UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-Q

(Mark One)

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

For the quarterly period ended June 30, 2017

or

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

Commission file number: 001-37576

Surgery Partners, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**47-3620923**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

40 Burton Hills Boulevard, Suite 500
Nashville, Tennessee 37215
(Address of principal executive offices and zip code)
(615) 234-5900
(Registrant's telephone number, including area code)

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

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer o	Accelerated filer x
Non-accelerated filer o	Smaller reporting company o
(Do not check if a smaller reporting company)	Emerging growth company o

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. o

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

As of August 9, 2017, there were 48,811,091 shares of the registrant's common stock outstanding.

SURGERY PARTNERS, INC.
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PART 1 - FINANCIAL INFORMATION

Item 1. Financial Statements

SURGERY PARTNERS, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
(Unaudited, amounts in thousands, except shares and per share amounts)

	June 30, 2017	December 31, 2016
ASSETS		
Current assets:		
Cash and cash equivalents	$ 57,034	$ 69,699
Accounts receivable, less allowance for doubtful accounts of $31,465 and $29,872, respectively	215,294	220,594
Inventories	29,680	28,777
Prepaid expenses and other current assets	42,332	32,014
Acquisition escrow deposit	7,971	10,871
Total current assets	352,311	361,955
Property and equipment, net	205,744	204,253
Intangible assets, net	43,421	48,023
Goodwill	1,569,408	1,555,204
Investments in and advances to affiliates	34,488	34,980
Restricted invested assets	315	315
Long-term deferred tax assets	80,166	83,793
Financing escrow asset	370,000	—
Other long-term assets	15,634	16,435
Total assets	$ 2,671,487	$ 2,304,958
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable	$ 48,210	$ 49,766
Accrued payroll and benefits	27,437	29,273
Acquisition escrow liability	7,971	10,871
Other current liabilities	72,465	68,993
Current maturities of long-term debt	29,919	27,822
Total current liabilities	186,002	186,725
Long-term debt, less current maturities	1,795,265	1,414,421
Long-term tax receivable agreement liability	122,351	122,351
Other long-term liabilities	76,101	76,266
Non-controlling interests—redeemable	176,252	180,521
Stockholders' equity:		
Preferred stock, $0.01 par value, 20,000,000 shares authorized, no shares issued or outstanding	—	—
Common stock, $0.01 par value, 300,000,000 shares authorized, 48,810,075 shares issued and outstanding at June 30, 2017; 48,488,616 shares issued and outstanding at December 31, 2016	488	485
Additional paid-in capital	324,340	320,543
Retained deficit	(318,576)	(311,351)
Total Surgery Partners, Inc. stockholders' equity	6,252	9,677
Non-controlling interests—non-redeemable	309,264	314,997
Total stockholders' equity	315,516	324,674
Total liabilities and stockholders' equity	$ 2,671,487	$ 2,304,958

See notes to unaudited condensed consolidated financial statements.

SURGERY PARTNERS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
(Unaudited, amounts in thousands, except shares and per share amounts)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	**2016**	**2017**	**2016**
Revenues	$ 288,353	$ 289,681	$ 574,536	$ 556,755
Operating expenses:				
Salaries and benefits	90,022	93,791	179,909	180,677
Supplies	74,084	66,915	145,244	130,577
Professional and medical fees	22,577	20,304	43,702	39,957
Lease expense	13,674	13,074	27,300	25,508
Other operating expenses	16,095	14,768	32,245	28,836
Cost of revenues	216,452	208,852	428,400	405,555
General and administrative expenses [1]	18,655	15,023	34,196	27,220
Depreciation and amortization	11,417	9,702	22,525	19,271
Provision for doubtful accounts	5,788	3,544	11,463	7,417
Income from equity investments	(1,052)	(1,082)	(2,252)	(1,840)
Loss on disposal or impairment of long-lived assets, net	405	1,331	1,601	1,125
Gain on litigation settlement	(3,794)	—	(3,794)	—
Loss on debt refinancing	—	—	—	8,281
Merger transaction and integration costs	2,904	1,325	3,241	4,497
Electronic health records incentive income	(161)	(2)	(302)	(95)
Other expense (income)	—	40	(2)	97
Total operating expenses	250,614	238,733	495,076	471,528
Operating income	37,739	50,948	79,460	85,227
Interest expense, net	(25,600)	(26,235)	(50,782)	(48,388)
Income before income taxes	12,139	24,713	28,678	36,839
Income tax expense	512	2,420	2,629	4,190
Net income	11,627	22,293	26,049	32,649
Less: Net income attributable to non-controlling interests	(16,098)	(20,173)	(33,274)	(37,720)
Net (loss) income attributable to Surgery Partners, Inc.	$ (4,471)	$ 2,120	$ (7,225)	$ (5,071)
Net (loss) income per share attributable to common stockholders				
Basic	$ (0.09)	$ 0.04	$ (0.15)	$ (0.11)
Diluted [2]	$ (0.09)	$ 0.04	$ (0.15)	$ (0.11)
Weighted average common shares outstanding				
Basic	48,145,729	48,019,652	48,112,909	48,018,228
Diluted [2]	48,145,729	48,129,041	48,112,909	48,018,228

[1] Includes contingent acquisition compensation expense of $1.8 million and $1.5 million for the three months ended June 30, 2017 and 2016, respectively, and $3.8 million and $1.5 million for the six months ended June 30, 2017 and 2016, respectively.
[2] The impact of potentially dilutive securities for the three and six months ended June 30, 2017 and the six months ended June 30, 2016 was not considered because the effect would be anti-dilutive in those periods.

See notes to unaudited condensed consolidated financial statements.

SURGERY PARTNERS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)
(Unaudited, amounts in thousands)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	**2016**	**2017**	**2016**
Net income	$ 11,627	$ 22,293	$ 26,049	$ 32,649
Other comprehensive income	—	—	—	—
Comprehensive income	$ 11,627	$ 22,293	$ 26,049	$ 32,649
Less: Comprehensive income attributable to non-controlling interests	(16,098)	(20,173)	(33,274)	(37,720)
Comprehensive (loss) income attributable to Surgery Partners, Inc.	$ (4,471)	$ 2,120	$ (7,225)	$ (5,071)

See notes to unaudited condensed consolidated financial statements.

SURGERY PARTNERS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(Unaudited, amounts in thousands, except shares)

	Common Stock		Additional Paid-in Capital	Retained Deficit	Non-Controlling Interests—Non-Redeemable	Total
	Shares	Amount				
Balance as of December 31, 2016	48,488,616	$ 485	$ 320,543	$ (311,351)	$ 314,997	$ 324,674
Net (loss) income	—	—	—	(7,225)	26,165	18,940
Issuance of restricted stock, net of forfeitures	354,058	3	(3)	—	—	—
Equity-based compensation	—	—	2,069	—	—	2,069
Cancellation of restricted shares	(32,599)	—	(658)	—	—	(658)
Acquisition and disposal of shares of non-controlling interests, net	—	—	2,389	—	(3,238)	(849)
Distributions to non-controlling interests—non-redeemable holders	—	—	—	—	(28,660)	(28,660)
Balance as of June 30, 2017	48,810,075	$ 488	$ 324,340	$ (318,576)	$ 309,264	$ 315,516

See notes to unaudited condensed consolidated financial statements.

SURGERY PARTNERS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(Unaudited, amounts in thousands)

	Six Months Ended June 30,	
	2017	**2016**
Cash flows from operating activities:		
Net income	$ 26,049	$ 32,649
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	22,525	19,271
Amortization of debt issuance costs and discounts	3,774	3,348
Amortization of unfavorable lease liability	(162)	(216)
Equity-based compensation	2,069	635
Loss on disposal or impairment of long-lived assets, net	1,601	1,125
Loss on debt refinancing	—	8,281
Deferred income taxes	1,894	3,890
Provision for doubtful accounts	11,463	7,417
Income from equity investments, net of distributions received	487	(611)
Changes in operating assets and liabilities, net of acquisitions and divestitures:		
Accounts receivable	(5,699)	(25,902)
Other operating assets and liabilities	(7,530)	24,150
Net cash provided by operating activities	56,471	74,037
Cash flows from investing activities:		
Purchases of property and equipment, net	(15,102)	(20,350)
Payments for acquisitions, net of cash acquired	(14,163)	(113,017)
Proceeds from divestitures	70	—
Net cash used in investing activities	(29,195)	(133,367)
Cash flows from financing activities:		
Principal payments on long-term debt	(113,364)	(424,348)
Borrowings of long-term debt	119,778	525,422
Payments of debt issuance costs	(941)	(12,555)
Lender financing escrow fee	(6,591)	—
Penalty on prepayment of debt	—	(4,900)
Distributions to non-controlling interest holders	(36,841)	(32,362)
(Payments) receipts related to ownership transactions with non-controlling interest holders	(745)	573
Financing lease obligation	(579)	(390)
Other financing activities	(658)	1,556
Net cash (used in) provided by financing activities	(39,941)	52,996
Net decrease in cash and cash equivalents	(12,665)	(6,334)
Cash and cash equivalents at beginning of period	69,699	57,933
Cash and cash equivalents at end of period	$ 57,034	$ 51,599

See notes to unaudited condensed consolidated financial statements.

SURGERY PARTNERS, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2017
(Unaudited)

1. Organization

Surgery Partners, Inc., a Delaware corporation (together with its subsidiaries, the "Company"), was formed on April 2, 2015, as a holding company for the purpose of facilitating an initial public offering (the "IPO") of shares of common stock. Prior to September 30, 2015, the Company conducted business through Surgery Center Holdings, Inc. and its subsidiaries. Surgery Center Holdings, LLC was and is the sole indirect owner of the equity interests of Surgery Center Holdings, Inc. and has no other material assets. On October 1, 2015, the Company completed its IPO of 14,285,000 shares of common stock at an offering price of $19.00 per share.

On September 30, 2015, Surgery Partners, Inc. became the direct parent and sole member of Surgery Center Holdings, LLC (the "Reorganization"). In the Reorganization, all of the equity interests held by the pre-IPO owners of Surgery Center Holdings, LLC were contributed to Surgery Partners, Inc. in exchange for 33,871,990 shares of common stock of Surgery Partners, Inc. and certain rights to additional payments under a tax receivable agreement. After giving effect to the Reorganization, Surgery Partners, Inc. is a holding company, and its sole material asset is an equity interest in Surgery Center Holdings, LLC.

On May 9, 2017, the Company entered into a series of transactions pursuant to which the Company agreed (i) to acquire NSH Holdco, Inc. ("NSH"), an owner and operator of surgical facilities, for approximately $760 million through a merger of SP Merger Sub, Inc., a wholly owned subsidiary of the Company, with and into NSH (the "NSH Merger"), pursuant to an Agreement and Plan of Merger, by and among the Company, SP Merger Sub, Inc., NSH, and IPC / NSH, L.P., solely in its capacity as sellers' representative (as amended by that certain Letter Amendment, dated July 7, 2017, the "NSH Merger Agreement") and (ii) to issue to BCPE Seminole Holdings LP ("Bain Capital"), an affiliate of Bain Capital Private Equity, up to 320,000 shares of the Company's preferred stock, par value $0.01 per share, to be created out of the authorized and unissued shares of the Company's preferred stock and designated as 10.00% Series A Convertible Perpetual Participating Preferred Stock at a purchase price per share of $1,000 (the "Preferred Private Placement"), pursuant to a Securities Purchase Agreement by and among the Company and Bain Capital (the "Preferred Purchase Agreement"). In connection with the NSH Merger and the Preferred Private Placement, on May 9. 2017, the Company also entered into (i) a Stock Purchase Agreement, by and among the Company, H.I.G. Surgery Centers, LLC ("H.I.G."), the Company's controlling stockholder, H.I.G. Bayside Debt & LBO Fund II L.P. (for the purposes stated therein) and Bain Capital (the "Common Stock Purchase Agreement"), pursuant to which H.I.G. agreed to sell all of its 26,455,651 shares of the Company's common stock to Bain Capital at a purchase price per share of $19.00 (together with the NSH Merger and the Preferred Private Placement, the "Transactions") and (ii) an amendment to that certain Income Tax Receivable Agreement, dated September 30, 2015, by and between the Company, H.I.G. (in its capacity as the Stockholders Representative) and the other parties referred to therein (the "TRA Amendment"). The Transactions have not yet been consummated and the TRA Amendment has not yet become effective. Following the consummation of the Transactions, NSH will be a wholly-owned subsidiary of the Company, and Bain Capital will be the controlling stockholder of the Company.

As of June 30, 2017, the Company owned and operated a national network of surgical facilities and ancillary services in 29 states. The surgical facilities, which include ambulatory surgery centers ("ASCs") and surgical hospitals, primarily provide non-emergency surgical procedures across many specialties, including, among others, gastroenterology ("GI"), general surgery, ophthalmology, orthopedics and pain management. The Company's surgical hospitals provide services such as diagnostic imaging, laboratory, obstetrics, oncology, pharmacy, physical therapy and wound care. Ancillary services are comprised of a diagnostic laboratory, multi-specialty physician practices, urgent care facilities, anesthesia services, optical services and specialty pharmacy services.

As of June 30, 2017, the Company owned or operated a portfolio of 103 surgical facilities, comprised of 98 ASCs and five surgical hospitals. The Company owns these facilities in partnership with physicians and, in some cases, healthcare systems in the markets and communities it serves. The Company owned a majority interest in 73 of the surgical facilities and consolidated 93 of these facilities for financial reporting purposes. In addition, the Company owned or operated a network of 59 physician practices.

The foregoing description of the Transactions, the NSH Merger Agreement, the Preferred Purchase Agreement, the Common Stock Purchase Agreement and the TRA Amendment do not purport to be complete and is subject to, and qualified in its entirety by, the full text of the respective agreements and any amendments thereto, copies of which are filed as Exhibit 2.1, Exhibit 10.1, Exhibit 10.2 and Exhibit 10.3, respectively, to the Company's Current Report on Form 8-K filed with the SEC on May 11, 2017. A copy of the amendment to the NSH Merger Agreement is filed as Exhibit 2.1 to the Company's Current Report on Form 8-K filed with the SEC on July 11, 2017.

2. Significant Accounting Policies

Principles of Consolidation

The condensed consolidated financial statements include the accounts of the Company and its wholly-owned subsidiaries, as well as interests in partnerships and limited liability companies controlled by the Company through its ownership of a majority voting interest or other rights granted to the Company by contract to manage and control the affiliate's business. All significant intercompany balances and transactions are eliminated in consolidation.

The accompanying condensed consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("GAAP") for interim financial information. Accordingly, they do not include all of the information and notes required by GAAP for complete financial statements. In the opinion of management, all adjustments (consisting of normal recurring adjustments) considered necessary for fair presentation of the Company's financial position and results of operations have been included. The Company's fiscal year ends on December 31 and interim results are not necessarily indicative of results for a full year or any other interim period. The condensed

consolidated balance sheet at December 31, 2016 has been derived from the audited financial statements as of that date. The information contained in these condensed consolidated financial statements should be read in conjunction with the Company's consolidated financial statements and notes thereto for the fiscal year ended December 31, 2016. The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the condensed consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Non-Controlling Interests

The physician limited partners and physician minority members of the entities that the Company controls are responsible for the supervision and delivery of medical services. The governance rights of limited partners and minority members are restricted to those that protect their financial interests. Under certain partnership and operating agreements governing these partnerships and limited liability companies, the Company could be removed as the sole general partner or managing member for certain events such as material breach of the partnership or operating agreement, gross negligence or bankruptcy. These protective rights do not preclude consolidation of the respective partnerships and limited liability companies.

Ownership interests in consolidated subsidiaries held by parties other than the Company are identified and generally presented in the condensed consolidated financial statements within the equity section but separate from the Company's equity. However, in instances in which certain redemption features that are not solely within the control of the Company are present, classification of non-controlling interests outside of permanent equity is required. Consolidated net income attributable to the Company and to the non-controlling interests are identified and presented on the condensed consolidated statements of operations; changes in ownership interests in which the Company retains a controlling interest are accounted for as equity transactions assuming the Company continues to consolidate related entities. Certain transactions with non-controlling interests are classified within financing activities in the condensed consolidated statements of cash flows.

The condensed consolidated financial statements of the Company include all assets, liabilities, revenues and expenses of surgical facilities in which the Company has sufficient ownership and rights to allow the Company to consolidate the surgical facilities. Similar to its investments in non-consolidated affiliates, the Company regularly engages in the purchase and sale of ownership interests with respect to its consolidated subsidiaries that do not result in a change of control.

Non-Controlling Interests — Redeemable. Each of the partnerships and limited liability companies through which the Company owns and operates its surgical facilities is governed by a partnership or operating agreement. In certain circumstances, the partnership and operating agreements for the Company's surgical facilities provide that the facilities will purchase all of the physicians' ownership if certain adverse regulatory events occur, such as it becoming illegal for the physicians to own an interest in a surgical facility, refer patients to a surgical facility or receive cash distributions from a surgical facility. The non-controlling interests - redeemable are reported outside of stockholders' equity in the condensed consolidated balance sheets.

A summary of activity related to the non-controlling interests—redeemable follows (in thousands):

Balance at December 31, 2016	$	180,521
Net income attributable to non-controlling interests—redeemable		7,109
Acquisition and disposal of shares of non-controlling interests, net—redeemable		(3,197)
Distributions to non-controlling interest—redeemable holders		(8,181)
Balance at June 30, 2017	$	176,252

Variable Interest Entities

The condensed consolidated financial statements include the accounts of variable interest entities in which the Company is the primary beneficiary under the provisions of Accounting Standards Codification Topic ("ASC") 810, *Consolidation*. As of June 30, 2017, the variable interest entities include five surgical facilities, three anesthesia practices and three physician practices. At December 31, 2016, the variable interest entities included five surgical facilities, three anesthesia practices and two physician practices. The change is due to a physician practice acquired during the three months ended June 30, 2017. The Company has the power to direct the activities that most significantly impact the variable interest entity's economic performance. Additionally, the Company would absorb the majority of the expected losses of these entities should they occur. As of June 30, 2017 and December 31, 2016, the condensed consolidated balance sheets of the Company included total assets of $93.3 million and $99.5 million, respectively, and total liabilities of $9.5 million and $10.7 million, respectively, related to the Company's variable interest entities.

Equity Method Investments

The Company has non-consolidating investments in surgical facilities and management companies that own or manage surgical facilities. These investments are accounted for using the equity method of accounting. The total amount of these investments included in investments in and advances to affiliates in the condensed consolidated balance sheets was $34.5 million and $35.0 million as of June 30, 2017 and December 31, 2016, respectively.

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the condensed consolidated financial statements and footnotes. Examples include, but are not limited to, estimates of accounts receivable allowances, professional and general liabilities and the estimate of deferred tax assets or liabilities. In the opinion of

management, all adjustments considered necessary for a fair presentation have been included. All adjustments are of a normal, recurring nature. Actual results could differ from those estimates.

Fair Value of Financial Instruments

The fair value of a financial instrument 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. The Company uses fair value measurements based on quoted prices in active markets for identical assets or liabilities (Level 1), inputs other than quoted prices in active markets that are either directly or indirectly observable (Level 2), or unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions (Level 3), depending on the nature of the item being valued.

The carrying amounts reported in the condensed consolidated balance sheets for cash and cash equivalents, accounts receivable, restricted invested assets and accounts payable approximate their fair values.

A summary of the carrying amounts and fair values of the Company's long-term debt follows (in thousands):

	Carrying Amount		Fair Value	
	June 30, 2017	December 31, 2016	June 30, 2017	December 31, 2016
2014 First Lien Credit Agreement, net of debt issuance costs and discount	$ 909,410	$ 911,784	$ 911,120	$ 917,528
Senior Unsecured Notes due 2021, net of debt issuance costs and discount	$ 389,095	$ 387,942	$ 420,223	$ 412,189
Senior Unsecured Notes due 2025, net of debt issuance costs	$ 367,100	$ —	$ 367,100	$ —
2014 Revolver Loan	$ 91,000	$ 85,000	$ 91,000	$ 85,000

The fair values of the 2014 First Lien Credit Agreement and the 2021 Unsecured Notes (in each case, as defined in Note 4, "Long-Term Debt") were based on a Level 2 computation using quoted prices for identical liabilities in inactive markets at June 30, 2017 and December 31, 2016, as applicable. The carrying amounts related to the Company's other long-term debt obligations, including the 2025 Unsecured Notes issued on June 30, 2017 and the 2014 Revolver Loan (in each case, as defined in Note 4, "Long-Term Debt"), approximate their fair values.

The Company maintains a supplemental executive retirement savings plan (the "SERP") for certain executive officers. The SERP is a non-qualified deferred compensation plan for eligible executive officers and other key employees of the Company that allows participants to defer portions of their compensation. The fair value of the SERP asset and liability was based on a quoted market price, or a Level 1 computation. As of June 30, 2017 and December 31, 2016, the fair value of the assets in the SERP were $1.8 million and $1.7 million, respectively, and were included in other long-term assets in the condensed consolidated balance sheets. The Company had a liability related to the SERP of $1.8 million and $1.7 million as of June 30, 2017 and December 31, 2016, respectively, which was included in other long-term liabilities in the condensed consolidated balance sheets.

Revenues

The Company recognizes revenues in the period in which the services are performed. Patient service revenues and receivables from third-party payors are recorded net of estimated contractual adjustments and allowances, which the Company estimates based on the historical trend of its cash collections and contractual write-offs, accounts receivable agings, established fee schedules, contracts with payors and procedure statistics.

A summary of revenues by service type as a percentage of total revenues follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Patient service revenues:				
Surgical facilities revenues	90.5%	90.0%	90.1%	90.6%
Ancillary services revenues	7.9%	7.7%	8.3%	7.2%
	98.4%	97.7%	98.4%	97.8%
Other service revenues:				
Optical services revenues	1.0%	1.2%	1.0%	1.3%
Other	0.6%	1.1%	0.6%	0.9%
	1.6%	2.3%	1.6%	2.2%
Total revenues	100.0%	100.0%	100.0%	100.0%

SURGERY PARTNERS, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2017
(Unaudited)

Patient service revenues. The fee charged for healthcare procedures performed in surgical facilities varies depending on the type of service provided, but usually includes all charges for usage of an operating room, a recovery room, special equipment, medical supplies, nursing staff and medications. The fee does not normally include professional fees charged by the patient's surgeon, anesthesiologist or other attending physician, which are billed directly by such physicians to the patient or third-party payor. However, in several surgical facilities, the Company charges for anesthesia services. Ancillary service revenues include fees for patient visits to the Company's physician practices, pharmacy services and diagnostic tests ordered by physicians. Patient service revenues are recognized on the date of service, net of estimated contractual adjustments and discounts from third-party payors, including Medicare and Medicaid. Changes in estimated contractual adjustments and discounts are recorded in the period of change. During the three and six months ended June 30, 2017, the Company recognized an increase to patient service revenues as a result of changes in estimates to third-party settlements related to prior years of approximately $128,000 and $506,000, respectively.

The following table sets forth patient service revenues by type of payor and as a percentage of total patient service revenues for the Company's consolidated surgical facilities (dollars in thousands):

	Three Months Ended June 30,			
	2017		2016	
	Amount	%	Amount	%
Patient service revenues:				
Private insurance	$ 140,922	49.6%	$ 145,211	51.3%
Government	118,381	41.7%	113,971	40.2%
Self-pay	5,760	2.0%	4,766	1.7%
Other [1]	18,771	6.7%	19,263	6.8%
Total patient service revenues	$ 283,834	100.0%	$ 283,211	100.0%
Other service revenues:				
Optical service revenues	$ 2,903		$ 3,395	
Other revenues	1,616		3,075	
Total net revenues	$ 288,353		$ 289,681	

	Six Months Ended June 30,			
	2017		2016	
	Amount	%	Amount	%
Patient service revenues:				
Private insurance	$ 279,925	49.5%	$ 277,426	50.9%
Government	235,259	41.6%	219,774	40.3%
Self-pay	11,831	2.1%	8,479	1.6%
Other [1]	38,465	6.8%	39,092	7.2%
Total patient service revenues	$ 565,480	100.0%	$ 544,771	100.0%
Other service revenues:				
Optical service revenues	$ 5,724		$ 7,019	
Other revenues	3,332		4,965	
Total net revenues	$ 574,536		$ 556,755	

(1) Other is comprised of anesthesia service agreements, auto liability, letters of protection and other payor types.

Other service revenues. Optical service revenues consist of product sales from the Company's optical laboratories as well as handling charges billed to the members of the Company's optical products purchasing organization.. The Company's optical products purchasing organization negotiates volume buying discounts with optical products manufacturers. The buying discounts and any handling charges billed to the members of the buying group represent the revenue recognized for financial reporting purposes. Revenue is recognized as orders are shipped to members. The Company bases its estimates for sales returns and discounts on historical experience and has not experienced significant fluctuations between estimated and actual return activity and discounts given. The Company's optical laboratories manufacture and distribute corrective lenses and eyeglasses to ophthalmologists and optometrists. Revenue is recognized when product is shipped, net of allowance for discounts.

Other revenues include management and administrative service fees derived from the non-consolidated facilities that the Company accounts for under the equity method, management of surgical facilities in which it does not own an interest, and management services provided to physician practices for which the Company is not required to provide capital or additional assets. The fees derived from these management

arrangements are based on a predetermined percentage of the revenues of each facility or practice and are recognized in the period in which services are rendered.

Cash and Cash Equivalents

The Company considers all highly liquid investments with a maturity of three months or less when purchased to be cash equivalents. The Company maintains its cash and cash equivalent balances at high credit quality financial institutions.

Accounts Receivable and Allowances for Contractual Adjustments and Doubtful Accounts

Accounts receivable are recorded net of contractual adjustments and allowances for doubtful accounts to reflect accounts receivable at net realizable value. Accounts receivable consists of receivables from federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies, employers and patients. Management recognizes that revenues and receivables from government agencies are significant to the Company's operations, but it does not believe that there is significant credit risk associated with these government agencies. Concentration of credit risk with respect to other payors is limited because of the large number of such payors. As of June 30, 2017 and December 31, 2016, the Company had a net third-party Medicaid settlements receivable of $1.1 million and $454,000, respectively.

The Company recognizes that final reimbursement of accounts receivable is subject to final approval by each third-party payor. However, because the Company has contracts with its third-party payors and also verifies insurance coverage of the patient before medical services are rendered, the amounts that are pending approval from third-party payors are not significant. The Company's policy is to collect co-payments and deductibles prior to providing medical services. It is also the Company's policy to verify a patient’s insurance 72 hours prior to the patient’s procedure. Patient services of the Company are primarily non-emergency, which allows the surgical facilities to control the procedures for which third-party reimbursement is sought and obtained. The Company does not require collateral from self-pay patients.

The Company analyzes accounts receivable at each of its facilities to ensure the proper aged category and collection assessment. At a consolidated level, the Company's policy is to review accounts receivable aging, by facility, to determine the appropriate allowance for doubtful accounts. Patient account balances are reviewed for delinquency based on contractual terms. This review is supported by an analysis of the actual revenues, contractual adjustments and cash collections received. An account balance is written off only after the Company has pursued collection with legal or collection agency assistance or otherwise has deemed an account to be uncollectible.

The receivables related to the Company's optical products purchasing organization are recognized separately from patient accounts receivable, as discussed above, and are included in other current assets in the condensed consolidated balance sheets. Such receivables were $9.0 million and $7.0 million at June 30, 2017 and December 31, 2016, respectively.

Inventories

Inventories, which consist primarily of medical and drug supplies, are stated at the lower of cost or market value. Cost is determined using the first-in, first-out method.

Prepaid Expenses and Other Current Assets

A summary of prepaid expenses and other current assets follows (in thousands):

	June 30, 2017	December 31, 2016
Prepaid expenses	$ 19,178	$ 11,158
Receivables - optical product purchasing organization	8,964	7,042
Insurance recoveries	2,305	2,476
Other current assets	11,885	11,338
Total	$ 42,332	$ 32,014

Property and Equipment

Property and equipment are stated at cost or, if obtained through acquisition, at fair value determined on the date of acquisition. Depreciation is recognized using the straight-line method over the estimated useful lives of the assets, generally three to five years for computers and software and five to seven years for furniture and equipment. Leasehold improvements are depreciated on a straight-line basis over the shorter of the lease term or the estimated useful life of the assets. Routine maintenance and repairs are expensed as incurred, while expenditures that increase capacities or extend useful lives are capitalized.

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A summary of property and equipment follows (in thousands):

	June 30, 2017	December 31, 2016
Land	$ 8,082	$ 8,082
Buildings and improvements	123,106	118,172
Furniture and equipment	16,234	14,670
Computer and software	33,238	29,902
Medical equipment	136,149	117,418
Construction in progress	4,333	2,396
Property and equipment, at cost	321,142	290,640
Less: Accumulated depreciation	(115,398)	(86,387)
Property and equipment, net	$ 205,744	$ 204,253

The Company also leases certain facilities and equipment under capital leases. Assets held under capital leases are stated at the present value of minimum lease payments at the inception of the related lease. Such assets are depreciated on a straight-line basis over the lesser of the lease term or the remaining useful life of the leased asset. The carrying values of assets under capital lease were $15.9 million and $15.4 million as of June 30, 2017 and December 31, 2016, respectively, net of accumulated depreciation of $12.6 million and $11.6 million, respectively.

Intangible Assets

The Company has indefinite-lived intangible assets related to the certificates of need held in jurisdictions where certain of its surgical facilities are located. The Company also has finite-lived intangible assets related to physician guarantee agreements, non-compete agreements, management agreements and customer relationships. Physician income guarantees are amortized into salaries and benefits costs in the condensed consolidated statements of operations over the commitment period of the contract, generally three to four years. Non-compete agreements and management rights agreements are amortized into depreciation and amortization expense in the condensed consolidated statements of operations over the service lives of the agreements, typically ranging from 2 to 5 years for non-compete agreements and 15 years for the management rights agreements. Customer relationships are amortized into depreciation and amortization expense in the condensed consolidated statements of operations over the estimated lives of the relationships, ranging from three to ten years.

A summary of the activity related to intangible assets for the six months ended June 30, 2017 follows (in thousands):

	Physician Income Guarantees	Management Rights	Non-Compete Agreements	Certificates of Need	Customer Relationships	Other	Total Intangible Assets
Balance at December 31, 2016	$ 813	$ 21,290	$ 16,457	$ 3,780	$ 3,704	$ 1,979	$ 48,023
Additions	175	—	92	14	—	—	281
Recruitment expense	(284)	—	—	—	—	—	(284)
Amortization	—	(865)	(2,843)	—	(550)	(341)	(4,599)
Balance at June 30, 2017	$ 704	$ 20,425	$ 13,706	$ 3,794	$ 3,154	$ 1,638	$ 43,421

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Goodwill

Goodwill represents the fair value of the consideration provided in an acquisition over the fair value of net assets acquired and is not amortized. Additions to goodwill include amounts resulting from new business combinations and incremental ownership purchases in the Company's subsidiaries.

A summary of activity related to goodwill for the six months ended June 30, 2017 follows (in thousands):

Balance at December 31, 2016	$	1,555,204
Acquisitions		13,137
Divestitures		(175)
Purchase price adjustments		1,242
Balance at June 30, 2017	$	1,569,408

Impairment of Long-Lived Assets, Goodwill and Intangible Assets

The Company evaluates the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist in accordance with Accounting Standards Codification (ASC) 350, *Intangibles- Goodwill and Other*. The Company performs an impairment test by preparing an expected undiscounted cash flow projection. If the projection indicates that the recorded amount of the long-lived asset is not expected to be recovered, the carrying value is reduced to estimated fair value. The cash flow projection and fair value represents management’s best estimate, using appropriate and customary assumptions, projections and methodologies, at the date of evaluation. The Company tests its goodwill and intangible assets for impairment at least annually, or more frequently if certain indicators arise.

Restricted Invested Assets

Restricted invested assets of $315,000 as of both June 30, 2017 and December 31, 2016 were related to a requirement under the operating lease agreement at the Company's Chesterfield, Missouri facility. In accordance with the provisions of the lease agreement, the Company has a deposit with the landlord that shall be held as security for performance under the Company's covenants and obligations within the agreement through January 2024.

Other Long-Term Assets

A summary of other long-term assets follows (in thousands):

		June 30, 2017		December 31, 2016
Notes receivable	$	817	$	716
Deposits		3,284		4,196
Assets of SERP		1,834		1,725
Debt issuance costs		1,199		1,488
Insurance recoverable		6,835		6,835
Other		1,665		1,475
Total	$	15,634	$	16,435

Other Current Liabilities

A summary of other current liabilities follows (in thousands):

		June 30, 2017		December 31, 2016
Interest payable	$	11,771	$	19,206
Current taxes payable		3,408		2,622
Insurance liabilities		6,814		6,625
Amounts due to patients and payors		14,660		12,221
Tax receivable agreement liability		999		999
Contingent acquisition compensation liability		6,555		4,589
Other accrued expenses		28,258		22,731
Total	$	72,465	$	68,993

Other Long-Term Liabilities

A summary of other long-term liabilities follows (in thousands):

	June 30, 2017	December 31, 2016
Facility lease obligations	$ 51,904	$ 52,653
Medical malpractice liability	10,453	10,453
Liability of SERP	1,834	1,725
Unfavorable lease liability	1,509	1,671
Other long-term liabilities	10,401	9,764
Total	$ 76,101	$ 76,266

The Company has facility lease obligations in connection with the surgical hospital located in Idaho Falls, Idaho and with a radiation oncology building at this facility. The obligation is payable to the lessor of this facility for the land, building and improvements. The current portion of the lease obligation was $1.3 million and $1.1 million at June 30, 2017 and December 31, 2016, respectively, and was included in other current liabilities in the condensed consolidated balance sheets. The long-term portion of the lease obligation, included in the table above, was $48.3 million and $48.9 million at June 30, 2017 and December 31, 2016, respectively.

Additionally, the Company has a facility lease obligation in connection with a surgical facility in Ocala, Florida payable to the lessor of this facility for the building. The current portion of the lease obligation was $189,000 and $182,000 at June 30, 2017 and December 31, 2016, respectively, and was included in other current liabilities in the condensed consolidated balance sheets. The long-term portion of the facility lease obligation, included in the table above, was $3.6 million and $3.7 million at June 30, 2017 and December 31, 2016, respectively.

Operating Leases

The Company leases office space and equipment for its surgical facilities, including surgical facilities under development. The lease agreements generally require the lessee, or the Company, to pay all maintenance, property taxes, utilities and insurance costs. The Company accounts for operating lease obligations and sublease income on a straight-line basis. Contingent obligations of the Company, as defined by each lease agreement, are recognized when specific contractual measures have been met, typically the result of an increase in the Consumer Price Index. Lease obligations paid in advance are recorded as prepaid rent and included in prepaid expenses and other current assets on the condensed consolidated balance sheets. The difference between actual lease payments and straight-line lease expense over the initial lease term, excluding optional renewal periods, is recorded as deferred rent and included in other current liabilities and other long-term liabilities on the condensed consolidated balance sheets.

Equity-Based Compensation

Transactions in which the Company receives employee and non-employee services in exchange for the Company’s equity instruments or liabilities that are based on the fair value of the Company’s equity securities or may be settled by the issuance of these securities are accounted for using a fair value method. The Company applies the Black-Scholes-Merton method of valuation in determining share-based compensation expense for option awards.

The Company’s policy is to recognize compensation expense using the straight line method over the relevant vesting period for units that vest based on time. In connection with the Reorganization, the Company’s board of directors and stockholders adopted the Surgery Partners, Inc. 2015 Omnibus Incentive Plan from which the Company’s future equity-based awards will be granted.

Professional, General and Workers' Compensation Insurance

The Company maintains general liability and professional liability insurance in excess of self-insured retentions through third party commercial insurance carriers in amounts that management believes is sufficient for the Company's operations, although, potentially, some claims may exceed the scope of coverage in effect. The professional and general insurance coverage is on a claims-made basis. Workers' compensation insurance is on an occurrence basis.

The Company expenses the costs under the self-insured retention exposure for general and professional liability and workers compensation claims which relate to (i) claims made during the policy period, which are offset by insurance recoveries and (ii) an estimate of claims incurred but not yet reported that are expected to be reported after the policy period expires. Reserves and provisions are based upon actuarially determined estimates. The reserves are estimated using individual case-basis valuations and actuarial analysis. Reserves for professional, general and workers' compensation claim liabilities are determined with no regard for expected insurance recoveries and are presented gross on the condensed consolidated balance sheets. Total professional, general and workers' compensation claim liabilities as of June 30, 2017 and December 31, 2016 are $13.5 million and $13.8 million, respectively. The balance includes expected insurance recoveries of $9.1 million and $9.3 million as of June 30, 2017 and December 31, 2016, respectively.

Income Taxes and Tax Receivable Agreement

The Company uses the asset and liability method to account for income taxes. Under this method, deferred income tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets

and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date. If a net operating loss carryforward exists, the Company makes a determination as to whether that net operating loss ("NOL") carryforward will be utilized in the future. A valuation allowance is established for certain net operating loss carryforwards when their recoverability is deemed to be uncertain. The carrying value of the net deferred tax assets assumes that the Company will be able to generate sufficient future taxable income in certain tax jurisdictions, based on estimates and assumptions. If these estimates and related assumptions change in the future, the Company may be required to adjust its deferred tax valuation allowances.

The Company, or one or more of its subsidiaries, files income tax returns in the U.S. federal jurisdiction and various state jurisdictions. With few exceptions, the Company is no longer subject to U.S. federal income tax examinations for years prior to 2013 or state income tax examinations for years prior to 2012.

As part of the Reorganization that was effective September 30, 2015, the Company entered into a Tax Receivable Agreement (“TRA”), the terms of which required the Company to pay to its stockholders as of immediately prior to the IPO 85% of the cash savings, if any, in U.S. federal, state or local tax that the Company actually realizes (or is deemed to realize in certain circumstances) as a result of (i) certain tax attributes, including NOLs, capital losses, charitable deductions, alternative minimum tax credit carryforwards and federal and state tax credits of Surgery Partners, Inc. and its affiliates relating to taxable years ending on or before the date of the Reorganization (calculated by assuming the taxable year of the relevant entity closes on the date of the Reorganization) that are or become available to the Company and its wholly-owned subsidiaries as a result of the Reorganization, and (ii) tax benefits attributable to payments made under the TRA, together with interest accrued at a rate of LIBOR plus 300 basis points from the date the applicable tax return is due (without extension) until paid.

As described in Note 1, "Organization," on May 9, 2017, the Company entered into the TRA Amendment. The TRA Amendment, which will become effective immediately prior to (but contingent upon) the consummation of the NSH Merger, provides for a fixed payment schedule.

Prior to the effectiveness of the TRA Amendment, the amounts payable under the TRA vary depending upon a number of factors, including the amount, character and timing of the taxable income of Surgery Partners, Inc. in the future. The Company estimates the total amounts payable would be approximately $123.4 million, if the tax benefits of related deferred tax assets are ultimately realized. The amounts payable were recognized during 2015 in conjunction with the release of the Company's valuation allowance recorded against the deferred tax assets.

After the effectiveness of the TRA Amendment, the amounts payable will be related to the projected tax savings to be realized by the Company over the next five years and are not dependent on actual savings. The Company estimates that the total amounts payable under the TRA, as amended, may be as high as $120.5 million.

The Company and its subsidiaries file a consolidated federal income tax return. The partnerships, limited liability companies, and certain non-consolidated physician practice corporations file separate income tax returns. The Company's allocable portion of each partnership's and limited liability company's income or loss is included in taxable income of the Company. The remaining income or loss of each partnership and limited liability company is allocated to the other owners.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, "*Revenue from Contracts with Customers*," along with subsequent amendments, updates and an extension of the effective date (collectively the “New Revenue Standard”), which outlines a single comprehensive model for recognizing revenue and supersedes most existing revenue recognition guidance, including guidance specific to the healthcare industry. This five-step process will require significant management judgment in addition to changing the way many companies recognize revenue in their financial statements. Additionally, and among other provisions, the New Revenue Standard requires expanded quantitative and qualitative disclosures, including disclosure about the nature, amount, timing and uncertainty of revenue. The provisions of the New Revenue Standard are effective for annual periods beginning after December 15, 2017, including interim periods within those years by applying either the full retrospective method or the modified retrospective approach upon adoption. The Company will adopt this ASU on January 1, 2018. Upon the continued evaluation of the New Revenue Standard, the Company currently plans to adopt using the modified retrospective method, including providing all requisite disclosures under such method.

In preparation for the adoption of the New Revenue Standard, the Company continues to evaluate and refine its estimates of the anticipated impacts the New Revenue Standard will have on its revenue recognition policies, procedures, financial position, results of operations, cash flows, financial disclosures and control framework. Specifically, the Company is continuing to evaluate its accounting policies and internal controls under the New Revenue Standard, as well as analyzing all of the potential effects of the New Revenue Standard, particularly with respect to non-patient service revenue sources. Upon further evaluation, the Company anticipates that the majority of its provision for doubtful accounts will continue to be recognized as an operating expense rather than as a direct reduction to revenues, given the Company’s practice of assessing a patient’s ability to pay prior to or on the date of providing healthcare services.

In February 2016, the FASB issued ASU 2016-02, “*Leases*,” which will require, among other items, lessees to recognize most leases as assets and liabilities on the balance sheet. Qualitative and quantitative disclosures will be enhanced to better understand the amount, timing and uncertainty of cash flows arising from leases. This guidance is effective for financial statements issued for fiscal years beginning after December 15, 2018, and interim periods within those fiscal years, with early adoption permitted. The Company believes the primary effect of adopting the new standard will be to record right-of-use assets and obligations for current operating leases.

In March 2016, the FASB issued ASU 2016-07, "*Investments- Equity Method and Joint Ventures*," which allows investments that now meet equity method treatment that were previously accounted for under a different method to apply the equity method prospectively from the date the investment qualifies for equity method treatment. ASU 2016-07 is effective prospectively for fiscal years beginning after December 15, 2016, including interim periods within those years. Early adoption is permitted. The Company adopted this ASU on January 1, 2017. The adoption of this ASU did not have a material impact on the Company's condensed consolidated financial position, results of operations, cash flows and financial disclosures.

In August 2016, the FASB issued ASU 2016-15, "*Classification of Certain Cash Receipts and Cash Payments*," which clarifies the classification of certain cash receipts and cash payments on the statement of cash flows. ASU 2016-15 is effective retrospectively for fiscal years beginning after December 15, 2017, including interim periods within those years. Early adoption is permitted. The Company is currently evaluating the impact this new guidance may have on the condensed consolidated cash flows.

In October 2016, the FASB issued ASU 2016-17, "*Interests Held through Related Parties That Are under Common Control*," which modifies existing guidance with respect to how a decision maker that holds an indirect interest in a VIE through a common control party determines whether it is the primary beneficiary of the VIE as part of the analysis of whether the VIE would need to be consolidated. Under the ASU, a decision maker would need to consider only its proportionate indirect interest in the VIE held through a common control party. Previous guidance had required the decision maker to treat the common control party's interest in the VIE as if the decision maker held the interest itself. As a result of the ASU, in certain cases, previous consolidation conclusions may change. ASU 2016-17 is effective prospectively for fiscal years beginning after December 15, 2016, including interim periods within those years. The Company adopted this ASU on January 1, 2017. The adoption of this ASU did not have a material impact on the Company's condensed consolidated financial position, results of operations, cash flows and financial disclosures.

In November 2016, the FASB issued ASU 2016-18, "*Statement of Cash Flows: Restricted Cash*," which will require the reconciliation of restricted cash in the statement of cash flows. ASU 2016-18 is effective retrospectively for fiscal years beginning after December 15, 2017, including interim periods within those years. Early adoption is permitted. The adoption of this ASU will not have a material impact on the Company's condensed consolidated cash flows.

In January 2017, the FASB issued ASU 2017-01, "*Business Combinations – Clarifying the Definition of a Business*," which narrows the definition of a business when evaluating whether transactions should be accounted for as asset acquisition or business combination. ASU 2017-01 is effective for fiscal years beginning after December 15, 2017, including interim periods within those years. Early adoption is permitted. The Company is currently evaluating the impact this new guidance may have on the condensed consolidated financial position, results of operations and cash flows.

In January 2017, the FASB issued ASU 2017-04, "*Simplifying the Test for Goodwill Impairment*," which eliminates the requirement to calculate the implied fair value of goodwill (i.e., Step 2 of the current goodwill impairment test) to measure a goodwill impairment charge. Instead, entities will record an impairment charge based on the excess of a reporting unit's carrying amount over its fair value (i.e., measure the charge based on the current Step 1). ASU 2017-04 is effective for fiscal years beginning after December 15, 2019, including interim periods within those years. Early adoption is permitted for annual and interim periods after January 1, 2017. The Company early adopted this ASU on January 1, 2017. The adoption of ASU 2017-04 only impacts the Company's financial statements in situations where an impairment of a reporting unit's assets is determined.

3. Acquisitions and Developments

The Company accounts for its business combinations in accordance with the fundamental requirements of the acquisition method of accounting and under the premise that an acquirer can be identified for each business combination. The acquirer is the entity that obtains control of one or more businesses in the business combination and the acquisition date is the date the acquirer achieves control. The assets acquired, liabilities assumed and any non-controlling interests in the acquired business at the acquisition date are recognized at their fair values as of that date, and the direct costs incurred in connection with the business combination are recorded and expensed separately from the business combination. Acquisitions in which the Company is able to exert significant influence but does not have control are accounted for using the equity method.

2017 Transactions

During the six months ended June 30, 2017, the Company completed acquisitions in existing markets of three physician practices for a combined purchase price of $14.2 million. The acquisitions were funded through cash from operations and proceeds from the Revolver (as defined in Note 4, "Long-Term Debt").

The aggregate amounts preliminarily recognized as of the acquisition date for each major class of assets and liabilities assumed in the acquisitions closed during the six months ended June 30, 2017 are as follows:

Cash consideration	$	14,163
Fair value of non-controlling interests		105
Aggregate fair value of acquisitions		14,268
Net assets acquired:		
Accounts receivable		871
Other current assets		18
Property and equipment		622
Intangible assets		92
Accounts payable		(99)
Other current liabilities		(187)
Long-term debt		(186)
Net assets acquired		1,131
Excess of fair value over identifiable net assets acquired		13,137

The fair values assigned to certain assets and liabilities assumed by the Company have been estimated on a preliminary basis and are subject to change as new facts and circumstances emerge that were present at the date of acquisition.

4. Long-Term Debt

A summary of long-term debt follows (in thousands):

	June 30, 2017	December 31, 2016
2014 Revolver Loan	$ 91,000	$ 85,000
2014 First Lien Credit Agreement	927,250	932,000
Senior Unsecured Notes due 2021	400,000	400,000
Senior Unsecured Notes due 2025	370,000	—
Subordinated Notes	1,000	1,000
Notes payable and secured loans	52,793	42,521
Capital lease obligations	14,787	13,996
Less: unamortized debt issuance costs and discount	(31,646)	(32,274)
Total debt	1,825,184	1,442,243
Less: Current maturities	29,919	27,822
Total long-term debt	$ 1,795,265	$ 1,414,421

2014 Revolver Loan

The 2014 Revolver Loan (“Revolver”), entered into on November 3, 2014, is a revolving credit facility used for working capital, acquisitions and development activities and general corporate purposes and matures on November 3, 2019. On October 7, 2015, the Company entered into an amendment to the 2014 First Lien Credit Agreement to increase certain lenders’ commitments under the Revolver from $80.0 million to an aggregate principal amount at any time outstanding not to exceed $150.0 million.

The Company has the option of classifying borrowings under the Revolver as either Alternate Base Rate ("ABR") loans or Eurodollar ("ED") loans. The interest base rate on an ABR loan is equal to the greatest of (a) the Prime Rate in effect on such day, (b) the Federal Funds Effective Rate in effect on such day plus 0.50% and (c) the adjusted LIBO Rate for a Eurodollar Borrowing with a one-month interest period plus 1.00%. In addition to the base rate, the Company is required to pay a 3.25% margin for ABR loans. The interest base rate on an ED loan is equal to (x) the LIBO Rate for such Eurodollar borrowing in effect for such Interest Period divided by (y) One minus the Statutory Reserves (if any) for such Eurodollar Borrowing for such interest period. In addition to the base rate, the Company is required to pay a 4.25% margin for ED loans. The Company must also pay quarterly commitment fees of 0.50% per annum of the average daily unused amount of the Revolver. As of June 30, 2017, the Company's availability on the Revolver was $55.9 million (including outstanding letters of credit of $3.1 million).

The 2014 First Lien Credit Agreement governs the Revolver and contains various covenants that include limitations on the Company's indebtedness, liens, acquisitions and investments. It additionally includes the requirement that, if triggered, the Company maintain a net leverage ratio within a specified range. As of June 30, 2017, the Company was in compliance with the covenants contained in the 2014 First Lien Credit Agreement.

2014 First Lien Credit Agreement

The 2014 First Lien Credit Agreement (“2014 First Lien”), entered into on November 3, 2014, is a senior secured obligation of Surgery Center Holdings, Inc. and is guaranteed on a senior secured basis by certain subsidiaries of the Company. The 2014 First Lien matures on November 3, 2020. On March 24, 2016, Surgery Center Holdings, Inc. and certain subsidiaries of the Company entered into an amendment to the 2014 First Lien to obtain an incremental term loan in an aggregate principal amount of $80.0 million, which increased the total term loan obligation under the 2014 First Lien to $950.0 million. On September 26, 2016, the Company entered into an amendment to the 2014 First Lien to reduce the interest margins for an ABR loan to 2.75% and for an ED loan to 3.75%.

The Company has the option of classifying the 2014 First Lien as either an ABR loan or an ED loan. The interest base rate on an ABR loan is equal to the greatest of (a) the Prime Rate in effect on such day, (b) the Federal Funds Effective Rate in effect on such day plus 0.50%, and (c) the Adjusted LIBO Rate for a Eurodollar Borrowing with a one-month interest period plus 1.00%; provided that the base rate shall not be less than 2.00% per annum. In addition to the base rate, the Company is required to pay a 2.75% margin for ABR loans. The interest base rate on an ED loan is equal to (x) the LIBO Rate for such Eurodollar borrowing in effect for such Interest Period divided by (y) One minus the Statutory Reserves (if any) for such Eurodollar Borrowing for such interest period; provided that the rate shall not be less than 1.00% per annum. In addition to the base rate, the Company is required to pay a 3.75% margin for ED loans. Accrued interest is payable in arrears on a quarterly basis. Within five business days after the earlier of (i) 90 days after the end of each fiscal year or (ii) the date on which financial statements have been delivered, the Company is required to make mandatory prepayments in amounts calculated in accordance with the excess cash flow provisions of the 2014 First Lien Credit Agreement. There were no excess cash flow payments required as of June 30, 2017.

The 2014 First Lien Credit Agreement governs the 2014 First Lien and contains various covenants that include limitations on the Company's indebtedness, liens, acquisitions and investments. As of June 30, 2017, the Company was in compliance with the covenants contained in the 2014 First Lien Credit Agreement. The 2014 First Lien is collateralized by substantially all of the assets of the Company.

2014 Second Lien Credit Agreement

The 2014 Second Lien Credit Agreement (“2014 Second Lien”), entered into on November 3, 2014, was prepaid in full on March 31, 2016. The 2014 Second Lien was a senior secured obligation of Surgery Center Holdings, Inc. and was guaranteed on a senior secured basis by the Company and certain of its subsidiaries. On March 31, 2016, the Company repaid the remaining principal of the 2014 Second Lien of $252.8 million with the proceeds of the issuance of the 2021 Unsecured Notes, defined below, of which $1.3 million was accrued interest. In connection with the prepayment, the Company incurred a loss on the extinguishment of debt of $8.3 million which included the write-off of loan costs and the original issue discount and a prepayment penalty for the six months ended June 30, 2016.

Senior Unsecured Notes due 2021

Effective March 31, 2016, one of the Company's subsidiaries, Surgery Center Holdings, Inc., issued $400.0 million in gross proceeds of senior unsecured notes due April 15, 2021 (the "2021 Unsecured Notes"). The 2021 Unsecured Notes bear interest at the rate of 8.875% per year, payable semi-annually on April 15 and October 15 of each year. The 2021 Unsecured Notes are a senior unsecured obligation of Surgery Center Holdings, Inc. and are guaranteed on a senior unsecured basis by each of Surgery Center Holdings, Inc.'s existing and future domestic wholly owned restricted subsidiaries that guarantees the Revolver and the 2014 First Lien (subject to certain exceptions).

The Company may redeem up to 35% of the aggregate principal amount of the 2021 Unsecured Notes, at any time before April 15, 2018, with the net cash proceeds of certain equity offerings at a redemption price equal to 108.875% of the principal amount to be redeemed, plus accrued and unpaid interest to, but excluding, the date of redemption, provided that at least 50% of the aggregate principal amount of the 2021 Unsecured Notes remain outstanding immediately after the occurrence of such redemption and such redemption occurs within 180 days of the date of the closing of any such qualified equity offering.

The Company may redeem the 2021 Unsecured Notes, in whole or in part, at any time prior to April 15, 2018 at a price equal to 100.000% of the principal amount to be redeemed plus an applicable make-whole premium, plus accrued and unpaid interest, if any, to, but excluding, the date of redemption. The Company may redeem the 2021 Unsecured Notes, in whole or in part, at any time on or after April 15, 2018, at the redemption prices set forth below (expressed as a percentage of the principal amount to be redeemed), plus accrued and unpaid interest, if any, to the date of redemption:

April 15, 2018 to April 14, 2019	106.656%
April 15, 2019 to April 14, 2020	104.438%
April 15, 2020 and thereafter	100.000%

If Surgery Center Holdings, Inc., experiences a change in control under certain circumstances, it must offer to purchase the notes at a purchase price equal to 101.000% of the principal amount, plus accrued and unpaid interest to, but excluding, the date of repurchase.

The 2021 Unsecured Notes contain customary affirmative and negative covenants, which among other things, limit the Company's ability to incur additional debt, pay dividends, create or assume liens, effect transactions with its affiliates, guarantee payment of certain debt securities, sell assets, merge, consolidate, enter into acquisitions and effect sale and leaseback transactions.

In connection with the offering of the 2021 Unsecured Notes, the Company recorded debt issuance costs of $8.4 million.

Senior Unsecured Notes due 2025

Effective June 30, 2017, SP Finco, LLC, a wholly owned subsidiary of Surgery Center Holdings, Inc., issued $370.0 million in gross proceeds of senior unsecured notes due July 1, 2025 (the "2025 Unsecured Notes"), which gross proceeds were deposited in an escrow account (the "Escrow Account") established at Wilmington Trust, National Association (in such capacity, the "Escrow Agent") in the name of the trustee under the indenture governing the 2025 Unsecured Notes (the "2025 Unsecured Notes Indenture") on behalf of the holders of the 2025 Unsecured Notes. The 2025 Unsecured Notes bear interest at the rate of 6.750% per year, payable semi-annually on January 1 and July 1 of each year, commencing on January 1, 2018. The 2025 Unsecured Notes are a senior unsecured obligation of SP Finco, LLC.

In connection with the closing of the NSH Merger and the release of the proceeds from the Escrow Account (the "Escrow Release"), SP Finco, LLC will be merged with and into Surgery Center Holdings, Inc., with Surgery Center Holdings, Inc. surviving such merger (the "Initial Issuer Merger") and assuming the rights and obligations of SP Finco, LLC under the 2025 Unsecured Notes and the 2025 Unsecured Notes Indenture by operation of law. From and after the release of the proceeds from the Escrow Account, the Initial Issuer Merger and the consummation of the NSH Merger, the 2025 Unsecured Notes will be guaranteed on a senior unsecured basis by each of Surgery Center Holdings, Inc.'s domestic wholly owned restricted subsidiaries that guarantees Surgery Center Holdings, Inc.'s senior secured credit facilities (subject to certain exceptions).

At June 30, 2017, the Company included the escrowed proceeds as a long-term asset in its condensed consolidated balance sheets.

The Company may redeem up to 40% of the aggregate principal amount of the 2025 Unsecured Notes at any time prior to July 1, 2020, with the net cash proceeds of certain equity issuances at a redemption price equal to 106.750% of the principal amount to be redeemed, plus accrued and unpaid interest to, but excluding, the date of redemption, provided that at least 50% of the aggregate principal amount of the 2025 Unsecured Notes remain outstanding immediately after the occurrence of such redemption and such redemption occurs within 180 days of the date of the closing of the applicable equity offering.

The Company may redeem the 2025 Unsecured Notes, in whole or in part, at any time prior to July 1, 2020, at a price equal to 100.000% of the principal amount to be redeemed plus the applicable premium, plus accrued and unpaid interest, if any, to, but excluding, the date of redemption. The Company may redeem the 2025 Unsecured Notes, in whole or in part, at any time on or after July 1, 2020, at the redemption prices set forth below (expressed as a percentage of the principal amount to be redeemed), plus accrued and unpaid interest, if any, to, but excluding, the date of redemption:

July 1, 2020 to June 30, 2021	103.375%
July 1, 2021 to June 30, 2022	101.688%
July 1, 2022 and thereafter	100.000%

If the NSH Merger does not occur on or prior to the applicable date set forth in the 2025 Unsecured Notes Indenture or, if earlier, the Company notifies the Escrow Agent that the NSH Merger will not be closed, then SP Finco, LLC will be required to redeem the 2025 Unsecured Notes within three business days at a price equal to 100.000% of the initial issue price of the 2025 Unsecured Notes, plus accrued and unpaid interest, if any, to, but excluding, the date of such redemption.

If Surgery Center Holdings, Inc. experiences a change in control under certain circumstances, it must offer to purchase the 2025 Unsecured Notes at a purchase price equal to 101.000% of the principal amount, plus accrued and unpaid interest to, but excluding, the date of repurchase.

The 2025 Unsecured Notes contain customary affirmative and negative covenants, which, upon consummation of the Initial Issuer Merger, among other things, will limit the Company's ability to incur additional debt, pay dividends, create or assume liens, effect transactions with its affiliates, guarantee payment of certain debt securities, sell assets, merge, consolidate, enter into acquisitions and effect sale and leaseback transactions.

In connection with the offering of the 2025 Unsecured Notes, the Company recorded debt issuance costs of $2.9 million.

Subordinated Notes

As of June 30, 2017, the Company had a subordinated debt facility ("Subordinated Notes") of $1.0 million. The Subordinated Notes, owed to H.I.G. Surgery Centers, LLC, had a maturity date of August 4, 2017 and had the interest rate of 17.00% per annum. As described in Note 8, "Subsequent Events," on August 3, 2017 the Company redeemed the Subordinated Notes, in whole, at a price equal 100% of the $1.0 million principal amount redeemed, plus accrued and unpaid interest.

Notes Payable and Secured Loans

Certain of the Company's subsidiaries have outstanding bank indebtedness, which is collateralized by the real estate and equipment owned by the surgical facilities to which the loans were made. The various bank indebtedness agreements contain covenants to maintain certain

financial ratios and also restrict encumbrance of assets, creation of indebtedness, investing activities and payment of distributions. At June 30, 2017, the Company was in compliance with its covenants contained in the credit agreement. The Company and its subsidiaries had notes payable to financial institutions of $52.8 million and $42.5 million as of June 30, 2017 and December 31, 2016, respectively. The Company and its subsidiaries also provide a corporate guarantee of certain indebtedness of the Company's subsidiaries.

Capital Lease Obligations

The Company is liable to various vendors for several equipment leases classified as capital leases. The carrying value of the leased assets was $15.9 million and $15.4 million as of June 30, 2017 and December 31, 2016, respectively.

5. Earnings Per Share

Basic and diluted earnings per share are calculated in accordance with ASC 260, *Earnings Per Share*, based on the weighted-average number of shares outstanding in each period and dilutive stock options, unvested shares and warrants, to the extent such securities exist and have a dilutive effect on earnings per share. The following is a reconciliation of the numerator and denominator of basic and diluted earnings per share for the three and six months ended June 30, 2017 and 2016 (in thousands except share and per share amounts):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Numerator:				
Net (loss) income attributable to Surgery Partners, Inc.	$ (4,471)	$ 2,120	$ (7,225)	$ (5,071)
Denominator:				
Weighted average shares outstanding- basic	48,145,729	48,019,652	48,112,909	48,018,228
Effect of dilutive securities [1]	—	109,389	—	—
Weighted average shares outstanding- diluted	48,145,729	48,129,041	48,112,909	48,018,228
(Loss) earnings per share:				
Basic	$ (0.09)	$ 0.04	$ (0.15)	$ (0.11)
Diluted [1]	$ (0.09)	$ 0.04	$ (0.15)	$ (0.11)
Dilutive securities outstanding not included in the computation of (loss) earnings per share as their effect is antidilutive:				
Stock options	1,312	—	1,056	—
Restricted shares	209,858	—	188,342	100,560

[1] The impact of potentially dilutive securities for the three and six months ended June 30, 2017 and the six months ended June 30, 2016 was not considered because the effect would be anti-dilutive in those periods.

6. Commitments and Contingencies

Professional, General and Workers' Compensation Liability Risks

The Company is subject to claims and legal actions in the ordinary course of business, including claims relating to patient treatment, employment practices and personal injuries. To cover these claims, the Company maintains general liability and professional liability insurance in excess of self-insured retentions through third party commercial insurance carriers in amounts that management believes is sufficient for the Company's operations, although, potentially, some claims may exceed the scope of coverage in effect. The professional and general insurance coverage is on a claims-made basis. Workers' compensation insurance is on an occurrence basis. Plaintiffs in these matters may request punitive or other damages that may not be covered by insurance. The Company is not aware of any such proceedings that would have a material adverse effect on the Company's business, financial position, results of operations or liquidity.

Laws and Regulations

Laws and regulations governing the Company's business, including those relating to the Medicare and Medicaid programs, are complex and subject to interpretation. These laws and regulations govern every aspect of how the Company's surgical facilities conduct their operations, from licensing requirements to how and whether the Company's facilities may receive payments pursuant to the Medicare and Medicaid programs. Compliance with such laws and regulations can be subject to future government agency review and interpretation as well as legislative changes to such laws. Noncompliance with such laws and regulations may subject the Company to significant regulatory action including fines, penalties, and exclusion from the Medicare, Medicaid and other federal healthcare programs. From time to time, governmental regulatory agencies will conduct inquiries of the Company's practices, including, but not limited to, the Company's compliance with federal and state fraud and abuse laws, billing practices and relationships with physicians. It is the Company's current practice and future intent to cooperate fully with such inquiries. The Company is not aware of any such inquiry that would have a material adverse effect on the Company's business, financial position, results of operations or liquidity.

Acquired Facilities

The Company, through its wholly-owned subsidiaries or controlled partnerships and limited liability companies, has acquired and will continue to acquire surgical facilities with prior operating histories. Such facilities may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations, such as billing and reimbursement, fraud and abuse and similar anti-referral laws. Although the Company attempts to assure that no such liabilities exist, obtain indemnification from prospective sellers covering such matters and institute policies designed to conform centers to its standards following completion of acquisitions, there can be no assurance that the Company will not become liable for past activities that may later be asserted to be improper by private plaintiffs or government agencies. There can be no assurance that any such matter will be covered by indemnification or, if covered, that the liability sustained will not exceed contractual limits or the financial capacity of the indemnifying party.

The Company cannot predict whether federal or state statutory or regulatory provisions will be enacted that would prohibit or otherwise regulate relationships which the Company has established or may establish with other healthcare providers or have materially adverse effects on its business or revenues arising from such future actions. Management believes, however, that it will be able to adjust the Company's operations so as to be in compliance with any statutory or regulatory provision as may be applicable.

Potential Physician Investor Liability

A majority of the physician investors in the partnerships and limited liability companies which operate the Company's surgical facilities carry general and professional liability insurance on a claims-made basis. Each partnership or limited liability company may, however, be liable for damages to persons or property arising from occurrences at the surgical facilities. Although the various physician investors and other surgeons generally are required to obtain general and professional liability insurance with tail coverage that extends beyond the period of any claims-made policies, such individuals may not be able to obtain coverage in amounts sufficient to cover all potential liability. Since most insurance policies contain exclusions, the physician investors will not be insured against all possible occurrences. In the event of an uninsured or underinsured loss, the value of an investment in the partnership interests or limited liability company membership units and the amount of distributions could be adversely affected.

Contingent Consideration

Pursuant to a purchase agreement dated December 24, 2009 (“the Purchase Agreement”), the Company acquired controlling interests in 36 business entities in various Florida locations which operate freestanding ASCs and provided anesthesia and pain management services (“the 2009 Acquisition”). The Purchase Agreement provided for maximum potential contingent consideration of up to $10.0 million based on operating results subsequent to the acquisition for the period from January 1, 2010 to December 31, 2010. Pursuant to the Purchase Agreement, the contingent consideration is payable as principal under a Subordinated Promissory Note, the form of which was delivered concurrent with the Purchase Agreement. The balance has remained outstanding due to ongoing litigation as a result of a civil claim. The Company has made indemnification claims against the Seller exceeding the amount of the contingent consideration liability, which the Company has a contractual right of offset against. Based on a court order in December 2016, the Company removed the contingent consideration liability on its consolidated balance sheets at December 31, 2016. On April 20, 2017, a settlement was reached between the two parties resulting in the Company receiving $3.9 million of which $2.7 million was paid from the escrow funds set up at the time of purchase and $1.2 million was paid by the seller. During the second quarter the Company recorded a gain on litigation settlement of $3.8 million for the settlement amount, net of legal costs.

In connection with an acquisition during the three months ended June 30, 2016, pursuant to the purchase agreement, the Company must pay consideration to the prior owners of the applicable facility should the requirements for continuing employment agreed to in the purchase agreement be met. As of June 30, 2017, the Company estimates it may have to pay $15.7 million in future contingent acquisition compensation expense over the remaining performance periods. The contingent acquisition compensation expense is recognized as a component of general and administrative expense in the condensed consolidated statements of operations and was $1.8 million and $1.5 million for the three months ended June 30, 2017 and 2016, respectively and $3.8 million and $1.5 million for the six months ended June 30, 2017 and 2016, respectively.

SURGERY PARTNERS, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2017
(Unaudited)

7. Segment Reporting

A public company is required to report annual and interim financial and descriptive information about its reportable operating segments. Operating segments, as defined, are components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating decision maker, or "CODM," in deciding how to allocate resources and in assessing performance.

The Company operates in three major lines of business that are also the Company's reportable operating segments - the operation of surgical facilities, the operation of optical services and the operation of ancillary services, which includes physician practices, a diagnostic laboratory and a specialty pharmacy.

Adjusted EBITDA is the primary profit/loss metric reviewed by the CODM in making key business decisions and on allocation of resources. The segment disclosures below provide a reconciliation from adjusted EBITDA back to net income in the reported condensed consolidated financial information.

The following tables present financial information for each reportable segment (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Revenues:				
Surgical facility services	$ 262,810	$ 263,783	$ 520,960	$ 509,453
Ancillary services	22,640	22,503	47,852	40,283
Optical services	2,903	3,395	5,724	7,019
Total revenues	$ 288,353	$ 289,681	$ 574,536	$ 556,755

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Segment Adjusted EBITDA:				
Surgical facility services	$ 49,946	$ 54,311	$ 98,187	$ 99,971
Ancillary services	429	3,068	4,211	6,568
Optical services	883	849	1,659	1,728
Total segment adjusted EBITDA [(1)]	$ 51,258	$ 58,228	$ 104,057	$ 108,267
General and administrative expenses	$ (18,655)	$ (15,023)	$ (34,196)	$ (27,220)
Non-cash stock compensation expense	1,435	502	2,069	635
Contingent acquisition compensation expense	1,814	1,530	3,847	1,530
Acquisition related costs	1,203	795	1,385	1,245
Total adjusted EBITDA [(1)]	37,055	46,032	77,162	84,457
Net income attributable to non-controlling interests	16,098	20,173	33,274	37,720
Depreciation and amortization	(11,417)	(9,702)	(22,525)	(19,271)
Interest expense, net	(25,600)	(26,235)	(50,782)	(48,388)
Income tax expense	(512)	(2,420)	(2,629)	(4,190)
Non-cash stock compensation expense	(1,435)	(502)	(2,069)	(635)
Contingent acquisition compensation expense	(1,814)	(1,530)	(3,847)	(1,530)
Merger transaction, integration and practice acquisition costs [(2)]	(4,137)	(2,192)	(4,728)	(6,108)
Gain on litigation settlement	3,794	—	3,794	—
Loss on disposal or impairment of long-lived assets, net	(405)	(1,331)	(1,601)	(1,125)
Loss on debt refinancing	—	—	—	(8,281)
Total net income	$ 11,627	$ 22,293	$ 26,049	$ 32,649

[(1)] The above table reconciles adjusted EBITDA by segment to net income as reflected in the unaudited condensed consolidated statements of operations.

When the Company uses the term “Adjusted EBITDA,” it is referring to net income minus (a) net income attributable to non-controlling interests plus (b) depreciation and amortization, (c) interest expense, net, (d) income tax expense, (e) non-cash stock compensation expense, (f) contingent acquisition compensation expense, (g) merger transaction, integration and practice acquisition costs, (h) gain on litigation settlement, (i) loss on disposal or impairment of long-lived assets and (j) loss on debt

refinancing. Non-controlling interests represent the interests of third parties, such as physicians, and in some cases, healthcare systems that own an interest in surgical facilities that the Company consolidates for financial reporting purposes. Our operating strategy is to apply a market-based approach in structuring its partnerships with individual market dynamics driving the structure. The Company believes that it is helpful to investors to present Adjusted EBITDA as defined above because it excludes the portion of net income attributable to these third-party interests and clarifies for investors the Company's portion of Adjusted EBITDA generated by its surgical facilities and other operations.

The Company uses Adjusted EBITDA as a measure of liquidity. It is included because the Company believes that it provides investors with additional information about its ability to incur and service debt and make capital expenditures.

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

(2) This amount includes merger transaction and integration costs of $2.9 million and $1.3 million for the three months ended June 30, 2017 and 2016, respectively, and practice acquisition costs of $1.2 million and $867,000 for the three months ended June 30, 2017 and 2016, respectively.

This amount includes merger transaction and integration costs of $3.2 million and $4.5 million for the six months ended June 30, 2017 and 2016, respectively, and practice acquisition costs of $1.5 million and $1.6 million for the six months ended June 30, 2017 and 2016, respectively.

	June 30, 2017	December 31, 2016
Assets:		
Surgical facility services	$ 1,912,913	$ 1,914,842
Ancillary services	185,195	184,002
Optical services	23,604	22,478
Total	2,121,712	2,121,322
General and administrative	$ 549,775	$ 183,636
Total assets	$ 2,671,487	$ 2,304,958

	Six Months Ended June 30,	
	2017	2016
Supplemental Information:		
Cash purchases of property and equipment, net:		
Surgical facility services	$ 11,266	$ 14,745
Ancillary services	1,740	2,951
Optical services	68	96
Total	$ 13,074	$ 17,792
General and administrative	$ 2,028	$ 2,558
Total cash purchases of property and equipment, net	$ 15,102	$ 20,350

8. Subsequent Events

On August 3, 2017 the Company redeemed the Subordinated Notes (as defined in Note 4, "Long-Term Debt"), in whole, at a price equal 100% of the $1.0 million principal amount redeemed, plus accrued and unpaid interest.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion and analysis of our financial condition and results of operations should be read in conjunction with the condensed consolidated financial statements and related notes included elsewhere in this report and included in our Annual Report on Form 10-K for the year ended December 31, 2016. This discussion contains forward-looking statements that involve risks and uncertainties. Our actual results may differ materially from those estimated or projected in any of these forward-looking statements. Unless otherwise indicated or the context otherwise requires, references herein to the "Company", "Surgery Partners", "we", "us" and "our" refer to, (i) Surgery Center Holdings, LLC and its consolidated subsidiaries, including Surgery Center Holdings, Inc., immediately prior to the Reorganization and (ii) Surgery Partners, Inc. and its consolidated subsidiaries, including Surgery Center Holdings, LLC and Surgery Center Holdings, Inc., immediately following the Reorganization. Unless the context implies otherwise, the term "affiliates" means direct and indirect subsidiaries of Surgery Center Holdings, LLC and Surgery Partners, Inc., as applicable, and partnerships and joint ventures in which such subsidiaries are partners. The terms "facilities" or "hospitals" refer to entities owned and operated by affiliates of Surgery Partners, and the term "employees" refers to employees of affiliates of Surgery Partners.

Cautionary Note Regarding Forward-Looking Statements

This report contains forward-looking statements, which are based on our current expectations, estimates and assumptions about future events. All statements other than statements of current or historical fact contained in this report are forward-looking statements. These statements include, but are not limited to, statements regarding our future financial position, business strategy, budgets, effective tax rate, projected costs and plans and objectives of management for future operations, as well as our expectations regarding the Transactions, the benefits of the Transactions, the anticipated timing of the Transactions, the expected closing of the Transactions and the actions contingent thereon, the performance of our business and other non-historical statements. The words "anticipate," "believe," "continue," "estimate," "expect," "intend," "may," "plan," "will," and similar expressions are generally intended to identify forward-looking statements. These statements involve risks, uncertainties and other factors that may cause actual results to differ from the expectations expressed in the statements. Many of these factors are beyond our ability to control or predict. These factors include, without limitation: (i) reductions in payments from government healthcare programs and managed care organizations; (ii) inability to contract with private third-party payors; (iii) changes in our payor mix or surgical case mix; (iv) failure to maintain relationships with our physicians; (v) payor controls designed to reduce the number of surgical procedures; (vi) inability to integrate operations of acquired surgical facilities, attract new physician partners, or acquire additional surgical facilities; (vii) shortages or quality control issues with surgery-related products, equipment and medical supplies; (viii) competition for physicians, nurses, strategic relationships, acquisitions and managed care contracts; (ix) inability to enforce non-compete restrictions against our physicians; (x) material liabilities incurred as a result of acquiring surgical facilities; (xi) litigation or medical malpractice claims; (xii) changes in the regulatory, economic and other conditions of the states where our surgical facilities are located; (xiii) substantial payments we expect to be required to make under the TRA; (xiv) the risk that the regulatory approvals required for the Transactions are not obtained; (xv) the risk that other conditions to the consummation of the Transactions are not satisfied; (xvi) the occurrence of any event, change or other circumstance that could give rise to unexpected liabilities, delays or the termination of any or all of the Transactions; and (xvii) other risks and uncertainties described in this report, including under the heading "Risk Factors," and discussed from time to time in the Company's reports filed with the SEC.

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

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

Executive Overview

As of August 9, 2017, we owned and operated a national network of surgical facilities, physician practices and a suite of ancillary services in 29 states. Our surgical facilities, which include ASCs and surgical hospitals, primarily provide non-emergency surgical procedures across many specialties, including, among others, gastroenterology ("GI"), general surgery, ophthalmology, orthopedics and pain management. Our surgical hospitals provide services, such as diagnostic imaging, laboratory, obstetrics, oncology, pharmacy, physical therapy and wound care. Our portfolio of outpatient surgical facilities is complemented by our suite of ancillary services, which support our physicians in providing high quality and cost-efficient patient care. These ancillary services are comprised of a diagnostic laboratory, multi-specialty physician practices, urgent care facilities, anesthesia services, optical services and specialty pharmacy services. As a result, we believe we are well positioned to benefit from rising consumerism and payors' and patients' focus on the delivery of high quality care and superior clinical outcomes in the lowest cost and care setting.

As of August 9, 2017, we owned or operated, primarily in partnership with physicians, a portfolio of 103 surgical facilities comprised of 98 ASCs and five surgical hospitals across 29 states. We owned a majority interest in 73 of the surgical facilities and consolidated 93 of these facilities for financial reporting purposes. In addition to surgical facilities, we owned or operated a network of 59 physician practices as of August 9, 2017. For the six months ended June 30, 2017, approximately 221,000 surgical procedures were performed in our surgical facilities, generating approximately $521.0 million in revenue.

As described in Note 1 of our condensed consolidated financial statements included previously in this report, on May 9, 2017, we entered into a series of transactions pursuant to which we agreed (i) to acquire NSH Holdco, Inc. ("NSH"), an owner and operator of surgical facilities, for approximately $760 million through a merger of SP Merger Sub, Inc., a wholly owned subsidiary of the Company, with and into NSH (the

"NSH Merger"), pursuant to an Agreement and Plan of Merger, by and among the Company, SP Merger Sub, Inc., NSH, and IPC / NSH, L.P., solely in its capacity as sellers' representative (as amended by that certain Letter Amendment, dated July 7, 2017, the "NSH Merger Agreement") and (ii) to issue to BCPE Seminole Holdings LP ("Bain Capital"), an affiliate of Bain Capital Private Equity, up to 320,000 shares of our preferred stock, par value $0.01 per share, to be created out of the authorized and unissued shares of our preferred stock and designated as 10.00% Series A Convertible Perpetual Participating Preferred Stock at a purchase price per share of $1,000 (the "Preferred Private Placement"), pursuant to a Securities Purchase Agreement by and among the Company and Bain Capital. In connection with the NSH Merger and the Preferred Private Placement, on May 9, 2017, we also entered into (i) a Stock Purchase Agreement, by and among the Company, H.I.G. Surgery Centers, LLC ("H.I.G."), our controlling stockholder, H.I.G. Bayside Debt & LBO Fund II L.P. (for the purposes stated therein) and Bain Capital, pursuant to which H.I.G. agreed to sell all of its 26,455,651 shares of our common stock to Bain Capital at a purchase price per share of $19.00 (together with the NSH Merger and the Preferred Private Placement, the "Transactions") and (ii) an amendment to that certain Income Tax Receivable Agreement, dated September 30, 2015, by and between the Company, H.I.G. (in its capacity as the Stockholders Representative) and the other parties referred to therein (the "TRA Amendment"). The Transactions have not yet been consummated, and the TRA Amendment has not yet become effective. Following the consummation of the Transactions, NSH will be a wholly-owned subsidiary of the Company, and Bain Capital will be our controlling stockholder. In addition to the planned acquisition of NSH, we continue to focus on improving our same-facility performance, selectively acquiring established facilities and developing new facilities. During the six months ended June 30, 2017, we completed acquisitions of three physician practices in existing markets, for an aggregate investment of $14.2 million.

Revenues

Our revenues consist of patient service revenues and other service revenues. Patient service revenues consist of revenue from our surgical facility services and ancillary services segments. Specifically, patient service revenues include fees for surgical or diagnostic procedures performed at surgical facilities that we consolidate for financial reporting purposes, as well as for patient visits to our physician practices, anesthesia services, pharmacy services and diagnostic screens ordered by our physicians. Other service revenues consist of product sales from our optical laboratories, as well as the discounts and handling charges billed to the members of our optical products purchasing organization. Other service revenues also include management and administrative service fees derived from our non-consolidated facilities that we account for under the equity method, management of surgical facilities and physician practices in which we do not own an interest and management services we provide to physician practices for which we are not required to provide capital or additional assets.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Patient service revenues:				
Surgical facilities revenues	90.5%	90.0%	90.1%	90.6%
Ancillary services revenues	7.9%	7.7%	8.3%	7.2%
	98.4%	97.7%	98.4%	97.8%
Other service revenues:				
Optical services revenues	1.0%	1.2%	1.0%	1.3%
Other	0.6%	1.1%	0.6%	0.9%
	1.6%	2.3%	1.6%	2.2%
Total revenues	100.0%	100.0%	100.0%	100.0%

Payor Mix

The following table sets forth by type of payor the percentage of our patient service revenues generated at the surgical facilities which we consolidate for financial reporting purposes in the periods indicated:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Private insurance payors	49.6%	51.3%	49.5%	50.9%
Government payors	41.7%	40.2%	41.6%	40.3%
Self-pay payors	2.0%	1.7%	2.1%	1.6%
Other payors [(1)]	6.7%	6.8%	6.8%	7.2%
Total	100.0%	100.0%	100.0%	100.0%

(1) Other is comprised of anesthesia service agreements, auto liability, letters of protection and other payor types.

Surgical Case Mix

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Gastrointestinal	23.7%	22.3%	23.4%	21.9%
General surgery	2.3%	2.4%	2.3%	2.4%
Ophthalmology	28.8%	29.8%	28.6%	29.8%
Orthopedic and pain management	32.7%	31.6%	33.2%	31.6%
Other	12.5%	13.9%	12.5%	14.3%
Total	100.0%	100.0%	100.0%	100.0%

Case Growth

Same-facility Information

Same-facility revenues include revenues from our consolidated and non-consolidated surgical facilities (excluding facilities acquired in new markets or divested during the current and prior period) along with the revenues from our ancillary services comprised of a diagnostic laboratory, multi-specialty physician practices, urgent care facilities, anesthesia services, optical services and specialty pharmacy services that complement our surgical facilities in our existing markets.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Cases	$ 112,314	$ 111,818	$ 218,300	$ 215,530
Case growth	0.4%	N/A	1.3%	N/A
Revenue per case	$ 2,640	$ 2,600	$ 2,663	$ 2,569
Revenue per case growth	1.5%	N/A	3.7%	N/A
Number of facilities	93	N/A	92	N/A

Segment Information

A public company is required to report annual and interim financial and descriptive information about its reportable operating segments. Operating segments, as defined, are components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating decision maker, or "CODM," in deciding how to allocate resources and in assessing performance. Aggregation of similar operating segments into a single reportable operating segment is permitted if the businesses have similar economic characteristics and meet the criteria established by GAAP.

Our business is comprised of the following three reportable segments:

Surgical Facility Services Segment: Our surgical facility services segment consists of the operation of ASCs and surgical hospitals, and includes our anesthesia services. Our surgical facilities primarily provide non-emergency surgical procedures across many specialties, including, among others, GI, general surgery, ophthalmology, orthopedics and pain management.

Ancillary Services Segment: Our ancillary services segment consists of a diagnostic laboratory, a specialty pharmacy and multi-specialty physician practices. These physician practices include our owned and operated physician practices pursuant to long-term management service agreements.

Optical Services Segment: Our optical services segment consists of an optical laboratory and an optical products group purchasing organization. Our optical laboratory manufactures eyewear, while our optical products purchasing organization negotiates volume buying discounts with optical product manufacturers.

Our financial information by reportable segment is prepared on an internal management reporting basis that the chief operating decision maker uses to allocate resources and assess the performance of the operating segments. Our operating segments have been defined based on the separate financial information that is regularly produced and reviewed by our CODM, which is our Chief Executive Officer.

Adjusted EBITDA is the primary profit/loss metric reviewed by the CODM in making key business decisions and on allocation of resources. We have provided a reconciliation from adjusted EBITDA back to net income in the reported condensed consolidated financial information.

The following tables present financial information for each reportable segment (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Revenues:				
Surgical facility services	$ 262,810	$ 263,783	$ 520,960	$ 509,453
Ancillary services	22,640	22,503	47,852	40,283
Optical services	2,903	3,395	5,724	7,019
Total revenues	$ 288,353	$ 289,681	$ 574,536	$ 556,755

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Segment Adjusted EBITDA:				
Surgical facility services	$ 49,946	$ 54,311	$ 98,187	$ 99,971
Ancillary services	429	3,068	4,211	6,568
Optical services	883	849	1,659	1,728
Total segment adjusted EBITDA [1]	$ 51,258	$ 58,228	$ 104,057	$ 108,267
General and administrative expenses	$ (18,655)	$ (15,023)	$ (34,196)	$ (27,220)
Non-cash stock compensation expense	1,435	502	2,069	635
Contingent acquisition compensation expense	1,814	1,530	3,847	1,530
Acquisition related costs	1,203	795	1,385	1,245
Total adjusted EBITDA [1]	37,055	46,032	77,162	84,457
Net income attributable to non-controlling interests	16,098	20,173	33,274	37,720
Depreciation and amortization	(11,417)	(9,702)	(22,525)	(19,271)
Interest expense, net	(25,600)	(26,235)	(50,782)	(48,388)
Income tax expense	(512)	(2,420)	(2,629)	(4,190)
Non-cash stock compensation expense	(1,435)	(502)	(2,069)	(635)
Contingent acquisition compensation expense	(1,814)	(1,530)	(3,847)	(1,530)
Merger transaction, integration and practice acquisition costs [2]	(4,137)	(2,192)	(4,728)	(6,108)
Gain on litigation settlement	3,794	—	3,794	—
Loss on disposal or impairment of long-lived assets, net	(405)	(1,331)	(1,601)	(1,125)
Loss on debt refinancing	—	—	—	(8,281)
Total net income	$ 11,627	$ 22,293	$ 26,049	$ 32,649

[1] The above table reconciles adjusted EBITDA by segment to net income as reflected in the unaudited condensed consolidated statements of operations.

When we use the term "Adjusted EBITDA," it is referring to net income minus (a) net income attributable to non-controlling interests plus (b) depreciation and amortization, (c) interest expense, net, (d) income tax expense, (e) non-cash stock compensation expense, (f) contingent acquisition compensation expense, (g) merger transaction, integration and practice acquisition costs, (h) gain on litigation settlement, (i) loss on disposal or impairment of long-lived assets and (j) loss on debt refinancing. Non-controlling interests represent the interests of third parties, such as physicians, and in some cases, healthcare systems that own an interest in surgical facilities that we consolidate for financial reporting purposes. Our operating strategy is to apply a market-based approach in structuring its partnerships with individual market dynamics driving the structure. We believe that it is helpful to investors to present Adjusted EBITDA as defined above because it excludes the portion of net income attributable to these third-party interests and clarifies for investors our portion of Adjusted EBITDA generated by our surgical facilities and other operations.

We use Adjusted EBITDA as a measure of liquidity. It is included because we believe that it provides investors with additional information about its ability to incur and service debt and make capital expenditures.

Adjusted EBITDA is not a measurement of financial performance or liquidity under GAAP. It should not be considered in isolation or as a substitute for net income, operating income, cash flows from operating, investing or financing activities, or any other measure calculated in accordance with generally accepted accounting principles. The items

excluded from Adjusted EBITDA are significant components in understanding and evaluating financial performance and liquidity. Our calculation of Adjusted EBITDA may not be comparable to similarly titled measures reported by other companies.

(2) This amount includes merger transaction and integration costs of $2.9 million and $1.3 million for the three months ended June 30, 2017 and 2016, respectively, and practice acquisition costs of $1.2 million and $867,000 for the three months ended June 30, 2017 and 2016, respectively.

This amount includes merger transaction and integration costs of $3.2 million and $4.5 million for the six months ended June 30, 2017 and 2016, respectively, and practice acquisition costs of $1.5 million and $1.6 million for the six months ended June 30, 2017 and 2016, respectively.

	June 30, 2017	December 31, 2016
Assets:		
Surgical facility services	1,912,913	1,914,842
Ancillary services	185,195	184,002
Optical services	23,604	22,478
Total	2,121,712	2,121,322
General and administrative	549,775	183,636
Total assets	2,671,487	2,304,958

	Six Months Ended June 30,	
	2017	2016
Supplemental Information:		
Cash purchases of property and equipment, net:		
Surgical facility services	$ 11,266	$ 14,745
Ancillary services	1,740	2,951
Optical services	68	96
Total	$ 13,074	$ 17,792
General and administrative	$ 2,028	$ 2,558
Total cash purchases of property and equipment, net	$ 15,102	$ 20,350

Critical Accounting Policies

Our significant accounting policies and practices are described in Note 2 of our condensed consolidated financial statements included previously in this report. In preparing our condensed consolidated financial statements in conformity with Generally Accepted Accounting Principles ("GAAP"), our management must make estimates and assumptions that affect the reported amounts of assets and liabilities and related disclosures at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Certain accounting estimates are particularly sensitive because of their complexity and the possibility that future events affecting them may differ materially from our current judgments and estimates. Our actual results could differ from those estimates. We believe that the following critical accounting policies are important to the portrayal of our financial condition and results of operations and require our management's subjective or complex judgment because of the sensitivity of the methods, assumptions and estimates used. This listing of critical accounting policies is not intended to be a comprehensive list of all of our accounting policies. In many cases, the accounting treatment of a particular transaction is specifically dictated by GAAP, with no need for management's judgment regarding accounting policy.

Consolidation and Control

Our condensed consolidated financial statements include the accounts of our Company, wholly-owned or controlled subsidiaries and variable interest entities in which we are the primary beneficiary. Our controlled subsidiaries consist of wholly-owned subsidiaries and other subsidiaries that we control through our ownership of a majority voting interest or other rights granted to us by contract to function as the sole general partner or managing member of the surgical facility. The rights of limited partners or minority members at our controlled subsidiaries are generally limited to those that protect their ownership interests, including the right to approve the issuance of new ownership interests, and those that protect their financial interests, including the right to approve the acquisition or divestiture of significant assets or the incurrence of debt that either physician limited partners or minority members are required to guarantee on a pro-rata basis based upon their respective ownership, or that exceeds 20.0% of the fair market value of the related surgical facility's assets. All significant intercompany balances and transactions, including management fees from consolidated surgical facilities, are eliminated in consolidation.

We hold less than a majority economic interest in five surgical facilities, three anesthesia practices and three physician practices over which we exercise controlling influence. Controlling influence includes financial interests, duties, rights and responsibilities for the day-to-day management of the entity. We also consider the relevant sections of the Accounting Standard Codification ("ASC") 810, *Consolidation*,

to determine if we have the power to direct the activities and are the primary beneficiary of (and therefore should consolidate) any entity whose operations we do not control with voting rights. As we were the primary beneficiary, we consolidated the above 11 entities at June 30, 2017.

Revenue Recognition

Our patient service revenues are derived from surgical procedures performed at our ASCs, patient visits to physician practices, anesthesia services provided to patients, pharmacy services and diagnostic screens ordered by our physicians. The fees for such services are billed either to the patient or a third-party payor, including Medicare and Medicaid. We recognize patient service revenues, net of contractual allowances, which we estimate based on the historical trend of our cash collections and contractual write-offs.

Our optical products purchasing organization negotiates volume buying discounts with optical product manufacturers. The buying discounts and any handling charges billed to the members of the purchasing organization represent the revenues recognized for financial reporting purposes. Revenue is recognized as orders are shipped to members. Product sale revenues from our optical laboratories and marketing products and services businesses, net of an allowance for returns and discounts, is recognized when the product is shipped or service is provided to the customer. We base our estimates for sales returns and discounts on historical experience and have not experienced significant fluctuations between estimated and actual return activity and discounts given.

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

Allowance for Contractual Adjustments and Doubtful Accounts

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

We estimate our allowances for doubtful accounts using similar information and analysis. While we believe that our allowances for contractual adjustments and doubtful accounts are adequate, if the actual write-offs are significantly different from our estimates, it could have a material adverse effect on our financial condition and results of operations. Because in most cases we have the ability to verify a patient's insurance coverage before services are rendered, and because we have entered into contracts with third-party payors which account for a majority of our total revenues, the out-of-period contractual adjustments have been minimal. Our net accounts receivable reflected allowances for doubtful accounts of $31.5 million and $29.9 million at June 30, 2017 and December 31, 2016, respectively.

Our collection policies and procedures are based on the type of payor, size of claim and estimated collection percentage for each patient account. The operating systems used to manage our patient accounts provide for an aging schedule in 30-day increments, by payor, physician and patient. We analyze accounts receivable at each of our surgical facilities to ensure the proper collection and aged category. The operating systems generate reports that assist in the collection efforts by prioritizing patient accounts. Collection efforts include direct contact with insurance carriers or patients, written correspondence and the use of legal or collection agency assistance, as required. Our days sales outstanding were 68 days for the six months ended June 30, 2017 and 70 days for the year ended December 31, 2016.

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

We recognize that final reimbursement of outstanding accounts receivable is subject to final approval by each third-party payor. However, because we have contracts with our third-party payors and we verify the insurance coverage of the patient before services are rendered, the amounts that are pending approval from third-party payors are minimal. Amounts are classified outside of self-pay if we have an agreement with the third-party payor or we have verified a patient's coverage prior to services rendered. It is our policy to collect co-payments and deductibles prior to providing services. It is also our policy to verify a patient's insurance 72 hours prior to the patient's procedure. Because our services are primarily non-emergency, our surgical facilities have the ability to control these procedures. Our patient service revenues from self-pay payors as a percentage of total revenues were approximately 2.1% and 1.5% for the six months ended June 30, 2017 and 2016, respectively.

Income Taxes and Tax Receivable Agreement

We use the asset and liability method to account for income taxes. Under this method, deferred income tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and

liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. If a net operating loss ("NOL") carryforward exists, we make a determination as to whether that NOL carryforward will be utilized in the future. A valuation allowance will be established for certain NOL carryforwards and other deferred tax assets where their recoverability is deemed to be uncertain. The carrying value of the net deferred tax assets is based upon estimates and assumptions related to our ability to generate sufficient future taxable income in certain tax jurisdictions. If these estimates and related assumptions change in the future, we will be required to adjust our deferred tax valuation allowances.

As of June 30, 2017, we maintained a valuation allowance against certain state NOLs and capital losses for which we believe it is more likely than not that they will not be realized. On a quarterly basis, we 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.

For the six months ended June 30, 2017, we recorded income tax expense at a rate of approximately 9.2% of income before income taxes. As a percentage of income before income taxes, we expect the tax rate to remain relatively constant throughout the year. As a percentage of net income after income attributable to non-controlling interests, we expect the tax rate for the year to be between 41% and 42%. Based upon the application of interim accounting guidance, however, the tax rate as a percentage of net income after income attributable to non-controlling interests will vary based upon the relative net income from period to period.

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 50.0% 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. As a result of the Symbion acquisition, approximately $179 million in NOL carryforwards are subject to an annual Section 382 base limitation of $4.9 million, and, as a result of the NovaMed acquisition, approximately $17 million in NOL carryforwards are subject to an annual Section 382 base limitation of $4.9 million. We expect the sale of H.I.G.'s shares to Bain Capital in connection with the Transactions, if consummated, will result in an ownership change as defined in Section 382. In such an event, we will 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, when combined with amounts allowable due to net unrecognized built in gains, will affect our ability to use any NOLs before they expire. However, no such assurances can be provided. 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.

As part of the Reorganization that was effective September 30, 2015, we entered into a Tax Receivable Agreement (“TRA”) under which generally we are required to pay to our stockholders as of immediately prior to the IPO 85% of the cash savings, if any, in U.S. federal, state or local tax that we actually realize (or are deemed to realize in certain circumstances) as a result of (i) certain tax attributes, including NOLs, capital losses, charitable deductions, alternative minimum tax credit carryforwards and federal and state tax credits of Surgery Partners, Inc. and its affiliates relating to taxable years ending on or before the date of the Reorganization (calculated by assuming the taxable year of the relevant entity closes on the date of the Reorganization) that are or become available to us and our wholly-owned subsidiaries as a result of the Reorganization, and (ii) tax benefits attributable to payments made under the TRA, together with interest accrued at a rate of LIBOR plus 300 basis points from the date the applicable tax return is due (without extension) until paid.

As described in Note 1 of our condensed consolidated financial statements included previously in this report, on May 9, 2017, we entered into the TRA Amendment. The TRA Amendment, which will become effective immediately prior to (but contingent upon) the consummation of the NSH Merger, provides for a fixed payment schedule. After the effectiveness of the TRA Amendment, the amounts payable pursuant to the TRA (as amended by the TRA Amendment) will be related to the projected tax savings we are to realize over the next five years and are not dependent on actual tax savings. We estimate that the total amounts payable under the TRA, as amended, may be as high as $120.5 million. Prior to the effectiveness of the TRA Amendment and the consummation of the Transactions, we estimate the total amounts payable under the TRA to be approximately $123.4 million as of both June 30, 2017 and December 31, 2016.

Long-Lived Assets, Goodwill and Intangible Assets

We evaluate the carrying value of long-lived assets when impairment indicators are present or when circumstances indicate that impairment may exist in accordance with ASC 350, *Intangibles- Goodwill and Other*. We perform an impairment test by preparing an expected undiscounted cash flow projection. If the projection indicates that the recorded amount of the long-lived asset is not expected to be recovered, the carrying value is reduced to estimated fair value. The cash flow projection and fair value represents management’s best estimate, using appropriate and customary assumptions, projections and methodologies, at the date of evaluation. We test our goodwill and intangible assets for impairment at least annually, or more frequently if certain indicators arise.

Off-Balance Sheet Arrangements

From time to time, we guarantee our pro-rata share of the third-party debts and other obligations of many of the non-consolidated partnerships and limited liability companies in which we own an interest. In most instances of these guarantees, the physicians and/or physician groups have also guaranteed their pro-rata share of the indebtedness to secure the financing. At June 30, 2017, we did not guarantee any debt of our non-consolidated surgical facilities.

Equity-Based Compensation

Transactions in which the Company receives employee and non-employee services in exchange for the Company's equity instruments or liabilities that are based on the fair value of the Company's equity securities or may be settled by the issuance of these securities are accounted for using a fair value method. The fair value of future stock options awarded will be based on the quoted market price of our common stock upon grant, as well as assumptions including expected stock price volatility, risk-free interest rate, expected dividends, and expected term.

Our policy is to recognize compensation expense using the straight line method over the relevant vesting period for units that vest based on time. Our equity-based compensation expense can vary in the future depending on many factors, including levels of forfeitures and whether performance targets are met and whether a liquidity event occurs. In connection with the Reorganization, our board of directors and stockholders adopted the Surgery Partners, Inc. 2015 Omnibus Incentive Plan from which our future equity-based awards will be granted.

Results of Operations

The following tables summarize certain results from the statements of operations for the three and six months ended June 30, 2017 and 2016. The tables also show the percentage relationship to revenues for the periods indicated (dollars in thousands):

	Three Months Ended June 30,			
	2017		2016	
	Amount	% of Revenues	Amount	% of Revenues
Revenues	$ 288,353	100.0 %	$ 289,681	100.0 %
Operating expenses:				
Cost of revenues	216,452	75.1 %	208,852	72.1 %
General and administrative expenses [1]	18,655	6.5 %	15,023	5.2 %
Depreciation and amortization	11,417	4.0 %	9,702	3.3 %
Provision for doubtful accounts	5,788	2.0 %	3,544	1.2 %
Income from equity investments	(1,052)	(0.4)%	(1,082)	(0.4)%
Loss on disposal or impairment of long-lived assets, net	405	0.1 %	1,331	0.5 %
Gain on litigation settlement	(3,794)	(1.3)%	—	— %
Merger transaction and integration costs	2,904	1.0 %	1,325	0.5 %
Electronic health records incentive income	(161)	(0.1)%	(2)	— %
Other expense	—	— %	40	— %
Total operating expenses	250,614	86.9 %	238,733	82.4 %
Operating income	37,739	13.1 %	50,948	17.6 %
Interest expense, net	(25,600)	(8.9)%	(26,235)	(9.1)%
Income before income taxes	12,139	4.2 %	24,713	8.5 %
Income tax expense	512	0.2 %	2,420	0.8 %
Net income	11,627	4.0 %	22,293	7.7 %
Less: Net income attributable to non-controlling interests	(16,098)	(5.6)%	(20,173)	(7.0)%
Net (loss) income attributable to Surgery Partners, Inc.	$ (4,471)	(1.6)%	$ 2,120	0.7 %

[1] Includes contingent acquisition compensation expense of $1.8 million and $1.5 million for the three months ended June 30, 2017 and 2016, respectively.

	Six Months Ended June 30,			
	2017		2016	
	Amount	% of Revenues	Amount	% of Revenues
Revenues	$ 574,536	100.0 %	$ 556,755	100.0 %
Operating expenses:				
Cost of revenues	428,400	74.6 %	405,555	72.8 %
General and administrative expenses [1]	34,196	6.0 %	27,220	4.9 %
Depreciation and amortization	22,525	3.9 %	19,271	3.5 %
Provision for doubtful accounts	11,463	2.0 %	7,417	1.3 %
Income from equity investments	(2,252)	(0.4)%	(1,840)	(0.3)%
Loss on disposal or impairment of long-lived assets, net	1,601	0.3 %	1,125	0.2 %
Gain on litigation settlement	(3,794)	(0.7)%	—	— %
Loss on debt refinancing	—	— %	8,281	1.5 %
Merger transaction and integration costs	3,241	0.6 %	4,497	0.8 %
Electronic health records incentive income	(302)	(0.1)%	(95)	— %
Other (income) expense	(2)	— %	97	— %
Total operating expenses	495,076	86.2 %	471,528	84.7 %
Operating income	79,460	13.8 %	85,227	15.3 %
Interest expense, net	(50,782)	(8.8)%	(48,388)	(8.7)%
Income before income taxes	28,678	5.0 %	36,839	6.6 %
Income tax expense	2,629	0.5 %	4,190	0.8 %
Net income	26,049	4.5 %	32,649	5.9 %
Less: Net income attributable to non-controlling interests	(33,274)	(5.8)%	(37,720)	(6.8)%
Net loss attributable to Surgery Partners, Inc.	$ (7,225)	(1.3)%	$ (5,071)	(0.9)%

[1] Includes contingent acquisition compensation expense of $3.8 million and $1.5 million for the six months ended June 30, 2017 and 2016, respectively.

Three Months Ended June 30, 2017 Compared to Three Months Ended June 30, 2016

Overview. During the three months ended June 30, 2017, our revenues were $288.4 million compared to $289.7 million for the three months ended June 30, 2016. The 2016 period included approximately $8.8 million of revenue from an anesthesia contract that was no longer in place during the 2017 period. Excluding this contract from both periods, we would have achieved revenue growth of 2.7%. We incurred a net loss attributable to Surgery Partners, Inc. for the 2017 period of $4.5 million, compared to net income of $2.1 million for the 2016 period.

Revenues. Revenues for the three months ended June 30, 2017 compared to the three months ended June 30, 2016 were as follows (dollars in thousands):

	Three Months Ended June 30,			
	2017	2016	Dollar Variance	Percent Variance
Patient service revenues	$ 283,834	$ 283,211	$ 623	0.2 %
Optical service revenues	2,903	3,395	(492)	(14.5)%
Other service revenues	1,616	3,075	(1,459)	(47.4)%
Total revenues	$ 288,353	$ 289,681	$ (1,328)	(0.5)%

Patient service revenues increased 0.2% to $283.8 million for the three months ended June 30, 2017 compared to $283.2 million for the three months ended June 30, 2016. The increase in patient service revenues was primarily attributable to the integration of acquisitions completed after June 30, 2016.

Cost of Revenues. Cost of revenues increased to $216.5 million for the three months ended June 30, 2017 compared to $208.9 million for the three months ended June 30, 2016. The increase is primarily attributable to the integration of acquisitions completed after June 30, 2016 and an increase in higher acuity case mix. As a percentage of revenues, cost of revenues were 75.1% for the 2017 period and 72.1% for the 2016 period.

General and Administrative Expenses. General and administrative expenses were $18.7 million for the three months ended June 30, 2017 compared to $15.0 million for the three months ended June 30, 2016. The increase is primarily due to an increase in stock compensation expense and costs incurred related to the planned relocation of the corporate office in Nashville, TN. As a percentage of revenues, general and administrative expenses were 6.5% for the 2017 period compared to 5.2% for the 2016 period.

Depreciation and Amortization. Depreciation and amortization increased to $11.4 million for the three months ended June 30, 2017 compared to $9.7 million for the three months ended June 30, 2016. As a percentage of revenues, depreciation and amortization expenses were 4.0% for the 2017 period and 3.3% for the 2016 period.

Provision for Doubtful Accounts. The provision for doubtful accounts increased to $5.8 million for the three months ended June 30, 2017 compared to $3.5 million for the three months ended June 30, 2016. As a percentage of revenues, the provision for doubtful accounts was 2.0% for the 2017 period and 1.2% for the 2016 period.

Income from Equity Investments. The income from equity investments was $1.1 million for the three months ended June 30, 2017 and 2016.

Loss on Disposal or Impairment of Long-Lived Assets, Net. The net loss on disposal of long-lived assets was $405,000 for the three months ended June 30, 2017 compared to $1.3 million for the three months ended June 30, 2016.

Merger Transaction and Integration Costs. We incurred $2.9 million of merger transaction and integration costs for the three months ended June 30, 2017 compared to $1.3 million for the three months ended June 30, 2016, related to the integration of our acquisitions.

Operating Income. Our operating income margin for the three months ended June 30, 2017 was 13.1% compared to 17.6% during the three months ended June 30, 2016. During the three months ended June 30, 2017, we recorded a gain on litigation settlement of $3.8 million, merger transaction and integration costs related to acquisitions of $2.9 million, contingent acquisition compensation expense of $1.8 million and a loss on disposal of long-lived assets of $405,000. Excluding the impact of these items, our operating income margin was 13.5% for the three months ended June 30, 2017.

During the three months ended June 30, 2016, we recorded $1.3 million of merger transaction and integration costs related to acquisitions, contingent acquisition compensation expense of $1.5 million and a loss on disposal of long-lived assets of $1.3 million. Excluding the impact of these items, our operating income margin was 19.0% for the three months ended June 30, 2016.

The decline primarily relates to an unfavorable payor mix shift on our higher acuity cases resulting in higher supply costs with lower reimbursement rates.

Interest Expense, Net. Interest expense, net, was $25.6 million for the three months ended June 30, 2017 compared to $26.2 million for the three months ended June 30, 2016. As a percentage of revenues, interest expense, net was 8.9% for the 2017 period compared to 9.1% for the 2016 period.

Income Tax Expense. The income tax expense was $512,000 for the three months ended June 30, 2017 compared to $2.4 million for the three months ended June 30, 2016. The effective tax rate was 4.2% for the three months ended June 30, 2017 compared to 9.8% for the three months ended June 30, 2016. As a percentage of net income after income attributable to non-controlling interests, we expect the tax rate for the year to be between 41% and 43%. Based upon the application of interim accounting guidance, however, the tax rate as a percentage of net income after income attributable to non-controlling interests will vary based upon the relative net income from period to period.

Net Income Attributable to Non-Controlling Interests. Net income attributable to non-controlling interests decreased to $16.1 million for the three months ended June 30, 2017 compared to $20.2 million for the three months ended June 30, 2016. As a percentage of revenues, net income attributable to non-controlling interests was 5.6% in the 2017 period and 7.0% for the 2016 period.

Six Months Ended June 30, 2017 Compared to Six Months Ended June 30, 2016

Overview. During the six months ended June 30, 2017, our revenues increased 3.2% to $574.5 million from $556.8 million for the six months ended June 30, 2016. The 2016 period included approximately $17.8 million of revenue from an anesthesia contract that was no longer in place during the 2017 period. Excluding this contract from both periods, we would have achieved revenue growth of 6.6%. We incurred a net loss attributable to Surgery Partners, Inc. for the 2017 period of $7.2 million, compared to $5.1 million for the 2016 period.

Revenues. Revenues for the three months ended June 30, 2017 compared to the three months ended June 30, 2016 were as follows (dollars in thousands):

	Six Months Ended June 30,			
	2017	2016	Dollar Variance	Percent Variance
Patient service revenues	$ 565,480	$ 544,771	$ 20,709	3.8 %
Optical service revenues	5,724	7,019	(1,295)	(18.4)%
Other service revenues	3,332	4,965	(1,633)	(32.9)%
Total revenues	$ 574,536	$ 556,755	$ 17,781	3.2 %

Patient service revenues increased 3.8% to $565.5 million for the six months ended June 30, 2017 compared to $544.8 million for the six months ended June 30, 2016. The increase in patient service revenues was primarily attributable to the integration of acquisitions completed after June 30, 2016.

Cost of Revenues. Cost of revenues were $428.4 million for the six months ended June 30, 2017 compared to $405.6 million for the six months ended June 30, 2016. The increase is primarily attributable to the integration of acquisitions completed after June 30, 2016 and an increase in higher acuity case mix. As a percentage of revenues, cost of revenues were 74.6% for the 2017 period and 72.8% for the 2016 period.

General and Administrative Expenses. General and administrative expenses were $34.2 million for the six months ended June 30, 2017 compared to $27.2 million for the six months ended June 30, 2016. The increase is primarily due to an increase in stock compensation expense, an increase in the contingent acquisition compensation expense and costs incurred related to the planned relocation of the corporate office in Nashville, TN. As a percentage of revenues, general and administrative expenses were 6.0% for the 2017 period compared to 4.9% for the 2016 period.

Depreciation and Amortization. Depreciation and amortization increased to $22.5 million for the six months ended June 30, 2017 compared to $19.3 million for the six months ended June 30, 2016. As a percentage of revenues, depreciation and amortization expenses were 3.9% for the 2017 period and 3.5% for the 2016 period.

Provision for Doubtful Accounts. The provision for doubtful accounts increased to $11.5 million for the six months ended June 30, 2017 compared to $7.4 million for the six months ended June 30, 2016. As a percentage of revenues, the provision for doubtful accounts was 2.0% for the 2017 period and 1.3% for the 2016 period.

Income from Equity Investments. The income from equity investments was $2.3 million for the six months ended June 30, 2017 compared to $1.8 million for the six months ended June 30, 2016.

Loss on Disposal or Impairment of Long-Lived Assets, Net. The net loss on disposal of long-lived assets was $1.6 million for the six months ended June 30, 2017 compared to $1.1 million for the six months ended June 30, 2016.

Loss on Debt Refinancing. We incurred a loss on debt refinancing of $8.3 million for the six months ended June 30, 2016 in connection with the paydown of the 2014 Second Lien, defined herein, and the write-off of the related debt issuance costs and discount in addition to a prepayment penalty.

Merger Transaction and Integration Costs. We incurred $3.2 million of merger transaction and integration costs for the six months ended June 30, 2017 compared to $4.5 million for the six months ended June 30, 2016.

Operating Income. Our operating income margin for the six months ended June 30, 2017 was 13.8% compared to 15.3% during the six months ended June 30, 2016. During the six months ended June 30, 2017, we recorded a gain on litigation settlement of $3.8 million, merger transaction and integration costs related to acquisitions of $3.2 million, contingent acquisition compensation expense of $3.8 million and a loss on disposal of long-lived assets of $1.6 million. Excluding the impact of these items, our operating income margin was 14.7% for the six months ended June 30, 2017.

During the six months ended June 30, 2016, we recorded a loss on debt refinancing of $8.3 million, $4.5 million of merger transaction and integration costs related to acquisitions, contingent acquisition compensation expense of $1.5 million and a loss on disposal of long-lived assets of $1.1 million. Excluding the impact of these items, our operating income margin was 18.1% for the six months ended June 30, 2016.

The decline primarily relates to an unfavorable payor mix shift on our higher acuity cases resulting in higher supply costs with lower reimbursement rates.

Interest Expense, Net. Interest expense, net, was $50.8 million for the six months ended June 30, 2017 compared to $48.4 million for the six months ended June 30, 2016. As a percentage of revenues, interest expense, net was 8.8% for the 2017 period compared to 8.7% for the 2016 period.

Income Tax Expense. The income tax expense was $2.6 million for the six months ended June 30, 2017 compared to $4.2 million for the six months ended June 30, 2016. The effective tax rate was 9.2% for the six months ended June 30, 2017 compared to 11.4% for the six months ended June 30, 2016. As a percentage of net income after income attributable to non-controlling interests, we expect the tax rate for the year to be between 41% and 43%. Based upon the application of interim accounting guidance, however, the tax rate as a percentage of net income after income attributable to non-controlling interests will vary based upon the relative net income from period to period.

Net Income Attributable to Non-Controlling Interests. Net income attributable to non-controlling interests decreased to $33.3 million for the six months ended June 30, 2017 compared to $37.7 million for the six months ended June 30, 2016. As a percentage of revenues, net income attributable to non-controlling interests was 5.8% in the 2017 period and 6.8% for the 2016 period.

Liquidity and Capital Resources

Operating Activities

The primary source of our operating cash flow is the collection of accounts receivable from federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies and individuals. During the six months ended June 30, 2017, our cash flow provided by operating activities was $56.5 million compared to $74.0 million in the six months ended June 30, 2016. The decline period over period is primarily related to interest payments of $17.8 million on our 2021 Unsecured Notes that were not incurred in the prior period. At June 30, 2017, we had working capital of $166.3 million compared to $175.2 million at December 31, 2016.

Investing Activities

Net cash used in investing activities during the six months ended June 30, 2017 was $29.2 million, which included $15.1 million related to purchases of property and equipment. Additionally, we purchased three physician practices for an aggregate purchase price of $14.2 million.

Net cash used in investing activities during the six months ended June 30, 2016 was $133.4 million, which included $20.4 million related to purchases of property and equipment, including $4.9 million related to the relocation of our hospital in Great Falls, Montana. Additionally, we paid $113.0 million in cash for acquisitions (net of cash acquired), of which $96.4 million, excluding $16.6 million of contingent acquisition consideration, related to the purchase of three surgical facilities, one of which was merged with an existing facility, six physician practices, a lab and a pharmacy. The remaining amount included an additional payment of $16.6 million to fund the final escrow payment related to the acquisition of Symbion Holding Corporation.

Financing Activities

Net cash used in financing activities during the six months ended June 30, 2017 was $39.9 million. During this period, we made distributions to non-controlling interest holders of $36.8 million and paid cash related to ownership transactions with consolidated affiliates of $745,000. Further, we made repayments on our long-term debt of $113.4 million offset by borrowings of $119.8 million. Our repayments and borrowings include a $104.0 million draw down and subsequent repayment of $98.0 million on our Revolver during the period. In addition, we paid debt issuance costs of $941,000 and paid $6.6 million to be held in escrow for the issuance of the 2025 Unsecured Notes.

Net cash provided by financing activities during the six months ended June 30, 2016 was $53.0 million. During this period, we made distributions to non-controlling interest holders of $32.4 million and received cash related to ownership transactions with consolidated affiliates of $573,000. Further, we made repayments on our long-term debt of $424.3 million offset by borrowings of $525.4 million. Our repayments and borrowings include a $38.0 million draw down and subsequent repayment of $163.3 million on our Revolver during the period. In addition, we paid debt issuance costs and the original issue discount of $12.6 million and a prepayment penalty on the payoff of the 2014 Second Lien of $4.9 million.

Long-Term Debt

A summary of long-term debt follows (in thousands):

	June 30, 2017	December 31, 2016
2014 Revolver Loan	$ 91,000	$ 85,000
2014 First Lien Credit Agreement	927,250	932,000
Senior Unsecured Notes due 2021	400,000	400,000
Senior Unsecured Notes due 2025	370,000	—
Subordinated Notes	1,000	1,000
Notes payable and secured loans	52,793	42,521
Capital lease obligations	14,787	13,996
Less: unamortized debt issuance costs and discount	(31,646)	(32,274)
Total debt	1,825,184	1,442,243
Less: Current maturities	29,919	27,822
Total long-term debt	$ 1,795,265	$ 1,414,421

2014 Revolver Loan

The 2014 Revolver Loan (“Revolver”), entered into on November 3, 2014, is a revolving credit facility used for working capital, acquisitions and development activities and general corporate purposes and matures on November 3, 2019. On October 7, 2015, we entered into an amendment to the 2014 First Lien Credit Agreement to increase certain lenders’ commitments under the Revolver from $80.0 million to an aggregate principal amount at any time outstanding not to exceed $150.0 million.

We have the option of classifying borrowings under the Revolver as either Alternate Base Rate ("ABR") loans or Eurodollar ("ED") loans. The interest base rate on an ABR loan is equal to the greatest of (a) the Prime Rate in effect on such day, (b) the Federal Funds Effective Rate in effect on such day plus 0.50% and (c) the adjusted LIBO Rate for a Eurodollar Borrowing with a one-month interest period plus 1.00%. In addition to the base rate, we are required to pay a 3.25% margin for ABR loans. The interest base rate on an ED loan is equal to (x) the LIBO Rate for such Eurodollar borrowing in effect for such Interest Period divided by (y) One minus the Statutory Reserves (if any) for such Eurodollar Borrowing for such interest period. In addition to the base rate, we are required to pay a 4.25% margin for ED loans. We must also pay quarterly commitment fees of 0.50% per annum of the average daily unused amount of the Revolver. As of June 30, 2017, our availability on the Revolver was $55.9 million (including outstanding letters of credit of $3.1 million).

The 2014 First Lien Credit Agreement governs the Revolver and contains various covenants that include limitations on our indebtedness, liens, acquisitions and investments. It additionally includes the requirement, if triggered, that we maintain a net leverage ratio within a specified range. As of June 30, 2017, we were in compliance with the covenants contained in the 2014 First Lien Credit Agreement.

2014 First Lien Credit Agreement

The 2014 First Lien Credit Agreement (“2014 First Lien”), entered into on November 3, 2014, is a senior secured obligation of Surgery Center Holdings, Inc. and is guaranteed on a senior secured basis by SP Holdco I, Inc. and certain of our subsidiaries. The 2014 First Lien matures on November 3, 2020. On March 24, 2016, Surgery Center Holdings, Inc. and certain of our subsidiaries entered into an amendment to the 2014 First Lien to obtain an incremental term loan in an aggregate principal amount of $80.0 million, which increased the total term loan obligation under the 2014 First Lien to $950.0 million. On September 26, 2016, we entered into an amendment to the 2014 First Lien to reduce the interest margins for an ABR loan to 2.75% and for an ED loan to 3.75%.

We have the option of classifying the 2014 First Lien as either an ABR loan or an ED loan. The interest base rate on an ABR loan is equal to the greatest of (a) the Prime Rate in effect on such day, (b) the Federal Funds Effective Rate in effect on such day plus 0.50%, and (c) the Adjusted LIBO Rate for a Eurodollar Borrowing with a one-month interest period plus 1.00%; provided that the base rate shall not be less than 2.00% per annum. In addition to the base rate, we are required to pay a 2.75% margin for ABR loans. The interest base rate on an ED loan is equal to (x) the LIBO Rate for such Eurodollar borrowing in effect for such Interest Period divided by (y) One minus the Statutory Reserves (if any) for such Eurodollar Borrowing for such interest period; provided that the rate shall not be less than 1.00% per annum. In addition to the base rate, we are required to pay a 3.75% margin for ED loans. Accrued interest is payable in arrears on a quarterly basis. Within five business days after the earlier of (i) 90 days after the end of each fiscal year or (ii) the date on which financial statements have been delivered, we are required to make mandatory prepayments in amounts calculated in accordance with the excess cash flow provisions of the 2014 First Lien Credit Agreement. There were no excess cash flow payments required as of June 30, 2017.

In connection with the incremental loan of $80.0 million in March 2016, we recorded an additional $1.6 million and $3.5 million as original issue discount and amounts paid to lender for debt related issuance costs, respectively.

The 2014 First Lien Credit Agreement that governs the 2014 First Lien and contains various covenants that include limitations on our indebtedness, liens, acquisitions and investments. As of June 30, 2017, we were in compliance with the covenants contained in the credit agreement. The 2014 First Lien is collateralized by substantially all of our assets.

2014 Second Lien Credit Agreement

The 2014 Second Lien Credit Agreement (“2014 Second Lien”), entered into on November 3, 2014, was prepaid in full on March 31, 2016. The 2014 Second Lien was a senior secured obligation of Surgery Center Holdings, Inc. and was guaranteed on a senior secured basis by us and certain of our subsidiaries. On March 31, 2016, we repaid the remaining principal of the 2014 Second Lien of $252.8 million with the proceeds of the issuance of the 2021 Unsecured Notes, defined below, of which $1.3 million was accrued interest. In connection with the prepayment, we incurred a loss on the extinguishment of debt of $8.3 million which included the write-off of loan costs and the original issue discount and a prepayment penalty for the six months ended June 30, 2016.

Senior Unsecured Notes due 2021

Effective March 31, 2016, one of our subsidiaries, Surgery Center Holdings, Inc., issued $400.0 million in gross proceeds of senior unsecured notes due April 15, 2021 (the "2021 Unsecured Notes"). The 2021 Unsecured Notes bear interest at the rate of 8.875% per year, payable semi-annually on April 15 and October 15 of each year. The 2021 Unsecured Notes are a senior unsecured obligation of Surgery Center Holdings, Inc. and are guaranteed on a senior unsecured basis by each of Surgery Center Holdings, Inc.'s existing and future domestic wholly owned restricted subsidiaries that guarantees the Revolver and the 2014 First Lien (subject to certain exceptions).

We may redeem up to 35% of the aggregate principal amount of the 2021 Unsecured Notes, at any time before April 15, 2018, with the net cash proceeds of certain equity offerings at a redemption price equal to 108.875% of the principal amount to be redeemed, plus accrued and unpaid interest to, but excluding, the date of redemption, provided that at least 50% of the aggregate principal amount of the 2021 Unsecured Notes remain outstanding immediately after the occurrence of such redemption and such redemption occurs within 180 days of the date of the closing of any such qualified equity offering.

We may redeem the 2021 Unsecured Notes, in whole or in part, at any time prior to April 15, 2018 at a price equal to 100.000% of the principal amount to be redeemed plus an applicable make-whole premium, plus accrued and unpaid interest, if any, to, but excluding, the date of redemption. We may redeem the 2021 Unsecured Notes, in whole or in part, at any time on or after April 15, 2018, at the redemption prices set forth below (expressed as a percentage of the principal amount to be redeemed), plus accrued and unpaid interest, if any, to the date of redemption:

April 15, 2018 to April 14, 2019	106.656%
April 15, 2019 to April 14, 2020	104.438%
April 15, 2020 and thereafter	100.000%

If Surgery Center Holdings, Inc., experiences a change in control under certain circumstances, we must offer to purchase the 2021 Unsecured Notes at a purchase price equal to 101.000% of the principal amount, plus accrued and unpaid interest to, but excluding, the date of repurchase.

The 2021 Unsecured Notes contain customary affirmative and negative covenants, which among other things, limit our ability to incur additional debt, pay dividends, create or assume liens, effect transactions with its affiliates, guarantee payment of certain debt securities, sell assets, merge, consolidate, enter into acquisitions and effect sale and leaseback transactions.

In connection with the offering of the 2021 Unsecured Notes, we incurred debt issuance costs of $8.4 million.

Senior Unsecured Notes due 2025

Effective June 30, 2017, SP Finco, LLC, one of our wholly owned, indirect subsidiaries, issued $370.0 million in gross proceeds of senior unsecured notes due July 1, 2025 (the “2025 Unsecured Notes”). The gross proceeds were deposited in an escrow account (the "Escrow Account") established at Wilmington Trust, National Association (in such capacity, the "Escrow Agent") in the name of the trustee under the indenture governing the 2025 Unsecured Notes (the "2025 Unsecured Notes Indenture") on behalf of the holders of the 2025 Unsecured Notes. The 2025 Unsecured Notes bear interest at the rate of 6.750% per year, payable semi-annually on January 1 and July 1 of each year, commencing on January 1, 2018. The 2025 Unsecured Notes are a senior unsecured obligation of SP Finco, LLC.

In connection with the closing of the NSH Merger (further described in Note 1 of our condensed consolidated financial statements included previously in this report) and the release of the proceeds from the Escrow Account (the “Escrow Release”), SP Finco, LLC will be merged with and into Surgery Center Holdings, Inc., with Surgery Center Holdings, Inc. surviving such merger (the “Initial Issuer Merger”) and assuming the rights and obligations of SP Finco, LLC under the 2025 Unsecured Notes and the 2025 Unsecured Notes Indenture by operation of law. From and after the release of the proceeds from the Escrow Account, the Initial Issuer Merger and the consummation of the NSH Merger, the 2025 Unsecured Notes will be guaranteed on a senior unsecured basis by each of Surgery Center Holdings, Inc.’s domestic wholly owned restricted subsidiaries that guarantees Surgery Center Holdings, Inc.’s senior secured credit facilities (subject to certain exceptions).

At June 30, 2017, we included the escrowed proceeds as a long-term asset in our condensed consolidated balance sheets.

We may redeem up to 40% of the aggregate principal amount of the 2025 Unsecured Notes at any time prior to July 1, 2020, with the net cash proceeds of certain equity issuances at a redemption price equal to 106.750% of the principal amount to be redeemed, plus accrued

and unpaid interest to, but excluding, the date of redemption, provided that at least 50% of the aggregate principal amount of the 2025 Unsecured Notes remain outstanding immediately after the occurrence of such redemption and such redemption occurs within 180 days of the date of the closing of the applicable equity offering.

We may redeem the 2025 Unsecured Notes, in whole or in part, at any time prior to July 1, 2020, at a price equal to 100.000% of the principal amount to be redeemed plus the applicable premium, plus accrued and unpaid interest, if any, to, but excluding, the date of redemption. We may redeem the 2025 Unsecured Notes, in whole or in part, at any time on or after July 1, 2020, at the redemption prices set forth below (expressed as a percentage of the principal amount to be redeemed), plus accrued and unpaid interest, if any, to, but excluding, the date of redemption:

July 1, 2020 to June 30, 2021	103.375%
July 1, 2021 to June 30, 2022	101.688%
July 1, 2022 and thereafter	100.000%

If the NSH Merger does not occur on or prior to the applicable date set forth in the 2025 Unsecured Notes Indenture or, if earlier, we notify the Escrow Agent that the NSH Merger will not be closed, then SP Finco, LLC will be required to redeem the 2025 Unsecured Notes within three business days at a price equal to 100.000% of the initial issue price of the 2025 Unsecured Notes, plus accrued and unpaid interest, if any, to, but excluding, the date of such redemption.

If Surgery Center Holdings, Inc., experiences a change in control under certain circumstances, we must offer to purchase the 2025 Unsecured Notes at a purchase price equal to 101.000% of the principal amount, plus accrued and unpaid interest to, but excluding, the date of repurchase.

The 2025 Unsecured Notes contain customary affirmative and negative covenants, which, upon consummation of the Initial Issuer Merger, among other things, will limit the our ability to incur additional debt, pay dividends, create or assume liens, effect transactions with its affiliates, guarantee payment of certain debt securities, sell assets, merge, consolidate, enter into acquisitions and effect sale and leaseback transactions.

In connection with the offering of the 2025 Unsecured Notes, we recorded debt issuance costs of $2.9 million.

Subordinated Notes

As of June 30, 2017, we had a subordinated debt facility ("Subordinated Notes") of $1.0 million. The Subordinated Notes, owed to H.I.G. Surgery Centers, LLC, had a maturity date of August 4, 2017 and had the interest rate of 17.00% per annum. As described in Note 8 of our unaudited condensed consolidated financial statements included previously in this report, on August 3, 2017 we redeemed the Subordinated Notes, in whole, at a price equal 100% of the $1.0 million principal amount redeemed, plus accrued and unpaid interest.

Notes Payable and Secured Loans

Certain of our subsidiaries have outstanding bank indebtedness, which is collateralized by the real estate and equipment owned by the surgical facilities to which the loans were made. The various bank indebtedness agreements contain covenants to maintain certain financial ratios and also restrict encumbrance of assets, creation of indebtedness, investing activities and payment of distributions. At June 30, 2017, we were in compliance with the covenants contained in the credit agreement. We and our subsidiaries had notes payable to financial institutions of $52.8 million and $42.5 million as of June 30, 2017 and December 31, 2016, respectively. We and our subsidiaries also provide a corporate guarantee of certain indebtedness of our subsidiaries.

Capital Lease Obligations

We are liable to various vendors for several equipment leases. The carrying value of the leased assets was $15.9 million and $15.4 million as of June 30, 2017 and December 31, 2016, respectively.

Summary

Based on our current level of operations, we believe cash flow from operations and available cash, together with available borrowings under the Revolver, will be adequate to meet our short-term (12 months or less) and longer-term (less than five years) liquidity needs.

EBITDA, Adjusted EBITDA and Credit Agreement EBITDA

When we use the term “EBITDA,” we are referring to net income minus (a) net income attributable to non-controlling interests plus (b) income tax expense, (c) interest expense, net, and (d) depreciation and amortization. Non-controlling interests represent the interests of third parties, such as physicians, and in some cases, healthcare systems that own an interest in surgical facilities that we consolidate for financial reporting purposes. Our operating strategy is to apply a market-based approach in structuring our partnerships with individual market dynamics driving the structure. We believe that it is helpful to investors to present EBITDA as defined above because it excludes the portion of net income attributable to these third-party interests and clarifies for investors our portion of EBITDA generated by our surgical facilities and other operations.

We use EBITDA as a measure of liquidity. We have included it because we believe that it provides investors with additional information about our ability to incur and service debt and make capital expenditures. When we use the term "Adjusted EBITDA", we are referring to EBITDA, as defined above, adjusted for (a) merger transaction, integration and practice acquisition costs, (b) non-cash stock compensation

expense, (c) loss on debt refinancing, (d) contingent acquisition compensation expense, (e) gain on litigation settlement and (f) loss on disposal or impairment of long-lived assets, net.

We use "Credit Agreement EBITDA" to determine our compliance under certain covenants pursuant to our credit facilities. When we use the term "Credit Agreement EBITDA," we are referring to Adjusted EBITDA, as defined above, further adjusted for (a) acquisitions, (b) non-cash expenses and (c) de novo start-up losses. These adjustments do not relate to our historical financial performance and instead relate to estimates compiled by our management and calculated in conformance with the definition of "Consolidated EBITDA" used in the credit agreements governing our credit facilities.

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

The following table reconciles EBITDA and Adjusted EBITDA to net income (in thousands and unaudited):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2016	2017	2016
Condensed Consolidated Statements of Operations Data (in thousands):				
Net income	$ 11,627	$ 22,293	$ 26,049	$ 32,649
(Minus):				
Net income attributable to non-controlling interests	16,098	20,173	33,274	37,720
Plus (minus):				
Income tax expense	512	2,420	2,629	4,190
Interest expense, net	25,600	26,235	50,782	48,388
Depreciation and amortization	11,417	9,702	22,525	19,271
EBITDA	33,058	40,477	68,711	66,778
Plus:				
Merger transaction, integration and practice acquisition costs	4,137	2,192	4,728	6,108
Non-cash stock compensation expense	1,435	502	2,069	635
Loss on debt refinancing	—	—	—	8,281
Contingent acquisition compensation expense	1,814	1,530	3,847	1,530
Gain on litigation settlement	(3,794)	—	(3,794)	—
Loss on disposal or impairment of long-lived assets, net	405	1,331	1,601	1,125
Adjusted EBITDA	$ 37,055	$ 46,032	$ 77,162	$ 84,457

The following table reconciles EBITDA, Adjusted EBITDA and Credit Agreement EBITDA to net income (in thousands and unaudited):

	Twelve Months Ended June 30, 2017
Condensed Consolidated Statements of Operations Data (in thousands):	
Net income	$ 78,483
(Minus):	
Net income attributable to non-controlling interests	71,184
Plus (minus):	
Income tax expense	5,534
Interest expense, net	102,965
Depreciation and amortization	42,805
EBITDA	158,603
Plus:	
Merger transaction, integration and practice acquisition costs	10,237
Tax receivable agreement	3,733
Non-cash stock compensation expense	3,455
Loss on debt refinancing	3,595
Contingent acquisition compensation expense	7,409
Gain on litigation settlement	(17,895)
Loss on disposal of investments and long-lived assets, net	2,831
Adjusted EBITDA	$ 171,968
Plus:	
Acquisitions [(1)]	32,199
Non-cash expenses	1,596
De novo start-up losses [(2)]	299
Credit Agreement EBITDA	206,062

[(1)] Represents impact of acquired anesthesia entities, physician practices and surgical facilities as if each acquisition had occurred on July 1, 2016 including cost savings from reductions in corporate overhead, supply chain rationalization, enhanced physician engagement, improved payor contracting and revenue synergies associated with rolling out our suite of ancillary services throughout both the acquired entities and Symbion portfolio. Further, this includes revenue synergies from other business initiatives as defined in the Credit Agreement.

[(2)] Relates to the losses associated with de novo in-market physician practices opened during the last twelve months.

Inflation

Inflation and changing prices have not significantly affected our operating results or the markets in which we operate.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, "*Revenue from Contracts with Customers*," along with subsequent amendments, updates and an extension of the effective date (collectively the “New Revenue Standard”), which outlines a single comprehensive model for recognizing revenue and supersedes most existing revenue recognition guidance, including guidance specific to the healthcare industry. This five-step process will require significant management judgment in addition to changing the way many companies recognize revenue in their financial statements. Additionally, and among other provisions, the New Revenue Standard requires expanded quantitative and qualitative disclosures, including disclosure about the nature, amount, timing and uncertainty of revenue. The provisions of the New Revenue Standard are effective for annual periods beginning after December 15, 2017, including interim periods within those years by applying either the full retrospective method or the modified retrospective approach upon adoption. We will adopt this ASU on January 1, 2018. Upon the continued evaluation of the New Revenue Standard, we currently plan to adopt using the modified retrospective method, including providing all requisite disclosures under such method.

In preparation for the adoption of the New Revenue Standard, we continue to evaluate and refine our estimates of the anticipated impacts the New Revenue Standard will have on our revenue recognition policies, procedures, financial position, results of operations, cash flows, financial disclosures and control framework. Specifically, we continue to evaluate our accounting policies and internal controls under the New Revenue Standard, as well as analyzing all of the potential effects of the New Revenue Standard, particularly with respect to non-patient service revenue sources. Upon further evaluation, we anticipate that the majority of our provision for doubtful accounts will continue to be recognized as an operating expense rather than as a direct reduction to revenues, given our practice of assessing a patient’s ability to pay prior to or on the date of providing healthcare services.

In February 2016, the FASB issued ASU 2016-02, "*Leases*," which will require, among other items, lessees to recognize most leases as assets and liabilities on the balance sheet. Qualitative and quantitative disclosures will be enhanced to better understand the amount, timing and uncertainty of cash flows arising from leases. This guidance is effective for financial statements issued for fiscal years beginning after December 15, 2018, and interim periods within those fiscal years, with early adoption permitted. We believe the primary effect of adopting the new standard will be to record right-of-use assets and obligations for current operating leases.

In March 2016, the FASB issued ASU 2016-07, "*Investments- Equity Method and Joint Ventures*," which allows investments that now meet equity method treatment and were previously accounted for under a different method to apply the equity method prospectively from the date the investment qualifies for equity method treatment. ASU 2016-07 is effective prospectively for fiscal years beginning after December 15, 2016, including interim periods within those years. Early adoption is permitted. We adopted this ASU on January 1, 2017. The adoption of this ASU did not have a material impact on our consolidated financial position, results of operations, cash flows and financial disclosures.

In August 2016, the FASB issued ASU 2016-15, "*Classification of Certain Cash Receipts and Cash Payments*," which clarifies the classification of certain cash receipts and cash payments on the statement of cash flows. ASU 2016-15 is effective retrospectively for fiscal years beginning after December 15, 2017, including interim periods within those years. Early adoption is permitted. We are currently evaluating the impact this new guidance may have on the consolidated cash flows.

In October 2016, the FASB issued ASU 2016-17, "*Interests Held through Related Parties That Are under Common Control*," which modifies existing guidance with respect to how a decision maker that holds an indirect interest in a VIE through a common control party determines whether it is the primary beneficiary of the VIE as part of the analysis of whether the VIE would need to be consolidated. Under the ASU, a decision maker would need to consider only its proportionate indirect interest in the VIE held through a common control party. Previous guidance had required the decision maker to treat the common control party's interest in the VIE as if the decision maker held the interest itself. As a result of the ASU, in certain cases, previous consolidation conclusions may change. ASU 2016-17 is effective prospectively for fiscal years beginning after December 15, 2016, including interim periods within those years. We adopted this ASU on January 1, 2017. The adoption of this ASU did not have a material impact on our consolidated financial position, results of operations, cash flows and financial disclosures.

In November 2016, the FASB issued ASU 2016-18, "*Statement of Cash Flows: Restricted Cash*," which will require the reconciliation of restricted cash in the statement of cash flows. ASU 2016-18 is effective retrospectively for fiscal years beginning after December 15, 2017, including interim periods within those years. Early adoption is permitted. The adoption of this ASU will not have a material impact on our consolidated cash flows.

In January 2017, the FASB issued ASU 2017-01, "*Business Combinations – Clarifying the Definition of a Business*," which narrows the definition of a business when evaluating whether transactions should be accounted for as asset acquisition or business combination. ASU 2017-01 is effective for fiscal years beginning after December 15, 2017, including interim periods within those years. Early adoption is permitted. We are currently evaluating the impact this new guidance may have on the consolidated financial position, results of operations and cash flows.

In January 2017, the FASB issued ASU 2017-04, "*Simplifying the Test for Goodwill Impairment*," which eliminates the requirement to calculate the implied fair value of goodwill (i.e., Step 2 of the current goodwill impairment test) to measure a goodwill impairment charge. Instead, entities will record an impairment charge based on the excess of a reporting unit's carrying amount over its fair value (i.e., measure the charge based on the current Step 1). ASU 2017-04 is effective for fiscal years beginning after December 15, 2019, including interim periods within those years. Early adoption is permitted for annual and interim periods after January 1, 2017. We early adopted this ASU on January 1, 2017. The adoption of ASU 2017-04 only impacts our financial statements in situations where an impairment of a reporting unit's assets is determined.

Sources of Revenue and Recent Regulatory Developments

General

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

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

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

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

Certificates of Need and Licensure

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

Our healthcare facilities also are subject to state licensing requirements for medical providers. Our ASCs have licenses to operate in the states in which they operate and must meet all applicable requirements for ASCs. In addition, even though our surgical facilities that are licensed as hospitals primarily provide surgical services, they must meet all applicable requirements for general hospital licensure. To assure continued compliance with these regulations, governmental and other authorities periodically inspect our surgical facilities. The failure to comply with these regulations could result in the suspension or revocation of a facility’s license. In addition, based on the specific operations of our surgical facilities, some of these facilities maintain a pharmacy license, a controlled substance registration, a clinical laboratory certification waiver, and environmental protection permits for biohazards and/or radioactive materials, as required by applicable law.

Healthcare Reform

The Affordable Care Act has been subject to a number of challenges to its constitutionality. On June 28, 2012, the United States Supreme Court upheld challenges to the constitutionality of the “individual mandate” provision, which generally requires all individuals to purchase healthcare insurance or pay a penalty, but struck down as unconstitutional the provision that would have allowed the federal government to revoke all federal Medicaid funding to any state that did not expand its Medicaid program. As a result, many states have refused to extend Medicaid eligibility to more individuals as envisioned by the law.

On June 25, 2015, the United States Supreme Court upheld the legality of premium subsidies made available by the federal government to individuals residing in the 36 states that have federally-run health insurance exchanges. The subsidies are provided to low-income individuals to assist with the cost of purchasing health insurance through federally-run health insurance exchanges. Other legal challenges to the Affordable Care Act are pending.

Initiatives to repeal the Affordable Care Act, in whole or in part, to delay elements of implementation or funding, and to offer amendments or supplements to modify its provisions have been persistent and have increased as a result of the 2016 election. The ultimate outcomes of legislative attempts to repeal or amend the Affordable Care Act and legal challenges to the Affordable Care Act are unknown. On May 4, 2017, the House of Representatives passed the American Health Care Act, which, if ultimately enacted into law in its current form, would repeal substantial portions of the Affordable Care Act, including the individual mandate. The American Health Care Act would replace means-tested insurance premium subsidies with age-adjusted tax credits and permit insurers to impose a surcharge up to 30 percent on individuals who go uninsured for more than two months and then purchase coverage. The American Health Care Act would also limit federal funding available for the Affordable Care Act’s Medicaid expansion and transition federal Medicaid funding to a per-capita cap basis. It remains unclear whether the American Health Care Act will be further amended or enacted. The Senate is also developing its own legislation to amend and potentially repeal portions of the Affordable Care Act. Any such future repeal, or amendment of the Affordable Care Act, including the American Health Care Act or legislation developed by the Senate, remains uncertain. Such legislation may have significant impact on the reimbursement for healthcare services generally, and may cause more individuals to become uninsured, rendering them unable to afford healthcare services offered by the Company. Accordingly, there can be no assurance that the adoption of any future federal or state healthcare reform legislation will not have a negative financial impact on the Company.

Moreover, other legislative changes have also been proposed and adopted since the Affordable Care Act was enacted. On August 2, 2011, the Budget Control Act of 2011, among other things, created measures for spending reductions by Congress. A Joint Select Committee on Deficit Reduction, tasked with recommending a targeted deficit reduction of at least $1.2 trillion for the years 2013 through 2021, was unable to reach required goals, thereby triggering the legislation’s automatic reduction to several government programs. This included aggregate reductions to Medicare payments to providers of 2% per fiscal year, which went into effect on April 1, 2013 and, due to subsequent legislative amendments, will remain in effect through 2025 unless additional Congressional action is taken. On January 2, 2013, President Obama signed into law the American Taxpayer Relief Act of 2012, which, among other things, further reduced Medicare payments to several providers, including hospitals, and increased the statute of limitations period for the government to recover overpayments to providers from three to five years. These and other similar new laws may result in additional reductions in Medicare and other health care funding, which could have a material adverse effect on our financial operations.

Medicare and Medicaid Private Contractor Audits

The Centers for Medicare and Medicaid Services (“CMS") has implemented a number of programs that use private contractors that contract with CMS to identify overpayments and underpayments and other potential sources of billing fraud. These contractors, known as Recovery Audit Contractors (“RACs”) and Zone Program Integrity Contractors (“ZPICs”) conduct both post-payment and pre-payment review

of claims submitted by Medicare providers. In addition, CMS employs Medicaid Integrity Contractors ("MICs") to perform post-payment audits of Medicaid claims and identify overpayments. Our facilities and providers continue to receive letters from auditors such as RACs and ZPICs requesting repayment of alleged overpayments for services and incur expenses associated with responding to and appealing these determinations, as well as the costs of repaying any overpayments. Moreover, in recent years, the increase in Medicare payment appeals has created a backlog such that resolving appeals often takes multiple years.

For instance, we received the results of a MIC audit that resulted in an overpayment obligation. HMS Federal Solutions, a MIC, completed the audit of one of our surgical hospitals for the period July 1, 2009 through May 31, 2012 and determined an overpayment obligation in the amount of approximately $4.6 million based on its extrapolation of a statistical sampling of claims, as well as a civil monetary penalty in the amount of $162,000, for a total amount owed to Idaho's Department of Health and Welfare, Medicaid Program Integrity Unit of approximately $4.7 million for failure to comply with Medicaid rules by billing for (i) non-covered services, (ii) services provided by non-eligible providers, (iii) services not provided and (iv) unauthorized services. We appealed the audit, which was settled during the quarter ending June 30, 2017 for $1.3 million.

Although all other repayments requested to date as a result of RAC, MIC and ZPIC audits have not been material to our Company, we are unable to quantify the aggregate financial impact of these audits on our facilities given the pending appeals and uncertainty about the extent of future audits.

Quality Improvement

The Medicare program presently requires hospitals and ASCs to report performance data on a variety of quality metrics. Facilities that fail to report are penalized with reduced Medicare payments. Additionally, payments to hospitals are adjusted based on the hospital's performance on these quality measures. A substantial portion of hospital payment is at risk depending on its individual performance relative to benchmarks and other hospitals' performance. There is a substantial risk that our Medicare payments could be reduced if our hospitals fail to perform adequately on these measures. Additionally, there is a risk that Medicare payments could be reduced if our facilities-hospitals and ASCs-fail to adequate report data as required by CMS. ASC payments are not yet adjusted based on performance against quality measures, but there is a substantial risk that Congress may soon link ASC Medicare payments to actual performance, in addition to reporting.

If the public performance data becomes a primary factor in determining where patients choose to receive care, and if competing hospitals and ASCs have better results than our facilities on those measures, we would expect that our patient volumes could decline.

Medicare and Medicaid Participation

The majority of our revenue is expected to continue to be received from third-party payors, including federal and state programs, such as Medicare and Medicaid, and commercial payors. To participate in the Medicare program and receive Medicare payment, our surgical facilities must comply with regulations promulgated by the Department of Health and Human Services ("HHS"). Among other things, these regulations, known as "conditions for coverage" or "conditions of participation," impose numerous requirements on our facilities, their equipment, their personnel and their standards of medical care, as well as compliance with all applicable state and local laws and regulations. On April 26, 2007, CMS issued a policy memorandum that reaffirmed its prior interpretation of its conditions of participation that all hospitals (other than critical access hospitals) participating in the Medicare program are required to provide basic emergency care interventions regardless of whether or not the hospital maintains an emergency department. Our five facilities licensed as hospitals are required to meet this requirement to maintain their participating provider status in the Medicare program. As of June 30, 2017, two of our hospitals, which do not have an emergency room, maintain a protocol for the transfer of patients requiring emergency treatment, which protocol may be interpreted as inconsistent with the 2007 CMS policy memorandum. Our surgical facilities must also satisfy the conditions of participation to be eligible to participate in the various state Medicaid programs. The requirements for certification under Medicare and Medicaid are subject to change and, in order to remain qualified for these programs, we may have to make changes from time to time in our facilities, equipment, personnel or services. Although we intend to continue to participate in these reimbursement programs, we cannot assure you that our surgical facilities will continue to qualify for participation.

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

Survey and Accreditation

Hospitals and healthcare facilities are subject to periodic inspection by federal, state and local authorities to determine their compliance with applicable regulations and requirements necessary for licensing, certification and accreditation. All of our hospitals and surgical facilities currently are licensed under appropriate state laws and are qualified to participate in the Medicare and Medicaid programs. Renewal and continuation of certain of these licenses, certifications and accreditations are based on inspections or other reviews generally conducted in the

normal course of business of health facilities. Loss of, or limitations imposed on, licenses or accreditations could reduce a facility's utilization or revenue, or its ability to operate all or a portion of its facilities.

Utilization Review

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

Federal Anti-Kickback Statute and Medicare Fraud and Abuse Laws

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

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

Under regulations issued by the Office of the Inspector General of the U.S. Department of Health and Human Services (the "OIG"), certain categories of activities are deemed not to violate the Anti-Kickback Statute (commonly referred to as the safe harbors). According to the preamble to these safe harbor regulations, the failure of a particular business arrangement to comply with the regulations does not determine whether the arrangement violates the Anti-Kickback Statute. The safe harbor regulations do not make conduct illegal, but instead outline standards that, if complied with, protect conduct that might otherwise be deemed in violation of the Anti-Kickback Statute. Failure to meet a safe harbor does not indicate that the arrangement violates the Anti-Kickback Statute, although it may be subject to additional scrutiny.

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

- The ASC must be an ASC certified to participate in the Medicare program, and its operating and recovery room space must be dedicated exclusively to the ASC and not a part of a hospital (although such space may be leased from a hospital if such lease meets the requirements of the safe harbor for space rental).
- Each investor must be either (a) a physician who derived at least one-third of his or her medical practice income for the previous fiscal year or 12-month period from performing procedures on the list of Medicare-covered procedures for ASCs, (b) a hospital, or (c) a person or entity not in a position to make or influence referrals to the center, nor to provide items or services to the ASC, nor employed by the ASC or any investor.
- Unless all physician-investors are members of a single specialty, each physician-investor must perform at least one-third of his or her procedures at the ASC each year. This requirement is in addition to the requirement that the physician-investor has derived at least one-third of his or her medical practice income for the past year from performing procedures.
- Physician-investors must have fully informed their referred patients of the physician's investment.
- The terms on which an investment interest is offered to an investor are not related to the previous or expected volume of referrals, services furnished or the amount of business otherwise generated from that investor to the entity.
- Neither the ASC nor any other investor nor any person acting on their behalf may loan funds to or guarantee a loan for an investor if the investor uses any part of such loan to obtain the investment interest.

- The amount of payment to an investor in return for the investment interest is directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.
- All physician-investors, any hospital-investor and the center agree to treat patients receiving benefits or assistance under a federal healthcare program in a non-discriminatory manner.
- All ancillary services performed at the ASC for beneficiaries of federal healthcare programs must be directly and integrally related to primary procedures performed at the ASC and may not be billed separately.
- No hospital-investor may include on its cost report or any claim for payment from a federal healthcare program any costs associated with the ASC.
- The ASC may not use equipment owned by or services provided by a hospital-investor unless such equipment is leased in accordance with a lease that complies with the Anti-Kickback Statute equipment rental safe harbor and such services are provided in accordance with a contract that complies with the Anti-Kickback Statute personal services and management contract safe harbor.
- No hospital-investor may be in a position to make or influence referrals directly or indirectly to any other investor or the ASC.

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

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

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

Our hospital investments do not fit wholly within the safe harbor for investments in small entities because more than 40.0% of the investment interests are held by investors who are either in a position to refer to the hospital or who provide services to the hospital and more than 40.0% of the hospital's gross revenue last year were derived from referrals generated by investors. However, we believe we comply with the remaining elements of the safe harbor.

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

Certain of our ASCs have entered into arrangements for professional services, including arrangements for anesthesia services. In a Special Advisory Bulletin issued in April 2003, the OIG focused on "questionable" contractual arrangements where a health care provider in one line of business (the "Owner") expands into a related health care business by contracting with an existing provider of a related item or service (the "Manager/Supplier") to provide the new item or service to the Owner's existing patient population, including federal health care program patients (so called "suspect Contractual Joint Ventures"). The Manager/Supplier not only manages the new line of business, but may also supply it with inventory, employees, space, billing, and other services. In other words, the Owner contracts out substantially the entire operation of the related line of business to the Manager/Supplier-otherwise a potential competitor-receiving in return the profits of the business as remuneration for its referrals. Through an Advisory Opinion, the OIG extended this suspect contractual joint venture analysis to arrangements between anesthesiologists and physician owners of ASCs. In Advisory Opinion 12-06, the OIG concluded that certain proposed arrangements between anesthesia groups and physician-owned ASCs could result in prohibited remuneration under the federal Anti-Kickback Statute. We believe our arrangements for anesthesia services are distinguishable from those described in Advisory Opinion 12-06 (May 25, 2012) and are in compliance with the requirements of the federal Anti-Kickback Statute. However, we cannot assure you that regulatory authorities would agree with that position.

We also may guarantee a surgical facility's third-party debt financing and certain lease obligations as part of our obligations under a management agreement. Physician investors are generally not required to enter into similar guarantees. The OIG might take the position that the failure of the physician investors to enter into similar guarantees represents a special benefit to the physician investors given to induce patient referrals and that such failure constitutes a violation of the Anti-Kickback Statute. We believe that the management fees (and in some cases guarantee fees) are adequate compensation to us for the credit risk associated with the guarantees and that the failure of the physician investors to enter into similar guarantees does not create a material risk of violating the Anti-Kickback Statute. However, the OIG has not issued any guidance in this regard.

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

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

Federal Physician Self-Referral Law

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

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

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

Five of our facilities are licensed as hospitals as of June 30, 2017. The Stark Law currently includes the Whole Hospital Exception, which applies to physician ownership of a hospital, provided such ownership is in the whole hospital and the physician is authorized to perform services at the hospital. We believe that physician investments in our facilities licensed as hospitals meet this requirement. However, changes to the Whole Hospital Exception have been the subject of recent regulatory action and legislation. Changes in the Affordable Care Act include:

- a prohibition on hospitals from having any physician ownership unless the hospital already had physician ownership and a Medicare provider agreement in effect as of December 31, 2010;
- a limitation on the percentage of total physician ownership or investment interests in the hospital or entity whose assets include the hospital to the percentage of physician ownership or investment as of March 23, 2010;
- a prohibition from expanding the number of beds, operating rooms, and procedure rooms for which it is licensed after March 23, 2010, unless the hospital obtains an exception from the Secretary;
- a requirement that return on investment be proportionate to the investment by each investor;
- restrictions on preferential treatment of physician versus non-physician investors;
- a requirement for written disclosures of physician ownership interests to the hospital’s patients and on the hospital’s website and in any advertising, along with annual reports to the government detailing such interests;
- a prohibition on the hospital or other investors from providing financing to physician investors;
- a requirement that any hospital that does not have 24/7 physician coverage inform patients of this fact and receive signed acknowledgments from the patients of the disclosure; and
- a prohibition on “grandfathered” status for any physician owned hospital that converted from an ASC to a hospital on or after March 23, 2010.

The Affordable Care Act also requires that each hospital with physician ownership submit an annual report of ownership and/or investment interest. Our hospitals have submitted their first reports. CMS has delayed the collection of the second report and publication of the first annual report. We cannot predict whether other proposed amendments to the Whole Hospital Exception will be included in any future legislation, including a repeal of the Affordable Care Act, or if Congress will adopt any similar provisions that would prohibit or otherwise restrict physicians from holding ownership interests in hospitals. Any such changes could have an adverse effect on our financial condition and results of operations.

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

False and Other Improper Claims

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

Over the past several years, the U.S. government has investigated an increasing number of healthcare providers for potential violations of the federal False Claims Act. The federal False Claims Act prohibits a person from knowingly presenting, or causing to be presented, a false or fraudulent claim to the U.S. government. The statute defines “knowingly” to include not only actual knowledge of a claim’s falsity, but also reckless disregard for or intentional ignorance of the truth or falsity of a claim. The Fraud Enforcement and Recovery Act of 2009 further expanded the scope of the False Claims Act by, among other things, creating liability for knowingly and improperly avoiding or decreasing an obligation to pay money to the federal government. The Affordable Care Act also created federal False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or the date by which a

corresponding cost report is due, whichever is later. This requirement has led to an increasing use of the self-disclosure protocols that have been implemented by CMS, the OIG and other governmental agencies by the healthcare industry. The Affordable Care Act also provided that claims submitted in connection with patient referrals that result from violations of the Anti-Kickback Statute constitute false claims for the purposes of the federal False Claims Act, and some courts have held that a violation of the Stark Law can result in False Claims Act liability as well. Because our surgical facilities perform hundreds of similar procedures a year for which they are paid by Medicare and other government health care programs, and there is a relatively long statute of limitations, a billing error or cost reporting error could result in significant civil or criminal penalties.

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

Other Fraud and Abuse Laws

The Medicare Patient and Program Protection Act of 1987, as amended by the Health Insurance Portability and Accountability Act of 1996, (“HIPAA”), and the Balanced Budget Act of 1997, impose civil monetary penalties and exclusion from state and federal healthcare programs on providers who commit violations of fraud and abuse laws. HIPAA authorizes the Secretary of the Department of Health & Human Services (“Secretary”), and in some cases requires the Secretary, to exclude individuals and entities that the Secretary determines have “committed an act” in violation of applicable fraud and abuse laws or improperly filed claims in violation of such laws from participating in any federal healthcare program. HIPAA also expanded the Secretary’s authority to exclude a person involved in fraudulent activity from participating in a program providing health benefits, whether directly or indirectly, in whole or in part, by the U.S. government. Additionally, under HIPAA, individuals who hold a direct or indirect ownership or controlling interest in an entity that is found to violate these laws may also be excluded from Medicare and Medicaid and other federal and state healthcare programs if the individual knew or should have known, or acted with deliberate ignorance or reckless disregard of, the truth or falsity of the information of the activity leading to the conviction or exclusion of the entity, or where the individual is an officer or managing employee of such entity. This standard does not require that specific intent to defraud be proven by OIG. Under HIPAA it is also a crime to defraud any commercial healthcare benefit program.

Federal and State Privacy and Security Requirements

We are subject to HIPAA, including The HITECH Act, which was enacted as part of The American Recovery and Reinvestment Act of 2009. The HITECH Act strengthened the requirements and significantly increased the penalties for violations of the HIPAA privacy and security regulations. On January 25, 2013, HHS issued the HIPAA Omnibus Rule, which became effective on March 26, 2013. Prior to the HIPAA Omnibus Rule, the HITECH Act required us to notify patients of any unauthorized access, acquisition, or disclosure of their unsecured protected health information that poses significant risk of financial, reputational or other harm to a patient. The HIPAA Omnibus Rule eliminated this harm threshold standard and instead we are now required to notify patients of any unauthorized access, acquisition, or disclosure of their unsecured protected health information in all situations except those in which we can demonstrate that there is a low probability that the protected health information has been compromised. We now have the burden of demonstrating through a risk assessment that a breach of protected health information has not occurred. This new more objective standard may lead to an increased number of occurrences that require breach notifications. In addition, the HIPAA Omnibus Rule also modified the following aspects of the HIPAA privacy and security regulations:

- makes our facilities’ business associates directly liable for compliance with certain of HIPAA’s requirements;
- makes our facilities liable for violations by their business associates if HHS determines an agency relationship exists between the facility and the business associate under federal agency law;
- adds limitations on the use and disclosure of health information for marketing and fund-raising purposes, and prohibits the sale of protected health information without individual authorization;
- expands our patients’ rights to receive electronic copies of their health information and to restrict disclosures to a health plan concerning treatment for which our patient has paid out of pocket in full;
- requires modifications to, and redistribution of, our facilities’ notice of privacy practices;
- requires modifications to existing agreements with business associates;
- adopts the additional HITECH Act provisions not previously adopted addressing enforcement of noncompliance with HIPAA due to willful neglect;
- incorporates the increased and tiered civil money penalty structure provided by the HITECH Act; and
- revises the HIPAA privacy rule to increase privacy protections for genetic information as required by the Genetic Information Nondiscrimination Act of 2008.

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

The HIPAA security standards require us to establish and maintain reasonable and appropriate administrative, technical and physical safeguards to ensure the integrity, confidentiality and the availability of electronic protected health and related financial information. Although the security standards do not reference or advocate a specific technology, and covered healthcare providers, plans and clearinghouses have the flexibility to choose their own technical solutions, the security standards have required us to implement significant new systems, business procedures and training programs.

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

The HITECH Act authorizes State Attorneys General to bring civil actions seeking either an injunction or damages in response to violations of HIPAA privacy and security regulations or the new data breach law that affects the privacy of their state residents. We expect vigorous enforcement of the HITECH Act's requirements by HHS and State Attorneys General. Additionally, HHS conducted a pilot audit program that concluded December 2012 in the first phase of HHS' implementation of the HITECH Act's requirements of periodic audits of covered entities and business associates to ensure their compliance with the HIPAA privacy and security regulations. HHS has allocated increased funding towards HIPAA enforcement activity and such enforcement activity has seen a marked increase over recent years. We cannot predict whether our surgical facilities will be able to comply with the final rules and the financial impact to our surgical facilities in implementing the requirements under the final rules when they take effect, or whether our hospitals will be selected for an audit, or the results of such an audit.

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

Adoption of Electronic Health Records

The HITECH Act includes provisions designed to increase the use of EHR by both physicians and hospitals. Beginning in 2011 and extending through 2016, eligible hospitals may receive incentive payments based upon successfully demonstrating meaningful use of its certified EHR technology. Beginning in 2015, those hospitals that do not successfully demonstrate meaningful use of EHR technology are subject to reduced payments from Medicare. EHR meaningful use objectives and measures that hospitals and physicians must meet in order to qualify for incentive payments will be implemented in three stages. Stage 1 has been in effect since 2011 and Stage 2 took effect for hospitals beginning in fiscal year 2014. On October 16, 2015, CMS published a final rule that consolidated Stage 1 and Stage 2 into a "Modified Stage 2" effective as of 2015 and set out requirements for Stage 3, which is set to take full effect in 2018. In connection with the acquisition of Symbion, we acquired six surgical facilities that are licensed as hospitals, five of which we own as of June 30, 2017. These hospitals began the implementation of EHR initiatives in 2012. We strive to comply with the EHR meaningful use requirements of the HITECH Act so as to qualify for incentive payments. Continued implementation of EHR and compliance with the HITECH Act will result in significant costs. We recorded income of $161,000 and $302,000 which was recognized during the three and six months ended June 30, 2017, respectively. We incurred negligible costs for hardware, software and implementation expenses during the same three month period. We do not currently know the extent of additional costs that will be associated with implementation of additional systems or the amount of future incentives that we will receive.

HIPAA Administrative Simplification Requirements

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

Emergency Medical Treatment and Active Labor Act

Our hospitals are subject to the Emergency Medical Treatment and Active Labor Act ("EMTALA"). This federal law requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency department for treatment and, if the patient is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the patient to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions or transfer exists regardless of a patient's ability to pay for treatment. Off-campus facilities such as surgery centers that lack emergency departments or otherwise do not treat emergency medical conditions generally are not subject to EMTALA. They must, however, have policies in place that explain how the location should proceed in an emergency situation, such as transferring the patient to the closest hospital with an emergency department. There are severe penalties under EMTALA if a hospital fails to screen or appropriately

stabilize or transfer a patient or if the hospital delays appropriate treatment in order to first inquire about the patient's ability to pay, including civil monetary penalties and exclusion from participation in the government health care programs. In addition, an injured patient, the patient's family or a medical facility that suffers a financial loss as a direct result of another hospital's violation of the law can bring a civil suit against that other hospital. CMS has actively enforced EMTALA and has indicated that it will continue to do so in the future. Although we believe that our hospitals comply with EMTALA, we cannot predict whether CMS will implement new requirements in the future and, if so, whether our hospitals will comply with any new requirements.

State Regulation

Many of the states in which our surgical facilities operate have adopted statutes and/or regulations that prohibit the payment of kickbacks or any type of remuneration in exchange for patient referrals and that prohibit healthcare providers from, in certain circumstances, referring a patient to a healthcare facility in which the provider has an ownership or investment interest. While these statutes generally mirror the federal Anti-Kickback Statute and Stark Law, they vary widely in their scope and application. Some are specifically limited to healthcare services that are paid for in whole or in part by the Medicaid program; others apply to all healthcare services regardless of payor; and others apply only to state-defined designated services, which may differ from the designated health services under the Stark Law. In addition, many states have adopted statutes that mirror the False Claims Act and that prohibit the filing of a false or fraudulent claim with a state governmental agency. We intend to comply with all applicable state healthcare laws, rules and regulations. However, these laws, rules and regulations have typically been the subject of limited judicial and regulatory interpretation. As a result, we cannot assure you that our surgical facilities will not be investigated or scrutinized by the governmental authorities empowered to do so or, if challenged, that their activities would be found to be lawful. A determination of non-compliance with the applicable state healthcare laws, rules, and regulations could subject our surgical facilities to civil and criminal penalties and could have a material adverse effect on our operations.

We are also subject to various state insurance statutes and regulations that prohibit us from submitting inaccurate, incorrect or misleading claims. Many state insurance laws and regulations are broadly worded and could be implicated, for example, if our surgical facilities were to adjust an out-of-network co-payment or other patient responsibility amounts without fully disclosing the adjustment on the claim submitted to the payor. While some of our surgical facilities adjust the out-of-network costs of patient co-payment and deductible amounts to reflect in-network co-payment costs when providing services to patients whose health insurance is covered by a payor with which the surgical facilities are not contracted, our policy is to fully disclose adjustments in the claims submitted to the payors. We believe that our surgical facilities are in compliance with all applicable state insurance laws and regulations regarding the submission of claims. We cannot assure you, however, that none of our surgical facilities' insurance claims will ever be challenged. If we were found to be in violation of a state's insurance laws or regulations, we could be forced to discontinue the violative practice, which could have an adverse effect on our financial position and results of operations, and we could be subject to fines and criminal penalties.

Fee Splitting; Corporate Practice of Medicine

The laws of many states prohibit physicians from splitting fees with non-physicians (i.e., sharing in a percentage of professional fees), prohibit non-physician entities (such as us) from practicing medicine and exercising control over or employing physicians and prohibit referrals to facilities in which physicians have a financial interest. The existence, interpretation and enforcement of these laws vary significantly from state to state. In light of these restrictions, in certain states we facilitate the provision of physician services by maintaining long-term management services agreements through our subsidiaries with affiliated professional contractors, which employ or contract with physicians and other healthcare professionals to provide physician professional services. Under these arrangements, our subsidiaries perform only non-medical administrative services, do not represent that they offer medical services and do not exercise influence or control over the practice of medicine by the physicians employed by the affiliated professional contractors. Although we believe that the fees we receive from affiliated professional contractors have been structured in a manner that is compliant with applicable fee-splitting laws, it is possible that a government regulator could interpret such fee arrangements to be in violation of certain fee-splitting laws. Future interpretations of, or changes in, these laws might require structural and organizational modifications of our existing relationships, and we cannot assure you that we would be able to appropriately modify such relationships. In addition, statutes in some states could restrict our expansion into those states.

Clinical Laboratory Regulation

Our clinical laboratories are subject to federal oversight under the Clinical Laboratory Improvement Amendments of 1988 ("CLIA") which extends federal oversight to virtually all clinical laboratories by requiring that they be certified by the federal government or by a federally-approved accreditation agency. CLIA requires that all clinical laboratories meet quality assurance, quality control and personnel standards. Laboratories also must undergo proficiency testing and are subject to inspections. Standards for testing under CLIA are based on the complexity of the tests performed by the laboratory, with tests classified as "high complexity," "moderate complexity," or "waived." Laboratories performing high complexity testing are required to meet more stringent requirements than moderate complexity laboratories. Laboratories performing only waived tests, which are tests determined by the Food and Drug Administration to have a low potential for error and requiring little oversight, may apply for a certificate of waiver exempting them from most of the requirements of CLIA. Our operations also subject to state and local laboratory regulation. CLIA provides that a state may adopt laboratory regulations different from or more stringent than those under federal law, and a number of states have implemented their own laboratory regulatory requirements. State laws may require that laboratory personnel meet certain qualifications, specify certain quality controls, or require maintenance of certain records. We believe that we are in material compliance with all applicable laboratory requirements, but no assurances can be given that our laboratories will pass all future licensure or certification inspections.

Regulatory Compliance Program

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

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

Item 3. Quantitative and Qualitative Disclosures about Market Risk

We are subject to market risk primarily from exposure to changes in interest rates based on our financing, investing and cash management activities. We utilize a balanced mix of maturities along with both fixed rate and variable rate debt to manage our exposures to changes in interest rates, and do not hold or issue any derivative financial instruments for this purpose.

Our variable rate debt instruments are primarily indexed to the prime rate or LIBOR. Interest rate changes would result in gains or losses in the market value of our fixed rate debt portfolio due to differences in market interest rates and the rates at the inception of the debt agreements. At June 30, 2017, we had outstanding principal amount of debt, excluding unamortized debt issuance costs and discounts, of $943.4 million in variable rate instruments. Assuming a hypothetical 100 basis points increase in LIBOR on our debt as of June 30, 2017, our quarterly interest expense would increase by approximately $2.4 million. Although there can be no assurances that interest rates will not change significantly, we do not expect changes in interest rates to have a material effect on our net earnings or cash flows in 2017 based on our indebtedness at June 30, 2017.

Item 4. Controls and Procedures

An evaluation was performed under the supervision and with the participation of our management, including the Chief Executive Officer and the Chief Financial Officer, of the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities and Exchange Act of 1934, as amended (the "Exchange Act")) as of the end of the period covered by this report to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act, is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms and to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is accumulated and communicated to our management, including the Chief Executive Officer and the Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosure. Based on, and as of the time of such evaluation, our management, including the Chief Executive Officer and Chief Financial Officer, concluded that our disclosure controls and procedures were not effective as a result of the material weakness identified by management as initially disclosed under "Item 9A-Controls and Procedures" in our Annual Report on Form 10-K for the year ended December 31, 2016.

Such material weakness pertains to lack of documentation evidencing certain controls involving revenue, accounts receivable and related allowances. Notwithstanding the identified material weakness, as of the date of this filing, management, including the Chief Executive Officer and Chief Financial Officer, believes that the unaudited consolidated financial statements contained in this Quarterly Report on Form 10-Q fairly present, in all material respects, our financial condition, results of operations and cash flows for the fiscal years presented in conformity with GAAP. Management is actively engaged in the implementation of a remediation plan to address the lack of documentation issue. The plan includes the implementation of enhanced documentation policies and procedures, along with the allocation of resources dedicated to training and monitoring these policies and procedures.

As a result of these efforts, as of the date of this filing management believes we have made progress toward remediating the underlying causes of the material weakness. Although we believe our remediation efforts will be effective in remediating the material weakness, there can be no assurance as to when the remediation plan will be fully implemented, or that the plan, as currently designed, will adequately remediate the material weakness. The material weakness will not be considered fully addressed until the enhanced policies and procedures over documentation evidencing certain controls involving revenue, accounts receivable and related allowances have been in operation for a sufficient period of time for our management to conclude that the material weakness has been fully remediated. We will continue to work on implementing and testing the enhanced documentation policies and procedures in order to make this final determination.

Other than our progress in our remediation efforts outlined above, there have been no changes during the quarter ended June 30, 2017 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Limitations on the Effectiveness of Controls

Our management, including the Chief Executive Officer and the Chief Financial Officer, recognizes that any set of controls and procedures, no matter how well-designed and operated, can provide only reasonable, not absolute, assurance of achieving the desired control objectives. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud, if any, with the Company have been detected. These inherent limitations include the realities that judgments in decision-making can be faulty and that breakdowns can occur because of simple error or mistake. Additionally, controls can be circumvented by the individual acts of some persons, by collusion of two or more people or by management override of controls. For these reasons, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

PART II - OTHER INFORMATION

Item 1. ***Legal Proceedings***

We are, from time to time, subject to claims and suits arising in the ordinary course of business, including claims for damages for personal injuries, breach of management contracts and employment related claims. In certain of these actions, plaintiffs request payment for damages, including punitive damages, that may not be covered by insurance. In the opinion of management, we are not currently a party to any proceedings that would have a material adverse effect on our business, financial condition or results of operations.

Item 1A. ***Risk Factors***

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

Risks Related to Our Business, Industry and the Transactions

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

We depend upon private and governmental third-party sources of payment for the services provided by physicians in our physician network, to patients in our surgical facilities and by our laboratory and diagnostic services. The amount that we receive in payment for our services may be adversely affected by market and cost factors that 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 Ambulatory Surgery Center payment system and refinements made by CMS to Medicare's reimbursement policies. For instance, cuts to the federal budget caused a 2.0% reduction in Medicare provider payments starting in 2013. Similarly, third-party payors may be successful in negotiating reduced reimbursement schedules with our facilities. Fixed fee schedules, capitation payment arrangements, exclusion from participation in or inability to reach agreements with managed care programs, reduction or elimination of payments or an increase in the payments at a rate that is less than the increase in our costs, or other factors affecting payments for healthcare services over which we have no control could have a material adverse effect on our business, prospects, results of operations and financial condition.

If we are unable to negotiate and enter into favorable contracts or maintain satisfactory relationships and renew existing contracts on favorable terms with managed care organizations or other private third-party payors, our revenue and profitability may decrease.

Payments from private third-party payors, including state workers' compensation programs and managed care organizations, represented approximately 50% of our patient service revenue for both the three and six months ended June 30, 2017. Most of these payments came from third-party payors with which our facilities have contracts. Managed care companies such as HMOs and PPOs, which offer prepaid and discounted medical service packages, represent a growing segment of private third-party payors. If we fail to enter into favorable contracts or maintain satisfactory relationships with managed care organizations, our revenue may decrease. Our competitive position has been, and will continue to be, affected by initiatives undertaken during the past several years by major purchasers of healthcare services, including insurance companies and employers, to revise payment methods and monitor healthcare expenditures in an effort to contain healthcare costs. For instance, managed care payors may lower reimbursement rates in response to increased obligations on payors imposed by the Affordable Care Act or future reductions in Medicare reimbursement rates. Further, managed care payors may narrow their provider networks in response to the need to negotiate lower reimbursement rates with providers. If we are unable to maintain strong relationships with payors, we may not be able to ensure participation in these narrow provider networks. Cost containment measures, such as fixed fee schedules, capitation payment arrangements, reductions in reimbursement schedules by third-party payors and closed provider networks, could also cause a reduction of our revenue in the future.

Some of our payments from third-party payors come from third-party payors with which our surgical facilities, physicians or subsidiaries that provide diagnostic services do not have a contract. In those cases where we provide services to a patient that does not use a third-party payor with which we have contracted, commonly known as "out-of-network" services, we generally charge the patients the same co-payment or other patient responsibility amounts that we would have charged had our surgical facilities had a contract with the payor. In accordance with insurance laws and regulations, we submit a claim for the services to the payor along with full disclosure that our surgical facility has charged the patient an in-network patient responsibility amount. Historically, those third-party payors who do not have contracts with our surgical facilities typically have paid our claims at higher than comparable contracted rates. However, over the past five years we have observed an increase in third-party payors adopting out-of-network fee schedules that are more comparable to our contracted rates or to take other steps to discourage their enrollees from seeking treatment at out-of-network surgical facilities. In these cases, we seek to enter into contracts with the payors.

Payments from workers' compensation payors represented approximately 6% of our patient service revenue for both the three and six months ended June 30, 2017. A majority of states have implemented workers' compensation provider fee schedules. In some cases, the fee schedule rates contain lower rates than the rates our surgical facilities have historically been paid for the same services. If states reduce the amounts paid to providers under the workers' compensation fee schedules, it could have a material adverse effect on our financial condition and results of operations.

Significant changes in our payor mix or surgical 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 surgical 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 no insurance, commercial insurance, Medicare coverage, Medicaid coverage and workers' compensation insurance, respectively. Since, generally speaking, we receive relatively higher payment rates from commercial and workers' compensation insurers than Medicare, Medicaid and other government-funded programs, 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 have an adverse effect on our business, prospects, results of operations and financial condition.

Surgical case mix refers to the relative share of total cases performed by specialty, such as GI, general surgery, ophthalmology, orthopedic and pain management. Generally speaking, certain types of our cases, such as orthopedic cases, generate relatively higher revenue than other types of cases, such as pain management and GI cases. Therefore, a significant shift in our surgical 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 surgical 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.

We have a history of net losses and may not achieve or sustain profitability in the future.

We have net losses of $4.5 million and $7.3 million for the three and six months ended June 30, 2017. We cannot assure you that our revenue will grow or that we will achieve or maintain profitability in the future. Growth of our revenue may slow or revenue may decline and expenses may increase for a number of possible reasons, including reduced demand for our services, regulatory shifts, failure to successfully continue to integrate the operations of Surgery Partners and Symbion and other risks and uncertainties. Even though we have achieved profitability during 2016 and 2015, we may not achieve, 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." All of these factors could contribute to future net losses and, if we are unable to meet these risks and challenges as we encounter them, our business may suffer. If we are not able to achieve, sustain or increase profitability, our business will be adversely affected and our stock price may decline.

We may be unable to obtain the regulatory approvals required to consummate the NSH Merger in a timely fashion, or at all, or may need to take certain actions that could have an adverse effect on our operation in order to obtain them. We may also be unable to obtain the debt financing necessary for us to complete the NSH Merger. Any delay or impediment in our ability to consummate the NSH Merger could have an adverse effect on our business, financial condition, results of operations or cash flows.

Consummation of the NSH Merger is subject to closing conditions, including, but not limited to, the following: (i) the required approval of the NSH Merger by NSH's stockholders, (ii) the expiration or early termination of the waiting period applicable to the consummation of the Transactions under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, (the "HSR Act") and (iii) the receipt of certain other regulatory approvals. There can be no assurance that we will obtain all the required regulatory approvals within the timeframe necessary to consummate the NSH Merger. In addition, as a condition to granting their approval, certain regulatory authorities may require us to agree to concessions or undertakings (including the additional divestiture of assets or businesses or the termination of relationships or contractual obligations) that could have an adverse effect on our business or that of the combined company. In the event that the NSH Merger is not consummated under certain circumstances specified in the NSH Merger Agreement, including our failure to obtain the required regulatory approvals, we may be required to pay to NSH a termination fee of $45.6 million. Because the consummation of the NSH Merger is a condition to closing the other Transactions, any delay or impediment in the consummation of the NSH Merger will also result in a delay or impediment to any or all of the remaining Transactions. The failure of the NSH Merger to close on a timely basis or at all, including if we are required to pay a termination fee in connection with the termination of the NSH Merger Agreement, could have an adverse effect on our business, financial condition, results of operations or cash flows.

If the NSH Merger is consummated, we may be unable to successfully integrate our operations with those of NSH and we may not realize the anticipated synergies and cost savings from our combination. If the NSH Merger does not achieve its intended results, our business, financial condition and results of operations could be materially and adversely affected.

If the NSH Merger is consummated, our combination with NSH will involve the integration of two companies that previously operated independently, and the unique business cultures of the two companies may prove to be incompatible. The anticipated integration of NSH into our operations will be a significant undertaking and will require significant attention from our management team. It is possible that the integration process could take longer than anticipated and could result in the loss of valuable employees and customer relationships, the disruption of each company's ongoing businesses, processes, and systems, additional operating expenses as a result of the integration of operations, potential impairment of intangible assets and goodwill acquired in the NSH Merger, or inconsistencies in standards, controls, procedures, practices, policies, and compensation arrangements, any of which could adversely affect our ability to achieve the anticipated benefits of the NSH Merger. Our results of operations could also be adversely affected by any issues attributable to NSH's operations that arise or are based on events or actions that occur prior to the closing of its acquisition. We may have difficulty addressing possible differences

in corporate cultures and management philosophies between NSH and us. The integration process is subject to a number of uncertainties, and no assurance can be given that the anticipated benefits will be realized or, if realized, the timing of their realization.

Although we currently expect to realize cost and revenue synergies if the Transactions are consummated, actual acquisition synergies could differ materially from our current expectations In addition, we cannot assure you that we will achieve the expected synergies or that these synergies and cost savings will not have other adverse effects on our business. Failure to achieve the anticipated benefits of the NSH Merger could result in increased costs or decreases in the amount of expected revenue and could materially adversely affect our business, financial condition and results of operations.

Failure to realize the expected cost savings or revenue synergies related to the NSH Merger could result in increased costs and have an adverse effect on the combined company's financial results and prospects.

We will incur substantial transaction fees and costs in connection with the Transactions and related debt financing and payoff, including the NSH Merger.

We expect to incur non-recurring transaction costs in connection with the Transactions and related debt financing and payoff totaling approximately $103.5 million, including initial purchasers' discounts, legal, accounting and financial advisory fees, commitment and other financing fees, and other transaction costs. Additional costs will be incurred in the course of the integration of our and NSH's operations. We cannot be certain that the expected elimination of duplicative costs or the realization of other expected efficiencies related to the integration of the businesses will offset the transaction and integration costs in the near term, or at all.

The assumption of unknown liabilities in the acquisition of NSH may harm our financial condition and results of operations.

If the NSH Merger is consummated, at the closing of the NSH Merger, we will assume all of NSH's liabilities, including known and unknown contingent liabilities (other than certain of NSH's existing debt, which will be paid off in connection with the NSH Merger). If there are significant unknown obligations, or if we incur significant losses arising from known contingent liabilities assumed by us upon closing of the acquisition, the combined company's business could be materially and adversely affected. We may learn additional information about NSH's business that adversely affects the combined company, such as unknown liabilities, or issues that could affect our ability to comply with applicable laws. As a result, we cannot assure you that the acquisition of NSH will be successful or that it will not, in fact, harm our business. Among other things, if NSH's liabilities are greater than expected, or if there are material obligations of which we are not aware, our business could be materially and adversely affected. If we become responsible for substantial unindemnified or uninsured liabilities, these liabilities may have a material adverse effect on our financial condition and results of operations.

We do not currently control NSH and will not control its business or assets until the consummation of the NSH Merger.

We do not currently control NSH and will not control its business or assets until the consummation of the NSH Merger. We cannot assure you that, prior to the consummation of the acquisition, NSH will be operated in the same way as it would be under our control.

We depend on physician utilization of our surgical facilities, which could decrease if we fail to maintain good relationships with affiliated physicians. Our ability to provide medical services at our facilities would be impaired and our revenue reduced if we are not able to maintain these relationships.

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

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

Physician treatment methodologies and governmental or commercial health insurance controls designed to reduce the number of surgical procedures may reduce our revenue and profitability.

Controls imposed by Medicare and 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 revenue 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 integrate operations of acquired surgical facilities, attract new physician partners, and to acquire and develop additional surgical facilities, on favorable terms. If we are unable to achieve any of these goals, our future growth could be limited and our operating results could be adversely affected.

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.

In addition, our growth strategy includes the acquisition and development 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. We have acquired interests in or developed all of our surgical facilities since our inception and we expect to continue to expand our operations in the future. We are currently evaluating potential acquisitions and development projects and expect to continue to evaluate acquisitions and development projects in the foreseeable future. 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. Further, the companies or assets we acquire in the future may not ultimately produce returns that justify our related investment.

Our acquisition activities, and our limited development activities, require substantial capital resources, and we may need to obtain additional capital or financing, from time to time, to fund these activities. Historically, we have funded acquisition and development activities through our credit facilities. 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, licensure requirements, antitrust laws, 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. The limited number of surgical facilities we develop typically incur losses in their early months of operation (more so in the case of surgical hospitals) and, until their case loads grow, they generally experience lower total revenue and operating margins than established surgical facilities, and we expect this trend to continue.

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. Further, any delays or unexpected costs incurred in connection with integration could have a material adverse effect on our operations and earnings. 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.

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.

In addition, although we conduct extensive due diligence prior to the acquisition of surgical facilities and seek indemnification from prospective sellers covering unknown or contingent liabilities, we may acquire facilities with unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations. Although we maintain professional liability insurance that provides coverage on a claims-made basis of $1.0 million per occurrence with a retention of $100,000 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. 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.

Our rapid growth has placed, and will continue to place, increased demands on our management, operational and financial information systems and other resources. Furthermore, expansions into new geographic markets and services may require us to comply with new and unfamiliar legal and regulatory requirements, which could impose substantial obligations on us and our management, cause us to expend

additional time and resources, and increase our exposure to penalties or fines for non-compliance with such requirements. To accommodate our past and anticipated future growth, and to compete effectively, we will need to continue to improve our management, operational and financial information systems and to expand, train, manage and motivate our workforce. Our personnel, systems, procedures or controls may not be adequate to support our operations in the future. Further, focusing our financial resources and management attention on the expansion of our operations may negatively impact our financial results. Any failure to improve our management, operational and financial information systems, or to expand, train, manage or motivate our workforce, could reduce or prevent our growth.

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, surgical 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, the surgical facilities may be unable to perform certain surgeries, which could adversely affect case volume or result in a negative shift in surgical 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 be expected to 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 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.

We face competition for patients, physicians 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 also unaffiliated hospitals in each market in which we operate. These hospitals have established relationships with physicians and payors. In addition, other companies either currently are in the same or similar business of developing, acquiring and operating surgical facilities or may decide to enter our business. Many of these companies have greater resources than we do, including financial, marketing, staff and capital resources. We also may compete with some of these companies for entry into strategic relationships with healthcare systems and healthcare professionals. In addition, many physician groups develop surgical facilities without a corporate partner. In recent years, more physicians are choosing to perform procedures, including pain management and gastrointestinal procedures, in an office-based setting rather than in a surgical facility. If we are unable to compete effectively with any of these entities or groups, we may be unable to implement our business strategies successfully and our financial position and results of operations could be adversely affected.

Competition for physicians and nurses, shortages of qualified personnel or other factors could increase our labor costs and adversely affect our revenue, profitability and cash flows.

Our operations are dependent on the efforts, abilities and experience of our physicians and clinical personnel. We compete with other healthcare providers, primarily hospitals and other surgical facilities, in attracting physicians to utilize our surgical facilities, nurses and medical staff to support our surgical facilities, recruiting and retaining qualified management and support personnel responsible for the daily operations of each of our facilities and in contracting with managed care payors in each of our markets. 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 three and six months ended June 30, 2017, our salary and benefit expenses represented approximately 31% of our revenue. 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 revenue 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 employees 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.

Some jurisdictions preclude us from entering into non-compete agreements with our physicians, and other non-compete agreements and restrictive covenants applicable to certain physicians and other clinical employees may not be enforceable.

We have contracts with physicians and other health professionals in many states. Some of our physician services contracts, as well as many of our physician services contracts with hospitals, include provisions preventing these physicians and other health professionals from competing with us both during and after the term of our contract with them. The law governing non-compete agreements and other forms of restrictive covenants varies from state to state. Some jurisdictions prohibit us from entering into non-compete agreements with our professional staff. Other states are reluctant to strictly enforce non-compete agreements and restrictive covenants against physicians and other healthcare professionals. Therefore, there can be no assurance that our non-compete agreements related to employed or otherwise contracted physicians and other health professionals will be enforceable if challenged in certain states. In such event, we would be unable to prevent former employed or otherwise contracted physicians and other health professionals from competing with us, potentially resulting in the loss of some of our hospital contracts and other business. Additionally, certain facilities have the right to employ or engage our providers after the termination or expiration of our contract with those facilities and cause us not to enforce our non-compete provisions related to those providers.

We may become involved in litigation which could negatively impact the value of our business.

From time-to-time we are involved in lawsuits, claims, audits and investigations, including those arising out of services provided, personal injury claims, professional liability claims, billing and marketing practices, employment disputes and contractual claims. We may become subject to future lawsuits, claims, audits and investigations that could result in substantial costs and divert our attention and resources and adversely affect our business condition. In addition, since our current growth strategy includes acquisitions, among other things, we may become exposed to legal claims for the activities of an acquired business prior to the acquisition. These lawsuits, claims, audits or investigations, regardless of their merit or outcome, may also adversely affect our reputation and ability to expand our business.

In addition, from time to time we have received, and expect to continue to receive, correspondence from former employees terminated by us who threaten to bring claims against us alleging that we have violated one or more labor and employment regulations. In certain instances former employees have brought claims against us and we expect that we will encounter similar actions against us in the future. An adverse outcome in any such litigation could require us to pay contractual damages, compensatory damages, punitive damages, attorneys' fees and costs.

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

In recent years, physicians, hospitals and other healthcare providers have become subject to an increasing number of legal actions alleging malpractice, product liability or related legal theories. Many of these actions involve large monetary claims and significant defense costs. We also owe certain defense and indemnity obligations to our officers and directors.

We maintain liability insurance in amounts that we believe are customary for the industry. Currently, we maintain professional liability insurance that provides coverage on a claims-made basis of $1.0 million per occurrence with a retention of $100,000 per occurrence and $3.0 million in annual aggregate coverage per surgical facility, including the facility and employed staff. We maintain general liability insurance that provides coverage on a occurrence basis of $1.0 million per occurrence with a retention of $25,000 per occurrence and $3.0 million in annual aggregate coverage per surgical facility. We also maintain business interruption insurance and property damage insurance, as well as an additional umbrella liability insurance policy in the aggregate amount of $33.0 million. Coverage under certain of these policies is contingent upon the policy being in effect when a claim is made regardless of when the events which caused the claim occurred. In addition, physicians who provide professional services in our surgical facilities are required to maintain separate malpractice coverage with similar minimum coverage limits. We also maintain a directors' and officers' insurance policy, which insures our directors and officers against unindemnified losses arising from certain wrongful acts in their capacities as directors and officers and reimburses us for those losses for which we have lawfully indemnified the directors and officers.

This insurance coverage may not cover all claims against us. Insurance coverage may not continue to be available at a cost allowing us to maintain adequate levels of insurance. If one or more successful claims against us were not covered by or exceeded the coverage of our insurance, our financial condition and results of operations could be adversely affected. Our business, profitability and growth prospects could suffer if we face negative publicity or we pay damages or defense costs in connection with a claim that is outside the scope or limits of coverage of any applicable insurance coverage, including claims related to adverse patient events, contractual disputes, professional and general liability, and directors' and officers' duties.

In addition, if our costs of insurance and claims increase, then our earnings could decline. Market rates for insurance premiums and deductibles have been steadily increasing. Our earnings and cash flows could be materially and adversely affected by any of the following:

- the collapse or insolvency of our insurance carriers;
- further increases in premiums and deductibles;
- increases in the number of liability claims against us or the cost of settling or trying cases related to those claims; or
- an inability to obtain one or more types of insurance on acceptable terms, if at all.

Financial pressures on patients, and current and future economic condition, may adversely affect our volume and surgical case mix.

Even as the U.S. economy shows signs of sustained, if modest, growth, many individuals throughout the country continue to experience difficult financial conditions. Our case volume and surgical case mix may be adversely affected by patients' unwillingness to pay for procedures in our facilities. Higher numbers of unemployed individuals generally translates into more individuals without healthcare insurance to help pay for procedures, thereby increasing the potential for persons to elect not to have procedures performed. 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 facilities' fee. Although we have taken steps to minimize the impact of these conditions, it is difficult to predict the degree to which our business will continue to be impacted by such conditions or the course of the economy in the future.

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. Additionally, there continues to be uncertainty regarding the Affordable Care Act, and any such result could adversely affect our business by exacerbating the financial pressures on patients, leading them to further delay or cancel non-emergency surgical procedures.

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

Our revenue are particularly sensitive to regulatory, economic and other conditions in the states of Florida and Texas. As of June 30, 2017, we owned and operated five consolidated surgical facilities in Texas and 22 consolidated surgical facilities in Florida. The Texas facilities represented approximately 11% of our revenue during each of the three and six months ended June 30, 2017. The Florida facilities represented approximately 21% and 22% of our revenue during the three and six months ended June 30, 2017, respectively.

In addition, our surgical hospital in Idaho Falls, Idaho represented 20% of our revenue during each of the three and six months ended June 30, 2017. This surgical hospital also provides ancillary services, including physician practices, radiation oncology and anesthesia services. If there were an adverse regulatory, economic or other development in any of the states in which we have a higher concentration of facilities, including Idaho, our case volumes could decline in such 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.

If any of our existing healthcare facilities lose their accreditation status or any of our new facilities fail to receive accreditation, such facilities could become ineligible to receive reimbursement under Medicare or Medicaid or other third-party payors.

The construction and operation of healthcare facilities are subject to extensive federal, state and local regulation relating to, among other things, the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting and compliance with building codes and environmental protection. Additionally, such facilities are subject to periodic inspection by government authorities and accreditation organizations to assure their continued compliance with these various standards.

All of our facilities are deemed certified, meaning that they are accredited, properly licensed under the relevant state laws and regulations and certified under the Medicare program or are in the process of applying for such accreditation, licensing or certification. The effect of maintaining certified facilities is to allow such facilities to participate in the Medicare and Medicaid programs. We believe that all of our facilities are in material compliance with applicable federal, state, local and other relevant accreditation and certification regulations and standards. However, should any of our healthcare facilities lose their deemed certified status and thereby lose certification under the Medicare or Medicaid programs, such facilities would be unable to receive reimbursement from either or both of those programs, and possibly from other third-party payors, and our business could be materially adversely affected.

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 limited partnerships ("LPs"), general partnerships ("GP") and limited liability companies ("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.

Additionally, many 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 or the interests of our stockholders.

We generally hold our ownership interests in facilities through limited or general partnerships, LLCs or limited liability partnerships ("LLPs") in which we maintain an ownership interest along with physicians and, in some cases, physicians and 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 owners. We also have a duty to operate our business for the benefit of our stockholders. As a result, we may encounter conflicts between our responsibility to the other owners and our responsibility to our stockholders. 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 or the stockholders best interest. 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 or limited liability company 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.

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 current practice of providing medical services in advance of payment or, in many cases, prior to assessment of ability to pay for such services, may have significant negative impact on our revenue, bad debt expense and cash flow. We bill numerous and varied payors, such as self-pay patients, managed care payors and Medicare and Medicaid. These different payors typically have different billing requirements that must be satisfied prior to receiving payment for services rendered. Reimbursement is typically conditioned on our documenting medical necessity and correctly applying diagnosis codes. Incorrect or incomplete documentation and billing information could result in non-payment for services rendered. 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.

Additional factors that could complicate our billing include:

- disputes between payors as to which party is responsible for payment;
- failure of information systems and processes to submit and collect claims in a timely manner;
- variation in coverage for similar services among various payors;
- the difficulty of adherence to specific compliance requirements, diagnosis coding and other procedures mandated by various payors; and
- failure to obtain proper physician credentialing and documentation in order to bill various payors.

We provide for bad debts principally based upon the type of payor and the age of the receivables. Our allowance for doubtful accounts at June 30, 2017 and December 31, 2016, represented 13% and 12% 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.

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

Because our senior management has been key to our growth and success, we are highly dependent on our senior management, including Michael Doyle, our Chief Executive Officer, and Teresa Sparks, our Executive Vice President and Chief Financial Officer. We do not maintain "key man" life insurance policies on any of our officers. 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. Because our senior management has contributed greatly to our growth since inception, the loss of key management personnel, without adequate replacements, or our inability to attract, retain and motivate sufficient numbers of qualified management personnel could have a material adverse effect on our financial condition and results of operations.

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

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

We may write-off intangible assets, such as goodwill.

As a result of purchase accounting for our various acquisition transactions, our balance sheet at June 30, 2017 contained intangible assets designated as either goodwill or intangibles totaling approximately $1.6 billion in goodwill and approximately $43.0 million in intangibles.

The acquisition of NSH, if consummated, may, and any other additional acquisitions that result in the recognition of additional intangible assets would cause an increase in these intangible assets. On an ongoing basis, we evaluate whether facts and circumstances indicate any impairment of the value of intangible assets. As circumstances change, we cannot assure you that the value of these intangible assets will be realized by us. If we determine that a significant impairment has occurred, we will be required to write-off the impaired portion of intangible assets, which could have a material adverse effect on our results of operations in the period in which the write-off occurs.

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

As of June 30, 2017, we had total indebtedness of approximately $1.0 billion under our $950.0 million senior secured first lien term loan (the "First Lien Term Loan"), which includes $150.0 million under a revolving credit facility (the "Revolver") of which approximately $55.9 million was available, $400.0 million senior unsecured notes due 2021 (the "2021 Unsecured Notes") and $370.0 million senior unsecured notes due 2025 (the "2025 Unsecured Notes" and, together with the First Lien Term Loan, the Revolver and the 2021 Unsecured Notes the "Term Loans and Revolving Facility"). In addition, subject to the restrictions in the Term Loans and Revolving Facility, we may incur significant additional indebtedness, which may be secured, from time to time, which could have important consequences, including:

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

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 may adversely affect our business, financial condition and results of operations.

Our ability to pay or to refinance our indebtedness and to fund working capital needs and planned capital expenditures will depend upon our future operating performance and our ability to generate cash, which will be affected by many factors beyond our control, including general economic, financial, competitive, legislative, regulatory, business and other factors.

If our business does not generate sufficient cash flow or if future borrowings are not available to us in an amount sufficient to enable us to pay our indebtedness or to fund our other liquidity needs, we may need to refinance all or a portion of our indebtedness on or before the maturity thereof, sell assets, reduce or delay capital investments or seek to raise additional capital, any of which could have a material adverse effect on our operations. In addition, we may not be able to affect any of these actions, if necessary, on commercially reasonable terms or at all. Our ability to restructure or refinance our indebtedness 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. The terms of existing or future debt instruments may limit or prevent us from taking any of these actions. In addition, any failure to make scheduled payments of interest and principal on our outstanding indebtedness would likely result in a reduction of our credit rating, which could harm our ability to incur additional indebtedness on commercially reasonable terms or at all. Our inability to generate sufficient cash flow to satisfy our debt service obligations, or to refinance or restructure our obligations on commercially reasonable terms or at all, may adversely affect our business, financial condition and results of operations.

Restrictive covenants in our debt instruments may adversely affect us.

The Term Loans and Revolving Facility contain various covenants that limit, among other things, our ability and the ability of our restricted subsidiaries to:

- incur additional indebtedness;
- make certain distributions, investments and other restricted payments;
- dispose of our assets;
- grant liens on our assets;
- engage in transactions with affiliates;
- merge, consolidate or transfer substantially all of our assets; and
- make payments to us (in the case of our restricted subsidiaries).

In addition, the Term Loans and Revolving Facility contain other and more restrictive covenants. As a result of these and other covenants and restrictions, we are and will be limited in how we conduct our business, and we may be unable to raise additional debt or equity financing to compete effectively or to take advantage of new business opportunities. In addition, there are covenants requiring us to maintain specified financial ratios triggered in certain situations and to satisfy other financial condition tests. Our ability to meet those financial ratios and tests can be affected by events beyond our control, and we cannot assure you that we will continue to meet those tests. A breach of any of these covenants could result in a default under the Term Loans and Revolving Facility. Upon the occurrence of an event of default under the Term Loans and Revolving Facility, the lenders could elect to declare all amounts outstanding under the Term Loans and Revolving Facility to be immediately due and payable and terminate all commitments to extend further credit. If we were unable to repay those amounts, the lenders could proceed against the collateral granted to them to secure that indebtedness. We have pledged substantially all of our assets, other than assets of our non-guarantor subsidiaries, as security under the Term Loans and Revolving Facility. If the lenders under the Term Loans and Revolving Facility accelerate the repayment of borrowings, we cannot assure you that we will have sufficient assets to repay our Term Loans and Revolving Facility and our other indebtedness.

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

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 credit agreements governing the Term Loans and Revolving Facility contain 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. In addition, as of June 30, 2017 we had approximately $55.9 million available for additional borrowings under the Revolver, all of which is permitted to be incurred under the credit agreement governing the Term Loans and Revolving Facility. 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.

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

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

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

We own and operate our surgical facilities through limited partnerships and limited liability companies. Local physicians, physician groups and healthcare systems also own an interest in all but three of these partnerships and limited liability companies. In the partnerships in which we are the general partner, we are liable for 100% of the debts and other obligations of the partnership, even if we do not own all of the partnership interests. For some of our surgical facilities, indebtedness at the partnership level is funded through intercompany loans that we provide. At June 30, 2017, our intercompany loans totaled $25.0 million. Through these loans we have a security interest in the partnership's or limited liability company's assets. However, our financial condition and results of operations would be materially adversely affected if our surgical facilities are unable to repay these intercompany loans, or such loans are challenged under certain health care laws. Additionally, at June 30, 2017, our global intercompany note, which we use to transfer debt balances between our subsidiaries, had a zero balance.

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

From time to time, we may guarantee our pro-rata share of the third-party debts and other obligations of many of the non-consolidated partnerships and limited liability companies in which we own an interest, subject to a limit provided in our credit agreements. In most instances of these guarantees, the physicians and/or physician groups have also guaranteed their pro-rata share of the indebtedness to secure the financing.

Our variable rate indebtedness subjects us to interest rate risk, which could cause our indebtedness service obligations to increase significantly.

Borrowings under the First Lien Term Loan and Revolving Facility are at variable rates of interest and expose us to interest rate risk. If interest rates increase, our debt service obligations on variable rate indebtedness would increase even though the amount borrowed remained the same, and our net income and cash flows, including cash available for servicing our indebtedness, would correspondingly decrease.

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.

The First Lien Term Loan is a senior secured first lien obligation of Surgery Center Holdings, Inc. and is guaranteed on a senior secured first priority basis and secured by substantially all of the assets, including pledges of equity interests, of Surgery Center Holdings, Inc., SP Holdco I, Inc. and the subsidiary guarantors described in the documentation, which are comprised of material wholly-owned non-excluded subsidiaries of Surgery Center Holdings, Inc.

We have the option of classifying the First Lien Term Loan and borrowings under the Revolver as either ABR loans or ED loans. The interest base rate on an ABR loan is equal to the greatest of (a) the Prime Rate in effect on such day, (b) the Federal Funds Effective Rate in effect on such day plus 0.50%, and (c) the Adjusted LIBO Rate for an ED Borrowing with a one-month interest period plus 1.00%; provided that, solely with respect to the First Lien Term Loans, the base rate shall not be less than 2.00% per annum. The interest base rate on an ED loan is equal to (x) the LIBO Rate for such Eurodollar borrowing in effect for such Interest Period divided by (y) One minus the Statutory Reserves (if any) for such Eurodollar Borrowing for such interest period; provided that, solely with respect to the First Lien Term Loans, the rate shall not be less than 1.00% per annum. Accrued interest is payable in arrears on a quarterly basis.

We may be limited in our ability to utilize, or may not be able to utilize, net operating loss carryforwards to reduce our future tax liability.

As of June 30, 2017, we had U.S. federal net operating loss ("NOL") carryforwards of approximately $408.7 million and state NOL carryforwards of approximately $542.7 million, which may be limited annually due to certain change in ownership provisions of Section 382 of the Internal Revenue Code of 1986, as amended (the "Code"). In addition, as a result of the Symbion acquisition, approximately $179 million in NOL carryforwards are subject to an annual Section 382 base limitation of $4.9 million, and, as a result of the NovaMed acquisition, approximately $17 million in NOL carryforwards are subject to an annual Section 382 base limitation of $4.9 million. Further, we expect the sale of H.I.G.'s shares to Bain Capital in connection with the Transactions, if consummated, to result in an ownership change as defined in Section 382. In such event, we will not be able to use our pre-ownership-change NOLs in excess of the limitation imposed by Section 382. These limitations, when combined with amounts allowable due to net unrecognized built in gains, are not expected to impact the realization of the deferred tax assets associated with these NOLs. Our federal NOL carryforwards will begin to expire in 2025 and will completely expire in 2036, and our state NOL carryforwards will begin to expire in 2017 and will completely expire in 2036. Future ownership changes may subject our NOL carryforwards to further annual limitations, which could restrict our ability to use them to offset our taxable income in periods following the ownership changes.

We entered into a tax receivable agreement that will require us to pay to the pre-IPO owners of Surgery Center Holdings, LLC (the "Pre-IPO Owners") for certain tax benefits, including for tax benefits attributable to pre-IPO NOLs, which amounts are expected to be material.

On September 30, 2015, Surgery Partners, Inc. became the direct parent and sole member of Surgery Center Holdings, LLC (the "Reorganization"). We indirectly acquired favorable tax attributes in connection with the Reorganization. These tax attributes would not be available to us in the absence of the consummation of the Reorganization. As part of the Reorganization, we entered into a tax receivable

agreement (the "TRA"). In connection with the Transactions, we entered into the TRA Amendment, which has not yet become effective. References to the TRA in these Risk Factors apply to the TRA, without giving effect to the TRA Amendment, unless explicitly stated.

Under the TRA, we will be required to pay to the Pre-IPO Owners 85% of the cash savings, if any, in U.S. federal, state or local tax that we actually realize (or are deemed to realize in certain circumstances) as a result of (i) certain tax attributes, including NOLs, capital losses, charitable deductions, alternative minimum tax credit carryforwards and federal and state tax credits of Surgery Center Holdings, Inc. and its affiliates relating to taxable years ending on or before the date of the Reorganization (calculated by assuming the taxable year of the relevant entity closes on the date of the Reorganization) that are or become available to us and our wholly-owned subsidiaries as a result of the Reorganization, and (ii) tax benefits attributable to payments made under the TRA. Under the TRA, generally we will retain the benefit of the remaining 15% of the applicable tax savings. See "Management's Discussion and Analysis of Financial Condition and Results of Operations-Income Taxes and Tax Receivable Agreement."

The actual utilization of the tax attributes that are the subject of the TRA, as well as the timing of any payments under the TRA, will vary depending upon a number of factors, including the amount, character and timing of our and our subsidiaries' taxable income in the future, our use of NOL carryforwards and the portion of our payments under the TRA constituting imputed interest. Limitations on the use of the NOLs may apply, including limitations under Section 382 of the Code.

Payments under the TRA are not conditioned on the Pre-IPO Owners continuing to own shares of our common stock. Payments under the TRA are expected to give rise to certain additional tax benefits attributable to deductions for imputed interest. Any such benefits are the subject of the TRA and will increase the amounts due thereunder. In addition, the TRA provides for interest, at a rate equal to LIBOR plus 300 basis points, accrued from the due date (without extensions) of the corresponding federal, state or local tax return to the date of payment specified by the TRA. Payments under the TRA will be based on the tax reporting positions that we determine, consistent with the terms of the TRA. We will not be reimbursed for any payments previously made under the TRA if the utilization of any tax attributes that are the subject of the TRA are subsequently disallowed; if it is determined that excess payments have been made under the TRA, certain future payments, if any, otherwise to be made will be reduced. As a result, in certain circumstances, payments could be made under the TRA in excess of the benefits that we actually realize in respect of the attributes to which the TRA relates.

We expect the payments we will be required to make under the TRA will be substantial. It is also possible we will be required to make withholding tax payments in respect of one or more Pre-IPO Owners. Because we are a holding company with no operations of our own, our ability to make payments under the TRA is dependent on the ability of our subsidiaries to make distributions to us. The TRA restricts our and our subsidiaries' ability to enter into any agreement or indenture that would restrict or encumber our ability to make payments under the TRA. To the extent that we are unable to make payments under the TRA, and such inability is a result of the terms of credit agreements and other debt documents that are materially more restrictive than those existing as of the date of the TRA, such payments will be deferred and will accrue interest at a rate of LIBOR plus 500 basis points until paid. If the terms of such credit agreements and other debt documents cause us to be unable to make payments under the TRA and such terms are not materially more restrictive than those existing as of the date of the TRA, such payments will be deferred and will accrue interest at a rate of LIBOR plus 300 basis points until paid. There can be no assurance that we will be able to finance our obligations under the TRA in a manner that does not adversely affect our working capital and growth requirements.

The terms of the TRA will, in certain circumstances, including certain changes of control, divestitures, or breaches of any material obligations under it (such as a failure to make any payment when due, subject to a specified cure period), provide for our (or our successor's) obligations under the TRA to accelerate and become payable in a lump sum amount equal to the present value of the anticipated future tax benefits calculated based on certain assumptions, including that we would have at such time sufficient taxable income to fully utilize the tax attributes that are the subject of the TRA. Additionally, if we or any of our subsidiaries transfers any asset to a corporation with which we do not file a consolidated tax return, we will be treated as having sold that asset in a taxable transaction for purposes of determining certain amounts payable pursuant to the TRA. As a result of the foregoing, (i) we could be required to make payments under the TRA that are greater than or less than the specified percentage of the actual tax savings we realize in respect of the tax attributes that are the subject of the TRA and (ii) we may be required to make an immediate lump sum payment equal to the present value of the anticipated future tax savings, which payment may be made years in advance of the actual realization of such future benefits, if any such benefits are ever realized. Our obligations under the TRA could have a substantial negative impact on our liquidity and could have the effect of adversely affecting our working capital and growth, and of delaying, deferring or preventing certain mergers, asset sales, other forms of business combinations or other changes of control.

The TRA Amendment provides for a fixed payment schedule. Upon the effectiveness of the TRA Amendment, the Company will make payments to H.I.G. (in its capacity as Stockholders Representative) on behalf of the other stockholders party thereto pursuant to that fixed payment schedule. The amounts payable are related to the projected tax savings we are to realize over the next five years and are not dependent on actual tax savings. After giving effect to the TRA Amendment, we estimate that the total amounts payable under the TRA may be as high as $120.5 million, but the ultimate amounts payable are likely to vary if there is a change in law as to the income tax rates applicable to domestic corporations.

Unanticipated changes in effective tax rates or adverse outcomes resulting from examination of our income or other tax returns could adversely affect our financial condition and results of operations.

We are subject to income taxes in the United States, and our domestic tax liabilities are subject to the allocation of expenses in differing jurisdictions. Our future effective tax rates could be subject to volatility or adversely affected by a number of factors, including:

- changes in the valuation of our deferred tax assets and liabilities;
- expected timing and amount of the release of any tax valuation allowances;
- tax effects of equity-based compensation;
- costs related to intercompany restructurings;
- changes in tax laws, regulations or interpretations thereof; or
- lower than anticipated future earnings in jurisdictions where we have lower statutory tax rates and higher than anticipated future earnings in jurisdictions where we have higher statutory tax rates.

In addition, we may be subject to audits of our income, sales and other transaction taxes by U.S. federal, state and local authorities. Outcomes from these audits could have an adverse effect on our financial condition and results of operations.

Our facilities may be adversely impacted by weather and other factors beyond our control, and disruptions in our disaster recovery systems or management continuity planning could limit our ability to operate our business effectively.

The financial results of our facilities may be negatively 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, employees and physician partners and force certain of our facilities to close temporarily or for an extended period of time. In certain markets, we have a large concentration of surgery centers that may be simultaneously affected by adverse weather condition or events beyond our control.

While we have disaster recovery systems and business continuity plans in place, any disruptions in our disaster recovery systems or the failure of these systems to operate as expected could, depending on the magnitude of the problem, adversely affect our operating results by limiting our capacity to effectively monitor and control our operations. Despite our implementation of a variety of security measures, our technology systems could be subject to physical or electronic break-ins, and similar disruptions from unauthorized tampering or weather related disruptions where our headquarters is located. In addition, in the event that a significant number of our management personnel were unavailable in the event of a disaster, our ability to effectively conduct business could be adversely affected.

Risks Related to Government Regulation

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

The Affordable Care Act has been subject to a number of challenges to its constitutionality. On June 28, 2012, the United States Supreme Court upheld challenges to the constitutionality of the “individual mandate” provision, which generally requires all individuals to purchase healthcare insurance or pay a penalty, but struck down as unconstitutional the provision that would have allowed the federal government to revoke all federal Medicaid funding to any state that did not expand its Medicaid program. As a result, many states have refused to extend Medicaid eligibility to more individuals as envisioned by the law.

On June 25, 2015, the United States Supreme Court upheld the legality of premium subsidies made available by the federal government to individuals residing in the 36 states that have federally-run health insurance exchanges. The subsidies are provided to low-income individuals to assist with the cost of purchasing health insurance through federally-run health insurance exchanges. Other legal challenges to the Affordable Care Act are pending.

Initiatives to repeal the Affordable Care Act, in whole or in part, to delay elements of implementation or funding, and to offer amendments or supplements to modify its provisions have been persistent and have increased as a result of the 2016 election. The ultimate outcomes of legislative attempts to repeal or amend the Affordable Care Act and legal challenges to the Affordable Care Act are unknown. On May 4, 2017, the House of Representatives passed the American Health Care Act, which, if ultimately enacted into law in its current form, would repeal substantial portions of the Affordable Care Act, including the individual mandate. The American Health Care Act would replace means-tested insurance premium subsidies with age-adjusted tax credits and permit insurers to impose a surcharge up to 30 percent on individuals who go uninsured for more than two months and then purchase coverage. The American Health Care Act would also limit federal funding available for the Affordable Care Act’s Medicaid expansion and transition federal Medicaid funding to a per-capita cap basis. It remains unclear whether the American Health Care Act will be further amended or enacted. The Senate is also developing its own legislation to amend and potentially repeal portions of the Affordable Care Act. Any such future repeal or amendment of the Affordable Care Act, including the American Health Care Act or legislation developed by the Senate, remains uncertain. Such legislation may have significant impact on the reimbursement for healthcare services generally, and may cause more individuals to become uninsured, rendering them unable to afford healthcare services offered by the Company. Accordingly, there can be no assurance that the adoption of any future federal or state healthcare reform legislation will not have a negative financial impact on the Company.

Moreover, other legislative changes have also been proposed and adopted since the Affordable Care Act was enacted. On August 2, 2011, the Budget Control Act of 2011, among other things, created measures for spending reductions by Congress. A Joint Select Committee on Deficit Reduction, tasked with recommending a targeted deficit reduction of at least $1.2 trillion for the years 2013 through 2021, was unable to reach required goals, thereby triggering the legislation’s automatic reduction to several government programs. This included aggregate reductions to Medicare payments to providers of 2% per fiscal year, which went into effect on April 1, 2013 and, due to subsequent legislative

amendments, will remain in effect through 2025 unless additional Congressional action is taken. On January 2, 2013, President Obama signed into law the American Taxpayer Relief Act of 2012, which, among other things, further reduced Medicare payments to several providers, including hospitals, and increased the statute of limitations period for the government to recover overpayments to providers from three to five years. These and other similar new laws may result in additional reductions in Medicare and other health care funding, which could have a material adverse effect on our financial operations.

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.

The healthcare industry is heavily regulated and 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, accreditation, certification and other requirements, including, but not limited to, those relating to:

- ownership and control of our facilities;
- operating policies and procedures;
- qualification, training and supervision of medical and support persons;
- pricing of, billing for and coding of services and properly handling overpayments, debt collection practices and the submission of false statements or claims;
- the necessity, appropriateness and 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;
- screening, stabilization and transfer of individuals who have emergency medical conditions and provision of emergency services;
- antitrust;
- building codes;
- workplace health and safety;
- licensure, certification and accreditation;
- fee-splitting and the corporate practice of medicine;
- handling of medication;
- confidentiality, data breach, identity theft and maintenance and protection of health-related and other personal information and medical records; and
- environmental protection, health and safety.

If we fail or have failed to comply with applicable laws and regulations, we could subject ourselves 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.

Many of these laws and regulations have not been fully interpreted by regulatory authorities or the courts, and their provisions are sometimes open to a variety of interpretations. Different interpretations or enforcement of existing or new laws and regulations could subject our current practices to allegations of impropriety or illegality, or require us to make changes in our operations, facilities, equipment, personnel, services, capital expenditure programs or operating expenses to comply with the evolving rules. Any enforcement action against us, even if we successfully defend against it, could cause us to incur significant legal expenses and divert our management's attention from the operation of our business.

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 may be unable to expand into new geographic markets.

A number of initiatives have been proposed during the past several years to reform various aspects of the healthcare system in the United States. In the future, different interpretations or enforcement of existing or new laws and regulations could subject our current practices to allegations of impropriety or illegality, or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. 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 governing the corporate practice of medicine or fee-splitting change, we may be required to restructure some of our relationships, which may result in a significant loss of revenue and divert other resources.

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

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

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

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

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

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

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

For the three and six months ended June 30, 2017, we derived approximately 42% of our revenue from government payors, including Medicare and Medicaid programs. The Medicare and Medicaid programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations concerning patient eligibility requirements, funding levels and the method of calculating payments or reimbursements, among other things; requirements for utilization review; and federal and state funding restrictions, any of which could materially increase or decrease payments from these government programs in the future, as well as affect the timing of payments to our facilities.

Additionally, the Budget Control Act of 2011 requires that Medicare reimbursement rates be reduced by 2%, which went into effect in April 2013 and, due to subsequent legislative amendments to the statute, will remain in effect through 2025 unless additional Congressional action is taken.

We cannot predict whether these automatic spending reductions will be rescinded, extended or increased by future legislative action. If these automatic spending reductions are increased or extended, such action could adversely affect our business, results of operations and/or financial condition.

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, if the scope of services covered by governmental payors is limited or if we, or one or more of our surgical facilities, are excluded from participation in the Medicare, Medicaid or other government-sponsored healthcare programs, there could be a material adverse effect on our business, financial condition, results of operations or cash flows.

During the past several years, healthcare payors, such as federal and state governments, insurance companies and employers, have undertaken initiatives to revise payment methodologies and monitor healthcare costs. As part of their efforts to contain healthcare costs, payors increasingly are demanding discounted fee structures or the assumption by healthcare providers of all or a portion of the financial risk relating to paying for care provided, often in exchange for exclusive or preferred participation in their benefit plans. We expect efforts to impose greater

discounts and more stringent cost controls by government and other payors to continue, thereby reducing the payments we receive for our services.

By way of example, under the Medicare program, physician payments were previously updated on an annual basis according to a statutory formula. Because application of the statutory formula for the update factor would result in a decrease in total physician payments, Congress would intervene with interim legislation on an annual basis to prevent the reductions. In April 2015, however, the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA, was signed into law, which repealed and replaced the statutory formula for Medicare payment adjustments to physicians. MACRA provides a permanent end to the annual interim legislative updates that had previously been necessary to delay or prevent significant reductions to payments under the Medicare Physician Fee Schedule. MACRA extended previous payment rates through June 30, 2015, with a 0.5% update for July 1, 2015 through December 31, 2015, and for each calendar year through 2019, after which there will be a 0% annual update each year through 2025. In addition, MACRA requires the establishment of the Merit-Based Incentive Payment System (“MIPS”), beginning in 2019, under which physicians may receive performance-based payment incentives or payment reductions based on their performance with respect to clinical quality, resource use, clinical improvement activities and meaningful use of electronic health records. MACRA also requires Centers for Medicare & Medicaid Services ("CMS"), beginning in 2019, to provide incentive payments for physicians and other eligible professionals that participate in alternative payment models, such as accountable care organizations, that emphasize quality and value over the traditional volume-based fee-for-service model. It is unclear what impact, if any, MACRA will have on our business and operating results, but any resulting decrease in payment may result in reduced demand for our services.

The amount of our provision for doubtful accounts is based on our assessments of historical collection trends, business and economic conditions, trends in federal and state governmental and private employer health coverage and other collection indicators. A continuation in trends that results in increasing the proportion of accounts receivable being comprised of uninsured accounts and deterioration in the collectability of these accounts could adversely affect our collections of accounts receivable, results of operations and cash flows. As enacted, the Affordable Care Act seeks to decrease, over time, the number of uninsured individuals. Specifically, the Affordable Care Act expands Medicaid eligibility and provides incentives to employers to offer and individuals to purchase health insurance. It is difficult to predict the full impact of the Affordable Care Act due to pending court challenges, legislative threats, implementation uncertainty, and its complexity.

Our surgical facilities do not satisfy the requirements for any of the safe harbors under the federal Anti-Kickback Statute. If a federal or state agency asserts a different position or enacts new laws in this regard, 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 revenue.

The statute commonly known as the federal Anti-Kickback statute (the “Anti-Kickback Statute”) prohibits the offer, payment, solicitation or receipt of any form of remuneration in return for referrals for items or services payable by Medicare, Medicaid, or any other federally funded healthcare program. Additionally, the Anti-Kickback Statute prohibits any form of remuneration in return for purchasing, leasing or ordering, or arranging for or recommending the purchasing, leasing or ordering of items or services payable by Medicare, Medicaid or any other federally funded healthcare program. The Anti-Kickback Statute is very broad in scope and many of its provisions have not been uniformly or definitively interpreted by existing case law or regulations. Moreover, several federal courts have held that the Anti-Kickback Statute can be violated if only one purpose (not necessarily the primary purpose) of a transaction is to induce or reward a referral of business, notwithstanding other legitimate purposes. In addition, a person or entity does not need to have actual knowledge of the statute or specific intent to violate it in order to have committed a violation. Moreover, the government may assert that a claim including items or services resulting from a violation of the federal Anti-Kickback Statute constitutes a false or fraudulent claim for purposes of the False Claims Act (discussed below). Violations of the Anti-Kickback Statute may result in substantial civil or criminal penalties, including up to five years imprisonment and criminal fines of up to $25,000 and civil penalties of up to $50,000 for each violation, plus three times the remuneration involved or the amount claimed and exclusion from participation in all federally funded healthcare 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, the U.S. Department of Health and Human Services ("HHS"), issued final regulations defining various “safe harbors” under the Anti-Kickback Statute. Business arrangements that meet the requirements of the safe harbors are not treated as criminal violations under 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: the “investment interest” safe harbor and the “personal services and management contracts” safe harbor. However, the structure of the partnerships and limited liability companies operating our surgery centers and surgical hospitals, as well as our various business arrangements involving physician group practices, do not satisfy all of the requirements of either safe harbor.

On November 19, 1999, HHS promulgated final regulations creating additional safe harbor provisions, including a safe harbor that applies to physician ownership of or investment interests in surgery centers. The surgery center safe harbor protects four types of investment arrangements: (1) surgeon owned surgery centers; (2) single specialty surgery centers; (3) multi-specialty surgery centers; and (4) hospital/physician surgery centers. Each category has its own requirements with regard to what type of physician may be an investor in the surgery center. In addition to the physician investor, the categories permit an “unrelated” investor, who is a person or entity that is not in a position to provide items or services related to the surgery center or its investors. Our business arrangements with our surgical facilities typically consist of one of our subsidiaries being an investor in each partnership or limited liability company that owns the facility, in addition to providing management and other services to the facility. Therefore, our business arrangements with our surgery centers, surgical hospitals and physician

groups do not qualify for “safe harbor” protection from government review or prosecution under the Anti-Kickback Statute, however, we attempt to otherwise structure our surgery centers to fit as closely as possible within the safe harbor. When a transaction or relationship does not fit within a safe harbor, it does not mean that an Anti-Kickback Statute violation has occurred; rather, it means that the facts and circumstances as well as the intent of the parties related to a specific transaction or relationship must be examined to determine whether or not any illegal conduct has occurred.

We employ dedicated marketing personnel whose job functions include the recruitment of physicians to perform surgery at our facilities. These employees are paid a base salary plus a productivity bonus. We believe our employment arrangements with these employees 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.

We also enter into lease agreements with physicians from time to time for the rental of space for our surgical facilities. We seek to structure these lease agreements so that they are in compliance with the Anti-Kickback Statute safe harbor provision regarding real estate leases. However, a government agency or private party may assert a contrary position.

If any of our business arrangements with physicians or sales and marketing personnel 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 revenue.

The federal physician self-referral law, commonly referred to as the Stark Law, prohibits a physician from making a Medicare or Medicaid reimbursed referral for a “designated health service” to an entity if the physician or a member of the physician’s immediate family has a “financial relationship” with the entity unless an exception applies. The list of “designated health services” under the Stark Law does not generally include ambulatory surgery services, but it does include inpatient and outpatient hospital service and services such as clinical laboratory services, and certain imaging services that may be provided and separately billed by an ASC or other facility. Under the current Stark Law and related regulations, services provided at an ASC are not covered by the statute, even if those services include imaging, laboratory services or other Stark designated health services, provided that (i) the ASC does not bill for these services separately, or (ii) if the center is permitted to bill separately for these services, they are specifically exempted from Stark Law prohibitions. These are generally radiology and other imaging services integral to performance of surgical procedures that meet certain requirements and certain outpatient prescription drugs. Services provided at our facilities licensed as hospitals are covered by the Stark Law. We attempt to structure our relationship with physicians who refer to our hospitals to meet an exception to the Stark Law where required, but the regulations implementing the exceptions are detailed and complex, and we cannot guarantee that every relationship complies fully with the Stark Law. We also believe that certain services provided by our managed physician network are covered by the Stark Law, but referrals for those services are exempt from the Stark Law under its “in-office ancillary services exception,” among others. Our diagnostic laboratory is also subject to the Stark Law, but we believe that we have structured our agreements with physicians so as to not violate the Stark Law and related regulations.

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

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 Affordable Care Act dramatically curtailed this exception and prohibits physician ownership in hospitals that did not have a Medicare provider agreement by December 31, 2010. As a result, the law effectively prevents the formation of new physician-owned hospitals that participate in Medicare and Medicaid after December 31, 2010. Each of our surgical hospitals had a Medicare provider agreement in place prior to December 31, 2010 and is therefore able to continue operating with the ownership structure that was in place prior to our IPO. However, the Affordable Care Act 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; and medical necessity of services provided. In addition, the Office of the Inspector General of the U.S. Department of Health

and Human Services (the “OIG”) and the U.S. Department of Justice (“DOJ”) have, from time to time, undertaken national enforcement initiatives that focus on specific billing practices or other suspected areas of abuse. In its 2013 Work Plan, the OIG stated its intention to review the safety and quality of care for Medicare beneficiaries having surgeries and procedures in ASCs and hospital outpatient departments. We have not received any material related audit letters to date.

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 and other federal and state healthcare programs. Claims filed with private insurers can also lead to criminal and civil penalties, including, but not limited to, penalties relating to violations of federal mail and wire fraud statutes, as well as penalties under the anti-fraud provisions of the HIPAA (as defined below). 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 False Claims Act ("FCA").

Over the past several years, the federal government has investigated an increasing number of healthcare providers for potential FCA violations, which, among other things, 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.

Moreover, another trend impacting healthcare providers is the increased use of the FCA, particularly by individuals who bring actions under that law. Under the “qui tam,” or whistleblower, provisions of the FCA, private parties may bring actions on behalf of the federal government. If the government intervenes and prevails in the action, the defendant may be required to pay three times the actual damages sustained by the government, plus mandatory civil monetary penalties of between $5,500 and $11,000 for each false claim submitted to the 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, the Fraud Enforcement and Recovery Act of 2009 (“FERA”) further expanded the scope of the FCA to create liability for knowingly and improperly avoiding or decreasing an obligation to pay money to the federal government and FERA, along with statutory provisions found in the Acts, created federal False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or, in certain cases, the date by which a corresponding cost report is due, whichever is later. Governmental authorities may challenge or scrutinize our operations or we may be the subject of a whistleblower lawsuit at any time. A determination that we have violated these laws could have a material adverse effect on our business, prospects, results of operations and financial condition.

The Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (the “HITECH Act”), and their implementing regulations (collectively referred to as “HIPAA”) also created new federal criminal statutes that prohibit among other actions, knowingly and willfully executing, or attempting to execute, a scheme to defraud any healthcare benefit program, including private third-party payors, knowingly and willfully embezzling or stealing from a healthcare benefit program, willfully obstructing a criminal investigation of a healthcare offense, and knowingly and willfully falsifying, concealing or covering up a material fact or making any materially false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services. Similar to the federal Anti-Kickback Statute, a person or entity does not need to have actual knowledge of the statute or specific intent to violate it in order to have committed a violation.

In addition, a person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration, including waivers of co-payments and deductible amounts (or any part thereof), that the person knows or should know is likely to influence the beneficiary’s selection of a particular provider, practitioner or supplier of Medicare or Medicaid payable items or services may be liable for civil monetary penalties of up to $10,000 for each wrongful act. Moreover, in certain cases, providers who routinely waive copayments and deductibles for Medicare and Medicaid beneficiaries can also be held liable under the Anti-Kickback Statute and civil False Claims Act, which can impose additional penalties associated with the wrongful act. Although this prohibition applies only to federal healthcare program beneficiaries, the routine waivers of copayments and deductibles offered to patients covered by commercial payors may implicate applicable state laws related to, among other things, unlawful schemes to defraud, excessive fees for services, tortious interference with patient contracts and statutory or common law fraud. To the extent our patient assistance programs or other discount policies are found to be inconsistent with applicable laws, we may be required to restructure or discontinue such programs, or be subject to other significant penalties.

To enforce compliance with the federal laws, the DOJ has recently increased its scrutiny of interactions between health care companies and health care providers, which has led to a number of investigations, prosecutions, convictions and settlements in the health care industry. Dealing with investigations can be time and resource consuming and can divert management’s attention from the business. In addition,

settlements with the DOJ or other law enforcement agencies have forced healthcare providers to agree to additional compliance and reporting requirements as part of a consent decree or corporate integrity agreement. Any such investigation or settlement could increase our costs or otherwise have an adverse effect on our business.

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 cannot be sure 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 Affordable Care Act expanded the RAC program's scope to include managed Medicare plans and to include Medicaid claims. In addition, CMS employs Medicaid Integrity Contractors ("MICs") to perform post-payment audits of Medicaid claims and identify overpayments. The Affordable Care Act 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 both internal and third-party audits and monitoring.

For instance, HMS Federal Solutions, a MIC, completed an audit of one of our surgical hospitals for the period July 1, 2009 through May 31, 2012 and determined an overpayment obligation in the amount of approximately $4.6 million based on its extrapolation of a statistical sampling of claims, as well as a civil monetary penalty in the amount of $162,000, for a total amount owed to Idaho's Department of Health and Welfare, Medicaid Program Integrity Unit of approximately $4.7 million for failure to comply with Medicaid rules by billing for (i) non-covered services, (ii) services provided by non-eligible providers, (iii) services not provided and (iv) unauthorized services. We appealed the audit, which was settled during the quarter ending June 30, 2017 for $1.3 million.

Although all other repayments requested to date as a result of RAC, MIC and ZPIC audits have not been material to our Company, we are unable to quantify the aggregate financial impact of these audits on our facilities given the pending appeals and uncertainty about the extent of future audits and whether the underlying conduct could be considered systemic. As such, 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, among other things, 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 or 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.

Our use and disclosure of personally identifiable information, including health information, is subject to federal and state privacy and security regulations, and our failure to comply with those regulations or to adequately secure the information we hold could result in significant liability or reputational harm.

HIPAA as well as numerous other federal and state laws and regulations, govern the collection, dissemination, use, privacy, security, confidentiality, integrity and availability of personally identifiable information ("PII"), including protected health information ("PHI"). HIPAA applies national privacy and security standards for PHI to covered entities such as us. HIPAA requires covered entities to maintain policies and procedures governing PHI that is used or disclosed, and to implement administrative, physical and technical safeguards to protect PHI, including PHI maintained, used and disclosed in electronic form. These safeguards include 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. While we undertake substantial efforts to secure the PHI we maintain, use and disclose in electronic form, a cyber-attack or other intrusion 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 potentially substantial fines and penalties. Ongoing implementation and oversight of these security measures involves significant time, effort and expense.

HIPAA also requires our surgical facilities to use standard transaction code sets and identifiers for certain standardized healthcare transactions, including billing and other claim transactions. We have undertaken significant efforts involving substantial time and expense to implement these requirements, and we anticipate that continual time and expense will be required to submit standardized transactions and to ensure that any newly acquired facilities can submit HIPAA-compliant transactions.

HIPAA requires 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. The HIPAA rules created a presumption that all non-permitted uses or disclosures of unsecured protected health information are breaches unless the covered entity establishes that there is a low probability the information has been compromised. HIPAA imposes mandatory civil and criminal penalties for violations of its requirements ranging up to $50,000 per violation, with a maximum civil penalty of $1.5 million in a calendar year for violations of the same requirement. However, a single breach incident can result in violations of multiple requirements, resulting in possible penalties well in excess of $1.5 million. In addition, the HITECH Act 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.

HIPAA also authorizes 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. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for violations of HIPAA's requirements, its standards have been used as a basis for the duty of care in state civil suits, such as those for negligence or recklessness in the handling of PHI. In addition, HIPAA mandates that the Secretary of HHS conduct periodic compliance audits of HIPAA covered entities such as us.

In addition, many states in which we operate may impose laws that are more protective of the privacy and security of PII than HIPAA. Where these state laws are more protective than HIPAA, we have to comply with their stricter provisions. Only some of these state laws impose fines and penalties upon violators, but some may afford private rights of action to individuals who believe their PII has been misused. California's patient privacy laws, for example, provide for penalties of up to $250,000 and permit injured parties to sue for damages. 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. New health information standards could have a significant effect on the manner in which we do business, and the cost of complying with new standards could be significant. We may not remain in compliance with the diverse privacy requirements in all of the jurisdictions in which we do business. If we fail to comply with HIPAA or similar state laws, we could incur substantial civil monetary or criminal penalties.

If we are unable to integrate and operate our information systems effectively or implement new systems and processes, 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 revenue. Moreover, we use the development and implementation of sophisticated and specialized technology to improve our profitability, 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 it may have an adverse effect on our ability to obtain new business, retain existing business and maintain or increase our profit margins and 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 threats from malicious persons and groups, new vulnerabilities, 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 loss, 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 robust 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.

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

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

If 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 other 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 Federal Trade Commission (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 regulation to which we are subject is constantly evolving and may change significantly in the future.

The regulation applicable to our business and to the healthcare industry generally to which we are subject is 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 NASDAQ rules and, therefore, we qualify for, and currently rely on, exemptions from certain corporate governance requirements. Our stockholders do not have the same protections afforded to stockholders of companies that are subject to such requirements.

As of June 30, 2017, H.I.G. controlled a majority of the voting power of our outstanding common stock. As a result, we are a "controlled company" within the meaning of the corporate governance standards of NASDAQ. Under these rules, a company of which more than a majority 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 requirement that a majority of the board of directors consist of independent directors;
- the requirement that we have a nominating/corporate governance committee that is composed entirely of independent directors with a written charter addressing the committee's purpose and responsibilities; and
- the requirement that we have a compensation committee that is composed entirely of independent directors with a written charter addressing the committee's purpose and responsibilities.

As of June 30, 2017, we have availed ourselves of certain of these exemptions. For example, as a result, we did not have a majority of independent directors for the entire period covered by this report (and may, in the future, have less than a majority of independent directors) and we do not have a nominating and corporate governance committee. Accordingly, our stockholders will not have the same protections afforded to stockholders of companies that are subject to all of the corporate governance requirements of NASDAQ.

There can be no assurance as to the period of time during which we will remain a "controlled company".

Our controlling stockholder has significant influence over us, including control over decisions that require the approval of stockholders, which could limit our stockholders' ability to influence the outcome of key transactions, including a change of control.

As of June 30, 2017, we were controlled by H.I.G. As of that time, H.I.G. beneficially owned approximately 55% of our outstanding common stock. For as long as H.I.G. continues to beneficially own shares of common stock representing more than a majority of the voting power of our common stock, it will be able to direct the election of all of the members of our board of directors and could exercise a controlling influence over our business and affairs, including any determinations with respect to mergers or other business combinations, the acquisition or disposition of assets, the incurrence of indebtedness, the issuance of any additional common stock or other equity securities, the repurchase or redemption of common stock and the payment of dividends. Similarly, H.I.G. will have the power to determine matters submitted to a vote of our stockholders without the consent of our other stockholders, will have the power to prevent a change in our control and could take other actions that might be favorable to it. Even if H.I.G. ceases to beneficially own a majority of the voting power of our common stock, it will continue to be able to strongly influence or effectively control our decisions.

Additionally, H.I.G. is in the business of making investments in companies and may acquire and hold interests in businesses that compete directly or indirectly with us. H.I.G. may also pursue acquisition opportunities that may be complementary to our business, and, as a result, those acquisition opportunities may not be available to us.

If the Transactions are consummated, immediately following the closing of the Transactions, Bain Capital will beneficially own stock representing approximately 66% of the voting power of all classes of our capital stock, and H.I.G. will no longer own any of our capital stock. As a result, Bain Capital could potentially have significant influence over all matters affecting us, including decisions regarding extraordinary business transactions, fundamental corporate transactions, appointment of members of our management, election of directors and our corporate and management policies.

Additionally, investment funds affiliated with Bain Capital are in the business of making investments in companies and may acquire and hold interests in businesses that compete directly or indirectly with us, or they may pursue acquisition opportunities that may be complementary to our business, and, as a result, those acquisition opportunities may not be available to us.

Our stock price could be extremely volatile, and, as a result, our stockholders may not be able to resell their shares at or above the price paid for them.

The stock market in general has been highly volatile. As a result, the market price of our common stock is likely to be similarly volatile, and investors in our common stock may experience a decrease, which could be substantial, in the value of their stock, including decreases unrelated to our operating performance or prospects, and could lose part or all of their investment. The price of our common stock could be subject to wide fluctuations in response to a number of factors, including those described elsewhere in this report and others such as:

- variations in our operating performance and the performance of our competitors;
- actual or anticipated fluctuations in our quarterly or annual operating results;
- publication of research reports by securities analysts about us or our competitors or our industry;
- announcements by us, our competitors or our vendors of significant contracts, acquisitions, joint marketing relationships, joint ventures or capital commitments;
- our failure or the failure of our competitors to meet analysts' projections or guidance that we or our competitors may give to the market;
- additions and departures of key personnel;
- strategic decisions by us or our competitors, such as acquisitions, divestitures, spin-offs, joint ventures, strategic investments or changes in business strategy;
- the passage of legislation or other regulatory developments affecting us or our industry;
- speculation in the press or investment community;
- changes in accounting principles;
- terrorist acts, acts of war or periods of widespread civil unrest;
- natural disasters and other calamities; and
- changes in general market and economic conditions.

In the past, securities class action litigation has often been initiated against companies following periods of volatility in their stock price. This type of litigation could result in substantial costs and divert our management's attention and resources, and could also require us to make substantial payments to satisfy judgments or to settle litigation.

Future issuances of capital stock may dilute our stockholders' percentage ownership in us, which could reduce their influence over matters on which stockholders vote.

Our board of directors has the authority, without action or vote of our stockholders, to issue all or any part of our authorized but unissued shares of common stock, including shares issuable upon the exercise of options, or shares of our authorized but unissued preferred stock. Issuances of common stock or voting preferred stock would reduce our current stockholders' influence over matters on which our stockholders vote and, in the case of issuances of preferred stock, would likely result in common stockholders' interest in us being subject to the prior rights of holders of that preferred stock.

Provisions in our charter documents and Delaware law may deter takeover efforts that could be beneficial to stockholder value.

Our certificate of incorporation and by-laws and Delaware law contain provisions that could make it harder for a third party to acquire us, even if doing so might be beneficial to our stockholders. These provisions include a classified board of directors and limitations on actions by our stockholders. In addition, our board of directors has the right to issue preferred stock without stockholder approval that could be used to dilute a potential hostile acquiror. Our certificate of incorporation also imposes some restrictions on mergers and other business combinations between us and any holder of 15.0% or more of our outstanding common stock other than affiliates of H.I.G.. As a result, our stockholders may lose their ability to sell their stock for a price in excess of the prevailing market price due to these protective measures, and efforts by stockholders to change the direction or management of the Company may be unsuccessful.

Our amended and restated certificate of incorporation designates courts in the State of Delaware as the sole and exclusive forum for certain types of actions and proceedings that may be initiated by our stockholders, which could limit our stockholders' ability to obtain a favorable judicial forum for disputes with us or our directors, officers or employees.

Our amended and restated certificate of incorporation provides that, subject to limited exceptions, the Court of Chancery of the State of Delaware will be the sole and exclusive forum for (i) any derivative action or proceeding brought on our behalf, (ii) any action asserting a claim of breach of a fiduciary duty owed by any of our directors, officers or other employees to us or our stockholders, (iii) any action asserting a claim against us arising pursuant to any provision of the DGCL, our amended and restated certificate of incorporation or our amended and restated bylaws or (iv) any other action asserting a claim against us that is governed by the internal affairs doctrine (each, a "Covered Proceeding"). In addition, our amended and restated certificate of incorporation provides that if any action the subject matter of which is a Covered Proceeding is filed in a court other than the specified Delaware courts without the approval of our board of directors (each, a "Foreign

Action"), the claiming party will be deemed to have consented to (i) the personal jurisdiction of the specified Delaware courts in connection with any action brought in any such courts to enforce the exclusive forum provision described above and (ii) having service of process made upon such claiming party in any such enforcement action by service upon such claiming party's counsel in the Foreign Action as agent for such claiming party. Any person or entity purchasing or otherwise acquiring any interest in shares of our stock shall be deemed to have notice of and to have consented to these provisions. These provisions may limit a stockholder's ability to bring a claim in a judicial forum that it finds favorable for disputes with us or our directors, officers or other employees, which may discourage such lawsuits against us and our directors, officers and employees. Alternatively, if a court were to find these provisions of our amended and restated certificate of incorporation inapplicable to, or unenforceable in respect of, one or more of the specified types of actions or proceedings, we may incur additional costs associated with resolving such matters in other jurisdictions, which could adversely affect our business and financial condition.

Because we have no current plans to pay cash dividends on our common stock for the foreseeable future, our stockholders may not receive any return on investment unless they sell their common stock for a price greater than that which they paid for it.

We may retain future earnings, if any, for future operations, expansion and debt repayment and have no current plans 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 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 credit facility. As a result, our stockholders may not receive any return on an investment in our common stock unless they sell their common stock for a price greater than that which they paid for it.

We have ceased to be an "emerging growth company" under the Jumpstart Our Business Startups Act of 2012 (the "JOBS Act"), and therefore, the reduced disclosure requirements applicable to emerging growth companies no longer apply to us.

We have ceased to be an "emerging growth company" under the JOBS Act. Accordingly, we are now subject to certain disclosure requirements that are applicable to other public companies that were not applicable to us as an "emerging growth company" and, as a result, we expect to incur significant additional expenses and devote substantial management effort toward ensuring compliance with these requirements, including the auditor attestation requirements of Section 404 of the Sarbanes-Oxley Act of 2002, as amended (the "Sarbanes-Oxley Act"), full disclosure obligations regarding executive compensation in our proxy statements and the requirements of holding a nonbinding advisory vote on certain executive compensation matters, such as "say on pay" and "say on frequency."

At the time of our initial public offering in 2015, we irrevocably elected not to take advantage of Section 107 of the JOBS Act which provides an "emerging growth company" with an extended transition period for complying with new or revised financial accounting standards. Accordingly, we have complied with new or revised financial accounting standards on the relevant dates on which adoption of such standards was required for non-emerging growth companies.

We are obligated to report on the effectiveness of our internal controls over financial reporting. These internal controls may not be effective and our independent registered public accounting firm may not be able to certify as to their effectiveness, which could have a significant and adverse effect on our business and reputation. Additionally, we have identified a material weakness in our internal control over financial reporting which could, if not remediated, result in material misstatements in our financial statements.

As a public company, we are required to evaluate our internal controls over financial reporting and to comply with Section 404 of the Sarbanes-Oxley Act. Following the consummation of the NSH Merger, NSH will become our subsidiary and our required evaluation and compliance will extend to NSH. Throughout our evaluation, we may identify material weaknesses that we may not be able to remediate in time to meet the applicable deadline imposed upon us for compliance with the requirements of Section 404 of the Sarbanes-Oxley Act. In addition, if we fail to achieve and maintain the adequacy of our internal controls, as such standards are modified, supplemented or amended from time to time, we may not be able to ensure that we can conclude on an ongoing basis that we have effective internal controls over financial reporting in accordance with Section 404 of the Sarbanes-Oxley Act.

An evaluation was performed under the supervision and with the participation of our management, including the Chief Executive Officer and the Chief Financial Officer, of the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities and Exchange Act of 1934, as amended (the "Exchange Act")) as of the end of the period covered by this report to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act, is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms and to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is accumulated and communicated to our management, including the Chief Executive Officer and the Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosure. Based on, and as of the time of such evaluation, our management, including the Chief Executive Officer and Chief Financial Officer, concluded that our disclosure controls and procedures were not effective as a result of the material weakness identified by management as initially disclosed under "Item 9A-Controls and Procedures" in our Annual Report on Form 10-K for the year ended December 31, 2016.

Such material weakness pertains to lack of documentation evidencing certain controls involving revenue, accounts receivable and related allowances. Notwithstanding the identified material weakness, as of the date of this filing, management, including the Chief Executive Officer and Chief Financial Officer, believes that the unaudited consolidated financial statements contained in this Quarterly Report on Form 10-Q fairly present, in all material respects, our financial condition, results of operations and cash flows for the fiscal years presented in conformity with GAAP. Management is actively engaged in the implementation of a remediation plan to address the lack of documentation issue. The

plan includes the implementation of enhanced documentation policies and procedures, along with the allocation of resources dedicated to training and monitoring these policies and procedures.

As a result of these efforts, as of the date of this filing, management believes we have made progress toward remediating the underlying causes of the material weakness. Although we believe our remediation efforts will be effective in remediating the material weakness, there can be no assurance as to when the remediation plan will be fully implemented, or that the plan, as currently designed, will adequately remediate the material weakness. The material weakness will not be considered fully addressed until the enhanced policies and procedures over documentation evidencing certain controls involving revenue, accounts receivable and related allowances have been in operation for a sufficient period of time for our management to conclude that the material weakness has been fully remediated. We will continue to work on implementing and testing the enhanced documentation policies and procedures in order to make this final determination.

In addition, in connection with the audit of the financial statements of National Surgical Healthcare, a wholly owned subsidiary of NSH, for the year ended December 31, 2014, the management of National Surgical Healthcare identified certain material weaknesses in National Surgical Healthcare's internal control over financial reporting pertaining to deficiencies in the accounting for the provision for income taxes, lease accounting, general ledger journal entries and inventory control. All identified deficiencies were remediated during National Surgical Healthcare's fiscal year ended December 31, 2015, with the exception of the deficiencies pertaining to general ledger journal entries and inventory control. The management of National Surgical Healthcare implemented a remediation plan to address the remaining material weaknesses, which such plan we intend to continue implementing going forward if the NSH Merger is consummated, but there can be no assurance as to when the remediation plan will be fully implemented, whether the plan will be modified or otherwise changed, or that the plan, as currently designed, will adequately remediate the material weakness.

If the remediation measures with respect to the outstanding material weaknesses described above prove to be insufficient to remediate the identified material weaknesses, respectively, or if additional material weaknesses or significant deficiencies in internal control are discovered or occur in the future, our consolidated financial statements may contain material misstatements and we could be required to restate our financial results, or the accuracy of our financial reporting could be adversely affected resulting in reputational harm, distractions to management and our board of directors, and disruptions to our business.

The requirements of being a public company may strain our resources and distract our management, which could make it difficult to manage our business.

As a public company, we are subject to the reporting requirements of the Exchange Act, and requirements of the Sarbanes-Oxley 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 controls 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. We have, and will continue to be, implementing 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 a public company, it is more expensive for us to obtain director and officer liability insurance, and we may be required to accept reduced coverage or incur substantially higher costs to obtain coverage. This could also make it more difficult for us to attract and retain qualified people to serve on our board of directors, our board committees, or as executive officers.

Furthermore, if we are unable to satisfy our obligations as a public company, we could be subject to delisting of our common stock, fines, sanctions, and other regulatory action and potentially civil litigation, which could have a material adverse effect on our financial condition and results of operations.

If securities or industry analysts do not continue to publish research or publish inaccurate or unfavorable research about our business, our stock price and trading volume could decline.

The trading market for our common stock will depend in part on the research and reports that securities or industry analysts publish about us or our business. If securities or industry analysts ceases coverage of us or fails to publish reports on us regularly, demand for our common stock could decrease, which could cause our stock price and trading volume to decline. If one or more of the analysts who covers us downgrades our common stock or publishes inaccurate or unfavorable research about our business, our stock price would likely decline.

Item 2. ***Unregistered Sales of Equity Securities and Use of Proceeds***

None.

Item 3. ***Defaults Upon Senior Securities***

None.

Item 4. ***Mine Safety Disclosures***

Not applicable.

Item 5. ***Other Information***

None.

Item 6. ***Exhibits***

No.	Description
2.1	Agreement and Plan of Merger by and among Surgery Partners, Inc., SP Merger Sub, Inc., NSH Holdco, Inc. and IPC / NSH, L.P., dated as of May 9, 2017 (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed May 11, 2017).*
2.2	Letter Amendment to Merger Agreement, by and among Surgery Partners, Inc., SP Merger Sub, Inc., NSH Holdco, Inc. and IPC / NSH, L.P., dated as of July 7, 2017 (incorporated herein by reference to Exhibit 2.1 to the Company's Current Report on Form 8-K filed July 11, 2017).*
4.1	Third Supplemental Indenture, dated as of May 25, 2017, by and among Surgery Center Holdings, Inc., the guarantors listed therein and Wilmington Trust, National Association, as trustee (incorporated herein by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed May 26, 2017).
4.2	Indenture, dated June 30, 2017, among SP Finco, LLC and Wilmington Trust, National Association, as Trustee (incorporated herein by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed July 6, 2017).
10.1	Securities Purchase Agreement by and among Surgery Partners, Inc. and BCPE Seminole Holdings LP, dated May 9, 2017 (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed May 11, 2017).*
10.2	Stock Purchase Agreement by and between H.I.G. Surgery Centers, LLC, H.I.G. Bayside Debt & LBO Fund II L.P. (for the specific purposes stated therein), BCPE Seminole Holdings LP and Surgery Partners, Inc., dated May 9, 2017 (incorporated herein by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed May 11, 2017).*
10.3	Amendment No. 1 to Income Tax Receivable Agreement, by and between Surgery Partners, Inc. and H.I.G. Surgery Centers, LLC (in its capacity as the Stockholders Representative), dated May 9, 2017 (incorporated herein by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K filed May 11, 2017).
31.1	Certification of Principal Executive Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Securities Exchange Act, as amended as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Principal Financial Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Securities Exchange Act, as amended as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
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

* Schedules and/or Exhibits have been omitted pursuant to Item 601(b)(2) of Regulation S-K. The Company agrees to furnish a supplemental copy of any omitted schedule to the SEC upon request.

SIGNATURES

Pursuant to the requirements 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.

SURGERY PARTNERS, INC.

By: /s/ Teresa F. Sparks
Teresa F. Sparks
Executive Vice President and Chief Financial Officer
(Principal Financial and Accounting Officer)

Date: August 9, 2017

EXHIBIT INDEX

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Exhibit 31.1

CERTIFICATION OF PRINCIPAL EXECUTIVE OFFICER PURSUANT TO RULE 13a-14(a) AND RULE 15d- 14(a) OF THE SECURITIES AND EXCHANGE ACT, AS AMENDED AS ADOPTED PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Michael T. Doyle, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Surgery Partners, 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 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)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) 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)designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) 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

   d) 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 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 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.

By: /s/ Michael T. Doyle
Michael T. Doyle
Chief Executive Officer
(Principal Executive Officer)

Date: August 9, 2017

Exhibit 31.2

CERTIFICATION OF PRINCIPAL FINANCIAL OFFICER PURSUANT TO RULE 13a-14(a) AND RULE 15d- 14(a) OF THE SECURITIES AND EXCHANGE ACT, AS AMENDED AS ADOPTED PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Teresa F. Sparks, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Surgery Partners, 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 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)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) 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)designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) 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

   d) 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 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 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.

By: /s/ Teresa F. Sparks
Teresa F. Sparks
Executive Vice President and Chief Financial Officer
(Principal Financial and Accounting Officer)

Date: August 9, 2017

Exhibit 32.1

CERTIFICATION OF THE CHIEF EXECUTIVE OFFICER PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the quarterly report on Form 10-Q of Surgery Partners, Inc. (the "Company") for the period ended June 30, 2017, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Michael T. Doyle, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, that:

1. The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2. The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company for the periods presented therein.

By: /s/ Michael T. Doyle
Michael T. Doyle
Chief Executive Officer
(Principal Executive Officer)

Date: August 9, 2017

Exhibit 32.2

CERTIFICATION OF THE CHIEF FINANCIAL OFFICER PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the quarterly report on Form 10-Q of Surgery Partners, Inc. (the "Company") for the period ended June 30, 2017, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Teresa F. Sparks, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Sec. 1350, as adopted pursuant to Sec. 906 of the Sarbanes-Oxley Act of 2002, that:

1. The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2. The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company for the periods presented therein.

By: /s/ Teresa F. Sparks
Teresa F. Sparks
Executive Vice President and Chief Financial Officer
(Principal Financial and Accounting Officer)

Date: August 9, 2017