph (e) hereof, the Committee shall, to the extent deemed appropriate by the Committee, make such adjustments in the terms and conditions of any Cash Incentive Award.

(g) No Other Rights

Except as expressly provided in the Plan or any Award Agreement, no Participant shall have any rights by reason of any subdivision or consolidation of shares of stock of any class, the payment of any dividends or dividend equivalents, any increase or decrease in the number of shares of stock of any class or any dissolution, liquidation, merger or consolidation of the Company or any other corporation. Except as expressly provided in the Plan, no issuance by the Company of shares of stock of any class, or securities convertible into shares of stock of any class, shall affect, and no adjustment by reason thereof shall be made with respect to, the number of shares or amount of other property subject to, or the terms related to, any Incentive Award.

(h) Savings Clause

(i) No provision of this Section 10 shall be given effect to the extent that such provision would cause any tax to become due under Section 409A of the Code.

(ii) With respect to Incentive Awards which are granted to Covered Employees and are intended to qualify as Performance-Based Compensation, no provision of this Section 10 shall be given effect to the extent that such provision would cause such Incentive Award to fail to so qualify as Performance-Based Compensation under Section 162(m) of the Code.

(iii) Furthermore, no provision of this Section 10 shall be given effect to the extent such provision would result in short-swing profits liability under Section 16 of the Exchange Act or violate the exemptive conditions of Rule 16b-3 of the Exchange Act.

11. Change in Control; Termination of Employment

(a) Change in Control

The consequences of a Change in Control, if any, will be set forth in the Award Agreement in addition to what is provided in Section 10 hereof.

(b) Termination of Employment

(i) Except as to any awards constituting stock rights subject to Section 409A of the Code, termination of Employment shall mean a separation from service within the meaning of Section 409A, unless the Participant is retained as a consultant pursuant to a written agreement and such agreement provides otherwise. The Employment of a Participant with the Company shall be deemed to have terminated for all purposes of the Plan if such person is employed by or provides services to a Person that is a Subsidiary of the Company and such Person ceases to be a Subsidiary of the Company, unless the Committee determines otherwise. A Participant who ceases to be an employee of the Company but continues, or simultaneously commences, services as a director of the Company shall be deemed to have had a termination of Employment for purposes of the Plan. Without limiting the generality of the foregoing, the Committee shall determine whether an authorized leave of absence, or absence in military or government service, shall constitute termination of Employment, provided that a Participant who is an employee will not be deemed to cease employment in the case of any leave of absence approved by the Company. Furthermore, no payment shall be made with respect to any Incentive Awards under the Plan that are subject to Section 409A of the Code as a result of any such authorized leave of absence or absence in military or government service unless such authorized leave or absence constitutes a separation from service for purposes of Section 409A of the Code and the regulations promulgated thereunder.

(ii) The Award Agreement shall specify the consequences with respect to such Option of the termination of Employment of the Participant holding the Option.

(iii) The consequences with respect to a Performance-Based Award of the termination of Employment of the Participant holding the Performance-Based Award shall be determined by the Committee in its sole discretion and set forth in the Award Agreement, it being intended that no agreement providing for a payment to a Participant upon termination of Employment shall be given effect to the extent that it would cause an Incentive Award that was intended to qualify as a Performance-Based Award to fail to so qualify.

12. Rights Under the Plan

(a) The Committee shall have full discretionary authority to administer the Plan, including discretionary authority to interpret and construe any and all provisions of the Plan and any Award Agreement thereunder, and to adopt, amend and rescind from time to time such rules and regulations for the administration of the Plan, including rules and regulations related to

sub-plans established for the purpose of satisfying applicable foreign laws and/or qualifying for preferred tax treatment under applicable foreign tax laws, as the Committee may deem necessary or appropriate. Decisions of the Committee shall be final, binding and conclusive on all parties. For the avoidance of doubt, the Committee may exercise all discretion granted to it under the Plan in a non-uniform manner among Participants.

(b) No Person shall have any rights as a stockholder with respect to any shares of Common Stock covered by or relating to any Incentive Award until the date of the issuance of such shares on the books and records of the Company. Except as otherwise expressly provided in Section 10 hereof, no adjustment of any Incentive Award shall be made for dividends or other rights for which the record date occurs prior to the date of such issuance. Nothing in this Section 12 is intended, or should be construed, to limit authority of the Committee to cause the Company to make payments based on the dividends that would be payable with respect to any share of Common Stock if it were issued or outstanding, or from granting rights related to such dividends.

(c) The Company shall not have any obligation to establish any separate fund or trust or other segregation of assets to provide for payments under the Plan. To the extent any person acquires any rights to receive payments hereunder from the Company, such rights shall be no greater than those of an unsecured creditor.

13. No Special Employment Rights; No Right to Incentive Award

(a) Nothing contained in the Plan or any Award Agreement shall confer upon any Participant any right with respect to the continuation of his or her Employment by the Company or interfere in any way with the right of the Company at any time to terminate such Employment or to increase or decrease the compensation of the Participant from the rate in existence at the time of the grant of an Incentive Award.

(b) No person shall have any claim or right to receive an Incentive Award hereunder. The Committee's granting of an Incentive Award to a Participant at any time shall neither require the Committee to grant an Incentive Award to such Participant or any other Participant or other person at any time nor preclude the Committee from making subsequent grants to such Participant or any other Participant or other person.

14. Securities Matters

(a) The Company shall be under no obligation to effect the registration pursuant to the Securities Act of any shares of Common Stock to be issued hereunder or to effect similar compliance under any state or local laws. Notwithstanding anything herein to the contrary, the Company shall not be obligated to cause to be issued shares of Common Stock pursuant to the Plan unless and until the Company is advised by its counsel that the issuance is in compliance with all applicable laws, regulations of governmental authority and the requirements of any securities exchange on which shares of Common Stock are traded. The Committee may require, as a condition to the issuance of shares of Common Stock pursuant to the terms hereof, that the recipient of such shares make such covenants, agreements and representations, and that any related certificates representing such shares bear such legends, as the Committee, in its sole discretion, deems necessary or desirable.

(b) The exercise of any Incentive Award (including, without limitation, any Option) granted hereunder shall only be effective at such time as counsel to the Company shall have determined that the issuance and delivery of shares of Common Stock pursuant to such exercise is in compliance with all applicable laws, regulations of governmental authority and the requirements of any securities exchange on which shares of Common Stock are traded. The Company may, in its sole discretion, defer the effectiveness of any exercise of an Incentive Award granted hereunder in order to allow the issuance of shares pursuant thereto to be made pursuant to registration or an exemption from registration or other methods for compliance available under federal or state or local securities laws. The Company shall inform the Participant in writing of its decision to defer the effectiveness of the exercise of an Incentive Award granted hereunder. During the period that the effectiveness of the exercise of an Incentive Award has been deferred, the Participant may, by written notice, withdraw such exercise and obtain the refund of any amount paid with respect thereto.

15. Withholding Taxes

(a) Cash Remittance

Whenever withholding tax obligations are incurred in connection with any Incentive Award, the Company shall have the right to require the Participant to remit to the Company in cash an amount sufficient to satisfy federal, state and local withholding tax requirements, if any, attributable to such event. In addition, upon the exercise or settlement of any Incentive Award in cash, or the making of any other payment with respect to any Incentive Award (other than in shares of Common Stock), the Company shall have the right to withhold from any payment required to be made pursuant thereto an amount sufficient to satisfy the federal, state and local withholding tax requirements, if any, attributable to such exercise, settlement or payment.

(b) Stock Remittance

At the election of the Participant, subject to the approval of the Committee, whenever withholding tax obligations are incurred in connection with any Incentive Award, the Participant may tender to the Company a number of shares of Common Stock that have been owned by the Participant for at least six (6) months (or such other period as the Committee may determine) having a Fair Market Value at the tender date determined by the Committee to be sufficient to satisfy the minimum federal, state and local withholding tax requirements, if any, attributable to such event. Such election shall satisfy the Participant's obligations under Section 15(a) hereof, if any.

(c) Stock Withholding

At the election of the Participant, subject to the approval of the Committee, whenever withholding tax obligations are incurred in connection with any Incentive Award, the Company

shall withhold a number of such shares having a Fair Market Value determined by the Committee to be sufficient to satisfy the minimum federal, state and local withholding tax requirements, if any, attributable to such event. Such election shall satisfy the Participant's obligations under Section 15(a) hereof, if any.

16. Amendment or Termination of the Plan

The Board of Directors may at any time suspend or discontinue the Plan or revise or amend it in any respect whatsoever; provided, however, that to the extent that any applicable law, tax requirement, or rule of a stock exchange requires shareholder approval in order for any such revision or amendment to be effective, such revision or amendment shall not be effective without such approval. The preceding sentence shall not restrict the Committee's ability to exercise its discretionary authority hereunder pursuant to Section 4 hereof, which discretion may be exercised without amendment to the Plan. No provision of this Section 16 shall be given effect to the extent that such provision would cause any tax to become due under Section 409A of the Code. Except as expressly provided in the Plan, no action hereunder may, without the consent of a Participant, adversely affect the Participant's rights under any previously granted and outstanding Incentive Award. Nothing herein shall cause a Performance-Based Award to cease to qualify under Section 162(m). Nothing in the Plan shall limit the right of the Company to pay compensation of any kind outside the terms of the Plan.

17. Recoupment

Notwithstanding anything in the Plan or in any Award Agreement to the contrary, the Company will be entitled to the extent permitted or required by applicable law (including, without limitation, the Dodd-Frank Wall Street Reform and Consumer Protection Act), Company policy and/or the requirements of an exchange on which the Company's shares are listed for trading, in each case, as in effect from time to time to recoup compensation of whatever kind paid or awarded by the Company at any time to a Participant under this Plan.

18. No Obligation to Exercise

The grant to a Participant of an Incentive Award shall impose no obligation upon such Participant to exercise such Incentive Award.

19. Transfers

Incentive Awards may not be sold, pledged, assigned, hypothecated, transferred, or disposed of in any manner other than by will or by the laws of descent or distribution and may be exercised, during the lifetime of a Participant, only by the Participant; provided, however that the Committee may permit Options that are not incentive stock options to be sold, pledged, assigned, hypothecated, transferred, or disposed of, on a general or specific basis, subject to such conditions and limitations as the Committee may determine. Upon the death of a Participant, outstanding Incentive Awards granted to such Participant may be exercised only by the executors or administrators of the Participant's estate or by any person or persons who shall have acquired

such right to exercise by will or by the laws of descent and distribution. No transfer by will or the laws of descent and distribution of any Incentive Award, or the right to exercise any Incentive Award, shall be effective to bind the Company unless the Committee shall have been furnished with (i) written notice thereof and with a copy of the will and/or such evidence as the Committee may deem necessary to establish the validity of the transfer and (ii) an agreement by the transferee to comply with all the terms and conditions of the Incentive Award that are or would have been applicable to the Participant and to be bound by the acknowledgements made by the Participant in connection with the grant of the Incentive Award.

20. Expenses and Receipts

The expenses of the Plan shall be paid by the Company. Any proceeds received by the Company in connection with any Incentive Award will be used for general corporate purposes.

21. Failure to Comply

In addition to the remedies of the Company elsewhere provided for herein, failure by a Participant to comply with any of the terms and conditions of the Plan or any Award Agreement, unless such failure is remedied by such Participant within ten days after having been notified of such failure by the Committee, shall be grounds for the cancellation and forfeiture of such Incentive Award, in whole or in part, as the Committee, in its absolute discretion, may determine.

22. Governing Law

The Plan and the rights of all persons under the Plan shall be construed and administered in accordance with the laws of the State of Delaware without regard to its conflict of law principles.

23. Severability

If all or any part of this Plan is declared by any court or governmental authority to be unlawful or invalid, such unlawfulness or invalidity shall not serve to invalidate any portion of this Plan not declared to be unlawful or invalid. Any Section or part of a Section so declared to be unlawful or invalid shall, if possible, be construed in a manner that will give effect to the terms of such Section or part of a Section to the fullest extent possible while remaining lawful and valid.

24. Effective Date and Term of Plan

The Effective Date of the Plan is October 24, 2013, subject to the approval of the Plan by the shareholders of the Company. No grants of Incentive Awards may be made under the Plan after October 24, 2023.

Exhibit 10.26

[Letterhead]

December 7, 2012

Thomas C. Geiser
1733 Ocean Avenue, Suite 325
Santa Monica, CA 90401

Dear Tom:

We would like to set forth the terms of your compensation as a director on the board of directors (the "Board") of Surgical Care Affiliates, LLC, a Delaware limited liability company ("SCA"), and such other subsidiaries of SCA as the Managing Member of ASC Acquisition LLC, a Delaware limited liability company (the "Parent"), may reasonably request from time to time. The terms of this letter agreement (this "Agreement") will be effective as of July 1, 2012 (the "Effective Date") and will supersede and replace any existing director compensation arrangements between the parties, including that certain letter agreement dated April 14, 2008, as of the Effective Date.

I. Annual Compensation.

You will receive (a) an annual cash retainer of $50,000 (the "Retainer"), payable in equal quarterly installments of $12,500 in arrears within 30 days after the end of each quarter of service (if you serve part of a quarter, the payment will be prorated based on the number of weeks in the quarter served and paid within 30 days of the termination of your service), and (b) $30,000 in the form of restricted stock units (the "RSUs") of the Parent, pursuant to a Restricted Equity Unit Grant Agreement in the form attached hereto. The initial RSU grant will occur as soon as practicable after the date hereof and will be effective for purposes of vesting as of July 1, 2012. Thereafter you shall receive $30,000 in the form of RSUs of the Parent on or about each anniversary of July 1, subject to your continuing to serve on the Board on each such anniversary. The RSUs will vest ratably over a two-year period (i.e., 50% vested 12 months after the grant and 100% vested 24 months after the grant), subject to your continuing to serve on the Board through such date.

II. Attendance at Board Meetings; Per Meeting Fee

You will be expected to use your reasonable best efforts to attend all Board meetings, and will be expected to attend a minimum of three quarterly Board meetings each year in person. Otherwise, you may attend such meeting by telephonic or other electronic means. Reasonable expenses actually incurred by you in traveling to the Board Meetings shall be reimbursed by SCA upon presentation of such documentation as SCA may reasonably request.

III. Reelection to the Board

Your continued service on the Board will be subject in all respects to the provisions of the limited liability agreements of each of SCA and the Parent.

Sincerely,

ASC ACQUISITION LLC, sole member of Surgical Care Affiliates, LLC
By: TPG Partners V, L.P., its Managing Member
By: TPG GenPar V, L.P., its general partner
By: TPG Advisors V, Inc., its general partner

By: /s/ Todd Sisitsky
Name: Todd Sisitsky
Title: Vice President

ACCEPTED:

/s/ Thomas C. Geiser
Thomas C. Geiser

Date: 12/31/12

Exhibit 10.26A

[Letterhead]

January 23, 2014

Thomas C. Geiser
1733 Ocean Avenue, Suite 325
Santa Monica, CA 90401

Dear Tom:

This letter is to confirm your designation by the board of directors (the "Board") of Surgical Care Affiliates, Inc., a Delaware corporation ("SCA"), as the Chair of SCA's Compliance Committee and the Chair of SCA's Acquisition Committee, and your agreement to serve a Chair of each of these committees. The terms of this letter agreement (this "Agreement") will be effective as of January 1, 2014 (the "Effective Date") and will augment and supplement the existing director compensation arrangement described in that certain letter agreement dated December 7, 2012.

I. Compensation for Service as Compliance Committee Chair and Acquisition Committee Chair

Effective January 1, 2014, you will receive an annual aggregate cash retainer of $15,000, representing two individual retainers of $7,500 each for serving as Chair of the Compliance Committee and the Chair of the Acquisition Committee, payable in equal quarterly installments of $3,750 in arrears within 30 days after the end of each quarter of service (if you serve part of a quarter, the payment will be prorated based on the number of weeks in the quarter served and paid within 30 days of the termination of your service).

II. Attendance at Board and Compliance and Acquisition Committee Meetings

You will be expected to use your reasonable best efforts to attend all Compliance Committee and Acquisition Committee meetings, either in person or by telephonic or other electronic means. Reasonable expenses actually incurred by you in traveling to the Compliance Committee or Acquisition Committee meetings shall be reimbursed by SCA upon presentation of such documentation as SCA may reasonably request.

III. Reelection to the Board and to Designation as Chair of Compliance Committee and as Chair of Acquisition Committee

Your continued service on the Board will be subject in all respects to the Certificate of Incorporation and Bylaws of SCA and the General Corporation Law of Delaware.

Sincerely,

SURGICAL CARE AFFILATES, INC.

By: /s/ Andrew Hayek
Name: Andrew Hayek
Title: CEO and President

ACCEPTED:

/s/ Thomas C. Geiser
Thomas C. Geiser

Date: 1/24/2014

Exhibit 10.27

[Letterhead]

October 1, 2013

Frederick A. Hessler
169 East 69th Street, Penthouse B
New York, NY 10021
fhessler@fahadvisor.com

Dear Fred:

We would like to set forth the terms of your compensation as a director on the board of directors (the "Board") of Surgical Care Affiliates, LLC, a Delaware limited liability company ("SCA"), and such other subsidiaries of SCA as the Managing Member of ASC Acquisition LLC, a Delaware limited liability company (the "Parent"), may reasonably request from time to time. The terms of this letter agreement (this "Agreement") will be effective as of your appointment to the Board, expected October 1, 2013 (the "Effective Date").

I. Annual Board of Directors Compensation

For your service as a Board members, you will receive (a) an annual cash retainer of $50,000, payable in equal quarterly installments of $12,500 in arrears within 30 days after the end of each quarter of service (if you serve part of a quarter, the payment will be prorated based on the number of weeks in the quarter served and paid within 30 days of the termination of your service), and (b) $30,000 in the form of restricted stock units (the "RSUs") of the Parent, pursuant to a Restricted Equity Unit Grant Agreement in the form attached hereto. The initial RSU grant will occur as soon as practicable after the date hereof and will be effective for purposes of vesting as of October 1, 2013. Thereafter you shall receive $30,000 in the form of RSUs of the Parent on or about each anniversary of October 1, subject to your continuing to serve on the Board on each such anniversary. The RSUs will vest ratably over a two-year period (i.e., 50% vested 12 months after the grant and 100% vested 24 months after the grant), subject to your continuing to serve on the Board through such date.

II. Compensation for Service as Audit Committee Chair

This letter will also confirm your selection and your agreement to serve as the Chair of SCA's Audit Committee. For such service, you will receive an annual cash retainer of $15,000, payable in equal quarterly installments of $3,750 in arrears within 30 days after the end of each quarter of service (if you serve part of a quarter, the payment will be prorated based on the number of weeks in the quarter served and paid within 30 days of the termination of your service).

III. Attendance at Board and Audit Committee Meetings

You will be expected to use your reasonable best efforts to attend all Board and Audit Committee meetings, and will be expected to attend a minimum of three quarterly Board meetings each year in person. Otherwise, you may attend such meeting by telephonic or other electronic means. Reasonable expenses actually incurred by you in traveling to the Board or Audit Committee Meetings shall be reimbursed by SCA upon presentation of such documentation as SCA may reasonably request.

IV. Reelection to the Board and as Audit Committee Chair

Your continued service on the Board will be subject in all respects to the provisions of the limited liability agreements of each of SCA and the Parent.

Sincerely,

ASC ACQUISITION LLC, sole member of Surgical Care Affiliates, LLC
By: TPG Partners V, L.P., its Managing Member
By: TPG GenPar V, L.P., its general partner
By: TPG Advisors V, Inc., its general partner

By: /s/ Todd Sisitsky
Name: Todd Sisitsky
Title: Vice President

ACCEPTED:

/s/ Frederick A. Hessler
Frederick A. Hessler
Date: Oct. 7, 2013

Exhibit 10.28

[Letterhead]

December 7, 2012

Curtis S. Lane
623 Fifth Avenue, 15th Floor
New York, NY 10022

Dear Curtis:

We would like to set forth the terms of your compensation as a director on the board of directors (the "Board") of Surgical Care Affiliates, LLC, a Delaware limited liability company ("SCA"), and such other subsidiaries of SCA as the Managing Member of ASC Acquisition LLC, a Delaware limited liability company (the "Parent"), may reasonably request from time to time. The terms of this letter agreement (this "Agreement") will be effective as of July 1, 2012 (the "Effective Date") and will supersede and replace any existing director compensation arrangements between the parties, including that certain letter agreement dated April 14, 2008, as of the Effective Date.

I. Annual Compensation.

You will receive (a) an annual cash retainer of $50,000 (the "Retainer"), payable in equal quarterly installments of $12,500 in arrears within 30 days after the end of each quarter of service (if you serve part of a quarter, the payment will be prorated based on the number of weeks in the quarter served and paid within 30 days of the termination of your service), and (b) $30,000 in the form of restricted stock units (the "RSUs") of the Parent, pursuant to a Restricted Equity Unit Grant Agreement in the form attached hereto. The initial RSU grant will occur as soon as practicable after the date hereof and will be effective for purposes of vesting as of July 1, 2012. Thereafter you shall receive $30,000 in the form of RSUs of the Parent on or about each anniversary of July 1, subject to your continuing to serve on the Board on each such anniversary. The RSUs will vest ratably over a two-year period (i.e., 50% vested 12 months after the grant and 100% vested 24 months after the grant), subject to your continuing to serve on the Board through such date.

II. Attendance at Board Meetings; Per Meeting Fee

You will be expected to use your reasonable best efforts to attend all Board meetings, and will be expected to attend a minimum of three quarterly Board meetings each year in person. Otherwise, you may attend such meeting by telephonic or other electronic means. Reasonable expenses actually incurred by you in traveling to the Board Meetings shall be reimbursed by SCA upon presentation of such documentation as SCA may reasonably request.

III. Reelection to the Board

Your continued service on the Board will be subject in all respects to the provisions of the limited liability agreements of each of SCA and the Parent.

Sincerely,

ASC ACQUISITION LLC, sole member of Surgical Care Affiliates, LLC
By: TPG Partners V, L.P., its Managing Member
By: TPG GenPar V, L.P., its general partner
By: TPG Advisors V, Inc., its general partner

By: /s/ Todd Sisitsky
Name: Todd Sisitsky
Title: Vice President

ACCEPTED:

/s/ Curtis S. Lane
Curtis S. Lane

Date: 1/2/13

Exhibit 10.29

[Letterhead]

December 7, 2012

Sharad Mansukani, M.D.
411 Park Lane
Moorestown, NJ 08057

Dear Sharad:

We would like to set forth the terms of your compensation as a director on the board of directors (the "Board") of Surgical Care Affiliates, LLC, a Delaware limited liability company ("SCA"), and such other subsidiaries of SCA as the Managing Member of ASC Acquisition LLC, a Delaware limited liability company (the "Parent"), may reasonably request from time to time. The terms of this letter agreement (this "Agreement") will be effective as of July 1, 2012 (the "Effective Date") and will supersede and replace any existing director compensation arrangements between the parties, including that certain letter agreement dated April 14, 2008, as of the Effective Date.

I. Annual Compensation.

You will receive (a) an annual cash retainer of $50,000 (the "Retainer"), payable in equal quarterly installments of $12,500 in arrears within 30 days after the end of each quarter of service (if you serve part of a quarter, the payment will be prorated based on the number of weeks in the quarter served and paid within 30 days of the termination of your service), and (b) $30,000 in the form of restricted stock units (the "RSUs") of the Parent, pursuant to a Restricted Equity Unit Grant Agreement in the form attached hereto. The initial RSU grant will occur as soon as practicable after the date hereof and will be effective for purposes of vesting as of July 1, 2012. Thereafter you shall receive $30,000 in the form of RSUs of the Parent on or about each anniversary of July 1, subject to your continuing to serve on the Board on each such anniversary. The RSUs will vest ratably over a two-year period (i.e., 50% vested 12 months after the grant and 100% vested 24 months after the grant), subject to your continuing to serve on the Board through such date.

II. Attendance at Board Meetings; Per Meeting Fee

You will be expected to use your reasonable best efforts to attend all Board meetings, and will be expected to attend a minimum of three quarterly Board meetings each year in person. Otherwise, you may attend such meeting by telephonic or other electronic means. Reasonable expenses actually incurred by you in traveling to the Board Meetings shall be reimbursed by SCA upon presentation of such documentation as SCA may reasonably request.

III. Reelection to the Board

Your continued service on the Board will be subject in all respects to the provisions of the limited liability agreements of each of SCA and the Parent.

Sincerely,

ASC ACQUISITION LLC, sole member of Surgical Care Affiliates, LLC
By: TPG Partners V, L.P., its Managing Member
By: TPG GenPar V, L.P., its general partner
By: TPG Advisors V, Inc., its general partner

By: /s/ Todd Sisitsky
Name: Todd Sisitsky
Title: Vice President

ACCEPTED:

/s/ Sharad Mansukani
Sharad Mansukani, M.D.

Date: 12-24-12

Exhibit 10.30

SURGICAL CARE AFFILIATES, INC.
INDEMNITY AGREEMENT

This Indemnity Agreement (the "Agreement"), dated as of , 2014, is made by and between **Surgical Care Affiliates, Inc.**, a Delaware corporation (the "Company"), and (the "Indemnitee").

RECITALS

A. The Company and Indemnitee recognize the continued difficulty in obtaining liability insurance for the Company's directors, officers, employees and other agents, the cost of such insurance and the general reductions in the coverage of such insurance;

B. The Company and Indemnitee recognize the substantial increase in corporate litigation in general, subjecting directors, officers, employees and other agents to expensive litigation risks at the same time as the availability and coverage of liability insurance has been severely limited;

C. The Company desires to attract and retain the services of talented and experienced individuals, such as Indemnitee, to serve as directors, officers, employees and agents of the Company and its subsidiaries and wishes to indemnify its directors, officers, employees and other agents to the maximum extent permitted by law;

D. Section 145 of the General Corporation Law of Delaware, under which the Company is organized ("Section 145"), empowers the Company to indemnify its directors, officers, employees and agents by agreement and to indemnify persons who serve, at the request of the Company, as the directors, officers, employees or agents of other corporations or enterprises, and expressly provides that the indemnification provided by Section 145 is not exclusive; and

E. In order to induce Indemnitee to serve or continue to serve as a director, officer, employee or agent of the Company and/or one or more subsidiaries of the Company free from undue concern for claims for damages arising out of or related to such services to the Company and/or one or more subsidiaries of the Company, the Company has determined and agreed to enter into this Agreement with Indemnitee.

AGREEMENT

NOW, THEREFORE, the Indemnitee and the Company hereby agree as follows:

1. Definitions. As used in this Agreement:

(a) "Agent" means any person who is or was a director, officer, employee or other agent of the Company or a Subsidiary; or is or was serving at the request of, for the convenience of, or to represent the interests of the Company or a Subsidiary as a director, officer, employee or agent of another foreign or domestic corporation, partnership, joint venture, trust or other enterprise; or was a director, officer, employee or agent of a foreign or domestic corporation which was a predecessor corporation of the Company or a Subsidiary, or was a director, officer, employee or agent of another enterprise at the request of, for the convenience of, or to represent the interests of such predecessor corporation.

(b) "Board" means the Board of Directors of the Company.

(c) A "Change in Control" shall be deemed to have occurred if (i) any "person," as such term is used in Sections 13(d) and 14(d) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), other than a trustee or other fiduciary holding securities under an employee benefit plan of the Company or a corporation owned directly or indirectly by the stockholders of the Company in substantially the same proportions as their ownership of stock of the Company, is or becomes the "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act), directly or indirectly, of securities of the Company representing 20% or more of the total voting power represented by the Company's then outstanding voting securities, (ii) during any period of two consecutive years, individuals who at the beginning of such period constituted the Board, together with any new directors whose election by the Board or nomination for election by the Company's stockholders was approved by a vote of at least two-thirds of the directors then still in office who either were directors at the beginning of the period or whose election or nomination was previously so approved, cease for any reason to constitute a majority of the Board, (iii) the stockholders of the Company approve a merger or consolidation or a sale of all or substantially all of the Company's assets with or to another entity, other than a merger, consolidation or asset sale that would result in the holders of the Company's outstanding voting securities immediately prior thereto continuing to represent (either by remaining outstanding or by being converted into voting securities of the surviving entity) at least a majority of the total voting power represented by the voting securities of the Company or such surviving or successor entity outstanding immediately thereafter, or (iv) the stockholders of the Company approve a plan of complete liquidation of the Company.

(d) "Expenses" shall include all out-of-pocket costs of any type or nature whatsoever (including, without limitation, all attorneys' fees and related disbursements), actually and reasonably incurred by the Indemnitee in connection with either the investigation, defense or appeal of a Proceeding or establishing or enforcing a right to indemnification under this Agreement, or Section 145 or otherwise; provided, however, that "Expenses" shall not include any judgments, fines, ERISA excise taxes or penalties, or amounts paid in settlement of a Proceeding.

(e) "Independent Counsel" means a law firm, or a partner (or, if applicable, member) of such a law firm, that is experienced in matters of corporation law and neither currently is, nor in the past five years has been, retained to represent: (i) the Company or the Indemnitee in any matter material to either such party or (ii) any other party to or witness in the Proceeding giving rise to a claim for indemnification hereunder. Notwithstanding the foregoing, the term "Independent Counsel" shall not include any person who, under the applicable standards of professional conduct then prevailing, would have a conflict of interest in representing either the Company or the Indemnitee in an action to determine the Indemnitee's rights under this Agreement.

(f) "Proceeding" means any threatened, pending, or completed action, suit or other proceeding, whether civil, criminal, administrative, or investigative.

(g) "Subsidiary" means any corporation of which more than 50% of the outstanding voting securities is owned directly or indirectly by the Company, by the Company and one or more other subsidiaries, or by one or more other subsidiaries.

2. Agreement to Serve. The Indemnitee agrees to serve and/or continue to serve as an Agent of the Company, at its will (or under separate agreement, if such agreement exists), in the capacity the Indemnitee currently serves as an Agent of the Company, so long as the Indemnitee is duly appointed or elected and qualified in accordance with the applicable provisions of the Bylaws of the Company or any Subsidiary or until such time as the Indemnitee tenders his or her resignation in writing; provided, however, that nothing contained in this Agreement is intended to create any right to continued employment or service by the Indemnitee. Indemnitee may at any time and for any reason resign from such position (subject to any contractual obligation the Indemnitee may have under any other agreement).

3. Liability Insurance.

(a) Maintenance of D&O Insurance. The Company hereby covenants and agrees that, so long as the Indemnitee shall continue to serve as an Agent of the Company and thereafter so long as the Indemnitee shall be subject to any possible Proceeding by reason of the fact that the Indemnitee was an Agent of the Company, the Company, subject to Section 3(c), shall promptly obtain and maintain in full force and effect directors' and officers' liability insurance ("D&O Insurance") in reasonable amounts from established and reputable insurers, as more fully described below.

(b) Rights and Benefits. In all policies of D&O Insurance, the Indemnitee shall qualify as an insured in such a manner as to provide the Indemnitee the same rights and benefits as are accorded to the most favorably insured of the Company's independent directors (as defined by the insurer) if the Indemnitee is such an independent director; of the Company's non-independent directors if the Indemnitee is not an independent director; of the Company's officers if the Indemnitee is an officer of the Company; or of the Company's key employees, if the Indemnitee is not a director or officer but is a key employee.

(c) Limitation on Required Maintenance of D&O Insurance. Notwithstanding any other provisions of this Agreement, the Company shall have no obligation to obtain or maintain D&O Insurance if the Company determines in good faith that: such insurance is not reasonably available; the premium costs for such insurance are disproportionate to the amount of coverage provided; the coverage provided by such insurance is limited by exclusions so as to provide an insufficient benefit; the Company is to be acquired and a tail policy of reasonable terms and duration is purchased for pre-closing acts or omissions by the Indemnitee; or the Company is to be acquired and D&O Insurance will be maintained by the acquirer that covers pre-closing acts and omissions by the Indemnitee.

4. Mandatory Indemnification. Subject to the terms of this Agreement:

(a) Third Party Actions. If the Indemnitee is a person who was or is a party or is threatened to be made a party to any Proceeding (other than an action by or in the right of the Company) by reason of the fact that the Indemnitee is or was an Agent of the Company, or by

reason of anything done or not done by the Indemnitee in any such capacity, the Company shall indemnify the Indemnitee against all Expenses and liabilities of any type whatsoever (including, but not limited to, losses, damages, judgments, fines, ERISA excise taxes and penalties, and amounts paid in settlement) actually and reasonably incurred by the Indemnitee in connection with the investigation, defense, settlement or appeal of such Proceeding, provided the Indemnitee acted in good faith and in a manner the Indemnitee reasonably believed to be in or not opposed to the best interests of the Company, and, with respect to any criminal action or Proceeding, had no reasonable cause to believe his or her conduct was unlawful.

(b) Derivative Actions. If the Indemnitee is a person who was or is a party or is threatened to be made a party to any Proceeding by or in the right of the Company by reason of the fact that the Indemnitee is or was an Agent of the Company, or by reason of anything done or not done by the Indemnitee in any such capacity, the Company shall indemnify the Indemnitee against all Expenses actually and reasonably incurred by the Indemnitee in connection with the investigation, defense, settlement or appeal of such Proceeding, provided the Indemnitee acted in good faith and in a manner the Indemnitee reasonably believed to be in or not opposed to the best interests of the Company.

(c) Actions where Indemnitee is Deceased. If the Indemnitee is a person who was or is a party or is threatened to be made a party to any Proceeding by reason of the fact that the Indemnitee is or was an Agent of the Company, or by reason of anything done or not done by the Indemnitee in any such capacity, and if, prior to, during the pendency of, or after completion of such Proceeding the Indemnitee is deceased, the Company shall indemnify the Indemnitee's spouse, heirs, executors and administrators against all Expenses and liabilities of any type whatsoever to the extent the Indemnitee would have been entitled to indemnification pursuant to this Agreement were the Indemnitee still alive.

(d) Certain Terminations. The termination of any Proceeding or of any claim, issue, or matter therein by judgment, order, settlement, or conviction, or upon a plea of *nolo contendere* or its equivalent, shall not (except as otherwise expressly provided in this Agreement) of itself create a presumption that the Indemnitee did not act in good faith and in a manner which the Indemnitee reasonably believed to be in or not opposed to the best interests of the Company or, with respect to any criminal action or Proceeding, that the Indemnitee had reasonable cause to believe that the Indemnitee's conduct was unlawful.

(e) Limitations. Notwithstanding the foregoing, the Company shall not be obligated to indemnify the Indemnitee for Expenses or liabilities of any type whatsoever for which payment is actually made to or on behalf of the Indemnitee under an insurance policy, or under a valid and enforceable indemnity clause, by-law or agreement.

5. Indemnification for Expenses in a Proceeding in Which the Indemnitee is Wholly or Partly Successful.

(a) Successful Defense. Notwithstanding any other provisions of this Agreement, to the extent the Indemnitee has been successful, on the merits or otherwise, in defense of any Proceeding (including, without limitation, an action by or in the right of the Company) in which the Indemnitee was a party by reason of the fact that the Indemnitee is or was an Agent of the

Company at any time, the Company shall indemnify the Indemnitee against all Expenses actually and reasonably incurred by or on behalf of the Indemnitee in connection with the investigation, defense or appeal of such Proceeding.

(b) Partially Successful Defense. Notwithstanding any other provisions of this Agreement, to the extent that the Indemnitee is a party to or a participant in any Proceeding (including, without limitation, an action by or in the right of the Company) in which the Indemnitee was a party by reason of the fact that the Indemnitee is or was an Agent of the Company at any time and is successful, on the merits or otherwise, as to one or more but less than all claims, issues or matters in such Proceeding, the Company shall indemnify the Indemnitee against all Expenses actually and reasonably incurred by or on behalf of the Indemnitee in connection with each successfully resolved claim, issue, or matter.

(c) Dismissal. For purposes of this section and without limitation, the termination of any claim, issue or matter in such a Proceeding by dismissal, with or without prejudice, shall be deemed to be a successful result as to such claim, issue, or matter.

6. Mandatory Advancement of Expenses. Subject to the terms of this Agreement and following notice pursuant to Section 7(a) below, the Company shall, to the fullest extent permitted by law, advance all Expenses reasonably incurred by the Indemnitee in connection with the investigation, defense, settlement, or appeal of any Proceeding to which the Indemnitee is a party or is threatened to be made a party by reason of the fact that the Indemnitee is or was an Agent of the Company upon receipt of (i) solely to the extent required by applicable law which cannot be waived, an undertaking by or on behalf of the Indemnitee to repay the amount advanced in the event that it shall ultimately be determined that the Indemnitee is not entitled to indemnification by the Company and (ii) satisfactory documentation supporting such Expenses. Such advances are intended to be an obligation of the Company to the Indemnitee hereunder and shall in no event be deemed to be a personal loan. The advances to be made hereunder shall be paid by the Company to the Indemnitee within twenty (20) days following delivery of a written request therefor by the Indemnitee to the Company. In the event that the Company fails to pay Expenses as incurred by the Indemnitee as required by this paragraph, Indemnitee may seek mandatory injunctive relief from any court having jurisdiction to require the Company to pay Expenses as set forth in this paragraph. If Indemnitee seeks mandatory injunctive relief pursuant to this paragraph, it shall not be a defense to enforcement of the Company's obligations set forth in this paragraph that Indemnitee has an adequate remedy at law for damages. Indemnitee shall, in all events, be entitled to advancement of Expenses, without regard to Indemnitee's: (a) ability to repay such amounts; or (b) ultimate entitlement to indemnification, until the final determination of the Proceeding.

7. Notice and Other Indemnification Procedures.

(a) Notice by Indemnitee. Promptly after receipt by the Indemnitee of notice of the commencement of or the threat of commencement of any Proceeding, the Indemnitee shall, if the Indemnitee believes that indemnification with respect thereto may be sought from the Company under this Agreement, notify the Company in writing of the commencement or threat of commencement thereof. Any failure by Indemnitee to notify the Company will not relieve the Company of its advancement or indemnification obligations under this Agreement unless, and

only to the extent that, the Company can establish that such omission to notify resulted in actual and material prejudice to it which prejudice cannot be reversed or otherwise eliminated without any material negative effect on the Company, and the omission to notify such Company will, in any event, not relieve the Company from any liability which it may have to indemnify Indemnitee otherwise than under this Agreement.

(b) Insurance. If the Company receives notice pursuant to Section 7(a) hereof of the commencement of a Proceeding that may be covered under D&O Insurance then in effect, the Company shall give prompt notice of the commencement of such Proceeding to the insurers in accordance with the procedures set forth in the respective policies. The Company shall thereafter take all necessary or desirable action to cause such insurers to pay, on behalf of the Indemnitee, all amounts payable as a result of such Proceeding in accordance with the terms of such policies.

(c) Defense. Indemnitee shall have the sole right and obligation to control the defense or conduct of any claim or Proceeding with respect to Indemnitee.

8. Right to Indemnification.

(a) Right to Indemnification. In the event that Section 5(a) is inapplicable, the Company shall indemnify the Indemnitee pursuant to this Agreement unless, and except to the extent that, it shall have been determined by one of the methods listed in Section 8(b) that the Indemnitee has not met the applicable standard of conduct required to entitle the Indemnitee to such indemnification. The Company agrees that Indemnitee shall be indemnified to the fullest extent permitted by law and that no determination shall be required in connection with such indemnification unless specifically required by applicable law which cannot be waived. In no event shall a determination be required in connection with indemnification for Expenses pursuant to Section 6 of this Agreement.

(b) Determination of Right to Indemnification. After the Indemnitee has submitted a written request for advancement (which shall be done at a time of Indemnitee's choosing), if a determination is required by law, a determination of the Indemnitee's right to indemnification hereunder shall be made at the election of the Board by (i) a majority vote of directors who are not parties to the Proceeding for which indemnification is being sought, even though less than a quorum, or by a committee consisting of directors who are not parties to the Proceeding for which indemnification is being sought, who, even though less than a quorum, have been designated by a majority vote of the disinterested directors, or (ii) if there are no such disinterested directors or if the disinterested directors so direct, by Independent Counsel (selected in the manner provided in Section 8(c) hereof) in a written opinion to the Board, a copy of which shall be delivered to the Indemnitee, or (iii) by the stockholders of the Company, or (iv) by a panel of three arbitrators, one of whom is selected by the Company, one of whom is selected by the Indemnitee and the last of whom is selected by the first two arbitrators so selected; *provided, however*, that, at the request of Indemnitee, or following any Change in Control not approved by a majority of the members of the Board who were directors immediately prior to such Change in Control, such determination shall be made by an Independent Counsel (selected in the manner provided in Section 8(c) hereof) as specified in clause (ii) or clause (iv) above.

(c) Selection of Independent Counsel. If the determination of entitlement to indemnification is to be made by Independent Counsel pursuant to Section 8(b) hereof, the Independent Counsel shall be selected as provided in this Section 8(c). The Independent Counsel shall be selected by the Indemnitee (unless Indemnitee shall request that such selection be made by the Board, in which event the Board shall make such selection on behalf of the Company, subject to the remaining provisions of this Section 8(c)), and Indemnitee or the Company, as the case may be, shall give written notice to the other, advising the Company or Indemnitee of the identity of the Independent Counsel so selected. Indemnitee or the Company may, within ten (10) days after written notice of selection shall have been given, deliver to the Company or Indemnitee, as the case may be, a written objection to such selection; provided, however, that such objection may be asserted only on the ground that the Independent Counsel so selected does not meet the requirements of "Independent Counsel" as defined in Section 1 of this Agreement, and the objection shall set forth with particularity the factual basis of such assertion. Absent a proper and timely objection, the person so selected by the Board shall act as Independent Counsel. If a timely written objection is made and substantiated, the Independent Counsel selected may not serve as Independent Counsel unless and until such objection is withdrawn or a court has determined that such objection is without merit. If, within twenty (20) days after submission by Indemnitee of a written request to the Company for indemnification, no Independent Counsel shall have been selected and not objected to, either the Company or Indemnitee may petition the Court of Chancery of the State of Delaware or other court of competent jurisdiction for resolution of any objection which shall have been made by the Indemnitee to the Company's selection of Independent Counsel and/or for the appointment as Independent Counsel of a person selected by the court or by such other person as the court shall designate, and the person with respect to whom all objections are so resolved or the person so appointed shall act as Independent Counsel under Section 8(b) hereof.

(d) Submission for Decision. If a determination is required by law, as soon as practicable, and in no event later than thirty (30) days after the Indemnitee's written request for indemnification, the method for determining the Indemnitee's right to indemnification shall be made. The Indemnitee shall cooperate with the person or persons or entity making such determination with respect to the Indemnitee's right to indemnification, including providing to such person, persons or entity upon reasonable advance request any documentation or information which is not privileged or otherwise protected from disclosure and which is reasonably available to the Indemnitee and reasonably necessary to such determination. Any Independent Counsel, member of the Board or stockholder of the Company shall act reasonably and in good faith in making a determination regarding the Indemnitee's entitlement to indemnification under this Agreement.

(e) Application to Court. If (i) the claim for indemnification or advancement of Expenses is denied, in whole or in part, (ii) no disposition of such claim is made by the Company within ninety (90) days after the request therefor, (iii) the advancement of Expenses is not timely made pursuant to Section 6 of this Agreement, or (iv) payment of indemnification is not made pursuant to Section 5 of this Agreement, the Indemnitee shall have the right to apply to the Delaware Court of Chancery, the court in which the Proceeding is or was pending or any other court of competent jurisdiction, for the purpose of enforcing the Indemnitee's right to indemnification (including the advancement of Expenses) pursuant to this Agreement.

(f) Expenses Related to the Enforcement or Interpretation of this Agreement. The Company shall indemnify the Indemnitee against all reasonable Expenses incurred by the Indemnitee in connection with any hearing or proceeding under this Section 8 involving the Indemnitee and against all reasonable Expenses incurred by the Indemnitee in connection with any other proceeding between the Company and the Indemnitee involving the interpretation or enforcement of the rights of the Indemnitee under this Agreement, unless a court of competent jurisdiction finds that each of the claims and/or defenses of the Indemnitee in any such proceeding was frivolous or made in bad faith.

9. Exceptions. Any other provision herein to the contrary notwithstanding, the Company shall not be obligated:

(a) Claims Initiated by Indemnitee. To indemnify or advance Expenses to the Indemnitee with respect to Proceedings or claims initiated or brought voluntarily by the Indemnitee and not by way of defense, with a reasonable allocation where appropriate, unless (i) such indemnification is expressly required to be made by law, (ii) the Proceeding was authorized by the Board, (iii) such indemnification is provided by the Company, in its sole discretion, pursuant to the powers vested in the Company under the General Corporation Law of Delaware, or (iv) the Proceeding is brought to establish or enforce a right to indemnification under this Agreement or any other statute or law or otherwise as required under Section 145 in advance of a final determination;

(b) Lack of Good Faith. To indemnify the Indemnitee for any Expenses incurred by the Indemnitee with respect to any Proceeding instituted by the Indemnitee to enforce or interpret this Agreement, if a court of competent jurisdiction determines that each of the material assertions made by the Indemnitee in such Proceeding was not made in good faith or was frivolous;

(c) Unauthorized Settlements. To indemnify the Indemnitee under this Agreement for any amounts paid in settlement of a Proceeding unless the Company consents to such settlement, which consent shall not be unreasonably withheld, delayed or conditioned; or

(d) Payments Contrary to Law. To indemnify or advance Expenses to the Indemnitee for which payment is prohibited by applicable law.

10. Presumptions; Burden and Standard of Proof. The parties intend and agree that, to the extent permitted by law, in connection with any determination with respect to Indemnitee's entitlement to indemnification hereunder by any person, including a court:

(a) it will be presumed that Indemnitee is entitled to indemnification under this Agreement (notwithstanding any adverse determination), and the Company or any other person or entity challenging such right will have the burden of proof to overcome that presumption in connection with the making by any person, persons or entity of any determination contrary to that presumption;

(b) Indemnitee will be deemed to have acted in good faith if Indemnitee's action is based on the records or books of account of the Company, including financial statements, or on information supplied to Indemnitee by the officers, employees, or committees of the board of

directors of the Company, or on the advice of legal counsel or other advisors (including financial advisors and accountants) for the Company or on information or records given in reports made to the Company by an independent certified public accountant or by an appraiser or other expert or advisor selected by the Company; and

(c) the knowledge and/or actions, or failure to act, of any director, officer, agent or employee of the Company or relevant enterprises will not be imputed to Indemnitee in a manner that limits or otherwise adversely affects Indemnitee's rights hereunder.

11. Non-Exclusivity. The provisions for indemnification and advancement of Expenses set forth in this Agreement shall not be deemed exclusive of any other rights which the Indemnitee may have under any provision of law, the Company's Certificate of Incorporation or Bylaws, the vote of the Company's stockholders or disinterested directors, other agreements, or otherwise, both as to action in the Indemnitee's official capacity and as to action in another capacity while occupying the Indemnitee's position as an Agent of the Company, and the Indemnitee's rights hereunder shall continue after the Indemnitee has ceased acting as an Agent of the Company and shall inure to the benefit of the heirs, executors and administrators of the Indemnitee.

12. Permitted Defenses. It shall be a defense to any action for which a claim for indemnification is made under this Agreement (other than an action brought to enforce a claim for Expenses pursuant to Section 6 hereof, provided that the required undertaking has been tendered to the Company) that the Indemnitee is not entitled to indemnification because of the limitations set forth in Sections 4 and 9 hereof. Neither the failure of the Company (including the Board) or an Independent Counsel to have made a determination prior to the commencement of such enforcement action that indemnification of the Indemnitee is proper in the circumstances, nor an actual determination by the Company (including the Board) or an Independent Counsel that such indemnification is improper, shall be a defense to the action or create a presumption that the Indemnitee is not entitled to indemnification under this Agreement or otherwise.

13. Subrogation. In the event the Company is obligated to make a payment under this Agreement, the Company shall be subrogated to the extent of such payment to all of the rights of recovery under an insurance policy or any other indemnity agreement covering the Indemnitee, who shall execute all documents required and take all action that may be necessary to secure such rights and to enable the Company effectively to bring suit to enforce such rights (provided that the Company pays the Indemnitee's costs and expenses of doing so), including without limitation by assigning all such rights to the extent of such indemnification or advancement of Expenses.

14. Primacy of Indemnification. The Company hereby acknowledges that the Indemnitee may have certain rights to indemnification, advancement of expenses, or liability insurance provided by a third-party investor and certain of its affiliates (collectively, the "Fund Indemnitors"). The Company hereby agrees that (i) it is the indemnitor of first resort, *i.e.*, its obligations to the Indemnitee under this Agreement and any indemnity provisions set forth in its Certificate of Incorporation, Bylaws or elsewhere (collectively, "Indemnity Arrangements") are primary, and any obligation of the Fund Indemnitors to advance expenses or to provide indemnification for the same expenses or liabilities incurred by the Indemnitee is secondary and

excess, (ii) it shall advance the full amount of expenses incurred by the Indemnitee and shall be liable for the full amount of all expenses, judgments, penalties, fines and amounts paid in settlement by or on behalf of the Indemnitee, to the extent legally permitted and as required by any Indemnity Arrangement, without regard to any rights the Indemnitee may have against the Fund Indemnitors, and (iii) it irrevocably waives, relinquishes and releases the Fund Indemnitors from any claims against the Fund Indemnitors for contribution, subrogation, or any other recovery of any kind arising out of or relating to any Indemnity Arrangement. The Company further agrees that no advancement or indemnification payment by any Fund Indemnitor on behalf of the Indemnitee shall affect the foregoing, and the Fund Indemnitors shall be subrogated to the extent of such advancement or payment to all of the rights of recovery of the Indemnitee against the Company. The Company and the Indemnitee agree that the Fund Indemnitors are express third party beneficiaries of the terms of this Section 14.]

15. Survival of Rights.

(a) All agreements and obligations of the Company contained herein shall continue during the period Indemnitee is an Agent of the Company and shall continue thereafter so long as Indemnitee shall be subject to any possible claim or threatened, pending or completed Proceeding by reason of the fact that Indemnitee was serving in the capacity referred to herein.

(b) The Company shall require any successor to the Company (whether direct or indirect, by purchase, merger, consolidation or otherwise) to all or substantially all of the business or assets of the Company, expressly to assume and agree to perform this Agreement in the same manner and to the same extent that the Company would be required to perform if no such succession had taken place.

16. Interpretation of Agreement. It is understood that the parties hereto intend this Agreement to be interpreted and enforced so as to provide indemnification to the Indemnitee to the fullest extent permitted by law, including those circumstances in which indemnification would otherwise be discretionary.

17. Severability. If any provision or provisions of this Agreement shall be held to be invalid, illegal or unenforceable for any reason whatsoever, (i) the validity, legality and enforceability of the remaining provisions of the Agreement (including, without limitation, all portions of any paragraphs of this Agreement containing any such provision held to be invalid, illegal or unenforceable, that are not themselves invalid, illegal or unenforceable) shall not in any way be affected or impaired thereby, and (ii) to the fullest extent possible, the provisions of this Agreement (including, without limitation, all portions of any paragraph of this Agreement containing any such provision held to be invalid, illegal or unenforceable, that are not themselves invalid, illegal or unenforceable) shall be construed so as to give effect to the intent manifested by the provision held invalid, illegal or unenforceable and to give effect to Section 16 hereof.

18. Modification and Waiver. No supplement, modification or amendment of this Agreement shall be binding unless it is in a writing signed by both of the parties hereto. No waiver of any of the provisions of this Agreement shall be deemed or shall constitute a waiver of any other provisions hereof (whether or not similar) nor shall such waiver constitute a continuing waiver.

19. Notice. All notices, requests, demands and other communications under this Agreement shall be in writing and shall be deemed to have been duly given (a) upon delivery if delivered by hand to the party to whom such notice or other communication shall have been directed, (b) if mailed by certified or registered mail with postage prepaid, return receipt requested, on the third business day after the date on which it is so mailed, (c) one business day after the business day of deposit with a nationally recognized overnight delivery service, specifying next day delivery, with written verification of receipt, or (d) on the same day as delivered by confirmed facsimile transmission if delivered during business hours or on the next successive business day if delivered by confirmed facsimile transmission after business hours. The address for notice to the Company shall be its principal place of business and the address for notice to the Indemnitee shall be as shown on the signature page of this Agreement, or, in either case, such other address as may have been furnished by such party to the other in the manner set forth above.

20. Governing Law. This Agreement shall be governed exclusively by and construed according to the laws of the State of Delaware as applied to contracts between Delaware residents entered into and to be performed entirely within Delaware. This Agreement is intended to be an agreement of the type contemplated by Section 145(f) of the General Corporation Law of Delaware.

21. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall for all purposes be deemed to be an original but all of which together shall constitute one and the same Agreement. Only one such counterpart signed by the party against whom enforcement is sought needs to be produced to evidence the existence of this Agreement.

The parties hereto have entered into this Indemnity Agreement effective as of the date first above written.

Indemnitee:

_____

Address: _____

_____

Company:

SURGICAL CARE AFFILIATES, INC.

By: _____

_____

Its: _____

Exhibit 10.31

Directors Grants

SURGICAL CARE AFFILIATES, INC.

2013 OMNIBUS LONG-TERM INCENTIVE PLAN

RESTRICTED STOCK UNIT AWARD AGREEMENT
TIME-VESTING RESTRICTED UNITS

This Restricted Stock Unit Award Agreement (the "Agreement"), is entered into as of [•] (the "Grant Date"), by and between Surgical Care Affiliates, Inc., a Delaware corporation (the "Company"), and [•], a director of the Company or one or more of its Subsidiaries (the "Participant").

Pursuant to the Surgical Care Affiliates, Inc. 2013 Omnibus Long-Term Incentive Plan, as amended (the "Plan"), the Board of Directors of the Company (or its Compensation Committee or a designee thereof) has determined that the Participant shall be granted an Incentive Award in the form of restricted stock units ("RSUs") upon the terms and subject to the conditions hereinafter contained. Capitalized terms used but not defined herein shall have the meanings assigned to them in the Plan.

1. Number of Units and Settlement. The Participant is hereby granted [•] RSUs, subject to the restrictions set forth herein. Each RSU granted hereunder represents the right to receive one share of the Company's Common Stock on the Settlement Date (as defined herein), upon the terms and subject to the conditions (including the vesting conditions) set forth in this Agreement and the Plan. With respect to those RSUs for which the restrictions on transfer as set forth in Section 2(a) hereof have lapsed pursuant to Sections 4 and 5, the Settlement Date shall occur on the earliest to occur of (i) the termination of the Participant's Employment (which shall include the Participant ceasing to serve as a director on the Company's Board of Directors, if the Participant does not otherwise remain Employed and otherwise subject to Section 11(b) of the Plan) or (ii) the occurrence of a Change in Control.

2. Terms of Restricted Stock Units. The grant of RSUs provided in Section 1 hereof shall be subject to the following terms, conditions and restrictions:

(a) The RSUs, and any interest therein, may not be sold, pledged, assigned, hypothecated, transferred, or disposed of in any manner other than by will or the laws of descent and distribution, prior to the lapse of restrictions set forth in the Plan and this Agreement applicable thereto.

(b) Notwithstanding any other provision of this Agreement, in no event shall any outstanding restrictions lapse prior to the satisfaction by the Participant of the liabilities described in Section 7 hereof.

(c) The Committee may, in its discretion, cancel all or any part of any outstanding restrictions prior to the expiration of the periods provided in Section 4 hereof.

3. Rights as a Stockholder. Since the RSUs granted hereunder shall be settled in shares of the Company's Common Stock, the Participant shall possess all incidents of ownership as to such shares that are transferred to the Participant in respect of the settlement of the RSUs, including the right to receive or reinvest dividends with respect to such shares (to the extent declared by the Company) and the right to vote such shares. Such incidents of ownership shall commence on each such respective Settlement Date, and only with respect to such shares that are transferred to the Participant on such Settlement Date.

4. Lapse of Restrictions. Except as may otherwise be provided herein, the restrictions on transfer set forth in Section 2(a) shall lapse:

(a) with respect to fifty percent (50%) of the RSUs, on the first anniversary of the Grant Date; and

(b) with respect to fifty percent (50%) of the RSUs, on the second anniversary of the Grant Date.

Upon each lapse of restrictions relating to the RSUs, and provided that the Participant shall have complied with the Participant's obligations under Section 7 hereof, the Company shall issue to the Participant or the Participant's personal representative one share of Common Stock on the Company's books and records, in exchange for each RSU with respect to which such restrictions have lapsed.

5. Effect of Certain Changes. In the event the Participant's Employment is terminated without Cause within the two (2) year period following the consummation of a Change in Control, all restrictions then outstanding with respect to the RSUs shall automatically expire and be of no further force and effect, and full payment in respect of the RSUs granted hereunder shall be made as soon as practicable thereafter, and in any event not more than 30 days following such termination of Employment, but only if permissible under Section 409A of the Internal Revenue Code; if such settlement is not permissible under Section 409A, then settlement shall occur in accordance with the other terms of this Agreement. For purposes hereof, "Cause" shall mean, unless otherwise provided in an employment agreement in effect immediately prior to such termination, (i) a failure of the Participant to reasonably and substantially perform his or her duties to the Company or any of its Subsidiaries (other than as a result of physical or mental illness or injury); (ii) the Participant's willful misconduct or gross negligence; (iii) a breach by the Participant of the Participant's fiduciary duty or duty of loyalty to the Company or its Affiliates; (iv) the commission by the Participant of any felony or other serious crime; or (v) a breach by the Participant of the terms of any agreement with the Company or any Subsidiary or any Company policies.

6. Termination of Employment. In the event that the Participant ceases to be Employed by the Company or any of its Subsidiaries for any reason, all RSUs with respect to which the restrictions set forth in Section 4 hereof shall not yet have lapsed (taking into account Sections 2 and 5) shall thereupon be automatically forfeited by the Participant.

7. Taxes. The Participant shall pay to the Company promptly upon request, and in any event at the time the Participant recognizes taxable income in respect of the RSUs, an amount equal to the taxes the Company determines it is required to withhold under applicable tax laws with respect to the settlement of the RSUs. Such payment shall be made in the form of cash, shares of Common Stock already owned or otherwise issuable upon the lapse of restrictions, or in a combination of such methods, subject to the terms of the Plan.

8. No Guarantee of Employment. Nothing set forth herein or in the Plan shall (i) confer upon the Participant any right of continued Employment for any period by the Company or any of its Subsidiaries, (ii) entitle the Participant to remuneration or benefits not set forth in the Plan, or (iii) interfere with or limit in any way the right of the Company or any Subsidiary to terminate such Participant's Employment.

9. Notices. Any notice required or permitted under this Agreement shall be in writing and deemed given when (i) delivered personally, (ii) mailed by United States certified or registered mail, return receipt requested, postage prepaid, or (iii) delivered by overnight courier service. Such notices shall be sent to the Participant at the last address specified in the Company's records (or such other address as the Participant may designate in writing to the Company), or to the Company at the following address (or such other address as the Company may designate in writing to the Participant):

Surgical Care Affiliates, Inc.
3000 Riverchase Galleria, Suite 500
Birmingham, AL 35244
Attn: General Counsel

10. Failure To Enforce Not a Waiver. The failure of the Company to enforce at any time any provision of this Agreement shall in no way be construed to be a waiver of such provision or of any other provision hereof.

11. Governing Law. This Agreement shall be governed by and construed according to the laws of the State of Delaware, without regard to its conflict of law principles.

12. Incorporation of Plan. A copy of the Plan is attached hereto and incorporated herein by reference and made a part of this Agreement. This Agreement and the RSUs shall be subject to the terms of the Plan, as it may be amended from time to time, provided that such amendment of the Plan is made in accordance with Section 16 of the Plan.

13. Clawback Policies. Notwithstanding anything in the Plan to the contrary, the Company will be entitled, to the extent permitted or required by applicable law, Company policy and/or the requirements of an exchange on which the Company's shares are listed for trading, in each case, as in effect from time to time, to recoup compensation of whatever kind paid by the Company or any of its affiliates at any time to a Participant under the Plan and the Participant, by accepting this award of RSUs pursuant to the Plan and this Agreement, agrees to comply with any Company request or demand for such recoupment.

14. Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be an original but all of which together shall represent one and the same agreement.

SURGICAL CARE AFFILIATES, INC.

By: _____
Name:
Title:

PARTICIPANT:

_____
[*Name*]

_____
Date

Exhibit 10.32

Employee Grants (4 Year Vesting)

SURGICAL CARE AFFILIATES, INC.

2013 OMNIBUS LONG-TERM INCENTIVE PLAN

RESTRICTED STOCK UNIT AWARD AGREEMENT
TIME-VESTING RESTRICTED UNITS

This Restricted Stock Unit Award Agreement (the "Agreement"), is entered into as of **[•]** (the "Grant Date"), by and between Surgical Care Affiliates, Inc., a Delaware corporation (the "Company"), and **[•]**, an employee of the Company or one or more of its Subsidiaries (the "Participant").

Pursuant to the Surgical Care Affiliates, Inc. 2013 Omnibus Long-Term Incentive Plan, as amended (the "Plan"), the Board of Directors of the Company (or its Compensation Committee or a designee thereof) has determined that the Participant shall be granted an Incentive Award in the form of restricted stock units ("RSUs") upon the terms and subject to the conditions hereinafter contained. Capitalized terms used but not defined herein shall have the meanings assigned to them in the Plan.

1. Number of Units and Settlement. The Participant is hereby granted **[•]** RSUs, subject to the restrictions set forth herein. Each RSU granted hereunder represents the right to receive one share of the Company's Common Stock on the Settlement Date (as defined herein), upon the terms and subject to the conditions (including the vesting conditions) set forth in this Agreement and the Plan. The Settlement Date shall occur on each date set forth under Section 4 that the restrictions on transfer set forth in Section 2(a) shall lapse.

2. Terms of Restricted Stock Units. The grant of RSUs provided in Section 1 hereof shall be subject to the following terms, conditions and restrictions:

(a) The RSUs, and any interest therein, may not be sold, pledged, assigned, hypothecated, transferred, or disposed of in any manner other than by will or the laws of descent and distribution, prior to the lapse of restrictions set forth in the Plan and this Agreement applicable thereto.

(b) Notwithstanding any other provision of this Agreement, in no event shall any outstanding restrictions lapse prior to the satisfaction by the Participant of the liabilities described in Section 7 hereof.

(c) The Committee may, in its discretion, cancel all or any part of any outstanding restrictions prior to the expiration of the periods provided in Section 4 hereof.

3. Rights as a Stockholder. Since the RSUs granted hereunder shall be settled in shares of the Company's Common Stock, the Participant shall possess all incidents of ownership as to such shares that are transferred to the Participant in respect of the settlement of the RSUs, including the right to receive or reinvest dividends with respect to such shares (to the extent declared by the Company) and the right to vote such shares. Such incidents of ownership shall commence on each such respective Settlement Date, and only with respect to such shares that are transferred to the Participant on such Settlement Date.

4. Lapse of Restrictions. Except as may otherwise be provided herein, the restrictions on transfer set forth in Section 2(a) shall lapse:

(a) with respect to twenty-five percent (25%) of the RSUs, on the first anniversary of the Grant Date;

(b) with respect to twenty-five percent (25%) of the RSUs, on the second anniversary of the Grant Date;

(c) with respect to twenty-five percent (25%) of the RSUs, on the third anniversary of the Grant Date; and

(d) with respect to twenty-five percent (25%) of the RSUs, on the fourth anniversary of the Grant Date.

Upon each lapse of restrictions relating to the RSUs, and provided that the Participant shall have complied with the Participant's obligations under Section 7 hereof, the Company shall issue to the Participant or the Participant's personal representative one share of Common Stock on the Company's books and records, in exchange for each RSU with respect to which such restrictions have lapsed.

5. Effect of Certain Changes. In the event the Participant's Employment is terminated without Cause within the two (2) year period following the consummation of a Change in Control, all restrictions then outstanding with respect to the RSUs shall automatically expire and be of no further force and effect, and full payment in respect of the RSUs granted hereunder shall be made as soon as practicable thereafter, and in any event not more than 30 days following such termination of Employment, but only if permissible under Section 409A of the Internal Revenue Code; if such settlement is not permissible under Section 409A, then settlement shall occur in accordance with the other terms of this Agreement. For purposes hereof, "Cause" shall mean, unless otherwise provided in an employment agreement in effect immediately prior to such termination, (i) a failure of the Participant to reasonably and substantially perform his or her duties to the Company or any of its Subsidiaries (other than as a result of physical or mental illness or injury); (ii) the Participant's willful misconduct or gross negligence; (iii) a breach by the Participant of the Participant's fiduciary duty or duty of loyalty to the Company or its Affiliates; (iv) the commission by the Participant of any felony or other serious crime; or (v) a breach by the Participant of the terms of any agreement with the Company or any Subsidiary or any Company policies.

6. Termination of Employment. In the event that the Participant ceases to be Employed by the Company or any of its Subsidiaries for any reason, all RSUs with respect to which the restrictions set forth in Section 4 hereof shall not yet have lapsed (taking into account Sections 2 and 5) shall thereupon be automatically forfeited by the Participant.

7. Taxes. The Participant shall pay to the Company promptly upon request, and in any event at the time the Participant recognizes taxable income in respect of the RSUs, an amount

equal to the taxes the Company determines it is required to withhold under applicable tax laws with respect to the settlement of the RSUs. Such payment shall be made in the form of cash, shares of Common Stock already owned or otherwise issuable upon the lapse of restrictions, or in a combination of such methods, subject to the terms of the Plan.

8. No Guarantee of Employment. Nothing set forth herein or in the Plan shall (i) confer upon the Participant any right of continued Employment for any period by the Company or any of its Subsidiaries, (ii) entitle the Participant to remuneration or benefits not set forth in the Plan, or (iii) interfere with or limit in any way the right of the Company or any Subsidiary to terminate such Participant's Employment.

9. Notices. Any notice required or permitted under this Agreement shall be in writing and deemed given when (i) delivered personally, (ii) mailed by United States certified or registered mail, return receipt requested, postage prepaid, or (iii) delivered by overnight courier service. Such notices shall be sent to the Participant at the last address specified in the Company's records (or such other address as the Participant may designate in writing to the Company), or to the Company at the following address (or such other address as the Company may designate in writing to the Participant):

Surgical Care Affiliates, Inc.
3000 Riverchase Galleria, Suite 500
Birmingham, AL 35244
Attn: General Counsel

10. Failure To Enforce Not a Waiver. The failure of the Company to enforce at any time any provision of this Agreement shall in no way be construed to be a waiver of such provision or of any other provision hereof.

11. Governing Law. This Agreement shall be governed by and construed according to the laws of the State of Delaware, without regard to its conflict of law principles.

12. Incorporation of Plan. A copy of the Plan is attached hereto and incorporated herein by reference and made a part of this Agreement. This Agreement and the RSUs shall be subject to the terms of the Plan, as it may be amended from time to time, provided that such amendment of the Plan is made in accordance with Section 16 of the Plan.

13. Clawback Policies. Notwithstanding anything in the Plan to the contrary, the Company will be entitled, to the extent permitted or required by applicable law, Company policy and/or the requirements of an exchange on which the Company's shares are listed for trading, in each case, as in effect from time to time, to recoup compensation of whatever kind paid by the Company or any of its affiliates at any time to a Participant under the Plan and the Participant, by accepting this award of RSUs pursuant to the Plan and this Agreement, agrees to comply with any Company request or demand for such recoupment.

14. Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be an original but all of which together shall represent one and the same agreement.

SURGICAL CARE AFFILIATES, INC.

By: _____
Name:
Title:

PARTICIPANT:

_____
[*Name*]

_____
Date

Exhibit 10.33

Option Grant Agreement

SURGICAL CARE AFFILIATES, INC.

2013 OMNIBUS LONG-TERM INCENTIVE PLAN

NON-QUALIFIED STOCK OPTION AGREEMENT

TIME-BASED OPTIONS

This Non-Qualified Stock Option Agreement (this "Option Agreement") is entered into as of **[•]** (the "Grant Date"), by and between Surgical Care Affiliates, Inc., a Delaware corporation (the "Company") and [•] (the "Participant").

Pursuant to the Surgical Care Affiliates, Inc. 2013 Omnibus Long-Term Incentive Plan, as amended (the "Plan"), the Board of Directors of the Company (or its Compensation Committee or a designee thereof) has determined that the Participant shall be granted an Incentive Award in the form of an Option upon the terms and subject to the conditions hereinafter contained. Capitalized terms used but not defined herein shall have the meanings assigned to them in the Plan.

1. Number and Price of Shares. The Company hereby grants to the Participant an Option to purchase **[•]** shares of the Company's Common Stock (the "Option Shares") at a price of **$[•]** per share (the "Option Price").

2. Vesting. Subject to the provisions of Section 4 hereof and to the Participant's continued Employment with the Company through each applicable vesting date, the Option shall vest and become exercisable in accordance with the following schedule:

(a) twenty-five percent (25%) of the Option shall vest and become exercisable on the first anniversary of the Grant Date;

(b) twenty-five percent (25%) of the Option shall vest and become exercisable on the second anniversary of the Grant Date;

(c) twenty-five percent (25%) of the Option shall vest and become exercisable on the third anniversary of the Grant Date; and

(d) twenty-five percent (25%) of the Option shall vest and become exercisable on the fourth anniversary of the Grant Date.

3. Method of Exercise. The Option, or any part thereof, shall be exercised by written notice from the Participant to the Secretary of the Company specifying the number of Option Shares to be purchased (which must be a whole number of shares) and accompanied by payment in full of the Option Price for the shares being purchased. Such payment may be made in (i) cash; (ii) shares of Common Stock (that the Participant has owned for at least one (1) year) having a Fair Market Value equal to such Option Price; (iii) a combination of cash and shares provided that such shares have been held by the Participant for at least one (1) year prior to such exercise; or (iv) a "cashless exercise" procedure (in the sole discretion of the Committee) involving a broker; provided, however, that such method and time for payment shall be permitted by and be

in compliance with applicable law. Each Option shall be exercisable in whole or in part, unless the aggregate Option Price of the Option then exercisable is less than $1,000, in which case the Participant shall only be entitled to exercise all such exercisable Options. No shares shall be issued until full payment therefor has been received by the Company and the provisions of Section 8 hereof shall have been complied with, and the Participant shall have no rights as a stockholder of the Company in respect of such shares until the date of the issuance by the Company of the shares in uncertificated form by book entry on the Company's books and records.

4. Term of Option.

(a) The Option shall be exercisable, in accordance with the provisions of Sections 2 and 3 hereof, through the tenth anniversary of the Grant Date, unless terminated earlier as provided herein. In the event the Participant's Employment is terminated for any reason, the unvested portion of the Option shall immediately be forfeited for no consideration as of the date of such termination.

(b) In the event the Participant's Employment is terminated by reason of the Participant's death or disability, the Option may, to the extent otherwise vested and exercisable pursuant to Section 2 above on the date of such termination, be exercised by the Participant or the Participant's estate, as applicable, at any time within one (1) year period following such date of termination, but in any event no later than the tenth anniversary of the Grant Date. The Option shall, to the extent not theretofore exercised or terminated, terminate upon the expiration of such one (1) year (or shorter) period.

(c) In the event that the Company terminates the Participant's Employment without Cause, the Option may, to the extent otherwise vested and exercisable pursuant to Section 2 above on the date of such termination, be exercised by the Participant at any time within the ninety (90) day period following such date of termination, but in any event no later than the tenth anniversary of the Grant Date. The Option shall, to the extent not theretofore exercised or terminated, terminate upon the expiration of such ninety (90) day (or shorter) period. For purposes of this Option Agreement, "Cause" shall mean, unless otherwise provided in an employment agreement in effect immediately prior to such termination, (i) a failure of the Participant to reasonably and substantially perform his or her duties to the Company or any of its Subsidiaries (other than as a result of physical or mental illness or injury); (ii) the Participant's willful misconduct or gross negligence; (iii) a breach by the Participant of the Participant's fiduciary duty or duty of loyalty to the Company or its Affiliates; (iv) the commission by the Participant of any felony or other serious crime; or (v) a breach by the Participant of the terms of any agreement with the Company or any Subsidiary or any Company policies.

5. Effect of Certain Changes. In the event the Participant's Employment is terminated without Cause within the two (2) year period following the consummation of a Change in Control, any then-outstanding unvested portion of the Option shall immediately vest in full as of the date of such termination.

6. Non-Transferability. The Option and the Participant's rights hereunder shall not be transferable other than by will or the law of descent and distribution, and during the lifetime of the Participant the Option may be exercised only by the Participant or by the Participant's guardian or legal representative.

7. No Guarantee of Employment. Nothing set forth herein shall (i) confer upon the Participant any right of continued employment or service for any period by the Company or any of its Affiliates, (ii) entitle the Participant to remuneration or benefits not set forth in the Plan, or (iii) interfere with or limit in any way the right of the Company or any such Affiliate to terminate the Participant's Employment.

8. Taxes. The Participant shall pay to the Company promptly upon request, and in any event at the time the Participant recognizes taxable income in respect of the Option, an amount equal to the taxes the Company determines it is required to withhold under applicable tax laws with respect to the exercise of such Option. Such payment shall be made in the form of cash, shares of Common Stock already owned or otherwise issuable upon the exercise of Options, or in a combination of such methods, subject to the terms of the Plan.

9. Failure to Enforce Not a Waiver. The failure of the Company to enforce at any time any provision of this Option Agreement shall in no way be construed to be a waiver of such provision or of any other provision hereof.

10. Governing Law. This Option Agreement shall be governed by and construed in accordance with the laws of the State of Delaware, without regard to its conflict of law principles.

11. Notices. Any notice required or permitted under this Option Agreement shall be in writing and deemed given when (i) delivered personally, (ii) mailed by United States certified or registered mail, return receipt requested, postage prepaid, or (iii) delivered by overnight courier service. Such notices shall be sent to the Participant at the last address specified in the Company's records (or such other address as the Participant may designate in writing to the Company), or to the Company at the following address (or such other address as the Company may designate in writing to the Participant):

Surgical Care Affiliates, Inc.
3000 Riverchase Galleria, Suite 500
Birmingham, AL 35244
Attn: General Counsel

12. Incorporation of Plan. A copy of the Plan is attached hereto and incorporated herein by reference and made a part of this Option Agreement. This Option Agreement and the Option shall be subject to the terms of the Plan, as it may be amended from time to time, provided that such amendment of the Plan is made in accordance with Section 16 of the Plan.

13. Clawback Policies. Notwithstanding anything in the Plan to the contrary, the Company will be entitled, to the extent permitted or required by applicable law, Company policy and/or the requirements of an exchange on which the Company's shares are listed for trading, in each case, as in effect from time to time, to recoup compensation of whatever kind paid by the Company or any of its affiliates at any time to a Participant under the Plan and the Participant, by accepting this award of an Option pursuant to the Plan and this Agreement, agrees to comply with any Company request or demand for such recoupment.

14. Counterparts. This Option Agreement may be executed in two or more counterparts, each of which shall be an original but all of which together shall represent one and the same agreement.

SURGICAL CARE AFFILIATES, INC.

By: _____
Name:
Title:

PARTICIPANT:

_____
[*Name*]

_____
Date

Exhibit 21.1

SURGICAL CARE AFFILIATES, INC.

List of Subsidiaries as of March 20, 2014

Legal Name of Subsidiary	Doing Business Name (if applicable)	State of Organization
2121 Surgery Center, Limited Partnership	Surgery Center of Santa Monica	CA
Advocate-SCA Holdings, LLC		DE
Alaska Surgery Center, Inc.		AK
Alaska Surgery Center, Limited Partnership	Alaska Surgery Center	AK
Aloha Surgical Center, L.P.	Aloha Surgical Center	TN
Antelope Valley Surgery Center, L.P.	Antelope Valley Surgery Center	CA
Arcadia Outpatient Surgery Center, L.P.	Arcadia Outpatient Surgery Center	CA
ASC Connecticut Holdings, LLC		DE
ASC Holdings of New Jersey, LLC		NJ
ASC Network, LLC		DE
ASC Operators, LLC		CA
ASC Operators-East Bay, LLC		CA
ASC Operators-San Francisco, LLC		CA
ASC Operators-San Luis Obispo, LLC		CA
ASC Operators-Santa Rosa, LLC		CA
ASC Operators-South Bay, LLC		CA
ASC Pacific Ventures, LLC		DE
Auburn Surgical Center, L.P.	Sutter Auburn Surgery Center	CA
Aurora Surgery Center Limited Partnership	Choice Surgicare	CO
Aurora-SC, Inc.		CO
Austin Center For Outpatient Surgery, L.P.	Northwest Hills Surgical Hospital	GA
B.R.A.S.S. Partnership in Commendam	B.R.A.S.S. Surgery Center	LA
Bakersfield Physicians Plaza Surgical Center, L.P.	Physicians Plaza Surgical Center	TN
Bakersfield-SC, LLC		DE
Ball Outpatient Surgery Center, LLC		IN
Beach Surgical Holdings LLC		CA
Belleville Surgical Center, Ltd., an Illinois Limited Partnership	Belleville Surgical Center	IL

Beltway Surgery Centers, L.L.C.	IU Health Beltway Surgery Centers; Indiana University Health Beltway Surgery Centers; Glen Lehman Endoscopy Suite; Indiana Hand to Shoulder Beltway Surgery Center; Beltway Surgery Center Spring Mill	IN
Bergan Mercy Surgery Center, LLC		NE
Birmingham Outpatient Surgery Center, Ltd.	Outpatient Care Center	AL
Birmingham Outpatient Surgical Center, LLC		DE
Blackstone Valley Surgicare Acquisition, L.P.	Blackstone Valley Surgicare	RI
Blackstone Valley Surgicare GP, LLC		DE
Blue Ridge Day Surgery Center, L.P.	Blue Ridge Surgery Center	TN
Blue Ridge GP, LLC		NC
Boca Raton Outpatient Surgery & Laser Center, LTD.	Boca Raton Outpatient Surgery & Laser Center	FL
BOSC Holdings, LLC		IN
BSC Holdings, LLC		IN
Camp Hill Ambulatory Centers		PA
Camp Hill-SCA Centers, LLC		DE
Castle Ambulatory Surgery Center, LLC	Windward Surgery Center	HI
Central Minnesota Surgical Center, LLC		MN
Channel Islands Surgicenter Properties, LLC		DE
Channel Islands Surgicenter, L.P.	Channel Islands Surgicenter	CA
Charleston Surgery Center Limited Partnership	Charleston Surgery Center	SC
Charlotte Surgery Center, Limited Partnership	Charlotte Surgery Center	NC
Charlotte Surgery Properties, LTD.		NC
Charlotte-SC, LLC		DE
Citrus Regional Surgery Center, L.P.	Citrus Surgery Center	TN
Cleburne Surgical Center, LLC	Texas Health Surgical Center Cleburne	TX
Colorado Springs Surgery Center, Ltd.	Colorado Springs Surgery Center	CO
Connecticut Surgery Center, Limited Partnership	Connecticut Surgery Center	CT
Connecticut Surgery Properties, LLC		DE
Connecticut Surgical Center, LLC		DE
Corpus Christi Endoscopy Center, L.L.P.		TX
Danbury Surgical Center, L.P.	Danbury Surgical Center	GA

Denton Surgery Center, LLC		TX
Digestive Disease Center, L.P.		CA
E Street Endoscopy, LLC	West Coast Endoscopy Center	FL
Eagle Highlands Surgery Center, LLC	Indiana University Health Eagle Highlands Surgery Center; IU Health Eagle Highlands Surgery Center; Meridian South Surgery Center	IN
East Bay Endoscopy Center, L.P.		DE
East Brunswick Surgery Center, LLC	Universirty SurgiCenter	NJ
eCode Solutions, LLC		DE
EHSC Holdings, LLC		IN
Emerald Coast Surgery Center, L.P.	Emerald Coast Surgery Center	TN
Endoscopy Center Affiliates, Inc.		DE
Fayetteville Ambulatory Surgery Center, L.P.	Fayetteville Ambulatory Surgery Center	NC
Florence Surgery Center, L.P.	Shoals Outpatient Surgery	TN
Fort Sutter Medical Building, a California Limited Partnership		CA
Fort Sutter Surgery Center, a California Limited Partnership	Fort Sutter Surgery Center; Sutter River City Surgery Center	CA
Gadsden Surgery Center, LLC		DE
Gadsden Surgery Center, Ltd.	Gadsden Surgery Center	AL
Gainesville Surgery Center, L.P.	Gainesville Surgery Center	TN
Geisinger-SCA Holdings, LLC		DE
Glenwood Surgical Center, L.P.	Glenwood Surgery Center	CA
Glenwood-SC, Inc.		TN
Golden Gate Endoscopy Center, LLC		CA
Golden Triangle Surgicenter, L.P.	Golden Triangle Surgicenter	CA
Grandview Surgery Center, LTD.	Grandview Surgery Center	PA
Greater Long Beach Endoscopy Center	Greater Long Beach Endoscopy Center	CA
Greensboro Specialty Surgery Center, LLC	Greensboro Specialty Surgical Center	NC
Greenville Surgery Center, LLC	Greenville Surgery Center	TX
Grossmont Surgery Center, L.P.	Grossmont Surgery Center	CA
Gwinnett Center for Outpatient Surgery, L.P.	Gwinnett Center for Outpatient Surgery	GA
H.I. Investments Holding Company, LLC		DE
Hartford Surgery Center, LLC	Hartford Surgical Center	DE
Hawthorn Place Outpatient Surgery Center, L.P.	Hawthorn Surgery Center	GA

Health Inventures Employment Solutions, LLC		DE
Health Inventures, LLC		DE
HealthEast Surgery Center-Maplewood, LLC	Maplewood Surgery Center	MN
Hoag Outpatient Centers, LLC	Hoag Endoscopy Center	CA
Honolulu Surgery Center, L.P.	Surgicare of Hawaii	TN
Huntsville Surgery Center, LTD		AL
Idaho ASC Holdings, LLC		DE
IEC Holdings, LLC		IN
Indian River Surgery Center, Ltd.	Indian River Surgery Center	FL
Indian River Surgery Properties, LLC		FL
Indiana Endoscopy Centers, LLC	Indiana University Health Endoscopy Centers; IU Health Endoscopy Centers	IN
Indiana University Health Saxony Surgery Center LLC	Saxony Surgery Center	IN
Inland Surgery Center, L.P.	Inland Surgery Center	CA
Joliet Surgery Center Limited Partnership	Amsurg Surgery Center	IL
Lackawanna Physicians Ambulatory Surgery Center, LLC	North East Surgery Center	PA
Lexington Surgery Center, Ltd.	Lexington Surgery Center	KY
Louisville S.C., Ltd.	Surgecenter of Louisville	KY
Louisville-SC Properties, Inc.		KY
Loyola Ambulatory Surgery Center at Oakbrook, Inc.		IL
Loyola Ambulatory Surgery Center at Oakbrook, L.P.	Loyola Ambulatory Surgery Center at Oakbrook	IL
Marin Health Ventures, LLC	Marin Specialty Surgery Center	CA
Marin Specialty Surgery Center, LLC		CA
Marin Surgery Holdings, Inc.		DE
Maryland Ambulatory Centers		MD
Maryland-SCA Centers, LLC		DE
McKenzie Surgery Center, L.P.	McKenzie Surgery Center	TN
Medical Partners Surgery Center, L.L.C.	Medical Partners Surgery Center	FL
Medical Surgical Centers of America, Inc.		DE
Melbourne Surgery Center, LLC	Melbourne Surgery Center	GA
MemorialCare Surgical Center at Saddleback, LLC	MemorialCare Surgical Center at Saddleback; Laguna Hills Surgery Center	CA
Memphis Surgery Center, LTD., L.P.	Memphis Surgery Center	TN
Memphis Surgery Properties, LTD., L.P.		TN
Memphis-SC, LLC		TN

Memphis-SP, LLC		TN
MGH/SCA, LLC		CA
Mississippi Surgery Holdings, LLC		DE
Mississippi Surgical Center Limited Partnership		MS
Mobile-SC, LTD.	Mobile Surgery Center	AL
Montgomery Surgery Center Limited Partnership	Montgomery Surgery Center	MD
Mountain View Endoscopy Center, LLC		CA
Mt. Pleasant Surgery Center, L.P.	Mt. Pleasant Surgery Center	TN
Muskogee Surgical Investors, LLC		OK
Nashville-SCA Surgery Centers, Inc.		TN
National Surgery Centers, LLC		DE
National Surgery Centers-Santa Monica, LLC		DE
Nebraska Spine Hospital, LLC		NE
Newport Beach Endoscopy Center, LLC	Newport Beach Orange Coast Endoscopy Center	CA
North Coast Surgery Center, Ltd., a California Limited Partnership	North Coast Surgery Center	CA
Northern Rockies Surgery Center, L.P.	Northern Rockies Surgery Center	TN
Northern Rockies Surgicenter, Inc.		MT
Northwest Surgicare, LLC		DE
Northwest Surgicare, Ltd., an Illinois Limited Partnership	Northwest Surgicare	IL
Norwalk Surgery Center, LLC		CT
NSC Channel Islands, LLC		CA
NSC Fayetteville, LLC		DE
NSC Greensboro West, LLC		DE
NSC Greensboro, LLC		DE
NSC Jacksonville, Inc.		FL
NSC Lancaster, LLC		DE
NSC Sarasota, Inc.		DE
NSC Seattle, Inc.		WA
NSC Upland, LLC		DE
NYSCA, LLC		NY
Orlando Center for Outpatient Surgery, L.P.	Orlando Center for Outpatient Surgery	GA
Owensboro Ambulatory Surgical Facility, Ltd.	Owensboro Surgery Center	KY
Paoli Ambulatory Surgery Center		PA

Paoli Surgery Center, L.P.	Paoli Surgery Center	TN
PASC Real Estate, LLC		CO
Pasteur Plaza Surgery Center GP, Inc.		DE
Pasteur Plaza Surgery Center, L.P.	Pasteur Plaza Surgery Center	GA
Peninsula Eye Surgery Center, LLC		CA
Perimeter Center for Outpatient Surgery, L.P.	Perimeter Surgery Center of Atlanta	GA
Physicians Plaza Holdings, LLC		CA
Pomerado Outpatient Surgical Center, Inc.		CA
Pomerado Outpatient Surgical Center, L.P.	Rancho Bernardo Surgery Center	CA
Premier Surgery Center of Louisville, L.P.	Premier Surgery Center of Louisville	TN
Pueblo Ambulatory Surgery Center, LLC	Pueblo Surgery Center	CO
Pueblo-SCA Surgery Center, LLC		DE
Redding Surgery Center, LLC	Apogee Surgery Center	CA
Redlands Ambulatory Surgery Center		CA
Redlands-SCA Surgery Centers, Inc.		CA
Redwood City Endoscopy Suite, LLC		CA
ROC Surgery LLC	Riley Outpatient Surgery Center at Indiana University Health; Riley Outpatient Surgery Center at IU Health; Riley Outpatient Surgery Center	IN
ROCS Holdings, LLC		IN
Sacramento Surgery Center Associates, L.P.	Capitol City Surgery Center	CA
Saint Joseph-SCA Holdings, LLC		DE
Salem Surgery Center, Ltd., an Oregon Limited Partnership	Northbank Surgical Center	OR
Salt Lake Surgical Center, L.P.	Salt Lake Surgical Center	GA
San Diego Endoscopy Center	San Diego Endoscopy Center	CA
San Francisco Endoscopy Center LLC		CA
San Luis Obispo Surgery Center, a California Limited Partnership	San Luis Obispo Surgery Center	CA
Santa Barbara Endoscopy Center, LLC		CA
Santa Cruz Endoscopy Center, LLC		CA
Santa Monica Surgical Partners, L.L.C.	Surgery Center of the Pacific	CA
Santa Rosa Surgery Center, L.P.	The Surgery Center of Santa Rosa	TN
Sarasota Endoscopy Center, L.P.	Endoscopy Center of Sarasota	GA
SC Affiliates, LLC		DE
SCA BOSC Holdings, LLC		DE

SCA Capital, LLC		DE
SCA Danbury Surgical Center, LLC		DE
SCA Development, LLC		DE
SCA eCode Solutions Private Limited		Uttar Pradesh, India
SCA EHSC Holdings, LLC		DE
SCA Holding Company, Inc.		DE
SCA Houston Hospital for Specialized Surgery, L.P.	Houston Hospital for Specialized Surgery	TX
SCA Idaho Holdings, LLC		DE
SCA IEC Holdings, LLC		DE
SCA Indiana Holdings, LLC		DE
SCA JV, LLC		DE
SCA Nashville Surgery Center, L.L.C.	Nashville Surgery Center	TN
SCA of Clarksville, Inc.		TN
SCA Pacific Holdings, Inc.		CA
SCA Pennsylvania Holdings, LLC		DE
SCA Premier Surgery Center of Louisville, LLC		DE
SCA ROCS Holdings, LLC		DE
SCA Salt Lake Surgical Center, Inc.		DE
SCA SSC Holdings, LLC		DE
SCA SSSC Holdings, LLC		DE
SCA Surgery Center of Cullman, LLC		DE
SCA Surgery Holdings, LLC		DE
SCA Surgery Partners, LLC		DE
SCA Surgicare of Laguna Hills, LLC		DE
SCA Teammate Support Network		AL
SCA-Albuquerque Surgery Properties, Inc.		NM
SCA-Blue Ridge, LLC		DE
SCA-Charleston, LLC		DE
SCA-Citrus, Inc.		TN
SCA-Colorado Springs, LLC		DE
SCA-Eugene, Inc.		TN
SCA-Florence, LLC		DE
SCA-Fort Collins, Inc.		CO
SCA-Fort Walton, Inc.		TN
SCA-Gainesville, LLC		DE
SCA-Honolulu, LLC		DE
SCA-Mecklenburg Development Corp.		NC

SCA-Mobile, LLC		DE
SCA-Mt. Pleasant, LLC		DE
SCA-Northeast Georgia Health, LLC		TN
SCA-Paoli, LLC		DE
SCA-San Luis Obispo, LLC		DE
SCA-Santa Rosa, Inc.		NV
SCA-Shelby Development Corp.		TN
SCA-South Jersey, LLC		DE
SCA-Sovereign Santa Monica, LLC		DE
SCA-Wausau, LLC		DE
SCA-Winter Park, Inc.		TN
Senate Street Surgery Center, LLC	Indiana University Health Senate Street Surgery Center; IU Health Senate Street Surgery Center	IN
SHC Atlanta, LLC		DE
SHC Austin, Inc.		GA
SHC Gwinnett, LLC		DE
SHC Hawthorn, Inc.		GA
SHC Melbourne, Inc.		GA
Shelby Surgery Properties, Inc.		TN
Somerset Surgery Center, Limited Partnership	Somerset Surgery Center	KY
South County Outpatient Management, LLC		DE
South County Outpatient Surgery Center, L.P.	South County Outpatient Surgery Center	MO
South County Surgical Center, LLC	South County Surgical Center	MO
South Placer Surgery Center, L.P.		CA
Southwest Surgical Center of Bakersfield, L.P.	Southwest Surgical Center	CA
Specialized Surgery of Houston, Inc.		TN
Springfield Surgery Center, L.P.	Springfield Surgery Center	TN
SSC Holdings, LLC		IN
SSSC Holdings, LLC		IN
St. Cloud Outpatient Surgery, Ltd., a Minnesota Limited Partnership	St. Cloud Surgical Center	MN
St. Cloud Surgical Center, LLC		DE
SunSurgery, LLC		DE
Surgery Center Holding, LLC		DE
Surgery Center of Boca Raton, Inc.		FL
Surgery Center of Clarksville, L.P.	Surgery Center of Clarksville	TN

Surgery Center of Colorado Springs, LLC		DE
Surgery Center of Cullman, LLC	Surgery Center of Cullman	AL
Surgery Center of Des Moines, LLC		DE
Surgery Center of Easton, LLC		DE
Surgery Center of Ellicott City, Inc.		DE
Surgery Center of Fairfield County, LLC	Surgery Center of Fairfield County	DE
Surgery Center of Fort Collins, LLC		CO
Surgery Center of Lexington, LLC		DE
Surgery Center of Louisville, LLC		DE
Surgery Center of Maui, LLC		DE
Surgery Center of Muskogee, LLC		DE
Surgery Center of Southern Pines, LLC		DE
Surgery Center of Spokane, LLC		DE
Surgery Center of Summerlin, LLC		DE
Surgery Center of Vero Beach, Inc.		TN
Surgery Centers of Des Moines, Ltd., an Iowa Limited Partnership		IA
Surgery Centers-West Holdings, LLC		DE
Surgical Care Affiliates Political Action Committee		AL
Surgical Care Affiliates, LLC		DE
Surgical Care Partners of Melbourne, LLC		DE
Surgical Caregivers of Fort Worth, LLC	Fort Worth Surgery Center	TX
Surgical Center at Premier, LLC	Surgical Center at Premier	TN
Surgical Center of Greensboro, LLC		NC
Surgical Center of South Jersey, Limited Partnership	Surgical Center of South Jersey	NJ
Surgical Center of Tuscaloosa Holdings, LLC		AL
Surgical Health Of Orlando, Inc.		FL
Surgical Health, LLC		DE
Surgical Holdings, Inc.		DE
Surgical Hospital Holdings of Oklahoma, LLC		DE
Surgical Hospital of Oklahoma, L.L.C.		OK
Surgical Properties of Houston, Inc.		TX
Surgicare of Belleville, LLC		DE
Surgicare of Huntsville, LLC		DE
Surgicare of Jackson, LLC		DE

Surgicare of Jackson, Ltd., a Mississippi Limited Partnership	Surgicare of Jackson	MS
Surgicare of Joliet, Inc.		IL
Surgicare of La Veta, Inc.		CA
Surgicare of La Veta, Ltd., a California Limited Partnership	La Veta Surgical Center	CA
Surgicare of Minneapolis, LLC		DE
Surgicare of Minneapolis, Ltd., a Minnesota Limited Partnership	Centennial Lakes Surgery Center	MN
Surgicare of Mobile, LLC		DE
Surgicare of Mobile, Ltd.	Surgicare of Mobile	AL
Surgicare of Oceanside, Inc.		CA
Surgicare of Owensboro, LLC		DE
Surgicare of Salem, LLC		DE
Surgicenters of Southern California, Inc.		CA
Sutter Alhambra Surgery Center, L.P.	Sutter Alhambra Surgery Center	CA
Sutter Street Endoscopy Center, LLC		CA
Texas Health Craig Ranch Surgery Center, LLC	Texas Health Surgery Center Craig Ranch	TX
Texas Health Flower Mound Orthopedic Surgery Center, LLC		TX
The Brevard Specialty Surgery Center, LLC		FL
The Eye Surgery Center of the Carolinas, L.P.	The Eye Surgery Center of the Carolinas	NC
The Surgery Center of Easton, L.P.	The Surgery Center of Easton	TN
The Surgical Center at Tenaya, L.P.	The Surgical Center at Tenaya	TN
Thousand Oaks Endoscopy Center, LLC	Thousand Oaks Endoscopy Center	CA
Three Rivers Surgical Care, L.P.	Three Rivers Surgical Care	TN
THR-SCA Holdings, LLC		TX
Treasure Valley Emerald Properties, LLC		DE
Treasure Valley Hospital Limited Partnership	Treasure Valley Hospital	ID
Treasure Valley Surgery Center - Nampa, LP		DE
Tri-City Medical Center ASC Operators, LLC		CA
Tuscaloosa Surgical Center, L.P.	Tuscaloosa Surgical Center	AL
UCSD Ambulatory Surgery Center, LLC	University Ambulatory Surgery Center	DE
Upland Outpatient Surgical Center, L.P.	Upland Outpatient Surgical Center	CA

Upland Specialty Medical Center, a California General Partnership		CA
Valley Hospital, L.L.C.		WA
Waco Outpatient Surgical Center, Inc.		TX
Waco Surgical Center, Ltd.	Waco Surgical Center	TX
Walk-In and Walk-Out Surgery Center, LLC		DE
Walnut Creek Endoscopy Center LLC		CA
Wausau Surgery Center, L.P.	Wausau Surgery Center	TN
Wauwatosa Outpatient Surgery Center, LLC		DE
Wauwatosa Surgery Center, Limited Partnership	Wauwatosa Surgery Center	WI
Wayland Square Surgicare Acquisition, L.P.	Wayland Square Sugicare	RI
Wayland Square Surgicare GP, Inc.		RI
West Coast Endoscopy Holdings, LLC		DE
Winter Park Surgery Center, L.P.	Physician's Surgical Care Center	TN
Winter Park, LLC		TN

Exhibit 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statement on Form S-8 (No. 333-192459) of Surgical Care Affiliates, Inc. of our report dated March 24, 2014 relating to the consolidated financial statements of Surgical Care Affiliates, Inc., which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP
Birmingham, Alabama
March 24, 2014

Exhibit 23.2

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statement on Form S-8 (No. 333-192459) of Surgical Care Affiliates, Inc. of our report dated March 24, 2014 relating to the consolidated financial statements of ASC Operators, LLC, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP
Birmingham, Alabama
March 24, 2014

Exhibit 24.1

SURGICAL CARE AFFILIATES, INC.
DIRECTOR'S POWER OF ATTORNEY

KNOW ALL PERSONS BY THESE PRESENTS, that the undersigned Director of Surgical Care Affiliates, Inc., a Delaware corporation (the "Company"), by his execution hereof or upon an identical counterpart hereof, does hereby constitute and appoint Andrew Hayek, Peter Clemens and Richard L. Sharff, Jr., and each or any of them, his true and lawful attorneys-in-fact and agents, with full power of substitution, to do any and all acts and things and to execute any and all instruments that said attorneys-in-fact and agents, or any of them, may deem necessary or advisable or may be required:

To enable the Company to comply with the Securities Exchange Act of 1934, as amended (the "1934 Act"), and any rules, regulations or requirements of the Securities and Exchange Commission (the "Commission") in respect thereof, in connection with the filing under the 1934 Act of the Company's Annual Report on Form 10-K for the year ended December 31, 2013 (the "2013 Annual Report"), including specifically, but without limiting the generality of the foregoing, power and authority to sign the name of the undersigned in the capacity of Director of the Company to the 2013 Annual Report to be filed with the Commission and to any instruments or documents filed as part of or in connection with the 2013 Annual Report, including any amendments or supplements thereto and granting unto each of said attorneys-in-fact and agents full power and authority to do and perform each and every act and thing requisite and necessary to be done, as fully to all intents and purposes as the undersigned might or could do in person, and the undersigned hereby ratifies and confirms all that said attorneys-in-fact and agents, or any of them, shall do or cause to be done by virtue hereof.

This power of attorney will be governed by and construed in accordance with the laws of the Delaware. The execution of this power of attorney is not intended to, and does not, revoke any prior powers of attorney.

IN WITNESS WHEREOF, the undersigned has hereunto set his hand this 18th day of March, 2014.

/s/ Thomas C. Geiser
Thomas C. Geiser
Director

SURGICAL CARE AFFILIATES, INC.
DIRECTOR'S POWER OF ATTORNEY

KNOW ALL PERSONS BY THESE PRESENTS, that the undersigned Director of Surgical Care Affiliates, Inc., a Delaware corporation (the "Company"), by his execution hereof or upon an identical counterpart hereof, does hereby constitute and appoint Andrew Hayek, Peter Clemens and Richard L. Sharff, Jr., and each or any of them, his true and lawful attorneys-in-fact and agents, with full power of substitution, to do any and all acts and things and to execute any and all instruments that said attorneys-in-fact and agents, or any of them, may deem necessary or advisable or may be required:

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This power of attorney will be governed by and construed in accordance with the laws of the Delaware. The execution of this power of attorney is not intended to, and does not, revoke any prior powers of attorney.

IN WITNESS WHEREOF, the undersigned has hereunto set his hand this 17th day of March, 2014.

/s/ Sharad Mansukani, M.D.
Sharad Mansukani, M.D.
Director

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SURGICAL CARE AFFILIATES, INC.
DIRECTOR'S POWER OF ATTORNEY

KNOW ALL PERSONS BY THESE PRESENTS, that the undersigned Director of Surgical Care Affiliates, Inc., a Delaware corporation (the "Company"), by his execution hereof or upon an identical counterpart hereof, does hereby constitute and appoint Andrew Hayek, Peter Clemens and Richard L. Sharff, Jr., and each or any of them, his true and lawful attorneys-in-fact and agents, with full power of substitution, to do any and all acts and things and to execute any and all instruments that said attorneys-in-fact and agents, or any of them, may deem necessary or advisable or may be required:

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This power of attorney will be governed by and construed in accordance with the laws of the Delaware. The execution of this power of attorney is not intended to, and does not, revoke any prior powers of attorney.

IN WITNESS WHEREOF, the undersigned has hereunto set his hand this 19th day of March, 2014.

/s/ Todd B. Sisitsky
Todd B. Sisitsky
Director

SURGICAL CARE AFFILIATES, INC.
DIRECTOR'S POWER OF ATTORNEY

KNOW ALL PERSONS BY THESE PRESENTS, that the undersigned Director of Surgical Care Affiliates, Inc., a Delaware corporation (the "Company"), by his execution hereof or upon an identical counterpart hereof, does hereby constitute and appoint Andrew Hayek, Peter Clemens and Richard L. Sharff, Jr., and each or any of them, his true and lawful attorneys-in-fact and agents, with full power of substitution, to do any and all acts and things and to execute any and all instruments that said attorneys-in-fact and agents, or any of them, may deem necessary or advisable or may be required:

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This power of attorney will be governed by and construed in accordance with the laws of the Delaware. The execution of this power of attorney is not intended to, and does not, revoke any prior powers of attorney.

IN WITNESS WHEREOF, the undersigned has hereunto set his hand this 17th day of March, 2014.

/s/ Jeffrey K. Rhodes
Jeffrey K. Rhodes
Director

SURGICAL CARE AFFILIATES, INC.
DIRECTOR'S POWER OF ATTORNEY

KNOW ALL PERSONS BY THESE PRESENTS, that the undersigned Director of Surgical Care Affiliates, Inc., a Delaware corporation (the "Company"), by his execution hereof or upon an identical counterpart hereof, does hereby constitute and appoint Andrew Hayek, Peter Clemens and Richard L. Sharff, Jr., and each or any of them, his true and lawful attorneys-in-fact and agents, with full power of substitution, to do any and all acts and things and to execute any and all instruments that said attorneys-in-fact and agents, or any of them, may deem necessary or advisable or may be required:

To enable the Company to comply with the Securities Exchange Act of 1934, as amended (the "1934 Act"), and any rules, regulations or requirements of the Securities and Exchange Commission (the "Commission") in respect thereof, in connection with the filing under the 1934 Act of the Company's Annual Report on Form 10-K for the year ended December 31, 2013 (the "2013 Annual Report"), including specifically, but without limiting the generality of the foregoing, power and authority to sign the name of the undersigned in the capacity of Director of the Company to the 2013 Annual Report to be filed with the Commission and to any instruments or documents filed as part of or in connection with the 2013 Annual Report, including any amendments or supplements thereto and granting unto each of said attorneys-in-fact and agents full power and authority to do and perform each and every act and thing requisite and necessary to be done, as fully to all intents and purposes as the undersigned might or could do in person, and the undersigned hereby ratifies and confirms all that said attorneys-in-fact and agents, or any of them, shall do or cause to be done by virtue hereof.

This power of attorney will be governed by and construed in accordance with the laws of the Delaware. The execution of this power of attorney is not intended to, and does not, revoke any prior powers of attorney.

IN WITNESS WHEREOF, the undersigned has hereunto set his hand this 19th day of March, 2014.

/s/ Curtis S. Lane
Curtis S. Lane
Director

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SURGICAL CARE AFFILIATES, INC.
DIRECTOR'S POWER OF ATTORNEY

KNOW ALL PERSONS BY THESE PRESENTS, that the undersigned Director of Surgical Care Affiliates, Inc., a Delaware corporation (the "Company"), by his execution hereof or upon an identical counterpart hereof, does hereby constitute and appoint Andrew Hayek, Peter Clemens and Richard L. Sharff, Jr., and each or any of them, his true and lawful attorneys-in-fact and agents, with full power of substitution, to do any and all acts and things and to execute any and all instruments that said attorneys-in-fact and agents, or any of them, may deem necessary or advisable or may be required:

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This power of attorney will be governed by and construed in accordance with the laws of the Delaware. The execution of this power of attorney is not intended to, and does not, revoke any prior powers of attorney.

IN WITNESS WHEREOF, the undersigned has hereunto set his hand this 21st day of March, 2014.

/s/ Frederick A. Hessler
Frederick A. Hessler
Director

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Exhibit 31.1

CERTIFICATION OF CHIEF EXECUTIVE OFFICER PURSUANT TO RULE 13a-14(a) OR RULE 15d-14(a) OF THE SECURITIES EXCHANGE ACT OF 1934, AS AMENDED

I, Andrew P. Hayek, certify that:

1. I have reviewed this Annual Report on Form 10-K of Surgical Care Affiliates, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (c) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: March 24, 2014

/s/ Andrew P. Hayek

Andrew P. Hayek
Chief Executive Officer

Exhibit 31.2

CERTIFICATION OF CHIEF FINANCIAL OFFICER PURSUANT TO RULE 13a-14(a) OR RULE 15d-14(a) OF THE SECURITIES EXCHANGE ACT OF 1934, AS AMENDED

I, Peter J. Clemens, certify that:

1. I have reviewed this Annual Report on Form 10-K of Surgical Care Affiliates, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) for the registrant and have:
   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   (b) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   (c) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: March 24, 2014

/s/ Peter J. Clemens
Peter J. Clemens
Chief Financial Officer

Exhibit 32.1

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350

Pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, the undersigned officer of Surgical Care Affiliates, Inc. (the "Company"), does hereby certify that the Annual Report on Form 10-K for the year ended December 31, 2013 of the Company fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934 and that the information contained in the Annual Report on Form 10-K fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: March 24, 2014

/s/ Andrew P. Hayek

Andrew P. Hayek
Chief Executive Officer

Exhibit 32.2

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350

Pursuant to 18 U.S.C §1350, as adopted pursuant to §906 of the Sarbanes-Oxley Act of 2002, the undersigned officer of Surgical Care Affiliates, Inc. (the "Company"), does hereby certify that the Annual Report on Form 10-K for the year ended December 31, 2013 of the Company fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934 and that the information contained in the Annual Report on Form 10-K fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: March 24, 2014

/s/ Peter J. Clemens

Peter J. Clemens
Chief Financial Officer