SURGERY PARTNERS

2018 Annual Report

SURGERY PARTNERS

Fellow Shareholders,

Transformative….that is the best way to describe 2018 for our Company, as we continued the journey of integrating National Surgical Healthcare and Surgery Partners and establishing a culture that enhances patient quality of life through partnership.

Over the course of 2018, we remained focused on reinforcing and building upon what we do best – operating high quality, short stay surgical facilities. This starts with differentiating ourselves by focusing on what matters most – clinical quality and patient satisfaction.

Clinical quality is our highest priority and a critical element of what our 4,000 affiliated physicians and 10,000 associates focus on every day. We continue to achieve best-in-class clinical quality scores relative to industry benchmarks and, in February 2019, we were informed that four of our short-stay surgical hospitals received a five-star rating from the Centers for Medicare and Medicaid Services ("CMS") regarding overall hospital quality. This rating from CMS, which less than 10 percent of hospitals in the US received, is just one of many data points regarding our continued commitment to clinical quality.

We also continued to achieve exceptionally high patient satisfaction scores in 2018, which has resulted in a best-in-class net promoter score of 91. A score that is only rivaled by some of the best consumer brand names in the world.

With our commitment to clinical quality and patient satisfaction as our foundation, we also took many steps to build upon our Company's ability to achieve sustainable long-term growth. We rebuilt our corporate management team and took a data-driven approach in analyzing strategic opportunities and challenges across our portfolio which led us to divest or close assets that were not aligned with our long-term growth goals. We also made substantial investments in platform consolidation, which eliminates execution distractions, provides data analytics that enable agility in decision making, and allows us to leverage our platforms for efficiencies. Finally, we invested in our business with a priority placed on organic volume and revenue growth along with margin expansion and strategic capital deployment focused on high growth assets.

Some key accomplishments in 2018:

- We pruned our asset base of non-strategic, lower growth assets, representing a total of over $100 million in annualized revenue;

- We recharged our organic growth engine, resulting in same store facility revenue growth in the third quarter and the fourth quarter of 11.4% and 7.4%, respectively. This growth is a result of both improved rates and case volume, with Q4 representing our largest same store case volume growth in the last seven quarters.
- We leveraged our scale resulting in improved results for our physician partners and margin expansion for our shareholders. This includes sustainable run rate supply chain savings along with a 10%+ reduction in corporate headcount, net of our reinvestments in the business.
- We invested in our infrastructure, including:
    - Moving 79% of our surgical facilities and clinical practices to our end state patient accounting platforms;
    - Migrating 95% of our surgical facilities and clinical practices to a common claims clearinghouse; and
    - Integrating 84% of our surgical facilities into a centralized data warehouse.
- Finally, we re-established our acquisition pipeline, deploying over $100 million in capital at attractive multiples and launching some of the most exciting de novo projects in the Company's history.

While we accomplished a lot in 2018, it was only the beginning of our transformative journey of becoming the premier short-stay, surgical facility operator in the United States. As the largest standalone, independent surgical services company, Surgery Partners occupies a unique position in today's marketplace where we are preferred by patients, providers and payors. Our patient satisfaction supports that we are focusing on the right areas. Our business model aligns with and empowers physicians, providing them with the resources they need to be doctors first and provide the best care for their patients, and our unwavering focus on reducing waste and cost in the healthcare system helps payors bend the cost curve by delivering material savings and a lower occurrence of adverse events when compared to similar procedures performed in acute care settings.

Surgery Partners has a compelling story to share that can truly transform the way healthcare is delivered in the United States. We have the right assets and team and look forward to seeing the Company deliver on its growth goals in 2019.

Thank you for your continued support and investment in Surgery Partners.

Wayne S. DeVeydt
Chief Executive Officer

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2018
or

☐ **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.)

310 Seven Springs Way, Suite 500
Brentwood, Tennessee 37027
(Address of principal executive offices and zip code)
(615) 234-5900
(Registrant's telephone number, including area code)

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

Title of Class	**Name of Exchange on Which Registered**
Common Stock, par value $0.01 per share	Nasdaq Global Select Market

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, 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 ☐	Accelerated filer ☒
Non-accelerated filer ☐	Smaller reporting company ☐
	Emerging growth company ☐

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. ☐

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

The aggregate market value of the registrant's voting and non-voting common equity held by non-affiliates of the registrant based on the closing price of the shares of common stock on The Nasdaq Stock Market on June 30, 2018, was $316.5 million.

As of March 12, 2019, there were 48,801,400 shares of the registrant's common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the definitive proxy statement for the registrant's annual stockholders' meeting to be held May 29, 2019 are incorporated by reference into Part III of this report.

SURGERY PARTNERS, INC.
FORM 10-K
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Cautionary Note Regarding Forward-Looking Statements

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

By their nature, forward-looking statements involve risks and uncertainties because they relate to events and depend on circumstances that may or may not occur in the future. We believe that these risks and uncertainties include, but are not limited to, those described in the "Risk Factors" section of this Annual Report, which include but are not limited to the following:

- the impact of future legislation and other healthcare regulatory reform actions, and the effect of that legislation and other regulatory actions on our business;
- our ability to comply with current healthcare laws and regulations;
- reductions in payments from government healthcare programs and managed care organizations;
- our ability to contract with private third-party payors;
- changes in our payor mix or surgical case mix;
- failure to maintain or develop relationships with our physicians on beneficial terms, or at all;
- the impact of payor controls designed to reduce the number of surgical procedures;
- our efforts to integrate operations of acquired businesses and surgical facilities, attract new physician partners, or acquire additional surgical facilities;
- shortages or quality control issues with surgery-related products, equipment and medical supplies;
- competition for physicians, nurses, strategic relationships, acquisitions and managed care contracts;
- our ability to attract and retain qualified healthcare professionals;
- our ability to enforce non-compete restrictions against our physicians;
- our ability to manage material liabilities whether known or unknown incurred as a result of acquiring surgical facilities;
- economic and competitive conditions;
- the outcome of legal and regulatory proceedings that have been or may be brought against us;
- changes in the regulatory, economic and other conditions of the states where our surgical facilities are located;
- substantial payments we are required to make under the tax receivable agreement; and
- our substantial indebtedness.

Although we base these forward-looking statements on assumptions that we believe are reasonable when made, we caution you that our actual results of operations, financial condition and liquidity, and the development of the industry in which we operate may differ materially from those made in or suggested by the forward-looking statements contained in this Annual Report. We have based these forward-looking statements on our current expectations and projections about future events and financial trends that we believe may affect our financial condition, results of operations, business strategy and financial needs. They can be affected by known or unknown risks, uncertainties and assumptions, including, among other things, the risks, uncertainties and assumptions described in Item 1A. "Risk Factors."

Our forward-looking statements speak only as of the date made. Other than as required by law, we undertake no obligation to publicly update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. You are advised, however, to consult any further disclosures we make on related subjects in our Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, press releases, and our website.

PART I

Item 1. Business

Overview

Surgery Partners, Inc., a Delaware corporation, acting through its subsidiaries, owns and operates a national network of surgical facilities and ancillary services. Surgery Partners, Inc. was formed April 2, 2015, as a holding company for the purpose of facilitating an initial public offering of shares of common stock. Prior to September 30, 2015, we conducted business through Surgery Center Holdings, Inc. and its subsidiaries. Unless the context otherwise indicates, Surgery Partners, Inc. and its subsidiaries are referred to herein as "Surgery Partners," "we," "us," "our" or the "Company."

On August 31, 2017, we completed the acquisition of NSH Holdco, Inc. (the “NSH Merger” or "acquisition of NSH"). Also on August 31, 2017, (i) we completed the sale and issuance of 310,000 shares of our 10.00% Series A Convertible Perpetual Participating Preferred Stock (the “Series A Preferred Stock”) to a fund advised by an affiliate of Bain Capital Private Equity LP (“Bain Capital”), at a purchase price of $1,000 per share in cash (the “Preferred Private Placement”), and (ii) Bain Capital completed its purchase of 26,455,651 shares (the “Purchased Shares”) of our common stock from H.I.G. Surgery Centers, LLC (“H.I.G.”) ("Private Sale"). As a result, Bain Capital became our controlling stockholder, holding Series A Preferred Stock and Common Stock that collectively represented approximately 65.7% of the voting power of all classes of capital stock of the Company as of August 31, 2017, and H.I.G. and its affiliated investment funds no longer own any capital stock of the Company. We refer to the Preferred Private Placement and the Private Sale collectively in this Annual Report on Form 10-K as the “Transactions.”

The following discussion of our business covers periods both prior to and subsequent to the Transactions. As discussed in the notes to the consolidated financial statements included in this report, in connection with the change of control effected by the Private Sale, we elected to apply “pushdown” accounting. We have presented the information for the year ended December 31, 2017 on a Predecessor period and Successor period combined basis (each as defined in Note 1. "Organization and Summary of Accounting Policies" of our consolidated financial statements) to facilitate meaningful comparisons of operating results to the prior year periods. You should read the following discussion together with our consolidated financial statements and related notes included elsewhere herein.

As of December 31, 2018, we owned or operated primarily in partnership with physicians, a portfolio of 123 surgical facilities in the United States comprised of 108 ambulatory surgical centers ("ASCs") and 15 surgical hospitals (“surgical hospitals,” and together with ASCs referred to as “surgical facilities” or “facilities”) across 31 states and we owned a majority interest in 84 of these facilities. During 2018, our physicians provided services to patients in our surgical facilities generating approximately $1.7 billion in revenue.

Our Growth Strategies

Our differentiated operating model employs a multifaceted strategy to grow revenue, earnings and cash flow. We believe the following are key components to this strategy:

- Deliver outstanding patient care and clinical outcomes;
- Continue to execute and expand upon our physician engagement strategy in attractive markets;
- Become the partner of choice for physicians seeking to become or stay independent;
- Drive organic growth at existing facilities through targeted physician recruitment, service line expansion and implementing our efficient operating model;
- Seek partnership opportunities with payors to make healthcare more affordable for their members;
- Continue our disciplined acquisition strategy;
- Introduce new service offerings to provide a more comprehensive continuum of care; and
- Enhance operational efficiencies and productivity by delivering on integration.

In addition, we believe favorable industry trends such as an aging population and advancements in medical technology will further drive growth.

Operations

We operate in three reporting segments: surgical facility services, ancillary services and optical services.

- 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, gastroenterology, general surgery, ophthalmology, orthopedics, and pain management.
- Our ancillary services segment consists of a diagnostic laboratory and multi-specialty physician practices. These physician practices include our owned and operated physician practices pursuant to long-term management service agreements.

- Our optical services segment consists of an optical products group purchasing organization, and until October 2018, an optical laboratory that manufactured eyewear.

Surgical Facility Services Segment

Surgical Facility Operations

As of December 31, 2018, we owned (primarily with physician investors or healthcare systems) or operated 123 surgical facilities, including 15 licensed hospitals. Our surgical facility services segment contributed approximately 95%, 93% and 91% of our total revenue in 2018, 2017 and 2016, respectively.

Our typical ASC is a free-standing facility that performs planned surgical procedures on an outpatient basis for patients not requiring hospitalization and for whom an overnight stay is not expected after surgery. Each center typically has one to four operating or procedure rooms with areas for reception, pre-operative care, recovery and administration. The staff of our ASCs generally includes a center administrator, registered nurses, operating room technicians, as well as other administrative staff.

Our surgical hospitals are generally larger than our ASCs and include inpatient hospital rooms and, in two cases, a limited scope emergency department. Our surgical hospitals also provide ancillary services such as diagnostic imaging, pharmacy, laboratory, obstetrics, physical therapy, oncology and wound care.

We operate both multi-specialty and single-specialty facilities. In multi-specialty facilities, a variety of surgical procedures are performed, including, among others, GI, general surgery, ophthalmology, orthopedics and pain management. We have diversified the mix of procedures performed at our facilities by strategically introducing select specialties that will complement existing facilities. In many cases, we keep certain facilities as single-specialty where it suits an individual facility or market demand.

Our surgical facilities are generally located in close proximity to physicians' offices. We provide each of our surgical facilities with a full range of financial, marketing and operating services. For example, our regional managed care directors assist the local management team at each of our surgical facilities in developing relationships with managed care providers and negotiating managed care contracts.

Surgical Facility Ownership Structure

We own and operate our surgical facilities through partnerships or limited liability companies with physicians, physician groups and healthcare systems. One of our wholly-owned subsidiaries typically serves as the general partner or managing member of our surgical facilities. We generally seek to own a majority interest in our surgical facilities, or otherwise have sufficient control over the facilities to be able to consolidate the financial results of operations of the facilities with ours. In some instances, we will acquire ownership in a surgical facility with the prior owners retaining ownership, and, in some cases, we offer new ownership to other physicians or healthcare systems. We hold majority ownership in 84 of the 123 surgical facilities in which we own an interest. We provide intercompany loans to some of the surgical facilities which often are secured by a pledge of assets of the facility. We also have a management agreement with the majority of our surgical facilities, under which we provide day-to-day management services for a management fee, which is typically equal to a percentage of the facility revenue.

Strategic Relationships

When attractive opportunities arise, we may develop, acquire or operate surgical facilities through strategic relationships with payors, healthcare systems, and other healthcare providers. We believe that forming such relationships can enhance our ability to attract physicians and access favorable managed care contracts for our surgical facilities in that market.

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

Sources of Revenue

Revenue from our surgical facilities is earned from facility fees related to healthcare services performed in our surgical facilities and is included in our patient service revenues. The fee charged for surgical services varies depending on the type of service provided, but usually includes all charges for usage of an operating room, a recovery room, special equipment, supplies, nursing staff and/or medications. Our fees do not typically include professional fees charged by the patient's surgeon, anesthesiologist or other attending physician, which are billed directly by such physicians to the patient or third-party payor.

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

The following table sets forth the percentage of total patient service revenues for our consolidated surgical facilities by type of payor for the periods indicated:

	Year Ended December 31,		
	2018	2017	2016
Private Insurance	54.6%	53.6%	51.5%
Government	37.6%	38.3%	39.9%
Self-pay	2.9%	2.4%	1.8%
Other	4.9%	5.7%	6.8%
Total patient service revenues	100.0%	100.0%	100.0%

We receive reimbursement from Medicare for surgical services based on three different payment systems depending on the site of service: hospital outpatient surgical services, hospital inpatient surgical services and outpatient surgical services generally provided in our ASCs.

Medicare Reimbursement - Hospital Outpatient Departments

Surgical services that are provided in hospital outpatient departments (“HOPDs”) are generally reimbursed by the Centers for Medicare and Medicaid Services ("CMS") using the Outpatient Prospective Payment System (the “OPPS”). The OPPS, established by the Secretary of the Department of Health and Human Services (“HHS”), determines payment amounts prospectively (generally the following calendar year) for various categories of medical services performed in HOPDs. On November 21, 2018, CMS published its OPPS final rule for 2019. The final rule provides for a payment rate increase of 1.35%. Hospitals that do not meet the reporting requirements of the Medicare Hospital Outpatient Quality Reporting Program will be subject to a 2.0% payment rate decrease.

Additionally, as a result of legislative changes related to off-campus HOPDs, certain off-campus HOPDs that began billing under the OPPS (or underwent certain changes) on or after November 2, 2015 are no longer paid for most services under the OPPS. Instead, these facilities are paid under the Medicare Physician Fee Schedule (“MPFS”), which typically results in lower reimbursements. Services provided in a dedicated emergency department are still paid under the OPPS. This change has not significantly affected reimbursement to any of our HOPDs, but we cannot assure you that our HOPDs will not be impacted in the future.

Medicare Reimbursement - Hospital Inpatient Services

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

On August 17, 2018, CMS published the IPPS final rule for federal fiscal year (“FFY”) 2019, which began on October 1, 2018. Under the FFY 2019 final rule, rates for inpatient stays in hospitals paid under the IPPS that successfully report certain quality data under the Hospital Inpatient Quality Reporting (“IQR”) Program and demonstrate meaningful use of certified electronic health record ("EHR") technology will be increased by 1.35%. Those hospitals that do not successfully report quality data under the IQR Program (but are meaningful EHR users) may receive a payment rate increase of only 0.625%. In addition to the IQR Program, hospitals will be subject to payment adjustments under the Value Based Purchasing Program, Readmissions Reduction Program and Hospital Acquired Conditions Reduction Programs that have been implemented by HHS.

Medicare Reimbursement - ASCs

Payments under the Medicare program to ASCs are also made based on the OPPS. However, the payment received from CMS is a percentage of the payment to HOPDs. Reimbursement rates for ASCs are updated annually based on changes in the consumer price index offset by multifactor productivity adjustments. Based on the OPPS Final Rule, ASC reimbursement rates will increase by 1.35% for 2019. CMS has established the Ambulatory Surgical Center for Quality Reporting ("ASCQR") Program as a pay-for-reporting, quality data program. Our ASCs that participate in the ASCQR Program receive the full annual update to the ASC payment rate. Those ASCs that do not successfully report quality data under the ASCQR Program may receive a payment reduction.

Annual Cost Reports

Hospitals participating in Medicare and Medicaid programs, whether paid on a reasonable cost basis or under a prospective payment system, may be required to meet certain financial reporting requirements. Federal and, where applicable, state regulations require submission of annual cost reports identifying medical costs and expenses associated with the services provided by each hospital to Medicare beneficiaries and Medicaid recipients. Annual cost reports required under the Medicare and Medicaid programs are subject to routine governmental audits. These audits may result in adjustments to the amounts ultimately determined to be payable to us under these reimbursement programs. Finalization of these audits often takes several years. Providers may appeal any final determination made in connection with an audit. While

ASCs are not currently subject to federal cost reporting requirements, it is possible that such requirements, which could be costly for us, will be implemented by CMS in the future.

Ancillary Services and Optical Services Segments

Ancillary Services

Our portfolio of outpatient surgical facilities is complemented by a suite of ancillary services, which support our physicians in providing high quality and cost-efficient patient care. Rather than contracting with third-party providers, in some geographies we own ancillary businesses including a diagnostic laboratory, multi-specialty physician practices, urgent care facilities and anesthesia services. Our Company, physicians and patients benefit from these services through improved clinical efficiency and scheduling, and from incremental revenue associated with retaining these fees. Our ancillary services segment contributed approximately 4%, 6% and 8% of our total revenue in 2018, 2017 and 2016, respectively. Our ancillary services includes a diagnostic laboratory and multi-specialty physician practices.

- We offer physicians toxicology testing services through our wholly-owned diagnostic laboratory, based in Tampa, Florida. Advanced toxicology screening provides physicians with the ability to identify when a patient is taking too much of a prescribed substance, when a patient is non-compliant with a prescribed substance or when a patient is taking unprescribed or illicit substances. Our diagnostic laboratory offerings support the needs of our physicians across our existing specialties and new service lines.
- We employ two models in connection with our network of multi-specialty physician practices. In the state of Florida, where the law does not preclude a business corporation from employing physicians, we own and operate Tampa Pain Relief Center, Inc., a wholly-owned business with several locations throughout Florida. In states other than Florida, we operate physician practices pursuant to long-term management service agreements with separate professional corporations that are wholly-owned by physicians.

Optical Services

Our optical services segment contributed approximately 1% of our total revenue in each of 2018, 2017 and 2016.

Sources of Revenue - Ancillary Services and Optical Services Segments

The fees charged for services in our other segments depend on a variety of factors, including the type of service provided, the location in which the service is provided and the provider of the service. Service fees are received from both private and government third-party sources of payment. The amounts that we receive in payment for the provision of ancillary and optical services may be adversely affected by market and cost factors as well as other factors over which we have no control, including Medicare, Medicaid and state regulations cost containment and utilization decisions and reduced reimbursement schedules of third-party payors.

Our ancillary services revenue primarily consists of fee for service revenue that is derived principally from the provision of physician and laboratory services to patients of our surgical facilities. Medicare pays for physician services based upon the MPFS. Payment rates under the MPFS are determined based on (i) relative value units for the services provided, (ii) a geographic adjustment factor and (iii) a conversion factor. Payment rates under the MPFS are updated annually by HHS. The primary element in each year's update calculation is the Medicare Economic Index ("MEI"), which is a measure of the inflation of the cost of operating a physician practice. The update is then adjusted in conformity with the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), which was enacted in April 2015. MACRA established a fixed 0.5% annual adjustment through calendar year 2018. Beginning in 2019, Medicare compensation to physicians and physician practices will be subject to adjustment under the Merit-Based Incentive Payment System ("MIPS"). Under MIPS, physicians will be assigned a composite performance score based on measures of quality, resource use, meaningful use of electronic health records, and clinical practice improvement activities. A threshold performance score will be set annually by CMS at the mean or median of all composite scores for a prior annual performance period. Performance exceeding the threshold will result in a positive adjustment, performance below the threshold will result in a negative adjustment, and performance at the threshold will result in no adjustment. Physicians who participate in certain alternative payment models, such as accountable care organizations, will be guaranteed a positive payment adjustment under MACRA. The effect of the payment methodology changes under MACRA on our physician practices cannot be predicted.

Certain of our laboratory ancillary services are reimbursed by Medicare under the Medicare Clinical Laboratory Fee Schedule ("CLFS"). Under a June 23, 2016 final rule that implemented the Protecting Access to Medicare Act of 2014 ("PAMA"), as of January 1, 2018 the CLFS payment methodology was adjusted so that payment amounts for laboratory tests on the CLFS is determined by calculating a weighted median of private payor rates using reported private payor rates and associated volume (number of tests). For tests that were paid on the CLFS prior to the implementation of PAMA, any reduction in payment amount will be phased in over the first 6 years of payment under the new system.

Acquisitions and Developments

On August 31, 2017, we completed the acquisition of NSH Holdco, Inc. for approximately $760 million, adding NSH's surgical facilities to our portfolio. At the same time, we completed the Transactions. In the last five years we have also completed the acquisition of Symbion, which materially expanded our network of existing facilities and ancillary services.

Acquisition Program. In addition to our corporate strategy, we continuously evaluate opportunities to expand our presence in the surgical facility market by making strategic acquisitions of existing surgical facilities and by developing new surgical facilities in cooperation with local physician partners and, when appropriate, healthcare systems and other strategic partners. We generally structure our partnerships as two-way arrangements where either we are a majority owner partnered with physicians or we are a minority owner with buy-up rights. These

buy-up rights give us the option to own a controlling interest at some point in the future. Alternatively, we may choose to pursue a three-way arrangement with physicians and a healthcare system.

We employ a dedicated acquisition team with experience in healthcare services. Our team seeks to acquire surgical facilities that meet our criteria, including prominence and quality of physician partners, specialty mix, opportunities for growth, level of competition in the local market, level of managed care penetration and our ability to access managed care organization contracts. We carefully evaluate each of our acquisition opportunities through an extensive due diligence process to determine which facilities have the greatest potential for growth and profitability improvements under our operating structure. Our team may also identify opportunities to attract additional physicians to increase the acquired facility's revenues and profitability.

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

Marketing

We primarily direct our sales and marketing efforts at physicians who would utilize our surgical facilities. Marketing activities directed at physicians and other healthcare providers are coordinated locally by the individual surgical facility and are supplemented by our dedicated corporate personnel. These activities generally emphasize the benefits offered by our surgical facilities compared to other facilities in the market, such as the proximity of our surgical facilities to physicians' offices, the ability to schedule consecutive cases without preemption by inpatient or emergency procedures, the efficient turnaround time between cases, our advanced surgical equipment and our simplified administrative procedures. Although the facility administrator is the primary point of contact, physicians who utilize our surgical facilities are important sources of recommendations to other physicians regarding the benefits of using our surgical facilities. Recruiting teams develop a target list of physicians, and we continually review our progress in successfully recruiting additional local physicians.

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

Competition

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

In developing or acquiring existing surgical facilities, we compete with other public and private surgical facility and hospital companies. Several large national companies own and/or manage surgical facilities, in some cases in connection with other lines of business with which we do not compete, including HCA Holdings, Inc., Envision Healthcare Corporation and Tenet Healthcare Corporation. We also face competition from local hospitals, physicians and other providers who may compete with us in the ownership and operation of surgical facilities, as well as the trend of physicians choosing to perform procedures in an office-based setting rather than in a surgical facility.

Seasonality

Our revenue fluctuates based on the number of business days in each calendar quarter, because the majority of services provided by physicians in our surgical facilities consist of scheduled procedures and office visits that occur during business hours. In addition, revenue in the fourth quarter could also be impacted by an increased utilization of services due to annual deductibles which are not usually met until later in the year and also as patients utilize their healthcare benefits before they expire at year-end.

Employees

At December 31, 2018, we had approximately 11,000 employees, including approximately 7,900 full-time employees. None of our employees are represented by a collective bargaining agreement. We believe that we have a good relationship with our employees.

Environmental

We are subject to various federal, state and local laws and regulations relating to the protection of the environment and human health and safety, including those governing the management and disposal of hazardous substances and wastes, the cleanup of contaminated sites and the maintenance of a safe workplace. Our operations include the use, generation and disposal of hazardous materials. We may, in the future,

incur liability under environmental statutes and regulations with respect to contamination of sites we own or operate (including contamination caused by prior owners or operators of such sites, adjoining properties or other persons) and the off-site disposal of hazardous substances. We believe that we have been and are in substantial compliance with the terms of all applicable environmental laws and regulations and that we have no liabilities under environmental requirements that we would expect to have a material adverse effect on our business, results of operations or financial condition (including our capital expenditures, earnings and competitive position).

Insurance

We maintain liability insurance in amounts that we believe are appropriate for our operations. 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 an 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, as well as an additional umbrella liability insurance policy in the aggregate amount of $33.0 million. We also maintain business interruption insurance and property damage insurance. 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 defined minimum coverage limits. While we believe that our insurance policies are adequate in amount and coverage for our operations, we cannot assure you that the insurance coverage is sufficient to cover all future claims or will continue to be available in adequate amounts or at a reasonable cost.

Private Third-Party Payors

Most private third-party payors reimburse us for services pursuant to written contracts. These contracts generally require that we offer discounts from our established charges. Some of our payments come from third-party payors with which we do not have written contracts. In those situations, commonly known as "out-of-network" services, we generally charge the patients the same co-payment or other patient responsibility amounts that we would have charged had we had a contract with the third-party payor. We also submit a claim for the services to the third-party payor along with full disclosure that we have charged the patient an in-network patient responsibility amount.

Governmental Regulation

General

Our businesses 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.

Certificates of Need, Licensure and Accreditation

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, in certain of these states, surgical facilities. We currently operate in 20 states that have certificate of need laws.

Our surgical 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.

As of December 31, 2018, the majority of our facilities were accredited by either The Joint Commission or the Accreditation Association for Ambulatory Health Care, two of the major national organizations that establish standards relating to the physical plant, administration, quality of patient care and operation of medical staffs of various types of healthcare facilities. The effect of accreditation by these organizations is to exempt the facilities from routine surveys by state agencies to determine compliance with CMS requirements. These accredited facilities are subject to periodic surveys by the accrediting organization to ensure that they are in compliance with the applicable standards. Many commercial health plans require our facilities to be accredited by one or both of these organizations in order to be participating providers. Failure to maintain accreditation would cause a facility to become subject to state survey agency oversight and potentially subject to increased scrutiny by CMS, and could result in a loss of payment from commercial health plans.

Affordable Care Act Repeal Efforts

Initiatives to repeal or modify the Affordable Care Act have been persistent over the past several years. As of December 31, 2018, legislative efforts to repeal and replace the Affordable Care Act in full have not been successful. However, as a result of the enactment of the

Tax and Jobs Act of 2017, the so-called "individual mandate," which requires most individuals to obtain qualifying health insurance coverage or pay a tax penalty, was repealed effective as of calendar year 2019. The repeal of the individual mandate and any other future repeal or replacement of the Affordable Care Act 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. The Affordable Care Act also remains subject to various lawsuits challenging its enforcement and constitutionality. Accordingly, there can be no assurance that the adoption of any future federal or state healthcare reform legislation, or any ruling by a court with respect to the Affordable Care Act, will not have a negative financial impact on the Company.

Medicare and Medicaid Private Contractor Audits

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 recently settled claims resulting from an audit for the period July 1, 2009 through May 31, 2012 in the second quarter of fiscal 2017. See Note 14. Commitments and Contingencies to our consolidated financial statements included in this Annual Report.

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.

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 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 (the "2007 CMS 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 facilities licensed as hospitals are required to meet this requirement to maintain their participating provider status in the Medicare program. As of December 31, 2018, six of our hospitals, which do not have an emergency room, maintain a protocol for the transfer of patients requiring emergency treatment. While we believe such protocols satisfy CMS requirements, CMS could interpret such protocols to be inconsistent with the 2007 CMS policy memorandum, which could jeopardize each facility's participation in the Medicare program. 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 associated 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.

Utilization Review

Federal law contains numerous provisions designed to ensure that services rendered by hospitals to Medicare and Medicaid patients meet professionally recognized standards, 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 of 1935 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-owners of 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.

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 outline standards that, if complied with, protect conduct that might otherwise be deemed in violation of the Anti-Kickback Statute. 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 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 certified to participate in the Medicare program, and its operating and recovery room space must be dedicated exclusively to the center and not a part of a hospital (although such space may be leased from a hospital if such lease meets the requirements of the safe harbor for space rental).
- 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 center, nor employed by the center 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 center 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 center.

We believe that the ownership and operations of our surgical facilities will not fully satisfy the ASC Safe Harbor requirements 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. While we believe our ASCs would nonetheless be found to be compliant with the Anti-Kickback Statute, 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 ASCs 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 centers 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 (June 19, 2007), 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.

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 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.

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 and physician practices. 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 No. 12-06 (May 25, 2012), 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, such as the Eliminating Kickbacks in Recovery Act (discussed below), 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.

Eliminating Kickbacks in Recovery Act

In addition to the Anti-Kickback Statute, the United States recently enacted a new law known as the Eliminating Kickbacks in Recovery Act (the "EKRA"). The EKRA is contained within the broader "Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act" ("SUPPORT Act"). The EKRA creates a new federal crime for knowingly and willfully: (1) soliciting or receiving any remuneration in return for referring a patient to a recovery home, clinical treatment facility, or laboratory; or (2) paying or offering any remuneration to induce such a referral or in exchange for an individual using the services of a recovery home, clinical treatment facility, or laboratory. Each conviction under the EKRA is punishable by up to $200,000 in monetary damages, imprisonment for up to ten (10) years, or both. Unlike the Anti-Kickback Statute, the EKRA is not limited to services reimbursable under a government healthcare program. While the SUPPORT Act targets substance abuse disorder prevention and recovery, Congress did not limit the EKRA to substance abuse drug testing (only one service line of a multitude provided by labs), and therefore it appears to prohibit payment for any patient referral to any laboratory for any service, unless an exception applies. While the EKRA does contain certain exceptions similar to the Anti-Kickback Statute Safe Harbors, those exceptions are more narrow than the Anti-Kickback Statute Safe Harbors.

Federal Physician Self-Referral Law

The federal physician self-referral law, or Stark Law, prohibits certain self-referrals for healthcare services. 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. "Designated health services" include inpatient and outpatient hospital services, clinical laboratory services and radiology services. 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.

Notably, "designated health services" does not include surgical services that are provided in an ASC. Furthermore, Stark Law regulations specifically define the term "designated health services" 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 could be materially adversely affected.

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, certain changes to the Whole Hospital Exception were made by the Affordable Care Act including:

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

- a limitation on the percentage of total physician ownership or investment interests in the hospital or entity whose assets include the hospital to the percentage of physician ownership or investment as of March 23, 2010;
- a prohibition from expanding the number of beds, operating rooms, and procedure rooms for which it is licensed after March 23, 2010, unless the hospital obtains an exception from the Secretary of the Department of Health & Human Services (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.

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 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.

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 and physician owners within our physician practices may make referrals for certain designated health services within their physician practices. We believe that our agreements with referral sources satisfy the requirements of the personal service arrangements exception and that our physician practices satisfy the physician services and in-office ancillary services exceptions 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.

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, 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. The HIPAA Omnibus Rule requires us 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.

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. 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 electronic health records ("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 did not successfully demonstrate meaningful use of EHR technology were 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 were implemented in three stages taking full effect in 2018. Our facilities licensed as 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 may result in significant costs.

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. We believe that our hospitals comply with EMTALA.

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

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 compliance with 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.

Where You Can Find More Information

We make available on or through the "Investors-SEC Filings" page of our website at www.surgerypartners.com, free of charge, copies of reports, such as Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q and Current Reports on Form 8-K, and amendments to those reports (along with certain other Company filings with the SEC), as soon as reasonably practicable after electronically filing such material with, or furnishing it to, the SEC. The information found on, or otherwise accessible through, our website is not incorporated by reference into, nor does it form a part of, this Annual Report or any other document that we file with the SEC.

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 described in the forward-looking statements contained in this report or in 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 and Industry

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, including surgical hospitals, 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, private 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 55%, 54% and 52% of our patient service revenue in 2018, 2017 and 2016, respectively. Most of these payments came from private 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 these 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 private third-party payors and closed provider networks, could also cause a reduction of our revenue in the future.

Some of our payments from private third-party payors come from payors with which our facilities or subsidiaries do not have a contract. If 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 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 private 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 private 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. We are not always successful in securing contracts with payors. If the proportion of our services subject to out-of-network fee schedules increases, we may experience a decrease in volume at our ASCs or other facilities due to fewer referrals of out-of-network patients.

Additionally, payments from workers' compensation payors represented approximately 5% of our patient service revenue in 2018. 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 an adverse impact on our operating results.

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 case mix or other factors relating to the type of cases performed 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. 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.

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 case mix toward a higher percentage of lower revenue cases, which could occur for reasons beyond our control, could result in a material adverse effect on our business, prospects, results of operations and financial condition.

As we operate in multiple markets, each with a different competitive landscape, shifts within our payor mix or case mix may not be uniform across all of our affiliated facilities. Rather, these shifts may be concentrated within certain markets due to local competitive factors. Therefore, the results of our individual affiliated facilities, including facilities that are material to our results, may be volatile, which could result in a material adverse effect on our business, prospects, results of operations and financial condition.

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

We had net losses attributable to Surgery Partners, Inc. of $205.7 million and $53.0 million and net income of $9.5 million, in 2018, 2017 and 2016, respectively. 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 NSH and other risks and uncertainties. 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," included elsewhere in this report. 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 fully realize the anticipated benefits of the NSH Merger if we do not 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.

The integration of NSH into our operations is a significant undertaking requiring 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. 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. Actual synergies may be lower than we currently expect, or may take longer to achieve than anticipated. In addition, we must achieve the anticipated savings, synergies and benefits without adversely affecting current revenues, earnings and investments in future growth. An inability to realize the full extent of the anticipated benefits of the NSH Merger, as well as any delays encountered in the integration process, could have an adverse effect upon our revenues, earnings, level of expenses and operating results, which may adversely affect the value of our common and preferred stock.

The integration may be complex and time consuming, and could require substantial resources and effort by management and others. The ongoing integration process may also disrupt our business or cause inconsistencies in standards, controls, procedures and policies that adversely affect our relationships with employees, business partners, customers and others with whom we have business or other dealings, or limit our ability to achieve the anticipated benefits of the NSH Merger. In addition, any difficulties in integrating the businesses could harm our reputation. If we are unable to successfully combine our business with that of NSH in an efficient, effective and timely manner, the anticipated benefits and cost savings of the NSH Merger may not be realized fully, or at all, or may take longer to realize than expected.

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 and 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.

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

As of December 31, 2018, we and our subsidiaries had approximately $2.3 billion aggregate principal amount of indebtedness outstanding, which includes approximately $1.4 billion principal amount of senior secured term loans (the "Term Loan") outstanding, $400.0 million principal amount of senior unsecured notes due 2021 (the "2021 Unsecured Notes") and $370.0 million senior unsecured notes due 2025 (the "2025 Unsecured Notes"). As of December 31, 2018, we had no outstanding borrowings under our $75.0 million senior secured revolving credit facility (the "Revolver" and, together with the Term Loan, the "Senior Secured Credit Facilities" and, together with the 2025 Unsecured Notes and the 2021 Unsecured Notes, the "Senior Indebtedness"). After giving effect to the $3.8 million principal amount of outstanding letters of credit issued under our Revolver, we had $71.2 million of unused commitments available to be borrowed under the Revolver. In addition to the Senior Indebtedness, our aggregate principal amount of indebtedness outstanding includes approximately $104.7 million of notes payable and capital lease obligations primarily related to property and equipment for operations. Our substantial level of indebtedness increases the risk that we may be unable to generate cash sufficient to pay amounts due in respect of our indebtedness. In addition, subject to applicable restrictions under our Senior Indebtedness, 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;
- making us more vulnerable to adverse changes in general economic, industry and competitive conditions and adverse changes in government regulation;
- requiring us to dedicate a substantial portion of our cash flow to making payments on our indebtedness, thereby reducing the availability of our cash flow to fund working capital, capital expenditures and other general corporate purposes;
- limiting our flexibility in reacting to competitive and other changes in our industry and economic conditions generally; and
- limiting our ability to borrow additional funds for working capital, capital expenditures, acquisitions, debt service requirements, execution of our business strategy or other general corporate purposes;

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, to a certain extent, is subject to general economic, financial, competitive, legislative, regulatory, business and other factors that are beyond our control.

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 history of net losses may impair our ability to service our indebtedness or repay outstanding amounts when they become due. In addition, 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, and also might include incurring additional fees in connection with refinancing, 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 2021 Unsecured Notes, 2025 Unsecured Notes and Senior Secured Credit Facilities impose significant operating and financial restrictions and limit the ability of us and our restricted subsidiaries to, among other things:

- incur additional indebtedness and guarantee indebtedness;
- pay dividends or make other distributions in respect of, or repurchase or redeem, capital stock;

- prepay, redeem or repurchase certain debt;
- make loans and investments;
- sell or otherwise dispose of assets;
- sell stock of our subsidiaries;
- incur liens;
- enter into transactions with affiliates;
- enter into agreements restricting certain of our subsidiaries' ability to pay dividends; and
- consolidate, merge or sell all or substantially all of our assets

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, we may be required to maintain specified financial maintenance ratios and satisfy other financial condition tests in connection with the Senior Indebtedness. The terms of any future indebtedness we may incur could include more restrictive covenants. We cannot assure you that we will be able to maintain compliance with these covenants in the future and, if we fail to do so, that we will be able to obtain waivers from the lenders and/or amend the covenants. Our failure to comply with the restrictive covenants described above as well as others contained in our future debt instruments from time to time could result in an event of default, which, if not cured or waived, could result in our being required to repay these borrowings before their maturity. If we are forced to refinance these borrowings on less favorable terms, our results of operations and financial condition could be adversely affected.

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 agreement governing the Senior Secured Credit Facilities and the indentures governing each of the 2021 Unsecured Notes and 2025 Unsecured Notes, respectively, 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 December 31, 2018 we had approximately $71.2 million available for additional borrowings under the Revolver (after giving effect to the $3.8 million aggregate principal amount of outstanding letters of credit issued under our Revolver at such time). If new debt is added to our or our subsidiaries' current debt levels, the related risks that we face would be increased.

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, 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 December 31, 2018, our intercompany loans totaled $36.5 million. Through these loans we may have a security interest in the partnership's or limited liability company's assets, depending upon the terms thereof in each instance. 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 December 31, 2018, our global intercompany note, which we use to transfer debt balances between our subsidiaries, had a $0.8 million balance.

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 our non-wholly owned non-consolidated partnerships and limited liability companies in which we own an interest in an amount proportionate to our pro rata share of the equity interests issued by such entity. In such instances, the physicians and/or physician groups typically also guarantee their pro-rata share of such indebtedness.

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

Borrowings under the Senior Secured Credit Facilities 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. We periodically enter into interest rate swap agreements to manage our exposure to these fluctuations. Our interest rate swap agreements involve the exchange of fixed and variable rate interest payments between two parties, based on common notional principal amounts and maturity dates. The notional amounts of the swap agreements represent balances used to calculate the exchange of cash flows and are not our assets or liabilities.

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 Senior Secured Credit Facilities are guaranteed, on a joint and several basis, by SP Holdco I, Inc. and each of Surgery Center Holdings, Inc.'s current and future wholly-owned domestic restricted subsidiaries (subject to certain exceptions) (the "Subsidiary Guarantors") and are secured by a first priority security interest in substantially all of Surgery Center Holdings, Inc.'s, SP Holdco I, Inc.'s and the Subsidiary Guarantors' assets (subject to certain exceptions).

The Senior Secured Credit Facilities bear interest at a rate per annum equal to (x) LIBOR plus a margin ranging from 3.00% to 3.25% per annum, depending on the Company's first lien net leverage ratio or (y) an alternate base rate (which will be the highest of (i) the prime rate, (ii) 0.50% per annum above the federal funds effective rate and (iii) one-month LIBOR plus 1.00% per annum (solely with respect to the Term Loan, the alternate base rate shall not be less than 2.00% per annum)) plus a margin ranging from 2.00% to 2.25% per annum. In addition, the Company is required to pay a commitment fee of 0.50% per annum in respect of unused commitments under the Revolver. The 2021 Unsecured Notes bear interest at the fixed rate of 8.875% per year. The 2025 Unsecured Notes bear interest at the fixed rate of 6.750% per year.

Discontinuation, reform or replacement of LIBOR may adversely affect our business.

The credit agreement governing the Senior Secured Credit Facilities permits interest on borrowings to be calculated based on LIBOR. LIBOR and certain other interest "benchmarks" may be subject to regulatory guidance and/or reform that could cause interest rates under our current or future debt agreements to perform differently than in the past or cause other unanticipated consequences. The U.K.'s Financial Conduct Authority, which regulates LIBOR, has announced that it intends to stop encouraging or requiring banks to submit rates for the calculation of LIBOR rates after 2021, and it is unclear if LIBOR will cease to exist or if new methods of calculating LIBOR will evolve. If LIBOR ceases to exist or if the methods of calculating LIBOR change from their current form, interest rates on our current or future debt obligations may be adversely affected.

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 and other procedure 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 and other procedure 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 surgical 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 businesses 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 to fund future acquisitions and development activities 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, as well as an additional umbrella liability insurance policy in the aggregate amount of $33.0 million, 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 and cost-effective 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 from other healthcare facilities and providers.

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 clinical personnel, including 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 year-ended December 31, 2018, our salary and benefit expenses represented approximately 30% 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 consists 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 our acquisition of such business. 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. 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.

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. It is difficult to predict the degree to which our business will continue to be impacted by economic conditions in the future.

In addition, certain 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 is particularly sensitive to regulatory, economic and other conditions in the states of Florida, Georgia and Texas. As of December 31, 2018, we owned and operated 11 consolidated surgical facilities in Texas, 9 consolidated surgical facilities in Georgia and 26 consolidated surgical facilities in Florida. The Texas facilities represented approximately 16% of our revenue in fiscal 2018, the Georgia facilities represented approximately 12.7% of our revenue in fiscal 2018, and the Florida facilities represented approximately 10% of our revenue in fiscal 2018.

In addition, our surgical hospital in Idaho Falls, Idaho represented 16% of our revenue during fiscal 2018. 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 ("GPs") 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 LPs, GPs, 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 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. 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.

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, including the NSH Merger, our balance sheet at December 31, 2018 contained intangible assets designated as either goodwill or intangibles totaling approximately $3.4 billion in goodwill and approximately $54.3 million in intangibles. 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.

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 December 31, 2018, we had U.S. federal net operating loss (“NOL”) carryforwards of approximately $516.8 million and state NOL carryforwards of approximately $589.9 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. As a result of the NSH acquisition, approximately $20.5 million in NOL carryforwards are subject to an annual Section 382 base limitation of $2.8 million. Further, the sale of H.I.G.'s shares to Bain Capital in connection with the Transactions resulted in an ownership change as defined in Section 382. As a result, 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 2037, and our state NOL carryforwards will begin to expire in 2019 and will completely expire in 2038. 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 make payments to the pre-IPO owners of Surgery Center Holdings, LLC (the "Pre-IPO Owners"), 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 with the Pre-IPO Owners. In connection with the Transactions completed in in August 2017, we entered into an agreement to amend the tax receivable agreement (as amended, the “TRA”), which became effective on August 31, 2017.

Pursuant the TRA, we agreed to make annual payments to H.I.G. in its capacity as the stockholders representative on behalf of the other pre-Reorganization stockholders pursuant to a fixed payment schedule. The final payment is scheduled to be made in 2024. The amounts payable under the TRA are calculated to equal the product of (i) an annual base amount and (ii) the sum of (x) the maximum corporate federal

income tax rate for the applicable year and (y) three percent. The amounts payable under the TRA are related to our projected realized tax savings over the next five years and are not dependent on our actual tax savings over the next five years. The calculations of amounts payable pursuant to the TRA is thus dependent on the maximum corporate federal income tax rate. 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 September 30, 2015, 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 September 30, 2015, such payments will be deferred and will accrue interest at a rate of LIBOR plus 300 basis points until paid. We estimate that the total remaining amounts payable under the TRA as of December 31, 2018 may be as high as $64.6 million, but the ultimate amounts payable are likely to vary if there are further changes 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. On December 22, 2017, the U.S. government enacted comprehensive tax legislation commonly referred to as the Tax Cuts and Jobs Act (the "Tax Act"). The Tax Act makes broad and complex changes to the Code, including:

- reducing the highest marginal U.S. federal corporate income tax rate from 35% to 21% for tax years beginning after December 31, 2017;
- limiting the extent to which net operating losses can be utilized against taxable income that would apply to losses created after December 31, 2017;
- changing rules related to the ability to apply net operating losses against later or earlier tax years that would apply to losses created after December 31, 2017;
- creating a new limitation on deductible interest expense for tax years beginning after December 31, 2017;
- eliminating the corporate alternative minimum tax ("AMT") and changing how existing AMT credits can be realized for tax years beginning after December 31, 2017; and
- generally repealing the performance-based compensation exception to the Section 162(m) $1.0 million deduction limitation and revising the definition of a covered employee for tax years beginning after December 31, 2017.

In addition to the changes implemented by the Tax Act and associated regulations and guidance, our future effective tax rates could be subject to volatility or adversely affected by a number of other 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

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 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.

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.

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 changed and continues to change how healthcare services are covered, delivered and reimbursed through, among other things, expanded coverage of uninsured individuals, reduced growth in Medicare program spending and the establishment and expansion of programs tying reimbursement to quality and clinical integration. The Affordable Care Act also reforms certain aspects of health insurance, quality of care and fraud and abuse enforcement.

Substantial uncertainty remains regarding the net effect of the Affordable Care Act on our business because the long-term impact of a number of factors, including the following, remains unclear:

- the responses of individuals, businesses and other market participants to the evolving choices and obligations under the Affordable Care Act;
- the states' decisions whether to implement the Medicaid expansion provisions of the Affordable Care Act, and under what terms;
- the effect of value-based purchasing and other quality programs established under the Affordable Care Act;
- the scope and nature of changes to Medicare reimbursement methods and programs, including accountable care organizations, bundled payment programs and other coordinated care models;
- the financial sustainability of the Health Insurance Marketplace, which may be impacted by whether a sufficient number of payors participate;
- our ability to participate in health insurance plans offered through the Health Insurance Marketplaces and the terms of our participation;
- the net effect of reductions in federal healthcare program spending under the Affordable Care Act; and
- the resolution of new and ongoing legislative and legal challenges to the Affordable Care Act.

Initiatives to repeal the Affordable Care Act, in whole or in part, and to offer amendments or supplements to modify its provisions have been persistent and have increased as a result of the 2016 election. However, as a result of the enactment of the Tax and Jobs Act of 2017, the "individual mandate" was repealed effective as of calendar year 2019. The repeal of the individual mandate and any other future repeal or replacement of the Affordable Care Act 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.

Because of the many variables involved, we are unable to predict the net effect of the Affordable Care Act and other associated changes within the healthcare industry on us or our operations. Depending on how the Affordable Care Act continues to be interpreted, implemented or changed, it 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 network of physicians. 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 management and business 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 specified in our partnership agreements and 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.

In 2018, 2017 and 2016, we derived approximately 38%, 38% and 40% of our revenue, respectively, 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.

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 any 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, 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 MPFS. MACRA extended previous payment rates through June 30, 2015, with a 0.5% update for each calendar year through 2018. In addition, MACRA requires the establishment of 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. For more information on the implementation of MACRA, see "Business - Sources of Revenue - Ancillary and Optical Services," elsewhere in this report.

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.

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 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, 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, 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. 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. Because our management fees are generally based on a percentage of revenue, our management agreements do not typically meet the Personal Services and Management Contracts safe harbor. 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.

In November1999, 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 the expanded safe harbor protection from government review or prosecution under the Anti-Kickback Statute. However, we believe that we are in compliance with the requirements of the Anti-Kickback Statute.

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.

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.

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 No. 12-06 (May 25, 2012), 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.

The Eliminating Kickbacks in Recovery Act may affect our financial relationships with referral sources utilizing our clinical laboratories

In addition to the Anti-Kickback Statute, the United States recently enacted a new law known as the Eliminating Kickbacks in Recovery Act, or the EKRA. The EKRA creates a new federal crime for knowingly and willfully: (1) soliciting or receiving any remuneration in return for referring a patient to a recovery home, clinical treatment facility, or laboratory; or (2) paying or offering any remuneration to induce such a referral or in exchange for an individual using the services of a recovery home, clinical treatment facility, or laboratory. Each conviction under the EKRA is punishable by up to $200,000 in monetary damages, imprisonment for up to ten (10) years, or both. Unlike the Anti-Kickback Statute, the EKRA is not limited to services reimbursable under a government healthcare program. While the EKRA does contain certain exceptions similar to the Anti-Kickback Statute Safe Harbors, those exceptions are more narrow than the Anti-Kickback Statute Safe Harbors. As a result, the operations at our clinical laboratories may be impacted by the EKRA.

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 December 30, 2010. 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, including us, continue to be the subject of federal and state 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 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.

The federal government may 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. 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 federal 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 $10,957 and $21,916 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. 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 have and may continue to challenge or scrutinize our operations. An allegation or determination that we have violated the law could have a material adverse effect on our business, prospects, results of operations and financial condition.

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 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.

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 suspended payments and 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.

On October 23, 2017, the Company received a series of civil investigative demands ("CIDs") from the federal government under the False Claims Act ("FCA") for documents and information dating back to January 1, 2010 relating to the medical necessity of certain drug tests conducted by the Company's physicians and submitted to laboratories owned and operated by the Company. The Company has been providing information to the government in response to the CIDs and currently has a non-binding agreement in principle with the DOJ on the financial terms of a settlement with the goal of resolving these matters. Based on those discussions, which are still ongoing, the Company has recorded a litigation-related charge of $46.0 million relating to an anticipated resolution of claims the government could assert arising out of these matters on the consolidated statements of operations. In addition, as part of any resolution of this investigation, the government may request that laboratories owned and operated by the Company enter into a corporate integrity agreement with the Office of Inspector General ("OIG"), which would impose additional compliance and related costs in the future. Until this matter is finally resolved, there can be no assurance that the amount the Company has reserved will be sufficient to cover the Company's losses related to this matter. Losses could increase or decrease depending on a number of factors, including whether or not a settlement is reached, the terms of the settlement, the parties to the settlement and whether any potential excluded party seeks indemnification from the Company, the cost of complying with the terms of the settlement, including potential monitoring fees related to any potential corporate integrity agreement, and other factors. For additional information, please refer to Note 14. Commitments and Contingencies to our audited financial statements included elsewhere in the report.

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, which may lead to 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. In addition, pending a determination regarding our compliance with these conditions, payment to us may be suspended and we may be required to devote significant time, effort and expense to demonstrate satisfactory compliance.

Our facilities could face decreased Medicare payments if they fail to report and meet various quality metrics.

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, our patient volumes could decline.

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. 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.

Cybersecurity attacks or intrusions could adversely impact our businesses.

We, independently and through third-party vendors, collect and store on our networks and devices sensitive information, including intellectual property, proprietary business information and personally identifiable information of our patients and employees. 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, cybersecurity 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.

We and our third-party vendors have been and likely will continue to be subject to attempted cybersecurity attacks. While there has been no material impact on our business or operations from these attempted attacks. There can be no assurance that we or our third-party vendors will not be subject to cybersecurity incidents that bypass our security measures, impact the integrity, availability or privacy of personal health information or other data subject to privacy laws or disrupt our information systems, devices or business, including our ability to provide various health care services.

The market for cybersecurity insurance is relatively new and coverage available for cybersecurity events may evolve as the industry matures. While we maintain insurance relating to cybersecurity events, such insurance is subject to a number of exclusions and may be insufficient to offset any losses, costs or damage we experience. As cyber threats continue to evolve, we will be required to expend additional resources to continue to enhance our information security measures or to investigate and remediate any information security vulnerabilities.

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 or integration delay 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, and our acquired surgical centers and hospitals 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.

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 December 31, 2018, Bain Capital 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 December 31, 2018, 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 December 31, 2018, we were controlled by Bain Capital. As of that time, Bain Capital beneficially owned approximately 67% of our outstanding common stock. For as long as Bain Capital continues to control 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, Bain Capital 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 Bain Capital 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.

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.

Since our initial public offering, the price of our common stock as reported on The Nasdaq Global Select Market has ranged from a low of $7.10 on November 1, 2017 to a high of $24.05 on June 28, 2017. 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;
- 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;
- our limited public float;
- 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.

Securities class action litigation is often 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. For example, see Part I, Item 3. Legal Proceedings - Stockholder Litigation.

Provisions in the certificate of designation governing our preferred stock and 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, the certificate of designation governing our preferred stock 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. The provisions in our organizational documents include a classified board of directors and limitations on actions by our stockholders. In addition, our board of directors has the right to issue additional 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 Bain Capital. Finally, our 10% Series A Convertible Perpetual Participating Preferred Stock accrues conversion value for each quarter it is outstanding and is subject, under certain circumstances, to a redemption premium, which could significantly increase the cost to a potential acquirer of buying all of the outstanding securities of the Company. As a result of these features, our stockholders may lose their ability to sell their stock for a price in excess of the prevailing market price, 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.

If we identify a material weakness in our internal control over financial reporting, then it 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. As disclosed in Item 9A. "Controls and Procedures", in connection with management's assessment of our internal control over financial reporting as of December 31, 2017, management recognized certain control deficiencies in our internal control over financial reporting that resulted in material weaknesses as of December 31, 2017. We implemented plans to successfully remediate these control deficiencies as of December 31, 2018.

There can be no assurance that additional material weaknesses in internal control will not be discovered or occur in the future. If we identify a material weakness, then 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.

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 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our corporate headquarters is located in Brentwood, Tennessee, where we currently lease approximately 85,000 square feet of office space pursuant to an agreement with an initial term expiring December 31, 2027. In addition, certain of our corporate operational functions are located in Tampa, Florida. Our Tampa, Florida office contains approximately 31,000 square feet of leased office space, pursuant to an agreement with an initial term expiring in 2027. Our surgical facilities typically are located on real estate leased by the partnership or limited liability company that operates the facility. The average facility size is 8,000 to 12,000 square feet, and is specifically tailored to meet the needs of physician-partners and their specialties. Of our 123 surgical facilities, 118 utilize leased real property. These leases generally have initial terms of ten years, but range from 2 to 15 years. Most of the leases contain options to extend the lease period for up to ten additional years. We generally guarantee the lease obligations of the partnerships and limited liability companies that own our surgical facilities. We expect to be able to renew or replace a substantial majority of these leases on substantially similar terms as they come due. We believe these spaces are sufficient and adequate for our needs at this time.

Item 3. Legal Proceedings

Stockholder Litigation. On December 4, 2017, a purported Company stockholder filed an action in the Delaware Court of Chancery (the "Delaware Action"). That action is captioned Klein v. H.I.G. Capital, L.L.C., et al., C.A. No. 2017-0862. The plaintiff in the Delaware Action asserted claims against (i) certain current and former members of the Company's Board of Directors (together, the "Directors"); (ii) H.I.G. Capital, LLC and certain of its affiliates (collectively, "H.I.G."); and (iii) Bain Capital Private Equity, L.P. and certain of its affiliates (collectively, "Bain Capital" and, together with the Directors and H.I.G., the "Defendants"). The plaintiff asserted derivative claims on behalf of the Company, which is a nominal defendant in the Delaware Action, as well as putatively direct claims on behalf of a purported class of Company stockholders. The plaintiff in the Delaware Action asserted that the Defendants breached their fiduciary duties in connection with the Transactions, and that, in the alternative, Bain Capital aided and abetted those purported breaches. The plaintiff also asserted an unjust enrichment claim against Bain Capital.

On January 2, 2018, the Defendants moved to dismiss the plaintiff's complaint. On December 19, 2018, the Court of Chancery issued a decision on that motion. Following that decision, all of the Directors have been dismissed from the Delaware Action. The Court did not dismiss the plaintiff's breach of fiduciary duty claim against H.I.G. or the aiding and abetting claim asserted against Bain Capital. However, the Court dismissed the plaintiff's breach of fiduciary duty and unjust enrichment claims against Bain Capital. In addition, the Court dismissed all of the plaintiff's claims that were asserted on behalf of a putative class of Company stockholders. Accordingly, all of the plaintiff's remaining claims in the Delaware Action are asserted derivatively on the Company's behalf.

Government Investigation. On October 23, 2017, the Company received several civil investigative demands ("CIDs") from the federal government under the False Claims Act ("FCA") for documents and information dating back to January 1, 2010 relating to the medical necessity of certain drug tests conducted by the Company's physicians and submitted to laboratories owned and operated by the Company. In addition, the Company has been informed by CMS that payments to its diagnostic laboratory, Logan Laboratories, have been suspended pending further investigation by CMS.

The Company has been providing information to the government in response to the CIDs and currently has a non-binding agreement in principle with the DOJ on the financial terms of a settlement with the goal of resolving these matters. Based on those discussions, which are still ongoing, we recorded a litigation-related charge of $46.0 million relating to these matters on the consolidated statements of operations. We believe that this reserve is sufficient to cover a potential resolution of the investigation relating to these matters, including legal expenses relating to the settlement that have not previously been recorded in our operating expenses. The ultimate timing, amount and/or final terms of any such resolution may differ materially from those anticipated or we may not be able to reach a resolution at all. It is reasonably possible that we will incur additional losses above the amount reserved, but we are not able to estimate such amounts at this time. See Item 1A "Risk Factors" elsewhere in this report under the heading "Risk Factors - Risks Related to Government Regulation - *Companies within the healthcare industry, including us, continue to be the subject of federal and state audits and investigations, including actions for false and other improper claims*."

Other Litigation. In addition, we are, from time to time, subject to claims and suits, or threats of claims or suits, relating to our 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, which may not be covered by insurance or may otherwise have a material adverse effect on our business or results of operations.

See Note 14. Commitments and Contingencies for additional information regarding pending legal proceedings, which information is incorporated herein by reference.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

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

Market Information for Common Stock

Our common stock trades under the symbol "SGRY" on the Nasdaq Global Select Market.

Stockholders

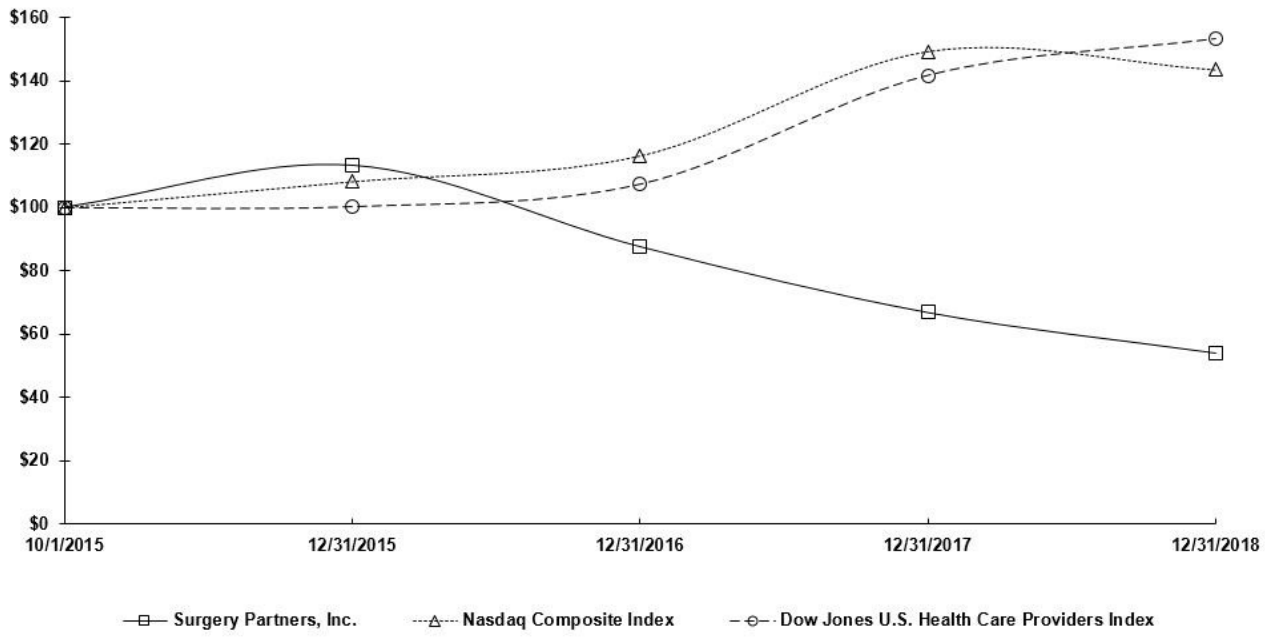
As of March 13, 2019, there were 117 holders of record of our common stock. The actual number of common stockholders is greater than the number of record holders, and includes stockholders who are beneficial owners, but whose shares are held in street name by brokers and other nominees. This number of holders of record also does not include stockholders whose shares may be held in trust by other entities.

Dividends

We have never declared or paid a cash dividend on our common stock, and have no current plans to declare or 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 our existing and future outstanding indebtedness we or our subsidiaries incur, including our credit facility. Additionally, because we are a holding company, we would depend on distributions from our subsidiaries to fund any potential dividends.

Stock Performance Graph

The following graph compares the cumulative total shareholder return on our common stock with the cumulative total returns of the Nasdaq Composite Index and the Dow Jones U.S. Health Care Providers Index. The graph begins on October 1, 2015, the day our shares were initially sold to the public. The comparison assumes $100 was invested in our common stock and in each of the indices on October 1, 2015 and assumes the reinvestment of dividends, if any.



	10/1/2015	12/31/2015	12/31/2016	12/31/2017	12/31/2018
Surgery Partners, Inc.	$ 100.00	$ 113.14	$ 87.52	$ 66.81	$ 54.06
Nasdaq Composite Index	$ 100.00	$ 108.22	$ 116.34	$ 149.20	$ 143.40
Dow Jones U.S. Health Care Providers Index	$ 100.00	$ 100.34	$ 107.40	$ 141.60	$ 153.10

This graph is furnished and not filed with the SEC or soliciting material under the Exchange Act and shall not be incorporated by reference into any such filings, irrespective of any general incorporation contained in such filing. The stock performance shown on the graph represents historical stock performance and is not necessarily indicative of future stock price performance.

Recent Purchases of Equity Securities by the Issuer and Affiliated Purchasers

On December 15, 2017, our Board of Directors authorized a share repurchase program of up to $50.0 million of our issued and outstanding common stock from time to time. The timing and size of repurchases will be determined based on market conditions and other factors. The authorization does not obligate us to repurchase any shares and we may repurchase shares of common stock at any time without prior notice. The share repurchases will be made in accordance with applicable securities laws in open market or privately negotiated transactions. The authorization does not have a specified expiration date, and the share repurchase program may be suspended, recommenced or discontinued at any time or from time to time without prior notice.

The following table presents information related to our repurchases of common stock for the periods indicated:

	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Program
(in thousands, except share and per share amounts)				
October 1, 2018 to October 31, 2018	—	$ —	—	$ 46,009
November 1, 2018 to November 30, 2018	—	$ —	—	$ 46,009
December 1, 2018 to December 31, 2018	7,976	$ 9.79	—	$ 46,009
Total	7,976	$ 9.79	—	$ 46,009

[1] Includes shares delivered to or withheld by us in connection with employee payroll tax withholding upon exercise or vesting of stock awards.

Item 6. Selected Financial Data

The table below contains selected consolidated financial and other data that has been derived from our audited consolidated financial statements for each of the years in the five-year period ended December 31, 2018. The timing of acquisitions and divestitures completed during the years presented affects the comparability of the selected financial data. The following table covers periods both prior to and subsequent to the Transactions. As discussed in the notes to the consolidated financial statements included in this report, in connection with the change of control effected by the Private Sale, we elected to apply "pushdown" accounting. We have presented the information for the year ended December 31, 2017 on a Predecessor period and Successor period combined basis (each as defined in Note 1. "Organization and Summary of Accounting Policies" of our consolidated financial statements) to facilitate meaningful comparisons of selected consolidated financial and other data to the prior year periods. The following selected consolidated financial and other data should be read in conjunction with "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Item 7 and our consolidated financial statements and the related notes included elsewhere in this report. The results presented below are not necessarily indicative of future results (dollars in thousands, except per share amounts):

	Year Ended December 31,				
	2018	2017	2016	2015	2014
Statements of Operations Data:					
Revenues [1]	$ 1,771,456	$ 1,341,219	$ 1,145,438	$ 959,891	$ 403,289
Net (loss) income	$ (95,626)	$ 28,736	$ 85,083	$ 72,845	$ (27,052)
Less: Net income attributable to non-controlling interests	(110,080)	(81,721)	(75,630)	(71,416)	(38,845)
Net (loss) income attributable to Surgery Partners, Inc.	(205,706)	(52,985)	9,453	1,429	(65,897)
Less: Amounts attributable to participating securities [2]	(32,426)	(26,047)	—	—	—
Net (loss) income attributable to common stockholders	$ (238,132)	$ (79,032)	$ 9,453	$ 1,429	$ (65,897)
Per common share data:					
Basic	$ (4.96)	$ (1.64)	$ 0.20	$ 0.04	$ (2.04)
Diluted [3]	$ (4.96)	$ (1.64)	$ 0.20	$ 0.04	$ (2.04)
Consolidated Balance Sheets Data:					
Working capital	$ 239,023	$ 260,220	$ 175,230	$ 129,668	$ 127,258
Total assets	4,676,267	4,622,773	2,304,958	2,104,443	1,855,771
Long-term debt, less current maturities	2,270,898	2,130,556	1,414,421	1,228,112	1,336,243
Redeemable preferred stock	359,346	330,806	—	—	—
Total stockholders' equity	1,098,945	1,336,610	324,674	297,927	29,536
Statements of Cash Flows Data:					
Net cash provided by operating activities	$ 144,600	$ 120,943	$ 125,239	$ 84,481	$ 21,949
Net cash used in investing activities	(128,862)	(783,449)	(184,749)	(134,842)	(271,106)
Net cash (used in) provided by financing activities	(6,344)	767,721	71,276	33,374	310,961
Other Data:					
Adjusted EBITDA [4]	$ 234,768	$ 164,301	$ 179,263	$ 158,053	$ 77,034
Adjusted EBITDA as a % of revenues	13.3%	12.3%	15.7%	16.5%	19.1%
Number of surgical facilities as of the end of period [5]	123	124	104	101	103
Number of consolidated surgical facilities included as of the end of period	106	108	94	90	91

[1] Revenues in 2018 reflect changes related to adoption of ASU 2014-09 as discussed in Note 1. "Organization and Summary of Accounting Policies."

[2] Includes accrued dividends for the Series A Preferred Stock for the year ended December 31, 2018. Includes accrued dividends of $10.4 million and a mark to redemption adjustment of $15.6 million for the year ended December 31. 2017. There were no participating securities during 2016, 2015 and 2014.

[3] The impact of potentially dilutive securities for the years ended December 31, 2018, 2017 and 2014 was not considered because the effect would be anti-dilutive in each of those periods.

[4] See Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations - Certain non-GAAP Metrics" for a table showing the reconciliation of Adjusted EBITDA to income before income taxes.

[5] Includes surgical facilities that we manage but in which we have no ownership interest.

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

The following discussion and analysis of our financial condition and results of operations should be read in conjunction with Item 6. “Selected Financial Data” and our audited consolidated financial statements and related notes included elsewhere in this report. This discussion contains forward-looking statements that involve risks and uncertainties. For additional information regarding certain of the risks and uncertainties that affect our business and the industry in which we operate, please see Item 1A. “Risk Factors” and Item 9A. “Controls and Procedures” found elsewhere in this report. Unless the context otherwise indicates, the terms "Surgery Partners," "we," "us," "our" or the "Company," as used herein, refer to Surgery Partners, Inc. and its subsidiaries. Unless the context implies otherwise, the term “affiliates” means direct and indirect subsidiaries of Surgery Partners, Inc., 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, Inc. and the term “employees” refers to employees of affiliates of Surgery Partners, Inc.

The following discussion and analysis of our financial condition and results of operations covers periods both prior to and subsequent to the Transactions (as defined in Item 1. Business above). Accordingly, the discussion and analysis of historical periods do not reflect the significant impact the Transactions had on the Company. As discussed in the notes to the consolidated financial statements included in this report, in connection with the change of control effected by the Private Sale, we elected to apply “pushdown” accounting. We have presented the information for the year ended December 31, 2017 on a Predecessor period and Successor period combined basis (each as defined in Note 1. "Organization and Summary of Accounting Policies" of our consolidated financial statements) to facilitate meaningful comparisons of operating results to the prior year period. You should read the following discussion together with our historical financial statements and related notes included elsewhere herein.

Executive Overview

As of December 31, 2018, we owned and operated a national network of surgical facilities, physician practices and a suite of ancillary services in 31 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. 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 December 31, 2018, we owned or operated, primarily in partnership with physicians, a portfolio of 123 surgical facilities comprised of 108 ASCs and 15 surgical hospitals across 31 states. We owned a majority interest in 84 of the surgical facilities and consolidated 106 of these facilities for financial reporting purposes. During the year ended December 31, 2018, approximately 521,000 surgical procedures were performed in our surgical facilities, generating approximately $1.7 billion in revenue.

We continue to focus on improving our same-facility performance, selectively acquiring established facilities and developing new facilities. During the year ended December 31, 2018, we acquired five surgical facilities in new markets, two surgical facilities in existing markets, one of which was merged into an existing facility and multiple physician practices for a total investment of $106.4 million. Further, during the year ended December 31, 2018 (Successor), we disposed of four surgery centers, two surgical hospitals and our optical laboratory for net cash proceeds of $18.7 million, and recognized a net pretax loss of $21.2 million. This non-cash loss was primarily a result of the write-off of the net assets of the facility (net of proceeds received) and was primarily driven by the write-off of the associated goodwill.

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, which were sold in 2018, 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 revenues by service type as a percentage of total revenues:

	Year Ended December 31,		
	2018	2017	2016
Patient service revenues:			
Surgical facilities revenues	93.6%	92.7%	90.3%
Ancillary services revenues	4.5%	5.7%	7.9%
	98.1%	98.4%	98.2%
Other service revenues:			
Optical services revenues	0.5%	0.8%	1.1%
Other	1.4%	0.8%	0.7%
	1.9%	1.6%	1.8%
Total revenues	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:

	Year Ended December 31,		
	2018	2017	2016
Private insurance payors	54.6%	53.6%	51.5%
Government payors	37.6%	38.3%	39.9%
Self-pay payors	2.9%	2.4%	1.8%
Other payors [(1)]	4.9%	5.7%	6.8%
Total	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. 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:

	Year Ended December 31,		
	2018	2017	2016
Gastrointestinal	21.4%	22.3%	22.7%
General surgery	3.0%	2.7%	2.4%
Ophthalmology	25.3%	27.9%	29.4%
Orthopedics and pain management	37.8%	34.5%	32.4%
Other	12.5%	12.6%	13.1%
Total	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 periods) along with the revenues from our ancillary services. The below table reflects the pro forma effect of the NSH acquisition for a full period in the year ended December 31, 2017.

	Year Ended December 31,	
	2018	2017
Cases	542,335	546,719
Case growth	(0.8)%	N/A
Revenues per case	$ 3,408	$ 3,220
Revenues per case growth	5.8 %	N/A
Number of facilities	109	N/A

Segment Information

Our business is comprised of three segments: (1) surgical facility services, (2) ancillary facility services and (3) optical services. For more information about the components of each segment, please see Part I, Item 1. Business--Operations included elsewhere in this report.

"All other" primarily consists of the Company's corporate general and administrative functions.

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

	Year Ended December 31,		
	2018	2017	2016
Revenues:			
Surgical facility services	$ 1,682,278	$ 1,253,183	$ 1,042,097
Ancillary services	79,633	76,921	90,836
Optical services	9,545	11,115	12,505
Total revenues	$ 1,771,456	$ 1,341,219	$ 1,145,438
Adjusted EBITDA:			
Surgical facility services	$ 309,513	$ 229,672	$ 214,218
Ancillary services	3,008	(8,781)	12,685
Optical services	2,500	2,950	3,308
All other	(80,253)	(59,540)	(50,948)
Total Adjusted EBITDA [(1)]	$ 234,768	$ 164,301	$ 179,263
Supplemental Information:			
Cash purchases of property and equipment, net:			
Surgical facility services	$ 34,178	$ 23,916	$ 29,157
Ancillary services	419	2,066	5,388
Optical services	46	156	351
All other	5,162	3,462	4,213
Total cash purchases of property and equipment, net	$ 39,805	$ 29,600	$ 39,109

[(1)] For a reconciliation of Adjusted EBITDA to income before income taxes as reflected in the audited consolidated statements of operations see "Certain Non-GAAP Metrics" below.

	December 31, 2018	December 31, 2017
Assets:		
Surgical facility services	$ 4,204,344	$ 4,072,521
Ancillary services	52,733	104,274
Optical services	20,084	48,309
All other	399,106	397,669
Total assets	$ 4,676,267	$ 4,622,773

Critical Accounting Policies

Our significant accounting policies and practices are described in Note 1 of our consolidated financial statements included elsewhere in this report. In preparing our consolidated financial statements in conformity with U.S. Generally Accepted Accounting Principles ("GAAP"), we 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 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.

Revenue Recognition

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, *Revenue from Contracts with Customers*. We adopted the new standard effective January 1, 2018, using the modified retrospective method. The presentation of the amount of earnings from operations and net earnings were unchanged upon adoption of the new standard; however, during the year of adoption, we determined that amounts historically considered to be bad debt should be considered an implicit price concession, as defined in FASB Accounting Standards Codification 606, "*Revenue From Contracts With Customers*". This resulted in changes to the presentation of revenues and the provision for bad debts in the consolidated statements of operations. Previously, the estimate for unrealizable amounts was recorded to the provision for bad debts and presented as a component of operating expenses. Upon reassessment during the year of adoption, the estimate for unrealizable amounts is now reflected as an implicit price concession as a reduction to arrive at net revenue. This change in presentation was not material to the financial statements.

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.

Accounts Receivable

Our patient service revenues and other receivables from third-party payors are recorded net of estimated implicit price concessions which are estimated based on the historical trend of our surgical facilities' cash collections and contractual write-offs, 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.

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 was 63 days for the year ended December 31, 2018 and 61 days for the year ended December 31, 2017.

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, where possible. 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 3% for the year ended December 31, 2018, and 2% for each of the years ended December 31, 2017 and 2016.

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 December 31, 2018, we had unused federal net operating loss carryforwards ("NOLs") of approximately $516.8 million. Such losses expire in various amounts at varying times beginning in 2025. Unless they expire, these NOLs may be used to offset future taxable income and thereby reduce our income taxes otherwise payable.

We recorded a valuation allowance against our deferred tax assets at December 31, 2018 and 2017 totaling $50.4 million and $11.0 million, respectively. The valuation allowance has been established for certain deferred tax assets for which we believe it is more likely than not that the tax benefits will not be realized, which are primarily Section 163(j) interest carryforwards, certain state net operating losses and capital loss carryforwards. If our expectations for future operating results on a consolidated basis or at the state jurisdiction level vary from actual results due to changes in healthcare regulations, general economic conditions, or other factors, we may need to adjust the valuation allowance, for all or a portion of our deferred tax assets. Our income tax expense in future periods will be reduced or increased to the extent of offsetting decreases or increases, respectively, in our valuation allowance in the period when the change in circumstances occurs. These changes could have a significant impact on our future earnings.

Section 382 ("Section 382") of the Internal Revenue Code of 1986, as amended (the "Code") imposes an annual limit on the ability of a corporation that undergoes an "ownership change" to use its NOLs to reduce its tax liability. An "ownership change" is generally defined as any change in ownership of more than 50.0% 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 in 2014, 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 in 2011, approximately $17 million in NOL carryforwards are subject to an annual Section 382 base limitation of $4.9 million. As a result of the NSH acquisition, approximately $20.5 million in NOL carryforwards are subject to an annual Section 382 base limitation of $2.8 million. The Private Sale resulted in an ownership change as defined in Section 382. As a result, approximately $461.2 million in NOL carryforwards are subject to an annual Section 382 base limitation of $14.2 million. At this time, we do not believe this limitation, 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.

The Tax Cuts and Jobs Act (the "Tax Act") was enacted on December 22, 2017. The Tax Act reduces the U.S. federal corporate tax rate from 35% to 21%, allows for 100% expensing of certain capital expenditures, and limits interest expense deductions beginning in 2018. The SEC staff issued SAB 118, which provides guidance on accounting for the tax effects of the Tax Act. SAB 118 provides a measurement period that should not extend beyond one year from the Tax Act enactment date for companies to complete the accounting under ASC 740. In accordance with SAB 118, a company must reflect the income tax effects of those aspects of the Tax Act for which the accounting under ASC 740 is complete. Our accounting for the following elements of the Tax Act is complete: reduction of U.S. federal corporate tax rate from 35% to 21%, 100% expensing of capital expenditures, and the interest expense limitation under Section 163j.

Tax Receivable Agreement

On May 9, 2017, we entered into an agreement to amend our Income Tax Receivable Agreement, dated September 30, 2015 (as amended, the "TRA"), between the Company, and the other parties referred to therein, which amendment became effective on August 31, 2017. Pursuant to the amendment to the TRA, we agreed to make payments to H.I.G., our former controlling shareholder, in its capacity as the stockholders representative pursuant to a fixed payment schedule. The amounts payable under the TRA are calculated as the product of (i) an annual base amount and (ii) the maximum corporate federal income tax rate for the applicable year plus three percent. The amounts payable under the TRA are related to our projected realized tax savings over the next five years and are not dependent on our actual tax savings. Amounts payable pursuant to the TRA will be adjusted downward in the event that the maximum corporate federal income tax rate is reduced. 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 September 30, 2015, 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 September 30, 2015, such payments will be deferred and will accrue interest at a rate of LIBOR plus 300 basis points until paid. As a result of the amendment to the TRA, we were required to value the liability under the TRA by discounting the fixed payment schedule using the Company's incremental borrowing rate.

Assuming our tax rate is 24%, calculated as the maximum corporate federal tax rate plus three percent, throughout the remaining term of the TRA, we estimate the total remaining amounts payable under the TRA are approximately $64.6 million as of December 31, 2018. The carrying value of the liability under the TRA, reflecting the discount as discussed above, was $48.5 million as of December 31, 2018

Impairment of Goodwill

We test goodwill for impairment at least annually, as of October 1, or more frequently if certain indicators arise. We test for goodwill impairment at the reporting unit level, which is defined as one level below an operating segment. As of October 1, 2018, we have identified three reporting units, which include the following: 1) Surgical Facilities, 2) Ancillary Services, and 3) The Alliance, including Optical Synergies ("Alliance"). The Alliance is a component of our Optical Services operating segment. In 2018, we disposed of two previously identified reporting units, Midwest Labs and Family Vision Care.

We compare the carrying value of the net assets of the reporting unit to the estimated fair value of the reporting unit. To determine the fair value of the reporting units, we obtained valuations at the reporting unit level prepared by third-party valuation specialists. This valuation is based on a combination of conventional income and market valuation calculations. The discounted cash flow ("DCF") model that is used in our income valuation is projected based on a year-by-year assessment that considers historical results, estimated market conditions, internal projections, and relevant publicly available statistics. Determining fair value requires the exercise of significant judgment, including assumptions about appropriate discount rates, perpetual growth rates and the amount and timing of expected future cash flows. The cash flows employed in the DCF analysis are based on our most recent budgets and business plans aligned with provided guidance and, when applicable, various growth rates are assumed for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risk inherent in the future cash flows of the respective reporting units. The variables within the discount rate, many of which are outside of our control, provide the best estimate of all assumptions applied within the DCF model. There can be no assurance that operations will achieve the future cash flows reflected in the projections. In determining the fair value under the market approaches, the analysis includes a control premium, which was based on observable market data and a review of selected transactions of companies that operate in our sector. While we believe that all assumptions utilized in the testing were appropriate, they may not reflect actual outcomes that could occur. Specific factors that could negatively impact the assumptions used include changes to the discount and growth rates and a change in the equity and enterprise premiums being realized in the market.

As of October 1, 2018, prior to our impairment testing, our three reporting units with allocated goodwill were as follows: 1) Surgical Facilities - $3.3 billion, 2) Ancillary Services - $80.0 million, and 3) The Alliance, including Optical Synergies ("Alliance") - $25.3 million. As of the October 1, 2018 valuation, the fair value for the Surgical Facilities reporting unit was substantially in excess of its carrying value. For the Ancillary Services and Alliance reporting units, the carrying value exceeded the fair value, resulting in non-cash impairment charges of $60.7 million and $13.7 million, respectively.

As a result of the impairment charges, the fair value equaled carrying value as of October 1, 2018 for the Ancillary Services and Alliance reporting units, any future adverse events or changes in the assumptions could require additional impairment. Subsequent to the date of our annual impairment test, we considered our operating results for the fourth quarter of 2018, macroeconomic, industry and market conditions, and other market indicators including our market capitalization. Based on our evaluation of all such factors, we concluded that an event had not occurred or circumstances had not changed that would more likely than not reduce the fair value of our reporting units below their carrying values.

In connection with the implementation of pushdown accounting, we performed our goodwill impairment test as of August 31, 2017, then re-evaluated for impairment at October 1, 2017. Both evaluations resulted in no impairment.

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. 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 periods indicated (dollars in thousands):

	Year Ended December 31,		
	2018	2017	2016
Revenues	$ 1,771,456	$ 1,341,219	$ 1,145,438
Operating expenses:			
Cost of revenues	1,361,431	1,013,800	821,196
General and administrative expenses	93,558	75,950	60,246
Depreciation and amortization	67,440	51,928	39,551
Provision for doubtful accounts	—	28,752	24,212
Income from equity investments	(8,898)	(6,467)	(4,764)
Loss on disposals and deconsolidations, net	31,822	1,720	2,355
Transaction and integration costs	31,665	13,054	8,738
Impairment charges	74,359	—	—
Loss on debt refinancing	—	18,211	11,876
Loss (gain) on litigation settlements	46,009	(12,534)	(14,101)
Gain on acquisition escrow release	—	(1,167)	—
Other income	(3,768)	(262)	(353)
Total operating expenses	1,693,618	1,182,985	948,956
Operating income	77,838	158,234	196,482
Gain on amendment to tax receivable agreement	—	16,392	—
Tax receivable agreement benefit (expense)	—	25,329	(3,733)
Interest expense, net	(147,003)	(117,669)	(100,571)
(Loss) income before income taxes	(69,165)	82,286	92,178
Income tax expense	26,461	53,550	7,095
Net (loss) income	(95,626)	28,736	85,083
Less: Net income attributable to non-controlling interests	(110,080)	(81,721)	(75,630)
Net (loss) income attributable to Surgery Partners, Inc.	$ (205,706)	$ (52,985)	$ 9,453

Year Ended December 31, 2018 Compared to Year Ended December 31, 2017

Overview. During 2018, our revenues increased 32.1% to $1.8 billion from $1.3 billion in 2017. We incurred net loss attributable to Surgery Partners, Inc. in 2018 of $205.7 million, compared to net loss of $53.0 million in 2017.

Revenues. Revenues for 2018 and 2017 were as follows (dollars in thousands):

	Year Ended December 31,	
	2018	2017
Patient service revenues	$ 1,736,975	$ 1,320,211
Optical service revenues	9,545	11,115
Other service revenues	24,936	9,893
Total revenues	$ 1,771,456	$ 1,341,219

Patient service revenues increased 31.6% to $1.7 billion in 2018 compared to $1.3 billion in 2017, primarily due to the 2017 acquisition of NSH. The increase in other service revenues is primarily due to an increase in management and administrative service fees derived from non-consolidated surgical facilities that we account for under the equity method and management of surgical facilities in which we do not own an interest, primarily due to the 2017 acquisition of NSH. Additionally, total revenues in 2018 reflect the impact of our adoption of ASU 2014-09 as discussed in "Critical Accounting Policies - *Revenue Recognition*" above.

Cost of Revenues. Cost of revenues were $1.4 billion in 2018 compared to $1.0 billion in 2017, with the increase in costs primarily attributable to our 2018 and 2017 acquisitions and an increase in supply costs associated with higher acuity surgical case volume. As a percentage of revenues, cost of revenues were 76.9% and 75.6% for 2018 and 2017, respectively.

General and Administrative Expenses. General and administrative expenses were $93.6 million and $76.0 million in 2018 and 2017, respectively. The increase in these expenses is primarily attributable to the acquisition of NSH, but also reflects increases in equity-based compensation, rent costs and general inflation. As a percentage of revenues, general and administrative expenses were 5.3% in 2018 compared to 5.7% in 2017. This increase includes $7.0 million attributable to the acquisition of NSH, which was included in our operations for four months of 2017 but for all 12 months of 2018.

Depreciation and Amortization. Depreciation and amortization was $67.4 million and $51.9 million in 2018 and 2017, respectively. The increase in 2018 is primarily attributable to the acquisition of NSH. As a percentage of revenues, depreciation and amortization expenses were 3.8% in 2018 and 3.9% in 2017.

Provision for Doubtful Accounts. As described in Note 1 to our consolidated financial statements, we adopted a new accounting standard in 2018, which resulted in a change in recognition of our provision for doubtful accounts. Beginning in 2018, we considered such amounts as implicit price concessions and recorded that estimate as a component of reported revenue. Prior periods were not reclassified based on the modified retrospective transition method adopted by the Company.

Income from Equity Investments. Income from equity investments was $8.9 million and $6.5 million in 2018 and 2017, respectively. The increase is attributed the four equity method investments that were included in the acquisition of NSH.

Loss on Disposals and Deconsolidations, Net. The net loss on disposals and deconsolidations was $31.8 million in 2018, which included a net loss of $20.1 million on the disposal of six surgical facilities and our optical laboratory, and the deconsolidation of a surgical facility. The remaining loss is related to disposals of other long-lived assets. The net loss on disposals and deconsolidations in 2017 was attributable to disposals of other long-lived assets.

Transaction and Integration Costs. We incurred $31.7 million of transaction and integration costs in 2018 compared to $13.1 million in 2017, as a majority of integration costs were incurred in 2018 for the NSH acquisition as well as other acquisitions that occurred in 2018 (refer to notes to consolidated financial statements for additional detail).

Impairment charges. As described in the Critical Accounting Policies section above, in 2018 we recorded a non-cash impairment charge of $60.7 million and $13.7 million for goodwill assigned to our Ancillary Services and Alliance reporting units, respectively. This charge was warranted based on the calculated fair value compared to the carrying value of these reporting units.

Loss on Debt Refinancing. In 2017, we incurred a loss on debt refinancing of $18.2 million. The 2017 loss includes the partial write-off of unamortized debt issuance costs and discount related to the prepayment of the then existing 2014 Revolver Loan and 2014 First Lien Credit Agreement and a portion of costs incurred with entering into the 2017 Senior Secured Credit Facilities (as defined in Note 5 to our consolidated financial statements).

Loss (Gain) on Litigation Settlement. We incurred a loss on a potential resolution of an investigation in the amount of $46.0 million in 2018 related to the government investigation discussed in Item 3. Legal Proceedings. In 2017, we recorded a gain of $12.5 million related to legal settlements reached in 2017.

Tax Receivable Agreement. In 2017, we recognized a tax receivable agreement gain of $16.4 million primarily as a result of the amendment of the TRA. No such gain occurred in 2018. Also in 2017, we recognized a tax receivable agreement benefit of $25.3 million related to a reduction in the corporate tax rate from the Tax Cuts and Jobs Act. We did not incur a tax receivable agreement benefit in 2018.

Interest Expense, Net. Interest expense, net, increased to $147.0 million in 2018 compared to $117.7 million in 2017. The increase primarily relates to the issuance of our $370 million Senior Unsecured Notes on June 30, 2017 due 2025 and an increase in our variable rate debt due to the refinancing of our Senior Secured Credit Facility as of August 31, 2017. Additionally, we entered into an incremental term loan amendment to provide for a $180.0 million senior secured incremental term loan, which was fully drawn on October 23, 2018. As a percentage of revenues, interest expense, net was 8.3% in 2018 compared to 8.8% in 2017.

Income Tax Expense (Benefit). Income tax expense was $26.5 million and $53.6 million in 2018 and 2017, respectively. The effective tax rate was (38.3)% for 2018 compared to 65.1% in 2017. The change in effective tax rate was primarily attributable to the tax-effect of the non-deductible goodwill impairment and the valuation allowance that was recorded related to the 163(j) interest deferred tax asset.

Net Income Attributable to Non-Controlling Interests. Net income attributable to non-controlling interests was $110.1 million and $81.7 million in 2018 and 2017, respectively. The increase in this amount is predominantly due to the inclusion of NSH for the full-year of 2018. As a percentage of revenues, net income attributable to non-controlling interests was 6.2% in the 2018 period and 6.1% for the 2017 period.

Year Ended December 31, 2017 Compared to Year Ended December 31, 2016

Overview. During 2017, our revenues increased 17.1% to $1.3 billion from $1.1 billion in 2016. We incurred net loss attributable to Surgery Partners, Inc. in 2017 of $53.0 million, compared to income of $9.5 million in 2016.

Revenues. Revenues for 2017 and 2016 were as follows (dollars in thousands):

	Year Ended December 31,	
	2017	2016
Patient service revenues	$ 1,320,211	$ 1,124,604
Optical service revenues	11,115	12,505
Other service revenues	9,893	8,329
Total revenues	$ 1,341,219	$ 1,145,438

Patient service revenues increased 17.4% to $1.3 billion in 2017 compared to $1.1 billion in 2016. This increase in patient service revenues was primarily attributable to the 2017 acquisition of NSH.

Cost of Revenues. Cost of revenues were $1.0 billion in 2017 compared to $821.2 million in 2016. The increase is primarily attributable to our 2017 and 2016 acquisitions, and an increase in supply costs due to a higher acuity surgical case volume. As a percentage of revenues, cost of revenues were 75.6% and 71.7% for 2017 and 2016, respectively.

General and Administrative Expenses. General and administrative expenses were $76.0 million and $60.2 million in 2017 and 2016, respectively. The increase is primarily attributable to the acquisition of NSH, but also reflects increases in equity-based compensation expense, rent costs, contingent acquisition compensation expense and general inflation. The remaining increase is attributable to overall growth of the business. As a percentage of revenues, general and administrative expenses were 5.7% for the 2017 period compared to 5.3% for the 2016 period.

Depreciation and Amortization. Depreciation and amortization was $51.9 million and $39.6 million in 2017 and 2016, respectively. The increase is primarily attributable to the acquisition of NSH, and the remeasurement of assets at fair value in connection with the application of pushdown accounting. As a percentage of revenues, depreciation and amortization expenses were 3.9% in 2017 and 3.5% in 2016.

Provision for Doubtful Accounts. The provision for doubtful accounts was $28.8 million in 2017 compared to $24.2 million in 2016. The increase is attributable to the acquisition of NSH. As a percentage of revenues, the provision for doubtful accounts was 2.1% for both 2017 and 2016.

Income from Equity Investments. Income from equity investments was $6.5 million and $4.8 million in 2017 and 2016, respectively. The increase is attributed to the four equity method investments that were included in the acquisition of NSH.

Loss on Disposals and Deconsolidations, Net. The net loss on disposals and deconsolidations was $1.7 million and $2.4 million 2017 and 2016, respectively, which was attributable to disposals of other long-lived assets for both periods.

Transaction and Integration Costs. We incurred $13.1 million of transaction and integration costs in 2017 compared to $8.7 million in 2016. The increase relates to the Transactions, as defined in Item 1. Business, on August 31, 2017, as well as other acquisitions that occurred in 2017.

Loss on Debt Refinancing. We incurred $18.2 million as a loss on debt refinancing in 2017 compared to $11.9 million in 2016. The 2017 loss includes the partial write-off of unamortized debt issuance costs and discount related to the prepayment of the then existing 2014 Revolver Loan and 2014 First Lien Credit Agreement and a portion of costs incurred with entering into the 2017 Senior Secured Credit Facilities.

Gain on Litigation Settlement. We recorded a gain on litigation settlement of $12.5 million in 2017 compared to $14.1 million in 2016. These items related to a legal settlements for the year in which the settlements were reached.

Tax Receivable Agreement. In 2017, we recognized a tax receivable agreement gain of $16.4 million primarily as a result of the amendment of the TRA. No such gain occurred in 2016. Also in 2017, we recognized a tax receivable agreement benefit of $25.3 million related to a reduction in the corporate tax rate from the Tax Cuts and Jobs Act. The 2016 expense was recorded to update the initial estimated liability for the filed tax returns and final 2015 tax losses that are included in the amounts payable under the TRA.

Interest Expense, Net. Interest expense, net, increased to $117.7 million in 2017 compared to $100.6 million in 2016. The increase primarily relates to the issuance of our $370 million Senior Unsecured Notes on June 30, 2017 due 2025 and the refinancing of our Senior Secured Credit Facility as of August 31, 2017.

Income Tax Expense (Benefit). Income tax expense was $53.6 million and $7.1 million in 2017 and 2016, respectively. The effective tax rate was 65.1% for 2017 and 7.7% for 2016. The change in effective tax rate was primarily attributable to the remeasurement of our deferred tax assets and liabilities due to the enactment of the 2017 Tax Cuts and Jobs Act.

Net Income Attributable to Non-Controlling Interests. Net income attributable to non-controlling interests was $81.7 million and $75.6 in 2017 and 2016, respectively. The increase is attributable to the acquisition of NSH. As a percentage of revenues, net income attributable to non-controlling interests was 6.1% in 2017 and 6.6% in 2016.

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. Cash flow provided by operating activities was $144.6 million, $120.9 million and $125.2 million in 2018, 2017 and 2016, respectively. The increase in operating cash flow in 2018 is primarily attributed to the additional revenue contribution from our 2017 acquisition of NSH plus other 2018 acquisitions, partially offset by integration costs and a decline in the performance of our ancillary business. The decline in operating cash flow for 2017, compared to 2016, was primarily related to the decline in performance of our ancillary business.

Investing Activities

Net cash used in investing activities in 2018 was $128.9 million, which included $39.8 million related to purchases of property and equipment. We paid $106.8 million, in cash for acquisitions (net of cash acquired), which included five surgical facilities in new markets, two surgical facilities in an existing market, one of which was merged into an existing facility and multiple physician practices. Further, we received $19.2 million in proceeds from disposals of six surgical facilities and our optical laboratory.

Net cash used in investing activities in 2017 was $783.4 million, which included $29.6 million related to purchases of property and equipment. We paid $755.1 million in cash for acquisitions (net of cash acquired), of which $711.7 million related to the acquisition of NSH. The remaining amount included the acquisitions of four physician practices and one surgical facility. Further, we received $1.3 million in proceeds from the disposal of a surgical facility.

Net cash used in investing activities in 2016 was $184.7 million, which included $39.1 million related to purchases of property and equipment. We paid $146.4 million in cash for acquisitions (net of cash acquired), of which $129.8 million, excluding the $16.6 million of contingent acquisition consideration, related to the purchase of six surgical facilities, one of which was merged with an existing facility, three anesthesia practices, eleven physician practices, a lab and a pharmacy. Further, we received $0.8 million in proceeds from the disposal of a surgical facility.

Financing Activities

Net cash used in financing activities in 2018 was $6.3 million. During this period, we made distributions to non-controlling interest holders of $109.0 million and payments related to ownership transactions with consolidated affiliates of $2.2 million. Further, we made repayments on our long-term debt of $157.6 million offset by borrowings of $282.7 million, which included incremental term loan borrowings of $180.0 million. In connection with the incremental term loan, we made payments of debt issuance costs of $3.0 million. In addition, we made preferred dividend payments of $7.8 million and repurchased $2.0 million of our common stock pursuant to our $50 million repurchase program announced on December 15, 2017.

Net cash provided by financing activities in 2017 was $767.7 million. During this period, we made distributions to non-controlling interest holders of $83.8 million and payments related to ownership transactions with consolidated affiliates of $0.5 million. Further, we made repayments on our long-term debt of $1.2 billion offset by borrowings of $1.8 billion. In addition, we made payments of debt issuance costs of $58.6 million and received proceeds on the issuance of preferred stock of $291.7 million, net of issuance costs, and repurchased $2.0 million of our common stock pursuant to our $50 million repurchase program announced on December 15, 2017.

Net cash provided by financing activities in 2016 was $71.3 million. During this period, we made distributions to non-controlling interest holders of $65.8 million and payments related to ownership transactions with consolidated affiliates of $20.1 million. Further, we made repayments on our long-term debt of $473.4 million offset by borrowings of $650.7 million. In addition, we made payments of debt issuance costs of $14.3 million and a penalty on the prepayment of debt of $4.9 million during the period.

Long-Term Debt

As of December 31, 2018, the carrying value of our total indebtedness, including capital leases, was $2.326 billion, which includes net unamortized fair value premium of $1.2 million and unamortized deferred financing costs of $2.9 million.

2017 Senior Secured Credit Facilities

As of December 31, 2018, we had term loan borrowings with a carrying value of $1.448 billion, consisting of outstanding aggregate principal of $1.453 billion and unamortized fair value discount of $5.5 million (the "Term Loan"). In 2018, we entered into an incremental term loan amendment, which amended and supplemented the Credit Agreement, dated as of August 31, 2017 (the "Credit Agreement"), to provide for an incremental borrowing of $180.0 million. The incremental amounts were fully drawn on October 23, 2018, and the proceeds thereof were used to fund acquisitions and for other general corporate purposes. The incremental borrowings bear interest and is subject to maturity, amortization and other terms consistent with the existing term loans outstanding as disclosed below.

The Term Loan matures on August 31, 2024 (or, if at least 50.0% of the 2021 Unsecured Notes (as defined below) shall have not either been repaid or refinanced with permitted indebtedness having a maturity date not earlier than six months after the maturity date of the Term Loan by no later than October 15, 2020, then October 15, 2020). The Term Loan amortizes in equal quarterly installments of 0.25% of the aggregate original principal amount of the Term Loan.

We have a revolving credit facility providing for revolving borrowings of up to $75.0 million (the "Revolver" and, together with the Term Loan, the "2017 Senior Secured Credit Facilities"). The Revolver will mature on August 31, 2022 (or, if at least 50.0% of the 2021 Notes have not either been repaid or refinanced with permitted indebtedness having a maturity date not earlier than six months after the maturity date of the Term Loan by no later than October 15, 2020, then October 15, 2020). As of December 31, 2018, our availability on the Revolver was $71.2 million (including outstanding letters of credit of $3.8 million).

The Revolver may be utilized for working capital, capital expenditures and general corporate purposes. Subject to certain conditions and requirements set forth in the credit agreement, we may request one or more additional incremental term loan facilities or one or more increases in the commitments under the Revolver.

The 2017 Senior Secured Credit Facilities bear interest at a rate per annum equal to (x) LIBOR plus a margin ranging from 3.00% to 3.25% per annum, depending on our first lien net leverage ratio or (y) an alternate base rate (which will be the highest of (i) the prime rate, (ii) 0.5% per annum above the federal funds effective rate and (iii) one-month LIBOR plus 1.00% per annum (solely with respect to the Term Loan, the alternate base rate shall not be less than 2.00% per annum)) plus a margin ranging from 2.00% to 2.25% per annum. In addition, we are required to pay a commitment fee of 0.50% per annum in respect of unused commitments under the Revolver.

Senior Unsecured Notes

We have senior unsecured notes due April 15, 2021 with a carrying value of $406.7 million as of December 31, 2018, consisting of outstanding aggregate principal of $400.0 million and unamortized fair value premium of $6.7 million (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.

We have $370.0 million aggregate principal amount of senior unsecured notes due July 1, 2025 (the "2025 Unsecured Notes") outstanding as of December 31, 2018. 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.

Other Debt

We and certain of our subsidiaries have other debt consisting of outstanding bank indebtedness of $79.3 million, which is collateralized by the real estate and equipment owned by the surgical facilities to which the loans were made, and capital lease obligations of $25.4 million for which we are liable to various vendors for several property and equipment leases classified as capital leases.

Summary

We believe we have sufficient liquidity in the next 12 to 18 months as described above. Nevertheless, we continue to monitor the state of the financial and credit markets and our current and expected liquidity and capital resource needs, and intend to continue to explore various financing alternatives to improve our capital structure, including reducing debt, extending maturities or relaxing financial covenants. These may include new equity or debt financings or exchange offers with existing security holders (including exchanges of debt for debt or equity) and other transactions involving our outstanding securities, given their secondary market trading prices. We cannot assure you, if we pursue any of these transactions, that we will be successful in completing a transaction on attractive terms, or at all.

Certain Non-GAAP Metrics

Adjusted EBITDA is not a measurement of financial performance under GAAP, and should not be considered in isolation or as a substitute for net income, operating income or any other measure calculated in accordance with GAAP. The items excluded from this non-GAAP metric are significant components in understanding and evaluating our financial performance. We believe such adjustments are appropriate, as the magnitude and frequency of such items can vary significantly and are not related to the assessment of normal operating performance. Our calculation of Adjusted EBITDA may not be comparable to similarly titled measures reported by other companies.

When we use the term "Adjusted EBITDA", we are referring to income before income taxes, adjusted for net income attributable to non-controlling interests, interest expense, net, depreciation and amortization, equity-based compensation expense, contingent acquisition compensation expense, transaction, integration and acquisition costs, loss (gain) on litigation settlements, gain on acquisition escrow release, loss on disposals and deconsolidations, net, reserve adjustments, impairment charges, gain on amendment to tax receivable agreement, tax receivable agreement (benefit) expense and loss on debt refinancing. We use Adjusted EBITDA as a measure of financial performance. Adjusted EBITDA is a key measure used by our management to assess operating performance, make business decisions and allocate resources.

The following table reconciles Adjusted EBITDA to (loss) income before income taxes, the most directly comparable GAAP financial measure (in thousands and unaudited):

	Year Ended December 31,		
	2018	2017	2016
Consolidated Statements of Operations Data:			
(Loss) income before income taxes	$ (69,165)	$ 82,286	$ 92,178
Plus (minus):			
Net income attributable to non-controlling interests	(110,080)	(81,721)	(75,630)
Interest expense, net	147,003	117,669	100,571
Depreciation and amortization	67,440	51,928	39,551
Equity-based compensation	9,344	5,584	2,021
Contingent acquisition compensation expense	1,510	7,039	5,092
Transaction, integration and acquisition costs [(1)]	33,856	17,007	11,617
Loss (gain) on litigation settlements	46,009	(12,534)	(14,101)
Gain on acquisition escrow release	—	(1,167)	—
Loss on disposals and deconsolidations, net	31,822	1,720	2,355
Reserve adjustments [(2)]	2,670	—	—
Impairment charges	74,359	—	—
Gain on amendment to tax receivable agreement	—	(16,392)	—
Tax receivable agreement (benefit) expense	—	(25,329)	3,733
Loss on debt refinancing	—	18,211	11,876
Adjusted EBITDA	$ 234,768	$ 164,301	$ 179,263

(1) This amount includes transaction and integration costs of $31.7 million, $13.1 million and $8.7 million in 2018, 2017 and 2016, respectively, and acquisition costs of $2.2 million, $3.9 million and $2.9 million in 2018, 2017 and 2016, respectively.

(2) This amount represents adjustments to revenue in connection with applying consistent policies across the combined company as a result of the integration of Surgery Partners and NSH.

We use Credit Agreement EBITDA as a measure of liquidity and to determine our compliance under certain covenants pursuant to our credit facilities. Credit Agreement EBITDA is determined on a trailing twelve-month basis. 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. Credit Agreement EBITDA is not a measurement of liquidity under GAAP, and should not be considered in isolation or as a substitute for any other measure calculated in accordance with GAAP. The items excluded from Credit Agreement EBITDA are significant components in understanding and evaluating our liquidity. Our calculation of Credit Agreement EBITDA may not be comparable to similarly titled measures reported by other companies.

When we use the term “Credit Agreement EBITDA,” we are referring to Adjusted EBITDA, as defined above, further adjusted for acquisitions and non-cash expenses. These adjustments do not relate to our historical financial performance and instead relate to estimates compiled by management and calculated in conformance with the definition of "Consolidated EBITDA" used in the credit agreements governing our credit facilities.

The following table reconciles Credit Agreement EBITDA to cash flows from operating activities, the most directly comparable GAAP financial measure (in thousands and unaudited):

	Year Ended December 31, 2018
Cash flows from operating activities	$ 144,600
Plus (minus):	
Net income attributable to non-controlling interests	(110,080)
Non-cash interest income, net	1,415
Deferred income taxes	(25,272)
Income from equity investments, net of distributions received	(243)
Changes in operating assets and liabilities, net of acquisitions and divestitures	(33,161)
Income tax expense	26,461
Interest expense, net	147,003
Transaction, integration and acquisition costs	33,856
Reserve adjustments	2,670
Contingent acquisition compensation expense	1,510
Loss on litigation settlement	46,009
Acquisitions [1]	38,701
Credit Agreement EBITDA	$ 273,469

[1] Represents impact of acquired physician practices and surgical facilities as if each acquisition had occurred on January 1, 2018, including cost savings from reductions in corporate overhead, supply chain rationalization, enhanced physician engagement, improved payor contracting and revenue synergies associated with the NSH acquisition. Further, this includes revenue synergies from other business initiatives as defined in the Credit Agreement.

Contractual Obligations and Commercial Commitments

The following table summarizes our contractual obligations by period as of December 31, 2018 (in thousands):

	Payments Due by Period				
	Total	Less than 1 year	1-3 years	4-5 years	More than 5 years
Long-term debt obligations, including interest [1]	$ 2,715,896	$ 196,046	$ 2,041,391	$ 66,337	$ 412,122
Capital lease obligations, including interest	28,898	8,846	11,384	4,441	4,227
Operating lease obligations [2]	812,489	81,455	142,377	118,463	470,194
Other financing obligations, including interest [3]	175,169	12,642	26,326	27,780	108,421
Tax receivable agreement	64,604	7,601	36,110	20,393	500
Total contractual obligations	$ 3,797,056	$ 306,590	$ 2,257,588	$ 237,414	$ 995,464

[1] Included in long-term debt obligations are principal and interest owed on our outstanding debt obligations. These amounts exclude our unamortized fair value adjustments related non-cash amortization for the Term Loan and 2021 Unsecured Notes. These obligations are explained further in Note 5 to our consolidated financial statements included elsewhere in this report. We used the applicable annual interest rate as of December 31, 2018 of 5.6%, based on LIBOR plus the applicable margin, for our $1.5 billion outstanding Term Loan to estimate interest payments on this variable rate debt instrument.

[2] This reflects our future minimum operating lease payments. We enter into operating leases in the normal course of business. Substantially all of our operating lease agreements have fixed payment terms based on the passage of time. Some lease agreements provide us with the option to renew the lease. Our future operating lease obligations would change if we exercised these renewal options and if we entered into additional operating lease agreements. These obligations are explained further in Note 6 to our consolidated financial statements included elsewhere in this report. Operating lease obligations do not include common area maintenance, insurance or tax payments for which we are also obligated to pay.

[3] Other financing obligations includes amounts due under our facility lease obligations at four of our surgical facilities as discussed further in Note 13 to our consolidated financial statements included elsewhere in this report.

Inflation

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

Recent Accounting Pronouncements

Please refer to Note 1 to our consolidated financial statements included elsewhere in this report for a discussion of the impact of the adoption of recently issued accounting standards and accounting standards not yet adopted.

Item 7A. 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. We periodically enter into interest rate swap agreements to manage our exposure to interest rate fluctuations. Our interest rate swap agreements involve the exchange of fixed and variable rate interest payments between two parties, based on common notional principal amounts and maturity dates. The notional amounts of the swap agreements represent balances used to calculate the exchange of cash flows and are not our assets or liabilities. Our credit risk related to these agreements is considered low because the swap agreements are with creditworthy financial institutions. The interest payments under these agreements are settled on a net basis. These derivatives have been recognized in the financial statements at their respective fair values. Changes in the fair value of these derivatives, which are designated as cash flow hedges, are included in other comprehensive income.

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 December 31, 2018, we had outstanding principal amount of debt of $1.458 billion in variable rate instruments. Assuming a hypothetical 100 basis points increase in LIBOR on our debt as of December 31, 2018, our annual interest expense would increase by approximately $14.6 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 2019 based on our indebtedness at December 31, 2018.

Item 8. Financial Statements and Supplementary Data

Information with respect to this Item is contained in our consolidated financial statements beginning on Page F-1 of this report.

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures

Disclosure Controls and Procedures and Limitations on the Effectiveness of Controls

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.

Management, with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of our disclosure controls and procedures as of the end of the period covered by this report. Based on the evaluation of our disclosure controls and procedures conducted as of December 31, 2018, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective.

Management's Report on Internal Control Over Financial Reporting

Management is responsible for establishing and maintaining adequate "internal control over financial reporting" (as such term is defined in Rule 13a-15(f)) under the Exchange Act) for the Company. Internal control over financial reporting includes maintaining records that in reasonable detail accurately and fairly reflect our transactions and disposition of assets; providing reasonable assurance that transactions are recorded as necessary for preparation of our financial statements; providing reasonable assurance that receipts and expenditures are made only in accordance with management and board authorizations; and providing reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of our assets that could have a material effect on our financial statements. Internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements prepared for external purposes in accordance with GAAP. Because of the inherent limitations in any internal control, no matter how well designed, 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.

Under the supervision and with the participation of management, including the Chief Executive Officer and Chief Financial Officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting as of December 31, 2018. The assessment was based on criteria established in the framework *Internal Control-Integrated Framework (2013)*, issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on that evaluation, management, including the Chief Executive Officer and Chief Financial Officer, determined that our internal control over financial reporting was effective as of December 31, 2018.

Deloitte & Touche LLP, the Company's independent registered public accounting firm, has issued an attestation report on the effectiveness of our internal control over financial reporting as of December 31, 2018. Their attestation report is included below in this Item 9A.

Remediation of Prior Year Material Weaknesses

During the years ended December 31, 2017 and 2016, management disclosed that certain control deficiencies in our internal control over financial reporting pertaining to the design and operating effectiveness of certain controls involving the initiation and recording of revenue and accounts receivable and the accurate estimate and recording of related allowances aggregated to a material weakness at December 31, 2017 and 2016. In order to remediate this material weakness, management took several actions, including increasing the number of individuals responsible for implementing and monitoring controls, training individuals responsible for designing, executing, testing and monitoring controls, adding new process-level and information technology controls and modifying existing controls to enhance documentation that evidences that controls were performed. We also added oversight controls over the estimation of contractual and bad debt allowances and facility-level and group-level detailed reviews of key control indicators. During the fourth quarter of 2018, we substantially completed our evaluation of the design of new controls and successfully completed testing of the improved controls. As a result, we have concluded that the material weakness related to revenue and accounts receivable and the accurate estimate and recording of related allowances have been remediated as of December 31, 2018.

In addition, management identified control deficiencies, which aggregated to a material weakness at December 31, 2017, relating to the lack of evidence to support the operating effectiveness of certain management review controls over the valuation inputs and assumptions of assets acquired and non-controlling interests and purchase accounting adjustments recorded for business combination accounting, including the application of pushdown accounting. During 2018, management improved its review controls over the use of valuation assumptions, including increasing the number of individuals involved in reviewing valuation inputs, challenging assumptions used by third party valuation firms and performing independent calculations. These additional controls also involved enhanced documentation that evidences that the controls were performed. During the fourth quarter of 2018, we implemented these new controls over the valuation inputs and assumptions used in our annual goodwill impairment evaluation. In this process, we successfully completed testing of the improved controls and concluded that the material weakness related to review controls over valuation inputs and assumptions has been remediated as of December 31, 2018.

There were no material errors in our financial results or balances and no restatement of prior period financial statements or change in previously released financial results was required as a result of the previously identified material weaknesses in internal controls over financial reporting.

Changes in Internal Control over Financial Reporting

Other than the remediation efforts identified above to address the previously identified material weakness, there were no changes in our internal control over financial reporting identified in connection with the evaluation required by Rules 13a-15(d) and 15d-15(d) of the Exchange Act that occurred during the quarter ended December 31, 2018 that materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of Surgery Partners, Inc.

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of Surgery Partners, Inc. and subsidiaries (the "Company") as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements as of and for the year ended December 31, 2018, of the Company and our report dated March 15, 2019, expressed an unqualified opinion on those financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying *Management's Report on Internal Control Over Financial Reporting*. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed 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. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, 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.

/s/ DELOITTE & TOUCHE LLP
Nashville, Tennessee
March 15, 2019

Item 9B. Other Information

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance

The information called for by Item 10 is incorporated herein by reference to the definitive Proxy Statement of the Company relating to the 2019 Annual Meeting of Stockholders (the "Definitive Proxy Statement"), which the Company intends to file within 120 days after the close of our fiscal year ended December 31, 2018.

Item 11. Executive Compensation

The information called for by Item 11 is incorporated herein by reference to the Definitive Proxy Statement referenced above in Item 10.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

The information called for by Item 12 is incorporated herein by reference to the Definitive Proxy Statement referenced above in Item 10.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The information called for by Item 13 is incorporated herein by reference to the Definitive Proxy Statement referenced above in Item 10.

Item 14. Principal Accounting Fees and Services

The information called for by Item 14 is incorporated herein by reference to the Definitive Proxy Statement referenced above in Item 10.

PART IV

Item 15. Exhibits and Financial Statement Schedules

(a) Financial Statements, Financial Statement Schedules and Exhibits

(1) Financial Statements

Our Consolidated Financial Statements and Notes thereto are set forth starting on page F-1 of this Annual Report on Form 10-K.

(2) Financial Statement Schedules

All financial schedules have been omitted either because they are not applicable or because the required information is provided in our Consolidated Financial Statements and Notes thereto, starting on page F-1 of this Annual Report on Form 10-K.

(3) 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 2.1 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).*
3.1	Amended and Restated Certificate of Incorporation of Surgery Partners, Inc., dated October 30, 2017 (incorporated herein by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed November 3, 2017).
3.2	Certificate of Designations, Preferences, Rights and Limitations of the 10.00% Series A Convertible Perpetual Participating Preferred Stock of Surgery Partners, Inc., dated August 31, 2017 (incorporated herein by reference to Exhibit 3.3 to the Company's Current Report on Form 8-K filed September 1, 2017).
3.3	Amended and Restated Bylaws of Surgery Partners, Inc., dated August 31, 2017 (incorporated herein by reference to Exhibit 3.2 to the Company's Current Report on Form 8-K filed September 1, 2017).
4.1	Indenture, dated March 31, 2016, among Surgery Center Holdings, Inc., the Guarantors from time to time party thereto 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 April 5, 2016).
4.2	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).
4.3	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).
4.4	Fourth Supplemental Indenture, by and among Surgery Center Holdings, Inc., Wilmington Trust, National Association, as Trustee, and certain other parties thereto, dated August 31, 2017 (incorporated herein by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed September 1, 2017).
4.5	First Supplemental Indenture, by and among Surgery Center Holdings, Inc., Wilmington Trust, National Association, as Trustee, and certain other parties thereto, dated August 31, 2017 (incorporated herein by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed September 1, 2017).
10.1	First Lien Incremental Term Loan Amendment and Consent, dated as of March 24, 2016, by and among SP Holdco I, Inc., Surgery Center (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed March 30, 2016).
10.2	Amendment No. 4 to Credit Agreement, dated as of September 26, 2016, by and among SP Holdco I, Inc., Surgery Center Holdings, Inc., Jefferies Finance LLC and the other guarantors and lenders party thereto (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed September 27, 2016).
10.3	Incremental Term Loan Amendment, dated as of October 23, 2018 with Jefferies, SP Holdco I, Inc., Surgery Center Holdings, Inc. and certain other parties thereto.
10.4	Office Lease Agreement dated November 17, 2015 between Highwoods Realty Limited Partnership and Surgery Partners, Inc. (incorporated herein by reference to Exhibit 10.21 to the Company's Annual Report on Form 10-K filed March 11, 2016).
10.5	First Amendment to Lease Agreement, dated August 29, 2016, between highwood Realty Limited Partnership and Surgery Partners, Inc. (incorporated herein by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q filed November 10, 2016).
10.6	Second Amendment to Lease Agreement, dated April 26, 2017, between Highwoods Realty Limited Partnership and Surgery Partners, Inc. (incorporated herein by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q filed May 10, 2017).
10.7	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).*
10.8	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).*
10.9	Amended and Restated Registration Rights Agreement by and among Surgery Partners, Inc., certain stockholders of Surgery Partners, Inc. and certain other parties thereto, dated August 31, 2017 (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed September 1, 2017).

10.10	Credit Agreement, by and among SP Holdco I, Inc., Surgery Center Holdings, Inc., Jefferies Finance LLC and the other guarantors and lenders party thereto, dated August 31, 2017 (incorporated herein by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed September 1, 2017).*
10.11	Tax Receivable Agreement, dated as of September 30, 2015, among Surgery Partners, Inc., H.I.G. Surgery Centers, LLC and certain other stockholders party thereto (incorporated herein by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q filed November 13, 2015).
10.12 (a)	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).
10.13 (a)	Form of TRA Waiver and Assignment Agreement (incorporated herein by reference to Exhibit 10.11 to the Company's Annual Report on Form 10-K filed March 16, 2018.
10.14 (a)	Form of Indemnification Agreement (incorporated herein by reference to Exhibit 10.14 to Amendment No. 1 to the Company's Registration Statement on Form S-1, filed September 14, 2015).
10.15 (a)	Surgery Partners, Inc. 2015 Omnibus Incentive Plan (incorporated herein by reference as Exhibit 4.3 to the Company's Registration Statement on Form S-8 filed October 6, 2015).
10.16 (a)	Surgery Partners, Inc. Cash Incentive Plan (incorporated herein by reference to Exhibit 10.8 to the Company's Quarterly Report on Form 10-Q filed November 13, 2015).
10.17 (a)	Symbion, Inc. Supplemental Executive Retirement Plan, Effective May 1, 2005 (incorporated herein by reference to Exhibit 10.17 to the Company's Registration Statement on Form S-1, Amended, filed September 21, 2015).
10.18 (a)	Form of Non-Statutory Stock Option Agreement under the 2015 Omnibus Incentive Plan (incorporated herein by reference to Exhibit 10.5 to the Company's Quarterly Report on Form 10-Q filed November 13, 2015).
10.19 (a)	Form of Non-Employee Director Non-Statutory Stock Option Agreement under the Surgery Partners, Inc. 2015 Omnibus Incentive Plan (incorporated herein by reference to Exhibit 10.6 to the Company's Quarterly Report on Form 10-Q filed November 13, 2015).
10.20 (a)	Form of Restricted Stock Agreement under the Surgery Partners, Inc. 2015 Omnibus Incentive Plan (incorporated herein by reference to Exhibit 10.7 to the Company's Quarterly Report on Form 10-Q filed November 13, 2015.
10.21 (a)	Form of Restricted Stock Award Agreement under the 2015 Surgery Partners, Inc. Omnibus Incentive Plan (incorporated herein by reference to Exhibit 99.1 to the Company's Current Report on Form 8-K filed March 15, 2016).
10.22 (a)	Form of Performance Stock Unit Award Agreement under the Surgery Partners, Inc. 2015 Omnibus Incentive Plan (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed July 5, 2016).
10.23 (a)	Form of Non-Employee Director Restricted Stock Award Agreement under the Surgery Partners, Inc. 2015 Omnibus Incentive Plan (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed April 3, 2017).
10.24 (a)	Form of Leveraged Performance Unit Award Agreement under the Surgery Partners, Inc. 2015 Omnibus Incentive Plan (incorporated herein by reference to Exhibit 10.5 to the Company's Current Report on Form 8-K filed September 8, 2017).
10.25 (a)	Form of Stock-Settled Stock Appreciation Right Agreement under the Surgery Partners, Inc. 2015 Omnibus Incentive Plan (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed December 20, 2018).
10.26 (a)	Amended and Restated Employment Agreement, dated September 17, 2015, between Surgery Partners, Inc., Symbion, Inc. and Teresa F. Sparks (incorporated herein by reference to Exhibit 10.11 to Amendment No. 2 to the Company's Registration Statement on Form S-1, filed September 21, 2015).
10.27 (a)	First Amendment to Amended and Restated Employment Agreement, dated December 21, 2017, by and between Surgery Partners, Inc., Symbion, Inc. and Teresa Sparks (incorporated herein by reference to Exhibit 10.25 to the Company's Annual Report on Form 10-K filed March 16, 2018).
10.28 (a)	Amended and Restated Employment Agreement, dated September 17, 2015, between Surgery Partners, Inc., Symbion, Inc. and John Crysel (incorporated herein by reference to Exhibit 10.12 to Amendment No. 2 to the Company's Registration Statement on Form S-1, filed September 21, 2015).
10.29 (a)	Letter Agreement to Employment Agreement, dated November 22, 2017, by and between Surgery Partners, Inc., Symbion, Inc. and John Crysel (incorporated herein by reference to Exhibit 10.27 to the Company's Annual Report on Form 10-K filed March 16, 2018).
10.30 (a)	Amended and Restated Employment Agreement, dated April 13, 2017, by and between Surgery Partners, Inc., Symbion, Inc. and Jennifer Baldock (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed April 17, 2017).
10.31 (a)	Amended and Restated Employment Agreement, dated April 13, 2017, by and between Surgery Partners, Inc., Symbion, Inc. and Dennis Dean (incorporated herein by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed April 17, 2017).
10.32 (a)	Employment Agreement, dated September 7, 2017, between Surgery Partners, Inc. and Cliff Adlerz (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed September 8, 2017).
10.33 (a)	Employment Agreement, dated January 4, 2018, between Surgery Partners, Inc., Surgery Partners, LLC and Wayne DeVeydt (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed January 8, 2018).
10.34 (a)	Employment Agreement, dated January 25, 2018, between Surgery Partners, Inc., Surgery Partners, LLC and R. David Kretschmer, 8 (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed January 29, 2018).
10.35 (a)	Consulting Services Agreement, dated September 7, 2017, by and between Surgery Partners, Inc. and Michael T. Doyle (incorporated herein by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K filed September 8, 2017).
10.36 (a)	Amendment No. 1 to Consulting Services Agreement, dated December 21, 2017, by and among Surgery Partners, Inc., Michael T. Doyle, and MD Healthcare Partners, LLC, dated December 21, 2017 (incorporated herein by reference to Exhibit 10.36 to the Company's Annual Report on Form 10-K filed March 16, 2018).
10.37 (a)	Separation and Consulting Services Agreement, dated January 25, 2018, by and between Surgery Partners, Inc. and Teresa Sparks (incorporated herein by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed January 29, 2018).

10.38 (a)	Employment Agreement, dated March 9, 2018, by and between Surgery Partners, Inc. and Thomas F. Cowhey (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed March 12, 2018).
10.39 (a)	Employment Agreement, dated February 11, 2019, by and between Surgery Partners, Inc., Surgery Partners, LLC and Eric Evans (incorporated herein by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed February 12, 2019).
16.1	Letter of Ernst & Young LLP, dated May 18, 2018 (incorporated herein by reference to Exhibit 16.1 to the Company's Current Report on form 8-K filed May 18, 2018).
21.1	List of Subsidiaries of the Registrant.
23.1	Consent of Independent Registered Public Accounting Firm (Deloitte).
23.2	Consent of Independent Registered Public Accounting Firm (Ernst & Young LLP).
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 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

(a) Management Contract or Compensatory Plan or Arrangement.

* 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 or exhibit to the SEC upon request.

Item 16. Form 10-K Summary

None.

INDEX TO FINANCIAL STATEMENTS

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Surgery Partners, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheet of Surgery Partners, Inc. and subsidiaries (the "Company") as of December 31, 2018, the related consolidated statement of operations, comprehensive loss, cash flow, and stockholders' equity for the period ended December 31, 2018, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2018, and the results of its operations and its cash flows for the period ended December 31, 2018, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated March 15, 2019, expressed an unqualified opinion on the Company's internal control over financial reporting.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ DELOITTE & TOUCHE LLP
Nashville, Tennessee
March 15, 2019

We have served as the Company’s auditor since 2018.

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of Surgery Partners, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheet of Surgery Partners, Inc. (the Company) as of December 31, 2017 (Successor), and the related consolidated statements of operations, comprehensive income (loss), shareholders' equity and cash flows for the periods September 1, 2017 to December 31, 2017 (Successor) and January 1, 2017 to August 31, 2017 (Predecessor) and the year ended December 31, 2016 (Predecessor), and the related notes (collectively referred to as the "financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the consolidated financial position of the Company at December 31, 2017 (Successor), and the results of its operations and its cash flows for the periods September 1, 2017 to December 31, 2017 (Successor) and January 1, 2017 to August 31, 2017 (Predecessor) and the year ended December 31, 2016 (Predecessor), in conformity with U.S. generally accepted accounting principles.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ Ernst & Young LLP

We served as the Company's auditor from 2014 to 2018.

Nashville, Tennessee

March 16, 2018, except for the last paragraph of Note 1, as to which the date is March 15, 2019

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

	Successor	
	December 31, 2018	**December 31, 2017**
ASSETS		
Current assets:		
Cash and cash equivalents	$ 184,308	$ 174,914
Accounts receivable, less allowance for doubtful accounts of $2,026 at December 31, 2017 (see Note 1)	307,642	288,023
Inventories	43,363	44,951
Prepaid expenses	16,225	16,835
Other current assets	36,784	38,502
Total current assets	588,322	563,225
Property and equipment, net	426,286	398,536
Intangible assets, net	54,293	58,908
Goodwill	3,382,846	3,346,838
Investments in and advances to affiliates	78,477	74,282
Long-term deferred tax assets	109,193	132,319
Other long-term assets	36,850	48,665
Total assets	$ 4,676,267	$ 4,622,773
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable	$ 83,292	$ 84,710
Accrued payroll and benefits	55,212	49,625
Other current liabilities	155,243	109,944
Current maturities of long-term debt	55,552	58,726
Total current liabilities	349,299	303,005
Long-term debt, less current maturities	2,270,898	2,130,556
Other long-term liabilities	271,187	222,480
Non-controlling interests—redeemable	326,592	299,316
Redeemable preferred stock - Series A; shares authorized, issued and outstanding - 310,000; redemption value - $359,346 and $330,806, respectively	359,346	330,806
Stockholders' equity:		
Preferred stock, $0.01 par value; shares authorized - 20,000,000; shares issued or outstanding - none	—	—
Common stock, $0.01 par value; shares authorized - 300,000,000; shares issued and outstanding - 48,869,204 and 48,687,136, respectively	489	487
Additional paid-in capital	673,619	695,560
Accumulated other comprehensive loss	(22,446)	—
Retained deficit	(247,022)	(41,316)
Total Surgery Partners, Inc. stockholders' equity	404,640	654,731
Non-controlling interests—non-redeemable	694,305	681,879
Total stockholders' equity	1,098,945	1,336,610
Total liabilities and stockholders' equity	$ 4,676,267	$ 4,622,773

See notes to consolidated financial statements.

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

	Successor		Predecessor	
	Year Ended December 31,	September 1 to December 31,	January 1 to August 31,	Year Ended December 31,
	2018	2017	2017	2016
Revenues	$ 1,771,456	$ 592,604	$ 748,615	$ 1,145,438
Operating expenses:				
Salaries and benefits	534,740	175,403	241,149	357,175
Supplies	490,251	161,015	193,322	269,239
Professional and medical fees	145,461	45,061	57,931	81,185
Lease expense	86,673	27,868	36,503	52,147
Other operating expenses	104,306	32,281	43,267	61,450
Cost of revenues	1,361,431	441,628	572,172	821,196
General and administrative expenses	93,558	29,153	46,797	60,246
Depreciation and amortization	67,440	21,804	30,124	39,551
Provision for doubtful accounts (see Note 1)	—	12,455	16,297	24,212
Income from equity investments	(8,898)	(3,319)	(3,148)	(4,764)
Loss on disposals and deconsolidations, net	31,822	5	1,715	2,355
Transaction and integration costs	31,665	7,470	5,584	8,738
Impairment charges	74,359	—	—	—
Loss on debt refinancing	—	—	18,211	11,876
Loss (gain) on litigation settlements	46,009	(8,740)	(3,794)	(14,101)
Gain on acquisition escrow release	—	(167)	(1,000)	—
Other (income) expense	(3,768)	45	(307)	(353)
Total operating expenses	1,693,618	500,334	682,651	948,956
Operating income	77,838	92,270	65,964	196,482
Gain on amendment to tax receivable agreement	—	1,098	15,294	—
Tax receivable agreement benefit (expense)	—	25,329	—	(3,733)
Interest expense, net	(147,003)	(48,740)	(68,929)	(100,571)
(Loss) income before income taxes	(69,165)	69,957	12,329	92,178
Income tax expense (benefit)	26,461	71,639	(18,089)	7,095
Net (loss) income	(95,626)	(1,682)	30,418	85,083
Less: Net income attributable to non-controlling interests	(110,080)	(39,634)	(42,087)	(75,630)
Net (loss) income attributable to Surgery Partners, Inc.	(205,706)	(41,316)	(11,669)	9,453
Less: Amounts attributable to participating securities	(32,426)	(26,047)	—	—
Net (loss) income attributable to common stockholders	$ (238,132)	$ (67,363)	$ (11,669)	$ 9,453
Net (loss) income per share attributable to common stockholders				
Basic	$ (4.96)	$ (1.39)	$ (0.24)	$ 0.20
Diluted [1]	$ (4.96)	$ (1.39)	$ (0.24)	$ 0.20
Weighted average common shares outstanding				
Basic	48,027,875	48,319,193	48,121,404	48,018,944
Diluted [1]	48,027,875	48,319,193	48,121,404	48,190,738

[1] The impact of potentially dilutive securities for the year ended December 31, 2018 (Successor), the four months ended December 31, 2017 (Successor) and the eight months ended August 31, 2017 (Predecessor) were not considered because the effect would be anti-dilutive in those periods.

See notes to consolidated financial statements.

SURGERY PARTNERS, INC.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)
(In thousands)

	Successor		*Predecessor*	
	Year Ended December 31,	**September 1 to December 31,**	**January 1 to August 31,**	**Year Ended December 31,**
	2018	**2017**	**2017**	**2016**
Net (loss) income	$ (95,626)	$ (1,682)	$ 30,418	$ 85,083
Other comprehensive (loss) income, net of tax:				
Derivative activity	(22,446)	—	—	—
Comprehensive (loss) income	$ (118,072)	$ (1,682)	$ 30,418	$ 85,083
Less: Comprehensive income attributable to non-controlling interests	(110,080)	(39,634)	(42,087)	(75,630)
Comprehensive (loss) income attributable to Surgery Partners, Inc.	$ (228,152)	$ (41,316)	$ (11,669)	$ 9,453

See notes to consolidated financial statements.

SURGERY PARTNERS, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(In thousands, except shares)

	Common Stock [1]		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Deficit	Non-Controlling Interests—Non-Redeemable	Total
	Shares	Amount					
Predecessor							
Balance as of December 31, 2015	48,156,990	$ 482	$ 316,294	$ —	$ (320,804)	$ 301,955	$ 297,927
Net income	—	—	—	—	9,453	57,607	67,060
Equity-based compensation	—	—	2,021	—	—	—	2,021
Issuance of restricted stock, net of forfeitures	331,626	3	(3)	—	—	—	—
Acquisition and disposal of shares of non-controlling interests, net [1]	—	—	2,231	—	—	4,053	6,284
Distributions to non-controlling interests—non-redeemable holders	—	—	—	—	—	(48,618)	(48,618)
Balance as of December 31, 2016	48,488,616	485	320,543	—	(311,351)	314,997	324,674
Net (loss) income	—	—	—	—	(11,669)	32,472	20,803
Equity-based compensation	—	—	3,697	—	—	—	3,697
Issuance of restricted and unrestricted shares	355,607	3	(3)	—	—	—	—
Cancellation of restricted shares	(33,908)	—	(790)	—	—	—	(790)
Acquisition of NSH	—	—	—	—	—	172,645	172,645
Acquisition and disposal of shares of non-controlling interests, net [1]	—	—	3,483	—	—	(5,629)	(2,146)
Distributions to non-controlling interests—non-redeemable holders	—	—	—	—	—	(38,875)	(38,875)
Balance as of August 31, 2017	48,810,315	$ 488	$ 326,930	$ —	$ (323,020)	$ 475,610	$ 480,008
Successor							
Balance as of September 1, 2017	48,810,315	$ 488	$ 720,118	$ —	$ —	$ 684,480	$ 1,405,086
Net (loss) income	—	—	—	—	(41,316)	26,703	(14,613)
Equity-based compensation	—	—	1,887	—	—	—	1,887
Preferred dividends	—	—	(10,481)	—	—	—	(10,481)
Mark to redemption adjustment	—	—	(15,566)	—	—	—	(15,566)
Issuance of restricted and unrestricted shares	112,107	1	(1)	—	—	—	—
Cancellation of restricted shares	(54,622)	—	(585)	—	—	—	(585)
Repurchase of shares	(180,664)	(2)	(2,007)	—	—	—	(2,009)
Acquisition and disposal of shares of non-controlling interests, net [1]	—	—	2,195	—	—	(4,042)	(1,847)
Distributions to non-controlling interests—non-redeemable holders	—	—	—	—	—	(25,262)	(25,262)
Balance as of December 31, 2017	48,687,136	487	695,560	—	(41,316)	681,879	1,336,610
Net (loss) income	—	—	—	—	(205,706)	75,534	(130,172)
Equity-based compensation	—	—	9,344	—	—	—	9,344
Preferred dividends	—	—	(32,426)	—	—	—	(32,426)
Other comprehensive loss	—	—	—	(22,446)	—	—	(22,446)
Issuance of restricted and unrestricted shares	519,605	5	(5)	—	—	—	—
Cancellation of restricted shares	(180,719)	(1)	(1,225)	—	—	—	(1,226)
Repurchase of shares	(156,818)	(2)	(1,980)	—	—	—	(1,982)
Acquisition and disposal of shares of non-controlling interests, net [1]	—	—	4,351	—	—	15,801	20,152
Distributions to non-controlling interests—non-redeemable holders	—	—	—	—	—	(78,287)	(78,287)
Other	—	—	—	—	—	(622)	(622)
Balance as of December 31, 2018	48,869,204	$ 489	$ 673,619	$ (22,446)	$ (247,022)	$ 694,305	$ 1,098,945

[1] Includes post acquisition date adjustments in all periods, including reallocation in application of pushdown accounting in the 2017 successor period.

See notes to consolidated financial statements.

SURGERY PARTNERS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

	Successor		Predecessor	
	Year Ended December 31,	September 1 to December 31,	January 1 to August 31,	Year Ended December 31,
	2018	2017	2017	2016
Cash flows from operating activities:				
Net (loss) income	$ (95,626)	$ (1,682)	$ 30,418	$ 85,083
Adjustments to reconcile net (loss) income to net cash provided by operating activities:				
Depreciation and amortization	67,440	21,804	30,124	39,551
Non-cash interest (income) expense, net	(1,415)	(780)	4,874	7,892
Equity-based compensation	9,344	1,887	3,697	2,021
Loss on disposals and deconsolidations, net	31,822	5	1,715	2,355
Impairment charges	74,359	—	—	—
Gain on legal settlements	—	(8,740)	—	(14,101)
Loss on debt refinancing	—	—	18,211	11,876
Gain on amendment to tax receivable agreement	—	(1,098)	(15,294)	—
Tax receivable agreement (benefit) expense	—	(25,329)	—	3,733
Deferred income taxes	25,272	71,031	(18,703)	6,882
Provision for doubtful accounts	—	12,455	16,297	24,212
Income from equity investments, net of distributions received	243	678	489	(846)
Changes in operating assets and liabilities, net of acquisitions and divestitures:				
Accounts receivable	(22,819)	(31,500)	8,837	(60,622)
Other operating assets and liabilities	55,980	14,494	(12,947)	17,203
Net cash provided by operating activities	144,600	53,225	67,718	125,239
Cash flows from investing activities:				
Purchases of property and equipment, net	(39,805)	(10,827)	(18,773)	(39,109)
Payments for acquisitions, net of cash acquired	(106,772)	(29,249)	(725,853)	(146,405)
Proceeds from divestitures	19,170	1,183	70	765
Other investing activities	(1,455)	—	—	—
Net cash used in investing activities	(128,862)	(38,893)	(744,556)	(184,749)
Cash flows from financing activities:				
Principal payments on long-term debt	(157,587)	(18,629)	(1,164,237)	(473,437)
Borrowings of long-term debt	282,741	409	1,805,966	650,707
Payments of debt issuance costs	(2,990)	(4)	(58,591)	(14,296)
Penalty on prepayment of debt	—	—	—	(4,900)
Proceeds from preferred stock issuance	—	—	310,000	—
Payments of stock issuance costs	—	—	(18,347)	—
Payments of preferred dividends	(7,810)	(1,316)	—	—
Distributions to non-controlling interest holders	(109,024)	(33,490)	(50,343)	(65,778)
(Payments) proceeds related to ownership transactions with non-controlling interest holders, net	(2,210)	998	(1,518)	(20,096)
Repurchase of shares	(1,982)	(2,009)	—	—
Financing lease obligation activity	(6,256)	1,007	(796)	(924)
Other financing activities	(1,226)	(590)	(789)	
Net cash (used in) provided by financing activities	(6,344)	(53,624)	821,345	71,276
Net increase (decrease) in cash, cash equivalents and restricted cash	9,394	(39,292)	144,507	11,766
Cash, cash equivalents and restricted cash at beginning of period	175,229	214,521	70,014	58,248
Cash, cash equivalents and restricted cash at end of period	$ 184,623	$ 175,229	$ 214,521	$ 70,014
Supplemental cash flow information:				
Interest paid, net of interest income received	145,370	40,872	68,646	79,262
Cash paid for income taxes	2,226	485	598	661
Non-cash purchases of property and equipment under capital leases and financing activities	61,005	14,872	8,469	9,226

See notes to consolidated financial statements.

1. Organization and Summary of Accounting Policies

Organization

Surgery Partners, Inc., a Delaware corporation (together with its subsidiaries, the "Company"), was formed April 2, 2015. On August 31, 2017, a fund advised by an affiliate of Bain Capital Private Equity ("Bain Capital"), purchased approximately 54.2% of the Company's outstanding common stock. As a result, Bain became the controlling stockholder of the Company, holding Series A Preferred Stock (as defined in Note 7. "Redeemable Preferred Stock") and common stock that collectively represent approximately 65.7% of the voting power of all classes of capital stock of the Company.

As of December 31, 2018 (Successor), the Company owned and operated a national network of surgical facilities and ancillary services in 31 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, general surgery, ophthalmology, orthopedics and pain management. The Company's surgical hospitals also 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 and optical services.

As of December 31, 2018 (Successor), the Company owned or operated a portfolio of 123 surgical facilities, comprised of 108 ASCs and 15 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 84 of the surgical facilities and consolidated 106 of these facilities for financial reporting purposes.

Basis of Presentation

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the 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. Actual results could differ from those estimates.

The 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.

In connection with the change of control effective August 31, 2017, the Company elected to apply "pushdown" accounting by applying the guidance in Financial Accounting Standards Board ("FASB") Accounting Standards Codification Topic 805, *Business Combinations*. Accordingly, the consolidated financial statements of the Company for periods before and after August 31, 2017 reflect different bases of accounting, and the financial positions and results of operations of those periods are not comparable. Throughout the Company's consolidated financial statements and the accompanying notes herein, periods prior to August 31, 2017 (the date of the change of control) are identified as "Predecessor" and periods after the change of control are identified as "Successor." See Note 2. "Acquisitions and Disposals" for further discussion of the change of control.

Variable Interest Entities

The consolidated financial statements include the accounts of variable interest entities ("VIE") in which the Company is the primary beneficiary under the provisions of Accounting Standards Codification 810, *Consolidation*. The Company has the power to direct the activities that most significantly impact a variable interest entity's economic performance. Additionally, the Company would absorb the majority of the expected losses from any of these entities should such expected losses occur. At December 31, 2018 (Successor), the variable interest entities include four surgical facilities, three anesthesia practices and four physician practices. In 2018 (Successor), the Company divested of one surgical facility and acquired a physician practice, which were classified as VIEs.

The total assets (excluding goodwill and intangible assets, net) of the consolidated VIEs included in the accompanying consolidated balance sheets as of December 31, 2018 (Successor) and 2017 (Successor), were $11.2 million and $13.1 million, respectively, and the total liabilities of the consolidated VIEs were $3.6 million and $5.8 million, respectively.

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.

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 consolidated balance sheets for cash and cash equivalents, accounts receivable, restricted invested assets and accounts payable approximate their fair values under Level 3 calculations.

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

	Successor			
	Carrying Amount		**Fair Value**	
	December 31, 2018	**December 31, 2017**	**December 31, 2018**	**December 31, 2017**
Term Loan	$ 1,447,931	$ 1,280,532	$ 1,382,774	$ 1,267,189
Senior Unsecured Notes due 2021	$ 406,719	$ 409,235	$ 407,227	$ 422,535
Senior Unsecured Notes due 2025	$ 370,000	$ 370,000	$ 320,513	$ 346,413

The fair values of the Term Loan, Senior Unsecured Notes due 2021 and the Senior Unsecured Notes due 2025 were based on a Level 2 inputs using quoted prices for identical liabilities in inactive markets at both December 31, 2018 (Successor) and 2017 (Predecessor). The carrying amounts related to the Company's other long-term debt obligations approximate their fair values under Level 3 calculations.

In 2018 (Successor), the Company entered into certain interest rate swap agreements (see Note 8. Derivatives and Hedging Activity). At December 31, 2018 (Successor), the fair value of these derivative instruments was $22.4 million, and was included in other long-term liabilities in the consolidated balance sheet. The fair value of these derivative financial instruments was based on a quoted market price, or a Level 2 computation. The Company had no derivative financial instruments as of December 31, 2017 (Successor).

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 December 31, 2018 (Successor) and 2017 (Predecessor), the fair value of both the assets and liabilities in the SERP were $1.4 million and $1.9 million, respectively, and were included in other long-term assets and other long-term liabilities in the consolidated balance sheets.

Revenues

In May 2014, the FASB issued Accounting Standards Update ("ASU") 2014-09, *Revenue from Contracts with Customers*. The Company adopted the new standard effective January 1, 2018, using the modified retrospective method. The presentation of the amount of earnings from operations and net earnings were unchanged upon adoption of the new standard; however, during the year of adoption, the Company determined that amounts historically considered to be bad debt should be considered an implicit price concession, as defined in FASB Accounting Standards Codification 606, "*Revenue From Contracts With Customers*". This resulted in changes to the presentation of revenues and the provision for bad debts in the consolidated statements of operations. Previously, the estimate for unrealizable amounts was recorded to the provision for bad debts and presented as a component of operating expenses. Upon reassessment during the year of adoption, the estimate for unrealizable amounts is now reflected as an implicit price concession as a reduction to arrive at net revenue.

The Company's revenues generally relate to contracts with patients in which the performance obligations are to provide healthcare services. The Company recognizes revenues in the period in which our obligations to provide health care services are satisfied and reports the amount that reflects the consideration the Company expects to be entitled to. The Company's performance obligations are generally satisfied over a period of less than one day. The contractual relationships with patients, in most cases, also involve a third-party payer (e.g., Medicare, Medicaid, managed care health plans, employers and commercial insurance companies, including plans offered through the health insurance exchanges) and the transaction prices for the services provided are dependent upon the terms provided by or negotiated with the third-party payers. The payment arrangements with third-party payers for the services provided to the related patients typically specify payments at amounts less than the Company's standard charges. The Company continually reviews the contractual estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms resulting from contract renegotiations and renewals.

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

	Successor		*Predecessor*	
	Year Ended December 31,	**September 1 to December 31,**	**January 1 to August 31,**	**Year Ended December 31,**
	2018	**2017**	**2017**	**2016**
Patient service revenues:				
Surgical facilities revenues	93.6%	94.3%	91.4%	90.3%
Ancillary services revenues	4.5%	4.2%	7.0%	7.9%
	98.1%	98.5%	98.4%	98.2%
Other service revenues:				
Optical services revenues	0.5%	0.6%	1.0%	1.1%
Other	1.4%	0.9%	0.6%	0.7%
	1.9%	1.5%	1.6%	1.8%
Total revenues	100.0%	100.0%	100.0%	100.0%

Patient service revenues. This includes revenue related to charging facility fees in exchange for providing patient care. 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 as performance obligations are satisfied. Performance obligations are based on the nature of services provided. Typically, the Company recognizes revenue at a point in time in which services are rendered and the Company has no obligation to provide further patient services. As the Company primarily performs outpatient procedures, performance obligations are generally satisfied same day and revenue is recognized on the date of service.

The Company determines the transaction price based on gross charges for services provided, net of estimated contractual adjustments, discounts from third-party payors. The Company estimates its contractual adjustments and discounts based on contractual agreements, its discount policies and historical experience. Changes in estimated contractual adjustments and discounts are recorded in the period of change. As a result of changes in estimates to third-party settlements related to prior years the Company recognized an increase to patient service revenues of $2.1 million for the year ended December 31, 2018 (Successor), no adjustments for the four months ended December 31, 2017 (Successor), and an increase to patient service revenues of approximately $1.1 million and $6.8 million during the eight months ended August 31, 2017 (Predecessor) and the year ended December 31, 2016 (Predecessor), respectively.

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. The Company satisfies the performance obligation and recognizes revenue when the 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. The Company satisfies the performance obligation and recognize revenue when the 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. These agreements typically require the Company to provide recurring management services over a multi-year period which are billed and collected on a monthly basis. 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 management services are rendered and billed.

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):

	Successor				*Predecessor*			
	Year Ended December 31,		September 1 to December 31,		January 1 to August 31,		Year Ended December 31,	
	2018		2017		2017		2016	
	Amount	%	Amount	%	Amount	%	Amount	%
Patient service revenues:								
Private insurance	$ 948,870	54.6%	$ 347,801	59.6%	$ 360,092	48.9%	$ 579,662	51.5%
Government	653,332	37.6%	196,926	33.7%	308,993	42.0%	448,953	39.9%
Self-pay	49,985	2.9%	15,233	2.6%	15,949	2.2%	19,817	1.8%
Other [1]	84,788	4.9%	23,843	4.1%	51,374	6.9%	76,172	6.8%
Total patient service revenues	$ 1,736,975	100.0%	$ 583,803	100.0%	$ 736,408	100.0%	$ 1,124,604	100.0%
Other service revenues:								
Optical service revenues	$ 9,545		$ 3,486		$ 7,629		$ 12,505	
Other revenues	24,936		5,315		4,578		8,329	
Total net revenues	$ 1,771,456		$ 592,604		$ 748,615		$ 1,145,438	

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

The increase in other revenues is primarily due to an increase in management and administrative service fees due to the acquisition of NSH. Total net revenues in 2018 additionally reflect the impact of the Company's adoption of ASU 2014-09 as discussed above.

Subsequent to the transactions on August 31, 2017 (Predecessor), the Company, as part of a review of operations undertaken to create a solid foundation to support the Company's long-term growth objectives, incurred a non-recurring adjustment to revenue of $15.6 million, which was attributable to an increase in reserves for certain accounts receivable during the eight months ended August 31, 2017 (Predecessor). The increase in reserves resulted from certain known events and actions during the eight months ended August 31, 2017 (Predecessor) related to select payors primarily in the Company’s ancillary services segment. Upon consideration of such additional information, related receivables were determined to have a low likelihood of collection. The majority of this adjustment related to receivables with balances from the first quarter of 2016 and prior.

Cash, Cash Equivalents and Restricted Cash

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.

Cash, cash equivalents and restricted cash reported within the consolidated statement of cash flows includes $0.3 million of restricted investments, which are reflected in other long-term assets in the consolidated balance sheet at both December 31, 2018 (Successor) and 2017 (Successor). These restricted investments represents restricted cash held in accordance with the provisions of a long-term operating lease agreement held as security for performance under the Company's covenants and obligations within the agreement through January 2024.

Accounts Receivable

Accounts receivable from third-party payors are recorded net of estimated implicit price concessions which are estimated based on the historical trend of the Company's surgical facilities’ cash collections and contractual write-offs, established fee schedules, relationships with payors and procedure statistics. While changes in estimated reimbursement from third-party payors remain a possibility, the Company expects that any such changes would be minimal and, therefore, would not have a material effect on its financial condition or results of operations.

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 December 31, 2018 (Successor) and December 31, 2017 (Successor), the Company had a net third-party Medicaid settlements liability of $4.8 million and $1.0 million, 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 considered significant. Amounts are classified outside of self-pay if the Company has an agreement with the third-party payor or has verified a patient’s coverage prior to services rendered. 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 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's 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 patient accounts provide for an aging schedule in 30-day increments, by payor, physician and patient. The Company analyzes accounts receivable at each of its 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.

A summary of the changes in the allowance for doubtful accounts receivable follows (in thousands):

	Balance at Beginning of Period	Provision for Doubtful Accounts	Accounts Written off, Net of Recoveries	Impact of adoption of ASC 606	Balance at End of Period
Predecessor					
Year ended December 31, 2016	$ 18,322	$ 24,212	$ (12,662)	$ —	$ 29,872
Eight months ended August 31, 2017	29,872	16,297	(14,096)	—	32,073
Successor					
Four months ended December 31, 2017	—	12,455	(10,429)	—	2,026
Year ended December 31, 2018	2,026	—	—	(2,026)	—

The receivables related to the Company's optical products purchasing organization are recognized separately from patient accounts receivable and are included in other current assets in the consolidated balance sheets. Such receivables were $8.5 million and $7.6 million at December 31, 2018 (Successor) and 2017 (Successor), respectively.

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. 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. For discussion on impairment for goodwill and indefinite-lived intangible assets, refer to Note 4. "Goodwill and Intangible Assets."

Professional and 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. The Company also maintains workers' compensation insurance, subject to a deductible.

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 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 consolidated balance sheets. Total professional, general and workers' compensation claim liabilities as of December 31, 2018 (Successor) and 2017 (Successor) were $18.2 million and $21.0 million, respectively. The balance includes expected insurance recoveries of $12.0 million and $12.8 million as of December 31, 2018 (Successor) and 2017 (Successor), respectively.

Derivative Instruments and Hedging Activities

In accordance with Accounting Standards Codification 815, *Derivatives and Hedging*, the Company records all derivatives on the balance sheet at fair value. The accounting for changes in the fair value of derivatives depends on the intended use of the derivative, whether the Company has elected to designate a derivative in a hedging relationship and apply hedge accounting and whether the hedging relationship has satisfied the criteria necessary to apply hedge accounting. Hedge accounting generally provides for the matching of the timing of gain or loss recognition on the hedging instrument with the recognition of the changes in the fair value of the hedged asset or liability that are attributable to the hedged risk in a fair value hedge or the earnings effect of the hedged forecasted transactions in a cash flow hedge. The Company may enter into derivative contracts that are intended to economically hedge certain of its risk, even though hedge accounting does not apply or the Company elects not to apply hedge accounting.

In accordance with the FASB’s fair value measurement guidance in ASU 2011-04, the Company made an accounting policy election to measure the credit risk of its derivative financial instruments that are subject to master netting agreements on a net basis by counterparty portfolio.

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 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 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 consolidated statements of cash flows.

The 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 partnership and limited liability company through which the Company owns and operates its surgical facilities is governed by a partnership or operating agreement. In certain circumstances, the applicable partnership or operating agreements for the Company's surgical facilities provide that the facilities will purchase all of the physician limited partners' or physician minority members', as applicable, ownership if certain adverse regulatory events occur, such as it becoming illegal for the physician(s) 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 consolidated balance sheets.

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

Predecessor		
Balance at December 31, 2016	$	180,521
Net income attributable to non-controlling interests—redeemable		9,615
Acquisition and disposal of shares of non-controlling interests, net—redeemable [(1)]		(3,323)
Distributions to non-controlling interest —redeemable holders		(11,468)
Acquisition of NSH		153,320
Balance at August 31, 2017	$	328,665
Successor		
Balance at September 1, 2017	$	271,001
Net income attributable to non-controlling interests—redeemable		12,931
Acquisition and disposal of shares of non-controlling interests, net—redeemable [(1)]		23,612
Distributions to non-controlling interest —redeemable holders		(8,228)
Balance at December 31, 2017		299,316
Net income attributable to non-controlling interests—redeemable		34,546
Acquisition and disposal of shares of non-controlling interests, net—redeemable [(1)]		23,748
Distributions to non-controlling interest —redeemable holders		(30,737)
Other		(281)
Balance at December 31, 2018	$	326,592

[(1)] Includes post acquisition date adjustments in all periods, including reallocation in application of pushdown accounting in the 2017 successor period.

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.

Recent Accounting Pronouncements

In May 2014, the FASB issued 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 requires significant management judgment in addition to changing the way many companies recognize revenue in their financial statements. The Company adopted this ASU on January 1, 2018 using the modified retrospective approach. During the initial year of adoption, the Company determined that amounts historically considered to be bad debt, and recognized as a component of operating expenses, are considered an implicit price concession, as defined in FASB Accounting Standards Codification 606, "*Revenue From Contracts With Customers*". As a result, generally amounts previously reflected as a provision for bad debts in the consolidated income statements would be categorized as a component of revenues. This determination resulted in the reclassification of amounts previously disclosed in the Company's quarterly reports in the year as bad debt expense to net revenues for the year ended December 31, 2018 (refer to Note 16. "Quarterly Financial Information (Unaudited)" for reclassified quarterly results). This change had no impact on net income, income taxes or the balance sheet for the year ended and as of December 31, 2018, or any interim period therein. The adoption of this standard did not have a material impact on the Company's consolidated financial position, results of operations or cash flows. Adoption of the standard resulted in the Company revising its related disclosures.

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 the Company's 2019 interim and annual financial statements. The Company plans to adopt ASU 2016-02 on January 1, 2019, using a modified retrospective transition approach for leases existing at, or entered into after, the beginning of the earliest comparative periods presented in the financial statements. 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 with material increases in reported property and equipment and liabilities. The Company is still finalizing its calculation of the cumulative effect of accounting change to be recognized upon adoption. The Company is currently working to complete the implementation of new processes and information technology tools to assist in its ongoing lease data collection and analysis, and updating accounting policies and internal controls in connection with the adoption of the new standard.

In November 2016, the FASB issued ASU 2016-18, "*Statement of Cash Flows – Restricted Cash*," which requires that a statement of cash flows explain the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. The Company adopted this ASU on January 1, 2018 and retrospectively applied the guidance to all periods presented in the consolidated statement of cash flows. The retrospective application to prior periods had no impact on the Company's cash flows from operating, investing and financing activities as previously disclosed. Refer to discussion of restricted cash under the heading "Cash, Cash Equivalents and Restricted Cash" above.

2. Acquisitions and Disposals

The Company accounts for 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. Any goodwill recognized is determined as the excess of the fair value of the consideration conveyed plus the fair value of any non-controlling interests in the acquisition over the fair value of the net assets acquired. Acquisitions in which the Company is able to exert significant influence but does not have control are accounted for using the equity method.

Acquired assets and assumed liabilities typically include, but are not limited to, fixed assets, intangible assets and professional liabilities. The valuations are based on appraisal reports, discounted cash flow analyses, actuarial analyses or other appropriate valuation techniques to determine the fair value of the assets acquired or liabilities assumed. Fair value attributable to non-controlling interests is based on a Level 3 computation using significant inputs that are not observable in the market. Key inputs used to determine the fair value include financial multiples used in the purchase of non-controlling interests, primarily from acquisitions of surgical facilities. Such multiples, based on earnings, are used as a benchmark for the discount to be applied for the lack of control or marketability. Fair value attributable to the property and equipment acquired is based on Level 3 computations using key inputs such as cost trend data and comparable asset sales. Fair value attributable to the intangible assets acquired is based on Level 3 computations using key inputs such as the Company's internally-prepared financial projections. Fair values assigned to acquired working capital are based on carrying amounts reported by the acquiree at the date of acquisition, which approximate their fair values.

Acquisitions

During the year ended December 31, 2018 (Successor), the Company acquired a controlling interest in five surgical facilities in new markets, two surgical facilities in existing markets, one of which was merged into an existing facility and multiple physician practices for a combined cash purchase price of $105.6 million, net of cash acquired. The 2018 acquisitions were funded through cash from operations. The total consideration related to these acquisitions was allocated to the assets acquired and liabilities assumed based upon their respective acquisition date fair values.

During the four months ended December 31, 2017 (Successor), the Company acquired a controlling interest in one surgical facility and one physician practice in existing markets for a combined cash purchase price of $29.4 million. The acquisitions were funded through cash from operations. During the eight months ended August 31, 2017 (Predecessor), the Company completed acquisitions in existing markets of

three physician practices for a combined cash purchase price of $14.2 million. The acquisitions were funded through cash from operations and proceeds from the then existing revolver loan.

The aggregate amounts preliminarily recognized for each major class of assets acquired and liabilities assumed for acquisitions completed in 2018 and 2017, including post acquisition date adjustments, are as follows (in thousands):

	Successor		*Predecessor*
	Year Ended December 31,	**September 1 to December 31,**	**January 1 to August 31,**
	2018 [1]	**2017**	**2017**
Cash consideration	$ 106,441	$ 29,448	$ 14,163
Fair value of non-controlling interests	63,774	21,893	105
Aggregate acquisition date fair value	$ 170,215	$ 51,341	$ 14,268
Net assets acquired:			
Current Assets	$ 12,254	$ 2,267	$ 777
Property and equipment	5,033	248	696
Intangibles	—	41	1,101
Goodwill	156,529	49,368	12,167
Other long-term assets	6,575	—	—
Current liabilities	(6,061)	(583)	(287)
Long-term liabilities	(4,115)	—	(186)
Aggregate acquisition date fair value	$ 170,215	$ 51,341	$ 14,268

[1] The fair values assigned to certain assets acquired and liabilities assumed by the Company in 2018 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.

During the year ended December 31, 2018 (Successor), no significant changes were made to the purchase price allocation of assets and liabilities, existing at the date of acquisition, related to individual acquisitions completed in 2017, excluding the acquisition of NSH as discussed below. The goodwill acquired in connection with the 2018 acquisitions was allocated to the Company's reportable segments as follows: $148.2 million to surgical facility services and $8.3 million to ancillary services. Approximately $93.9 million of goodwill recorded for the 2018 acquisitions is deductible for tax purposes. The results of operations of the 2018 acquisitions are included in the Company's results of operations beginning on the dates of acquisitions, and were not considered significant for the year ended December 31, 2018 (Successor).

Acquisition of NSH

On August 31, 2017 (Predecessor), the Company completed its acquisition of NSH for total cash consideration of $711.7 million, net of cash acquired, including $19.6 million funded to an escrow account. During 2018 (Successor), information existing at the acquisition date became known to the Company as part of its continuing evaluation of the assets and liabilities existing at the date of acquisition, resulting in a net increase to goodwill of $1.1 million. The corresponding changes to certain classes of assets and liabilities from the preliminary allocation recorded at August 31, 2017 (Predecessor), are reflected in the table below, which was finalized as of August 31, 2018 (Successor). The increase to goodwill during the period includes a working capital settlement payment resulting in additional cash consideration of $1.2 million.

The acquisition date fair value for each major class of assets acquired and liabilities assumed, including post acquisition date adjustments, are as follows (in thousands):

Cash consideration	$	764,007
Fair value of non-controlling interests		325,965
Aggregate fair value of acquisition	$	1,089,972
Net assets acquired:		
Cash and cash equivalents	$	51,159
Accounts receivable		71,639
Inventories		14,986
Prepaid expenses and other current assets		18,367
Property and equipment		174,100
Intangible assets		27,881
Goodwill		871,373
Investments in and advances to affiliates		29,737
Long-term deferred tax assets		20,212
Other long-term assets		26,988
Accounts payable		(29,652)
Accrued payroll and benefits		(30,853)
Other current liabilities		(23,937)
Current maturities of long-term debt		(16,416)
Long-term debt, less current maturities		(42,770)
Other long-term liabilities		(72,842)
Total fair value of net assets acquired	$	1,089,972

Change of Control - Pushdown Accounting

On August 31, 2017, Bain Capital became the controlling stockholder of the Company, holding preferred and common stock that collectively represent approximately 65.7% of the voting power of all classes of capital stock of the Company as of August 31, 2017. In connection with this change of control, the Company elected to apply "pushdown" accounting by applying the guidance in Accounting Standards Codification 805. In accordance with Accounting Standards Codification 805, all identifiable assets and liabilities of the Company were measured at and adjusted to fair value as of August 31, 2017, and similarly goodwill was recognized based on the terms of the transaction and the fair value of the new basis of the net assets of the Company.

During 2018 (Successor), information existing at the transaction date became known to the Company as part of its evaluation of the assets and liabilities existing at August 31, 2017, resulting in a net decrease to goodwill of $18.2 million and corresponding changes to certain classes of assets and liabilities from the preliminary allocation recorded, that are reflected in the table below, which was finalized as of August 31, 2018 (Successor). The post transaction date adjustments for pushdown accounting during the period includes a net increase of $3.9 million to the preliminary amounts assigned to intangible assets. The remaining adjustments to goodwill are attributable to a $17.9 million decrease to the preliminary fair value assigned to non-controlling interests, a $1.1 million increase related to the acquisition of NSH (discussed above), and a $2.5 million increase to other long-term liabilities.

The transaction date fair value recognized in connection with the application of pushdown accounting for each major class of assets and liabilities as of August 31, 2017, including post transaction date adjustments, are as follows (in thousands):

Equity attributable to Surgery Partners, Inc.	$	721,764
Redeemable preferred stock		310,000
Fair value of non-controlling interests		939,083
Aggregate fair value	$	1,970,847
Net assets:		
Cash and cash equivalents	$	214,206
Accounts receivable		252,911
Inventories		44,310
Prepaid expenses and other current assets		61,438
Property and equipment		379,685
Intangible assets		63,978
Goodwill		3,281,728
Investments in and advances to affiliates		75,113
Restricted invested assets		315
Long-term deferred tax asset		206,073
Other long-term assets		50,666
Accounts payable		(64,921)
Accrued payroll and benefits		(56,535)
Other current liabilities		(97,617)
Current maturities of long-term debt		(49,942)
Long-term debt, less current maturities		(2,142,375)
Long-term tax receivable agreement liability		(78,498)
Other long-term liabilities		(169,688)
Total fair value of net assets	$	1,970,847

Disposals and Deconsolidation

During the year ended December 31, 2018 (Successor), the Company disposed of four surgery centers, two surgical hospitals and its optical laboratory for net cash proceeds of $18.7 million, and recognized a net pretax loss of $21.2 million included in loss on disposals and deconsolidations, net in the consolidated statement of operations for the year ended December 31, 2018 (Successor). This non-cash loss was primarily a result of the write-off of the net assets of the facility (net of proceeds received) and was primarily driven by the write-off of the associated goodwill.

During the year ended December 31, 2018 (Successor), the Company sold a portion of its interest in one surgery center for net cash proceeds of $0.5 million. As a result of this transaction, the Company lost control of the previously controlled entity but retains a noncontrolling interest, resulting in the deconsolidation of the previously consolidated entity. The remaining noncontrolling interest was accounted for as an equity method investment, and initially measured and recorded at fair value as of the date of the transaction. The transaction resulted in a pretax gain on deconsolidation of $1.1 million, which is included in loss on disposals and deconsolidations, net, in the accompanying consolidated statement of operations for the year ended December 31, 2018 (Successor). The gain was determined based on the difference between the fair value of the Company's retained interest in the entity and the carrying value of both the tangible and intangible assets of the entity immediately prior to the transaction less cash proceeds received. The fair value measurement utilizes Level 3 inputs, which include unobservable data, to measure the fair value of the retained noncontrolling interest. The fair value determination was based on a combination of multiple valuation methods, which included discounted cash flow and market value approach, which incorporates estimates of future earnings and market valuation multiples for certain guideline companies. The fair value of the investment of $2.0 million was recorded as a component of investments in and advances to affiliates in the accompanying consolidated balance sheets.

During the four months ended December 31, 2017 (Successor), the Company disposed of one surgical facility for $1.3 million, resulting in a pre-tax gain of approximately $0.8 million. During the eight months ended August 31, 2017 (Predecessor), the Company disposed of one surgical facility. The proceeds and pre-tax gain for the sale were not significant.

3. 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 20 to 40 years for buildings and building improvements, 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.

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 amortized on a straight-line basis over the lesser of the lease term or the remaining useful life of the leased asset.

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

	Successor	
	December 31, 2018	**December 31, 2017**
Land	$ 19,550	$ 19,561
Buildings and improvements	200,390	188,571
Furniture and equipment	24,069	20,813
Computer and software	33,877	28,578
Medical equipment	139,571	138,112
Construction in progress	64,948	22,581
Property and equipment, at cost	482,405	418,216
Less: Accumulated depreciation	(56,119)	(19,680)
Property and equipment, net	$ 426,286	$ 398,536

Depreciation expense was $62.5 million for the year ended December 31, 2018 (Successor), $20.0 million for the four months ended December 31, 2017 (Successor), $24.1 million for the eight months ended August 31, 2017 (Predecessor) and $30.0 million for the year ended December 31, 2016 (Predecessor). Amortization expense related to assets under capital leases is included in depreciation expense. The carrying values of assets under capital lease were $22.7 million and $16.2 million as of December 31, 2018 (Successor) and 2017 (Successor), respectively, net of accumulated depreciation of $6.4 million and $5.8 million, respectively.

4. Goodwill and Intangible Assets

Goodwill represents the fair value of the consideration provided in an acquisition over the fair value of net assets acquired and is not amortized. The Company has indefinite-lived intangible assets related to the certificates of need held in jurisdictions where certain of its surgical facilities are located and Medicare licenses. 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 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 consolidated statements of operations over the service lives of the agreements, typically ranging from two to five years for non-compete agreements and 15 years for the management rights agreements. Customer relationships are amortized into depreciation and amortization expense in the consolidated statements of operations over the estimated lives of the relationships, ranging from three to ten years.

The Company tests its goodwill and indefinite-lived intangible assets for impairment at least annually, as of October 1, or more frequently if certain indicators arise. The Company tests for goodwill impairment at the reporting unit level, which is defined as one level below an operating segment. As of October 1, 2018, the Company has identified three reporting units, which include the following: 1) Surgical Facilities, 2) Ancillary Services, and 3) The Alliance, including Optical Synergies ("Alliance"). The Alliance is a component of the Optical Services operating segment. In 2018, the Company disposed of two previously identified reporting units, Midwest Labs and Family Vision Care.

The Company compares the carrying value of the net assets of the reporting unit to the estimated fair value of the reporting unit. To determine the fair value of the reporting units, the Company obtained valuations at the reporting unit level prepared by third-party valuation specialists which utilized a combination of the income and market approaches. The discounted cash flow model is projected based on a year-by-year assessment that considers historical results, estimated market conditions, internal projections, and relevant publicly available statistics. Determining fair value requires the exercise of significant judgment, including assumptions about appropriate discount rates, perpetual growth rates and the amount and timing of expected future cash flows. The significant judgments are typically based upon Level 3 inputs, generally defined as unobservable inputs representing the Company's own assumptions. The cash flows employed in the discounted cash flow analysis are based on the Company's most recent budgets and business plans aligned with provided guidance and, when applicable, various growth rates are assumed for years beyond the current business plan period. Discount rate assumptions are based on an assessment of the risk inherent in the future cash flows of the respective reporting units. The variables within the discount rate, many of which are outside of the Company's control, provide the best estimate of all assumptions applied within the DCF model. There can be no assurance that operations will achieve the future cash flows reflected in the projections. In determining the fair value under the market approaches, the analysis includes a control premium, which was based on observable market data and a review of selected transactions of companies that operate in the Company's sector. While the Company believes that all assumptions utilized in the testing were appropriate, they may not reflect actual outcomes that could occur. Specific factors that could negatively impact the assumptions used include changes to the discount and growth rates and a change in the equity and enterprise premiums being realized in the market.

As of October 1, 2018 (Successor), prior to our impairment testing, the Company had three reporting units with allocated goodwill were as follows: 1) Surgical Facilities - $3.3 billion, 2) Ancillary Services - $80.0 million, and 3) The Alliance, including Optical Synergies ("Alliance") - $25.3 million. As of the October 1, 2018 (Successor) valuation, the fair value for the Surgical Facilities reporting unit was substantially in excess of its carrying value. For the Ancillary Services and Alliance reporting units, the carrying value exceeded the fair value, resulting in non-cash impairment charges of $60.7 million and $13.7 million, respectively, in accordance with ASU No. 2017-04.

As a result of the impairment charges, the fair value equaled carrying value as of October 1, 2018 (Successor) for the Ancillary Services and Alliance reporting units, any future adverse events or changes in the assumptions could require additional impairment. Subsequent to the date of our annual impairment test, the Company considered its operating results for the fourth quarter of 2018, macroeconomic, industry and market conditions, and other market indicators including its market capitalization. Based on its evaluation of all such factors, the Company concluded that an event had not occurred or circumstances had not changed that would more likely than not reduce the fair value of its reporting units below their carrying values.

In connection with the implementation of pushdown accounting, the Company performed its goodwill impairment test as of August 31, 2017 (Predecessor), then re-evaluated for impairment at October 1, 2017 (Successor). Both evaluations resulted in no impairment. There were also no impairment charges recorded during the year ended December 31, 2016 (Predecessor).

A summary of the changes in the carrying amount of goodwill for the years ended December 31, 2018 and 2017 follows (in thousands):

Predecessor	
Balance at December 31, 2016	$ 1,555,204
Acquisitions, including post acquisition adjustments	859,543
Divestitures and deconsolidations	(175)
Balance at August 31, 2017	$ 2,414,572

Successor	
Balance at September 1, 2017	$ 3,269,225
Acquisitions, including post acquisition adjustments	79,570
Divestitures and deconsolidations	(1,957)
Balance at December 31, 2017	3,346,838
Acquisitions, including post acquisition adjustments	143,469
Divestitures and deconsolidations	(33,102)
Impairment	(74,359)
Balance at December 31, 2018	$ 3,382,846

Additions to goodwill include new acquisitions and incremental ownership acquired in the Company's subsidiaries. A summary of the Company's acquisitions for the years ended December 31, 2018 and 2017 is included in Note 2. "Acquisitions and Disposals."

A summary of the components of intangible assets follows (in thousands):

	Successor					
	December 31, 2018			**December 31, 2017**		
	Gross Carrying Amount	**Accumulated Amortization**	**Net**	**Gross Carrying Amount**	**Accumulated Amortization**	**Net**
Finite-lived intangible assets:						
Management rights agreements	$ 41,600	$ (4,223)	$ 37,377	$ 42,600	$ (1,058)	$ 41,542
Other	6,378	(2,738)	3,640	5,752	(942)	4,810
Total finite-lived intangible assets	47,978	(6,961)	41,017	48,352	(2,000)	46,352
Indefinite-lived intangible assets	13,276	—	13,276	12,556	—	12,556
Total intangible assets	$ 61,254	$ (6,961)	$ 54,293	$ 60,908	$ (2,000)	$ 58,908

Amortization expense for intangible assets was $4.9 million for the ended December 31, 2018 (Successor), $1.8 million for the four months ended December 31, 2017 (Successor), $6.0 million for the eight months ended August 31, 2017 (Predecessor) and $9.6 million for the year ended December 31, 2016 (Predecessor).

Total estimated amortization expense for the next five years and thereafter related to intangible assets follows (in thousands):

2019	$ 4,617
2020	4,206
2021	3,647
2022	2,936
2023	2,144
Thereafter	23,467
Total	$ 41,017

5. Long-Term Debt

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

	Successor	
	December 31, 2018	December 31, 2017
Revolver	$ —	$ —
Term Loan [1]	1,447,931	1,280,532
Senior Unsecured Notes due 2021 [2]	406,719	409,235
Senior Unsecured Notes due 2025	370,000	370,000
Notes payable and secured loans	79,341	101,921
Capital lease obligations	25,374	27,594
Less: unamortized debt issuance costs and original issue discount	(2,915)	—
Total debt	2,326,450	2,189,282
Less: Current maturities	55,552	58,726
Total long-term debt	$ 2,270,898	$ 2,130,556

[1] Includes unamortized fair value discount of $5.5 million and $6.2 million as of December 31, 2018 (Successor) and 2017 (Successor), respectively.

[2] Includes unamortized fair value premium of $6.7 million and $9.2 million as of December 31, 2018 (Successor) and 2017 (Successor), respectively.

2017 Senior Secured Credit Facilities

On August 31, 2017 (Predecessor), the Company entered into a credit agreement (the "Credit Agreement") providing for a $1.29 billion senior secured term loan (the "Term Loan") and a $75.0 million revolving credit facility (the "Revolver" and, together with the Term Loan, the "2017 Senior Secured Credit Facilities"). The Term Loan was fully drawn on August 31, 2017 (Predecessor) and the proceeds thereof were used to finance the acquisition of NSH, to repay amounts outstanding under the Company's then-existing 2014 First Lien Credit Agreement and 2014 Revolver Loan and amounts outstanding under the existing senior secured credit facilities of NSH, and to pay fees and expenses in connection with the foregoing and other previously disclosed transactions that occurred on August 31, 2017 (Predecessor). The Revolver may be utilized for working capital, capital expenditures and general corporate purposes. Subject to certain conditions and requirements set forth in the Credit Agreement, the Company may request one or more additional incremental term loan facilities or one or more increases in the commitments under the Revolver. As of December 31, 2018 (Successor), the Company's availability on the Revolver was $71.2 million (including outstanding letters of credit of $3.8 million).

On October 23, 2018, the Company entered into an incremental term loan amendment, which amended and supplemented the Credit Agreement, dated as of August 31, 2017, to provide for a $180.0 million senior secured incremental term loan. The incremental amounts were fully drawn on October 23, 2018, and the proceeds thereof were used to fund acquisitions and for other general corporate purposes. The incremental borrowing bears interest and is subject to maturity, amortization and other terms consistent with the existing term loans outstanding under the Credit Agreement as disclosed below.

The Term Loan will mature on August 31, 2024 and the Revolver will mature on August 31, 2022; however, both the Term Loan and the Revolver will mature on October 15, 2020 if at least 50.0% of the 2021 Unsecured Notes (defined below) have not been repaid or refinanced with permitted indebtedness with a maturity date six months after the of the original maturity date of the Term Loan.

The 2017 Senior Secured Credit Facilities bear interest at a rate per annum equal to (x) LIBOR plus a margin ranging from 3.00% to 3.25% per annum, depending on the Company's first lien net leverage ratio or (y) an alternate base rate (which will be the highest of (i) the prime rate, (ii) 0.5% per annum above the federal funds effective rate and (iii) one-month LIBOR plus 1.00% per annum (solely with respect to the Term Loan, the alternate base rate shall not be less than 2.00% per annum)) plus a margin ranging from 2.00% to 2.25% per annum. In addition, the Company is required to pay a commitment fee of 0.50% per annum in respect of unused commitments under the Revolver.

The Term Loan amortizes in equal quarterly installments of 0.25% of the aggregate original principal amount of the Term Loan. The Term Loan is subject to mandatory prepayments based on excess cash flow for the applicable fiscal year that will depend on the first lien net leverage ratio as of the last day of the applicable fiscal year, as well as upon the occurrence of certain other events, as described in the Credit Agreement. There were no excess cash flow payments required as of December 31, 2018 (Successor).

With respect to the Revolver, the Company is required to comply with a maximum consolidated total net leverage ratio of 9.50:1.00, which covenant will be tested quarterly on a trailing four quarter basis only if, as of the last day of the applicable fiscal quarter the Revolver is drawn in an aggregate amount greater than 35% of the total commitments under the Revolver. Such financial maintenance covenant is subject to an equity cure. The Credit Agreement includes customary negative covenants restricting or limiting the ability of the Company and its restricted subsidiaries, to, among other things, sell assets, alter its business, engage in mergers, acquisitions and other business combinations, declare dividends or redeem or repurchase equity interests, incur additional indebtedness or guarantees, make loans and investments, incur

liens, enter into transactions with affiliates, prepay certain junior debt, and modify or waive certain material agreements and organizational documents, in each case, subject to customary and other agreed upon exceptions. The Credit Agreement also contains customary affirmative covenants and events of default. As of December 31, 2018 (Successor), the Company was in compliance with the covenants contained in the Credit Agreement.

The 2017 Senior Secured Credit Facilities are guaranteed, on a joint and several basis, by SP Holdco I, Inc. and each of Surgery Center Holdings, Inc.'s current and future wholly-owned domestic restricted subsidiaries (subject to certain exceptions) (the "Subsidiary Guarantors") and are secured by a first priority security interest in substantially all of Surgery Center Holdings, Inc.'s, SP Holdco I, Inc.'s and the Subsidiary Guarantors' assets (subject to certain exceptions).

In connection with the Term Loan and Revolver, the Company recorded debt issuance costs and discount of $28.2 million, in the Predecessor period of 2017, which were eliminated with the application of pushdown accounting. In connection with the repayment of the Company's 2014 First Lien Credit Agreement, the Company recorded a debt extinguishment loss of $18.2 million, included in the loss on debt refinancing in the consolidated statement of operations for the eight months ending August 31, 2017 (Predecessor). The loss includes the partial write-off of unamortized debt issuance costs and discount related to the 2014 Revolver Loan and 2014 First Lien Credit Agreement and a portion of costs incurred with the 2017 Senior Secured Credit Facilities.

In connection with the application of pushdown accounting, the Company remeasured and recorded the Term Loan at fair value using a measurement date of August 31, 2017. The fair value was based on a Level 2 computation using quoted prices for identical liabilities in inactive markets. As a result, the Company recorded a fair value discount of $6.5 million as of the measurement date, which is reported in the consolidated balance sheets as a direct deduction from the face amount the Term Loan. The Company amortizes the fair value discount to interest expense over the life of the Term Loan.

In connection with the incremental borrowings, the Company recorded debt issuance costs and discount of $3.0 million.

Senior Unsecured Notes due 2021

Effective March 31, 2016 (Predecessor), the Company 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 2017 Senior Secured Credit Facilities (subject to certain exceptions).

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% of the principal amount, plus accrued and unpaid interest to, but excluding, the date of repurchase. The change of control as discussed in Note 1. "Organization and Summary of Accounting Policies", did not trigger 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 in the Predecessor period, which were eliminated with the application of pushdown accounting.

In connection with the application of pushdown accounting, the Company remeasured and recorded the 2021 Unsecured Notes at fair value using a measurement date of August 31, 2017. The fair value was based on a Level 2 computation using quoted prices for identical liabilities in inactive markets. As a result, the Company recorded a fair value premium of $10.0 million as of the measurement date, which is reported in the consolidated balance sheets as a direct addition to the face amount the notes. The Company amortizes the fair value premium to interest expense over the life of the 2021 Unsecured Notes.

Senior Unsecured Notes due 2025

Effective June 30, 2017 (Predecessor), the Company issued $370.0 million in gross proceeds of senior unsecured notes due July 1, 2025 (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. The 2025 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 2017 Senior Secured Credit Facilities (subject to certain exceptions).

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 106.75% 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% 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 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, 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 2025 Unsecured Notes, the Company recorded debt issuance costs of $17.3 million in the Predecessor period, which were eliminated with the application of pushdown accounting.

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 December 31, 2018 (Successor), the Company was in compliance with its covenants contained in the credit agreements. The Company and its subsidiaries had notes payable to financial institutions of $79.3 million and $101.9 million as of December 31, 2018 (Successor) and 2017 (Successor), respectively.

Capital Lease Obligations

The Company is liable to various vendors for several property and equipment leases classified as capital leases. The carrying value of the leased assets was $22.7 million and $16.2 million as of December 31, 2018 (Successor) and 2017 (Successor), respectively.

Maturities

A summary of maturities for the Company's long-term debt, excluding unamortized fair value discount and premium discussed above, for the next five years and thereafter as of December 31, 2018 follows (in thousands):

2019	$ 55,552
2020	1,459,069
2021	415,733
2022	11,079
2023	7,868
Thereafter	378,835
Total debt	$ 2,328,136

6. 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. Lease obligations paid in advance are recorded as prepaid rent and included in prepaid expenses and other current assets on the 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 consolidated balance sheets.

Future minimum lease payments for non-cancellable operating and capital leases for the next five years and thereafter at December 31, 2018 follows (in thousands):

	Operating Leases	Capital Leases
2019	$ 81,455	$ 8,846
2020	75,649	6,680
2021	66,728	4,704
2022	61,261	2,907
2023	57,202	1,534
Thereafter	470,194	4,227
Total minimum payments	$ 812,489	28,898
Less: imputed interest		(3,524)
Capital lease obligations		$ 25,374

The Company has various non-cancellable sub-lease arrangements. The total future minimum rentals to be received under these arrangements as of December 31, 2018 is estimated to be $3.4 million.

Rental expense for operating leases was $83.5 million for the year ended December 31, 2018 (Successor). $27.8 million for the four months ended December 31, 2017 (Successor), $39.2 million for the eight months ended August 31, 2017 (Predecessor) and $47.3 million for the year ended December 31, 2016 (Predecessor). Included in these amounts, the Company incurred lease expense under operating lease agreements with physician investors who are related parties of $20.2 million for the year ended December 31, 2018 (Successor), $7.5 million for the four months ended December 31, 2017 (Successor), $9.8 million for the eight months ended August 31, 2017 (Predecessor) and $14.4 million for year ended December 31, 2016 (Predecessor).

7. Redeemable Preferred Stock

On August 31, 2017, the Company completed the sale issuance of 310,000 shares of the Company's preferred stock, par value $0.01 per share, designated as 10.00% Series A Convertible Perpetual Participating Preferred Stock (the “Series A Preferred Stock”) to Bain Capital at a purchase price of $1,000 per share for an aggregate purchase price of $310.0 million (the "Preferred Private Placement"). The net proceeds were used to finance a portion of the acquisition of NSH.

The accrued value of the Series A Preferred Stock is convertible into shares of common stock at a price per share of common stock equal to $19.00, subject to certain adjustments as provided in the Certificate of Designations, Preferences, Rights and Limitations of the 10.00% Series A Convertible Perpetual Participating Preferred Stock of Surgery Partners, Inc. (the “Series A Certificate of Designation”), at any time at the option of the holder. In addition, the Company may require the conversion of all, but not less than all, of the Series A Preferred Stock pursuant to the terms and conditions of the Series A Certificate of Designation, after the second anniversary of the date of issuance, if the volume weighted average closing price of the Common Stock for any 20 out of 30 consecutive trading days prior to such date, equals or exceeds $42.00 per share.

The Company cannot redeem the Series A Preferred Stock prior to the fifth anniversary of its issuance and thereafter, may redeem all, but not less than all, of the Series A Preferred Stock for cash pursuant to and subject to the terms and conditions of the Series A Certificate of Designation. The holders of Series A Preferred Stock may cause the Company to redeem the Series A Preferred Stock upon the occurrence of certain change of control transactions of the Company or the common stock ceasing to be listed or quoted on a trading market. The Company adjusts the carrying amount of the Series A Preferred Stock to equal the redemption value at the end of each reporting period as if it were also the redemption date. Changes in the redemption value are recognized immediately as they occur.

The Series A Preferred Stock ranks senior to the common stock and any other capital stock of the Company with respect to dividends, redemption and any other rights upon the liquidation, dissolution or winding up of the Company, and the holders thereof are entitled to vote with the holders of common stock, together as a single class, on all matters submitted to a vote of the Company’s stockholders. In addition to participating in any dividends that may be declared with respect to the common stock on an as-converted basis, each share of Series A Preferred Stock accrues dividends daily at a dividend rate of 10.00%, compounding quarterly, and in any given quarter, subject to certain conditions, the Board of Directors of the Company may declare a cash dividend in an amount up to 50% of the amount of the dividend that has accrued and accumulated during such quarter through the end of such quarter, and the amount of any quarterly dividend paid in cash shall not compound on the applicable date and shall not be included in the accrued value of the Series A Preferred Stock. In the event of the Company’s liquidation, dissolution or winding-up (whether voluntary of involuntary), holders of Series A Preferred Stock will be entitled to receive out of the assets of the Company available for distribution to shareholders, after satisfaction of any liabilities and obligations to creditors of the Company, with respect to each Series A Preferred Share, an amount equal to the greater of (i) $1,000.00 per share, plus dividends compounded to date, plus

dividends accrued but not yet compounded and (ii) the amount that a holder of one share of common stock would receive, assuming the Series A Preferred Stock had converted into shares of common stock.

In connection with the issuance of Series A Preferred Stock, the Company incurred issuance costs of $18.3 million in the eight months ended August 31, 2017 (Predecessor), which were eliminated with the application of pushdown accounting.

A summary of activity related to the redeemable preferred stock for the year ended December 31, 2018 (Successor) follows (in thousands):

Successor		
Balance at December 31, 2017	$	330,806
Dividends accrued		32,426
Cash dividends declared		(3,886)
Balance at December 31, 2018	$	359,346

There were no unpaid cash dividends declared at December 31, 2018 (Successor). Cash dividends declared but unpaid at December 31, 2017 (Successor) were $3.9 million, and were included in other current liabilities in the consolidated balance sheet. The aggregate and per share amounts of unpaid cumulative preferred dividends as of December 31, 2018 (Successor) were $33.8 million and $108.97, respectively.

8. Derivatives and Hedging Activities

Cash Flow Hedges of Interest Rate Risk

The Company's objectives in using interest rate derivatives are to add stability to interest expense and to manage its exposure to interest rate movements. To accomplish this objective, the Company primarily uses interest rate swaps as part of its interest rate risk management strategy. During 2018, such derivatives were used to hedge the variable cash flows associated with existing variable-rate debt.

For derivatives designated and that qualify as cash flow hedges of interest rate risk, the gain or loss on the derivative is recorded in Accumulated Other Comprehensive Income and subsequently reclassified into interest expense in the same period(s) during which the hedged transaction affects earnings, as documented at hedge inception in accordance with the Company's accounting policy election. Amounts reported in accumulated other comprehensive income related to derivatives will be reclassified to interest expense as interest payments are made on the Company's variable-rate debt. Over the next 12 months, the Company estimates that $5.1 million will be reclassified as an increase to interest expense.

As of December 31, 2018 (Successor), the Company had three interest rate swaps with a current notional amount of $900.0 million and a termination date of November 30, 2023. The Company classifies its derivative financial instruments as a long-term liability included in other long-term liabilities in the consolidated balance sheet as of December 31, 2018 (Successor). The Company had no derivative financial instruments as of December 31, 2017 (Successor).

For the year ended December 31, 2018 (Successor), the Company incurred losses related to the effective portion of derivatives, which were recognized in accumulated other comprehensive income, gross of tax effect, of $23.1 million. For the year ended December 31, 2018 (Successor), the Company reclassified $0.6 million of losses from accumulated other comprehensive income to interest expense, gross of tax effect.

9. Earnings Per Share

Basic and diluted earnings per share are calculated in accordance with Accounting Standards Codification 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. Beginning September 1, 2017 (Successor), in connection with the issuance of the Series A Preferred Stock, the Company began computing basic and diluted earnings per share using the two-class method. The two-class method of computing earnings per share is an earnings allocation method that determines earnings per share for common shares and participating securities according to their participation rights in dividends and undistributed earnings. Refer to Note 7. "Redeemable Preferred Stock", for further disclosure of the terms and conditions, including the participation rights, of the Series A Preferred Stock.

A reconciliation of the numerator and denominator of basic and diluted earnings per share follows (in thousands except share and per share amounts):

	Successor		*Predecessor*	
	Year Ended December 31,	September 1 to December 31,	January 1 to August 31,	Year Ended December 31,
	2018	2017	2017	2016
Numerator:				
Net (loss) income attributable to Surgery Partners, Inc.	$ (205,706)	$ (41,316)	$ (11,669)	$ 9,453
Less: amounts allocated to participating securities [1]	32,426	10,481	—	—
Less: mark to redemption adjustment		15,566	—	—
Net (loss) income attributable to common stockholders	$ (238,132)	$ (67,363)	$ (11,669)	$ 9,453
Denominator:				
Weighted average shares outstanding- basic	48,027,875	48,319,193	48,121,404	48,018,944
Effect of dilutive securities [2]	—	—	—	171,794
Weighted average shares outstanding- diluted	48,027,875	48,319,193	48,121,404	48,190,738
(Loss) earnings per share:				
Basic	$ (4.96)	$ (1.39)	$ (0.24)	$ 0.20
Diluted [2]	$ (4.96)	$ (1.39)	$ (0.24)	$ 0.20
Securities outstanding not included in the computation of diluted (loss) earnings per share as their effect is antidilutive:				
Stock options	82,602	—	—	—
Restricted shares	198,267	62,850	105,944	—
Convertible preferred stock	—	—	N/A	N/A

[1] Amounts allocated to participating securities includes dividends accrued during the Successor periods for the Series A Preferred Stock. The Series A Preferred Stock does not participate in undistributed losses. There were no participating securities during the Predecessor periods.

[2] The impact of potentially dilutive securities for the year ended December 31, 2018 (Successor), four months ended December 31, 2017 (Successor) and the eight months ended August 31, 2017 (Predecessor), were not considered because the effect would be anti-dilutive in each of those periods.

Share Repurchase Transactions

On December 15, 2017, the Board of Directors authorized a share repurchase program of up to $50.0 million of the Company's issued and outstanding common stock from time to time. The timing and size of repurchases will be determined based on market conditions and other factors. The authorization does not obligate the repurchase any shares and the Company may repurchase shares of common stock at any time without prior notice. The share repurchases will be made in accordance with applicable securities laws in open market or privately negotiated transactions. The authorization does not have a specified expiration date, and the share repurchase program may be suspended, recommenced or discontinued at any time or from time to time without prior notice.

In December 2017 (Successor), the Company repurchased 180,664 shares of its common stock at an average price of $11.12 per share through market purchases. In 2018 (Successor), the Company repurchased 156,818 shares of its common stock at an average price of $12.64 per share through market purchases, leaving approximately $46.0 million of repurchase authorization available under the December 2017 authorization at December 31, 2018 (Successor).

10. Income Taxes

Income Taxes

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. Any change in tax rates that could impact deferred tax assets or liabilities are recognized in the same period the change occurs. If a net operating loss ("NOL") carryforward exists, the Company makes a determination as to whether that 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 2015 or state income tax examinations for years prior to 2014.

The Company and certain of its subsidiaries file a consolidated federal income tax return. The partnerships, limited liability companies, and certain non-consolidated physician practice corporations also 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.

The Company made income tax payments of $2.2 million for the year ended December 31, 2018 (Successor), $0.5 million and $0.6 million for the four months ended December 31, 2017 (Successor) and eight months ended August 31, 2017 (Predecessor), respectively and $0.7 million and for the year ended December 31, 2016 (Predecessor).

Income tax expense (benefit) is comprised of the following (in thousands):

	Successor		*Predecessor*	
	Year Ended December 31,	**September 1 to December 31,**	**January 1 to August 31,**	**Year Ended December 31,**
	2018	**2017**	**2017**	**2016**
Current:				
Federal	$ (324)	$ (111)	$ —	$ (31)
State	1,511	990	614	244
Deferred:				
Federal	16,525	77,472	(17,288)	7,326
State	8,749	(6,712)	(1,415)	(444)
Total income tax expense (benefit)	$ 26,461	$ 71,639	$ (18,089)	$ 7,095

A reconciliation of the provision for income taxes as reported in the consolidated statements of operations and the amount of income tax expense (benefit) computed by multiplying consolidated income (loss) in each year by the U.S. federal statutory rate of 21% (2018) and 35% (2017 and 2016) follows (in thousands):

	Successor		*Predecessor*	
	Year Ended December 31,	**September 1 to December 31,**	**January 1 to August 31,**	**Year Ended December 31,**
	2018	**2017**	**2017**	**2016**
Tax expense (benefit) at U.S.federal statutory rate	$ (14,525)	$ 24,485	$ 4,315	$ 32,263
State income tax, net of U.S. federal tax benefit	9,955	1,685	(456)	(86)
Change in valuation allowance	26,946	529	1,324	354
Net income attributable to non-controlling interests	(23,117)	(13,872)	(14,731)	(26,470)
Changes in measurement of uncertain tax positions	(73)	(191)	20	(262)
Stock option compensation	509	306	37	(200)
Differences related to divested facilities	6,037	(429)	(1,708)	—
Nondeductible transaction costs	23	2,058	(977)	—
Tax return reconciling differences	1,748	—	(316)	1,635
Change in effective tax rate	493	64,343	(825)	—
Tax Receivable Agreement liability	901	(7,404)	(4,782)	(327)
Goodwill impairment	8,892	—	—	—
Litigation settlement	8,577	—	—	—
Other	95	129	10	188
Total income tax expense (benefit)	$ 26,461	$ 71,639	$ (18,089)	$ 7,095

The components of temporary differences and the approximate tax effects that give rise to the Company's net deferred tax asset are as follows (in thousands):

	Successor	
	December 31, 2018	**December 31, 2017**
Deferred tax assets:		
Medical malpractice liability	$ 3,456	$ 3,236
Accrued vacation and incentive compensation	2,933	2,125
Net operating loss carryforwards	139,404	137,794
Allowance for bad debts	2,510	2,545
Capital loss carryforwards	3,701	3,024
Deferred rent	1,866	—
Amortization of intangible assets	2,437	—
Deferred financing costs	14,638	17,004
Section 163(j) interest	27,338	
Interest rate swap liability	5,431	
TRA liability	1,176	1,042
Other deferred assets	7,010	4,961
Total gross deferred tax assets	211,900	171,731
Less: Valuation allowance	(50,430)	(11,032)
Total deferred tax assets	161,470	160,699
Deferred tax liabilities:		
Depreciation on property and equipment	(3,925)	(12,098)
Amortization of intangible assets	—	(12,441)
Basis differences of partnerships and joint ventures	(47,749)	(2,399)
Deferred rent	—	(717)
Other deferred liabilities	(603)	(725)
Total deferred tax liabilities	(52,277)	(28,380)
Net deferred tax assets	$ 109,193	$ 132,319

The Company had federal net operating loss carryforwards of $516.8 million as of December 31, 2018, which expire between 2025 and 2037 and state net operating loss carryforwards of $589.9 million as of December 31, 2018, which expire between 2019 and 2038. The Company had capital loss carryforwards of $14.8 million as of December 31, 2018, which expire between 2019 and 2023. The Company had federal and state credit carryforwards of $1.0 million as of December 31, 2018. The federal credits do not expire, and the state credits expire between 2019 and 2030.

The Company has recorded a valuation allowance against deferred tax assets at December 31, 2018 and 2017 totaling $50.4 million and $11.0 million, respectively, which represents an increase of $39.4 million. The valuation allowance continues to be provided for certain deferred tax assets for which the Company believes it is more likely than not that the tax benefits will not be realized, which are primarily Section 163(j) interest carryforwards, certain state net operating losses and capital loss carryforwards.

The Company has evaluated the realizability of its deferred tax assets based on sources of positive and negative evidence, and determined that it is more likely than not that the net operating loss carryforwards will be realized. The determination was made based upon projections of future book and taxable income. If the Company's 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, the Company may need to adjust the valuation allowance, for all or a portion of its deferred tax assets. The Company's income tax expense in future periods will be reduced or increased to the extent of offsetting decreases or increases, respectively, in its valuation allowance in the period when the change in circumstances occurs. These changes could have a significant impact on the Company's future earnings.

Included in the increase in the valuation allowance for the year ended December 31, 2018 was an increase of approximately $6.3 million that was recorded to additional-paid-in-capital as the result of the tax effect of the disposals of shares of non-controlling interests and the interest rate swap liability. Also included in the increase in the valuation allowance was an increase of approximately $0.1 million that was recorded to goodwill related to certain deferred tax assets acquired during the year. Approximately $8.1 million of the valuation allowance as of December 31, 2018 is recorded against deferred tax assets that, if subsequently recognized, will be credited directly to contributed capital.

A reconciliation of the beginning and ending liability for gross unrecognized tax benefits for the years ended December 31, 2018 and 2017 is as follows (in thousands):

	Successor	
	December 31, 2018	**December 31, 2017**
Unrecognized tax benefits at beginning of year	$ 690	$ 1,061
Additions for acquired positions	—	36
Additions for tax positions of prior years	7	—
Reductions for tax positions of prior year	(629)	(407)
Settlements	(7)	—
Unrecognized tax benefits at end of year	$ 61	$ 690

The Company recognizes interest and penalties related to uncertain tax positions in its provision for income taxes in the consolidated statements of operations. For both the years ended December 31, 2018 and 2017, the Company had approximately $0.1 million of accrued interest and penalties related to uncertain tax positions. The total amount of accrued liabilities related to uncertain tax positions that would affect the Company's effective tax rate, if recognized, is $0.1 million and $0.2 million as of December 31, 2018 and 2017, respectively. The reserves are included in long-term taxes payable and long-term deferred tax assets in the consolidated balance sheet as of December 31, 2018.

The Tax Cuts and Jobs Act (the "Tax Act") was enacted on December 22, 2017. The Tax Act reduces the U.S. federal corporate tax rate from 35% to 21%, allows for 100% expensing of certain capital expenditures, and limits interest expense deductions beginning in 2018. The SEC staff issued SAB 118, which provides guidance on accounting for the tax effects of the Tax Act. SAB 118 provides a measurement period that should not extend beyond one year from the Tax Act enactment date for companies to complete the accounting under ASC 740. In accordance with SAB 118, a company must reflect the income tax effects of those aspects of the Tax Act for which the accounting under ASC 740 is complete. The Company's accounting for the following elements of the Tax Act is complete: reduction of U.S. federal corporate tax rate from 35% to 21%, 100% expensing of capital expenditures, and the interest expense limitation under Section 163j.

11. 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’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 September 2015, the Company adopted the Surgery Partners, Inc. 2015 Omnibus Incentive Plan ("2015 Omnibus Incentive Plan") from which all equity-based awards will be granted. Under this plan, the Company can grant stock options, SARs, restricted stock, unrestricted stock, stock units, performance awards, cash awards and other awards convertible into or otherwise based on shares of its common stock. As of December 31, 2018, 4,815,700 shares were authorized to be granted under the 2015 Omnibus Incentive Plan and 3,377,923 were available for future equity grants.

Restricted Share-Based Awards

During the year ended December 31, 2018 (Successor), the Company granted 519,605 restricted stock awards ("RSAs") to certain officers, employees and non-employee directors in accordance with the 2015 Omnibus Incentive Plan. During the four months ended December 31, 2017 (Successor) and the eight months ended August 31, 2017 (Predecessor), the Company granted 112,107 and 251,904 RSAs, respectively. Vesting and payment of these RSAs are generally subject to continuing service of the employee or non-employee director over the ratable vesting periods beginning one year from the date of grant to three or five years after the date of grant. The fair values of these RSAs were determined based on the closing price of the Company’s common stock on the trading date immediately prior to the grant date.

During the year ended December 31, 2018 (Successor), the Company granted 335,074 performance-based restricted stock units ("PSUs") subject to the achievement of a combination of performance conditions. There were no grants during the four months ended December 31, 2017 (Successor). During the eight months ended August 31, 2017 (Predecessor) the Company granted 232,242 PSUs. In addition to the achievement of the performance conditions, these PSUs are generally subject to the continuing service of the employee over the ratable vesting period from the earned date continuing for two years. The performance condition for the targeted PSUs granted during the eight months ended August 31, 2017 (Predecessor) is based on the Company’s achievement of annually established targets for adjusted earnings per share for 2017. For these restricted stock units, the number of shares payable at the end of the performance periods ranges from 0% to 150% of the targeted units based on the Company’s actual performance and/or market conditions results as compared to the targets. These stock units are not considered outstanding until earned. During the year ended December 31, 2018 (Successor), none of the PSUs granted were deemed to have been earned. No units granted were deemed to have been earned during the four months ended December 31, 2017 (Successor). During the eight months ended August 31, 2017 (Predecessor), 136,550 of the PSUs granted were deemed to have been earned.

Additionally, during the year ended December 31, 2018 (Successor), the Company granted 127,292 leverage performance restricted stock units ("LPUs") subject to the achievement of a combination of market conditions. During the four months ended December 31, 2017 (Successor), the Company granted 215,823 LPUs. There were no grants during the eight months ended August 31, 2017 (Predecessor). In addition to the achievement of the market conditions, these LPUs are generally subject to the continuing service of the employee over the ratable vesting period from the performance period end date continuing for three years. The market condition for the LPUs granted during the four months ended December 31, 2017 (Successor) is based on the Company's three-year annualized total shareholder return relative to the companies making up the S&P Composite 1500 Health Care Index as of the grant date. These stock units are not considered outstanding until earned. During the four months ended December 31, 2017 (Successor), none of the LPUs granted were deemed to have been earned.

For these restricted stock units, the number of shares payable at the end of the vesting periods ranges from 0% to 500% of the targeted units based on the Company's actual performance and/or market conditions results as compared to the targets. The fair values of these restricted stock units were determined based on a combination, where applicable, of the closing price of the Company's common stock on the trading date immediately prior to the grant date for units subject to performance conditions, or at its Monte-Carlo simulation value for units subject to market conditions. The Company recognizes compensation expense for the portion of the targeted performance-based restricted stock units subject to market conditions even if the condition is never satisfied. However, if the performance conditions are not met for the portion of the targeted performance-based restricted stock units subject to such performance conditions, no compensation expense will be recognized, and any previously recognized compensation expense will be reversed. Forfeitures are recognized as incurred.

Restricted Share-Based Activity

A summary of non-vested restricted share-based activity for the years ended December 31, 2018, 2017, and 2016 follows:

	Unvested Shares		Weighted Average Grant Date Fair Value
Predecessor			
Outstanding at January 1, 2016	167,654	$	2.53
Granted/Earned	384,629		15.09
Forfeited/Cancelled	(53,003)		11.85
Vested	(37,038)		6.31
Outstanding at December 31, 2016	462,242	$	3.72
Granted/Earned	388,454		18.40
Forfeited/Cancelled	(67,771)		18.01
Vested	(169,881)		10.29
Outstanding at August 31, 2017	613,044	$	16.02
Successor			
Outstanding at September 1, 2017	613,044	$	16.02
Granted/Earned	112,107		11.15
Forfeited/Cancelled	(54,622)		10.94
Vested	(96,073)		17.03
Outstanding at December 31, 2017	574,456	$	15.95
Granted/Earned	519,605		16.10
Forfeited/Cancelled	(180,719)		15.09
Vested	(210,318)		16.31
Outstanding at December 31, 2018	703,024	$	16.18

Stock Options and Stock Appreciation Rights

The Company granted 700,000 stock options during the year ended December 31, 2018. The Company did not grant any stock options during the year ended December 31, 2017. During the year ended December 31, 2016, the Company granted options to purchase shares of the Company's common stock to certain directors in accordance the 2015 Omnibus Incentive Plan. Options to purchase shares are granted with an exercise price equal to the fair market value of the Company's common stock on the day of grant, based on the closing price of the Company's common stock on the trading date immediately prior to the grant date. Fifty percent (50%) of the Stock Option Awards will vest in five equal annual installments on each of the first five anniversaries of the date of grant, generally subject to continued employment on each vesting date. Twenty-five percent (25%) of the award will vest based on satisfaction of the time condition and the achievement by the Company of an average closing price of a share of Common Stock on the Nasdaq Stock Market of $25.00 over a period of sixty (60) consecutive trading days, and twenty-five percent (25%) of the award will vest based on satisfaction of the time condition and the achievement by the Company

of an average closing price of a share of Common Stock on the Nasdaq Stock Market of $35.00 over a period of sixty (60) consecutive trading days, in each case, generally subject to continued employment on each vesting date. Forfeitures are recognized as incurred.

On December 16, 2018, the Company cancelled 200,000 stock options and replaced them with 200,000 stock-settled stock appreciation right awards (the "SAR Awards"). These were the only SAR Awards granted as of the year ended December 31, 2018. The Company did not grant any SAR Awards for the years ended December 31, 2017 and 2016. The SAR Awards had a base price equal to the exercise price of the cancelled stock options. Fifty percent (50%) of the SAR Awards will vest in five equal annual installments on each of the first five anniversaries of the date of grant, generally subject to continued employment on each vesting date. Twenty-five percent (25%) of the award will vest based on satisfaction of the time condition and the achievement by the Company of an average closing price of a share of Common Stock on the Nasdaq Stock Market of $25.00 over a period of sixty (60) consecutive trading days, and twenty-five percent (25%) of the award will vest based on satisfaction of the time condition and the achievement by the Company of an average closing price of a share of Common Stock on the Nasdaq Stock Market of $35.00 over a period of sixty (60) consecutive trading days, in each case, generally subject to continued employment on each vesting date. Forfeitures are recognized as incurred.

Option/SAR Valuation

In applying the Monte Carlo simulation model to value both the stock options and SAR Awards, the Company used the following assumptions:

- *Risk-free interest rate*. The risk-free interest rate is used as a component of the fair value of stock options to take into account the time value of money. For the risk-free interest rate, the Company uses the implied yield on United States Treasury zero-coupon issues with a remaining term equal to the expected life, in years, of the options granted.
- *Expected volatility*. Volatility, for the purpose of share-based compensation, is a measurement of the amount that a share price has fluctuated. Expected volatility involves reviewing historical volatility and determining what, if any, change the share price will have in the future. The Company used historical stock price information of certain peer group companies for a period of time equal to the expected option life period to determine estimated volatility.
- *Expected life, in years*. A clear distinction is made between the expected life of an option and the contractual term of the option. The expected life of an option is considered the amount of time, in years, that an option is expected to be outstanding before it is exercised. Whereas, the contractual term of the stock option is the term an option is valid before it expires.
- *Expected dividend yield*. Since issuing dividends will affect the fair value of a stock option, GAAP requires companies to estimate future dividend yields or payments. The Company has not historically issued dividends and does not intend to issue dividends in the future. As a result, the Company does not apply a dividend yield component to its valuation.

The following table sets forth the assumptions used by the Company to estimate the fair value of options and SAR Awards granted in 2018 under the 2015 Omnibus Incentive Plan:

Expected volatility	60% - 65%
Risk-free interest rate	2.50% - 2.90%
Expected dividends	—
Average expected term (years)	10
Fair value of stock options granted	$8.48 - $9.44

The following table sets forth the assumptions used by the Company to estimate the fair value of options granted in 2016 and 2015 under the 2015 Omnibus Incentive Plan:

Expected volatility	29% - 43%
Risk-free interest rate	0.54% - 1.36%
Expected dividends	—
Average expected term (years)	2.56
Fair value of stock options granted	$2.64 - $5.74

The estimated fair value of options is amortized to expense on a straight-line basis over the options' vesting period.

Stock Option and Stock Appreciation Rights Activity

A summary of stock option and SAR Award activity for the years ended December 31, 2018, 2017, and 2016 follows:

	Options/ SARs	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (years)
Predecessor			
Outstanding at January 1, 2016	8,488	$ 20.03	3.0
Granted	7,779	17.99	1.6
Exercised	—		
Forfeited/Cancelled	—		
Outstanding at December 31, 2016	16,267	$ 19.05	1.8
Granted	—		
Exercised	(3,580)	15.36	
Forfeited/Cancelled	—		
Outstanding at August 31, 2017	12,687	$ 20.10	1.5
Successor			
Outstanding at September 1, 2017	12,687	$ 20.10	1.5
Granted	—		
Exercised	—		
Forfeited/Cancelled	—		
Outstanding at December 31, 2017	12,687	$ 20.10	1.2
Granted	700,000	12.90	10.0
Exercised	—		
Forfeited/Cancelled	(200,000)	$ 12.90	10.0
Outstanding at December 31, 2018 [(1)]	512,687	$ 13.03	9.8

[(1)] Of the outstanding options, 11,287 were exercisable as of December 31, 2018 (Successor).

Other information pertaining to equity-based compensation

At December 31, 2018 (Successor), unrecognized compensation cost related to unvested shares was approximately $18.6 million. Unrecognized compensation cost will be expensed annually based on the number of shares that vest during the year.

The Company records equity-based compensation expense to recognize the fair value of the restricted shares that vest and stock options granted. The Company recorded equity-based compensation expense of $9.3 million for the year ended December 31, 2018 (Successor), $1.9 million for the four months ended December 31, 2017 (Successor), $3.7 million for the eight months ended August 31, 2017 (Predecessor) and $2.0 million for the year ended December 31, 2016 (Predecessor).

12. Employee Benefit Plans

Surgery Partners 401(k) Plan

The Surgery Partners 401(k) Plan is a defined contribution plan whereby certain employees who have completed at least one month of service, including at least one hour of service during that period of time, are eligible to participate. Employees may enroll in the plan immediately upon completion of the minimum service requirement. The Surgery Partners 401(k) Plan allows eligible employees to make contributions of varying percentages or flat dollar amounts of their annual compensation, up to the maximum allowable amounts by the Internal Revenue Service ("IRS"). Eligible employees may or may not receive a match by the Company of their contributions. Employer contributions vest incrementally over a period of five years. The Company's contributions were $7.6 million for the year ended December 31, 2018 (Successor), $2.3 million for the four months ended December 31, 2017 (Successor), $2.8 million for the eight months ended August 31, 2017 (Predecessor) and $5.1 million for the year ended December 31, 2016 (Predecessor).

Supplemental Executive Retirement Savings Plan

In connection with the Symbion acquisition, the Company acquired and continues to maintain a supplemental executive retirement savings plan (the "SERP") for certain former executives of a prior business combination. The SERP provides supplemental retirement savings alternatives to eligible officers and key employees of the Company by allowing participants to defer portions of their compensation. Under

the SERP, eligible employees may enroll in the plan before December 31 to be entered in the plan the following year. Eligible employees may defer into the SERP up to 25% of their normal period payroll and up to 50% of their annual bonus. If the enrolled employee contributes a minimum of 2% of his or her base salary into the SERP, the Company will contribute 2% of the enrolled employee's base salary to the plan and has the option of contributing additional amounts. Periodically, the enrolled employee's deferred amounts are transferred to a plan administrator. The plan administrator maintains separate non-qualified accounts for each enrolled employee to track deferred amounts. On May 1 of each year, the Company is required to make its contribution to each enrolled employee's account. See Note 1. "Organization and Summary of Accounting Policies" for information about the fair value of the assets and liabilities in the SERP.

13. Other Current and Long-Term Liabilities

Other Current Liabilities

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

	Successor	
	December 31, 2018	**December 31, 2017**
Interest payable	$ 20,755	$ 20,537
Amounts due to patients and payors	20,053	18,096
Accrued legal settlement	42,342	—
Accrued expenses and other	72,093	71,311
Total	$ 155,243	$ 109,944

Other Long-Term Liabilities

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

	Successor	
	December 31, 2018	**December 31, 2017**
Facility lease obligations	$ 149,811	$ 121,627
Other	121,376	100,853
Total	$ 271,187	$ 222,480

At four of the Company's surgical facilities, the Company has financing obligations payable to the lessors of certain land, buildings and improvements. Payments are allocated to principal adjustments of the financing obligations and interest expense. The current portions of the financing obligations were $7.0 million and $6.3 million at December 31, 2018 (Successor) and 2017 (Predecessor), respectively, and were included in other current liabilities in the consolidated balance sheets. The long-term portions of the financing obligations are included as facility lease obligations in the table above.

In 2017, one of the Company's surgical facilities entered into a development agreement to construct a new hospital. Due to certain provisions of the agreement, the surgical facility is deemed the owner during construction, and as such, the Company records the ongoing costs as incurred as a deferred financing obligation. As of December 31, 2018 (Successor), the Company recorded a total of $50.2 million of costs for this project, of which $36.6 million and $13.6 million were recorded during the years ended December 31, 2018 (Successor) and 2017 (Successor), respectively. These project costs are included as non-cash additions to property and equipment, net in the consolidated balance sheet and as a component of facility lease obligations.

14. Commitments and Contingencies

Professional and General 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. The Company maintains general liability and professional liability insurance in excess of self-insured retentions, on a claims-made basis through third party commercial insurance carriers. Although management believes the coverage is sufficient for the Company's operations, some claims may potentially exceed the scope of coverage in effect. The Company also maintains workers' compensation insurance, subject to a deductible. Plaintiffs in these matters may request punitive or other damages that may not be covered by insurance.

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.

On October 23, 2017, the Company received several civil investigative demands ("CIDs") from the federal government under the False Claims Act ("FCA") for documents and information dating back to January 1, 2010 relating to the medical necessity of certain drug tests conducted by the Company's physicians and submitted to laboratories owned and operated by the Company. In addition, the Company has been informed by CMS that payments to its diagnostic laboratory, Logan Laboratories, have been suspended pending further investigation by CMS. The Company has been providing information to the government in response to the CIDs and currently has a non-binding agreement in principle with the DOJ on the financial terms of a settlement with the goal of resolving these matters. Based on those discussions, which are still ongoing, The Company recorded a litigation-related charge of $46.0 million relating to these matters on the consolidated statements of operations. The Company believes that this reserve is sufficient to cover a potential resolution with the government relating to these matters, including legal expenses relating to the settlement that have not previously been recorded in operating expenses. The ultimate timing, amount and/or final terms of any such resolution may differ materially from those anticipated or the Company may not be able to reach a resolution at all. It is reasonably possible that the Company will incur additional losses above the amount reserved, but the Company is not able to estimate such amounts at this time. See Item 1A "Risk Factors" included elsewhere in this report under the heading "Risk Factors - Risks Related to Government Regulation - *Companies within the healthcare industry, including us, continue to be the subject of federal and state audits and investigations, including actions for false and other improper claims*."

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.

Tax Receivable Agreement

On May 9, 2017, the Company entered into an agreement to amend that certain Income Tax Receivable Agreement, dated September 30, 2015 (as amended, the "TRA"), by and between the Company, and the other parties referred to therein, which amendment became effective on August 31, 2017. Pursuant to the amendment to the TRA, the Company agreed to make payments to H.I.G., the Company's former controlling shareholder, in its capacity as the stockholders representative pursuant to a fixed payment schedule. The amounts payable under the TRA are calculated as the product of (i) an annual base amount and (ii) the maximum corporate federal income tax rate for the applicable year plus three percent. The amounts payable under the TRA are related to the Company's projected realized tax savings over the next six years and are not dependent on the Company's actual tax savings over such period. The calculation of amounts payable pursuant to the TRA is thus dependent on the maximum corporate federal income tax rate. To the extent that the Company is 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 September 30, 2015, 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 the Company to be unable to make payments under the TRA and such terms are not materially more restrictive than those existing as of September 30, 2015, such payments will be deferred and will accrue interest at a rate of LIBOR plus 300 basis points until paid.

As a result of the amendment to the TRA, the Company was required to value the liability under the TRA by discounting the fixed payment schedule using the Company's incremental borrowing rate. During the eight months ended August 31, 2017 (Predecessor), the Company recognized a reduction in the carrying value of the liability under the TRA of $43.9 million, with $15.3 million of the reduction recorded to a gain on amendment of TRA and $28.6 million recorded as a reduction to the goodwill recorded in connection with the application of pushdown accounting related to the change of control. As a result of the reduction in the corporate tax rate from the Tax Cuts and Jobs Act, the Company remeasured the value of the liability under the TRA pursuant to the calculation terms as described above. During the four months ended December 31, 2017 (Successor), the Company recognized a reduction in the carrying value of the liability under the TRA of $25.3 million, included as a tax receivable agreement benefit in the consolidated statement of operations.

Assuming the Company's tax rate is 24%, calculated as the maximum corporate federal tax rate plus three percent, throughout the remaining term of the TRA, the Company estimates the total remaining amounts payable under the TRA was approximately $64.6 million and $65.1 million as of December 31, 2018 (Successor) and 2017 (Successor), respectively. The carrying value of the liability under the TRA, reflecting the discount as discussed above, was $48.5 million and $44.3 million as of December 31, 2018 (Successor) and 2017 (Successor), respectively. The current portion of the liability was $7.6 million and $0.5 million as of December 31, 2018 (Successor) and 2017 (Successor), respectively, and is included as a component of other current liabilities in the consolidated balance sheet. The long-term portion is included as a component of other long-term liabilities in the consolidate balance sheet.

Contingent Consideration

In connection with certain prior period acquisitions, pursuant to the applicable purchase agreements, the Company was required to pay consideration to the prior owners of the applicable facilities should the requirements for continuing employment agreed to in the purchase agreements be met. In accordance with Accounting Standards Codification 805, Business Combinations, contingent consideration with a continuing employment provision is recognized ratably over the defined performance period as compensation expense. The Company recognized contingent acquisition compensation expense of $1.5 million for the year ended December 31, 2018 (Successor), $1.9 million for the four months ended December 31, 2017 (Successor) and $5.1 million for both the eight months ended August 31, 2017 (Predecessor) and the year ended December 31, 2016 (Predecessor). The Company recorded the expense as a component of general and administrative expenses in the consolidated statement of operations. The Company has no further contingent acquisition compensation expense obligations.

Other

In connection with the Company's integration of the corporate office functions related to the acquisition of NSH, the Company closed its Chicago, Illinois office on September 30, 2018 (Successor). As a result, the Company recognized a cease-use liability of $1.4 million, representing the estimated costs that will continue to be incurred under the office lease for its remaining term. The estimated costs were included as transaction and integration costs in the consolidated statement of operations for the year ended December 31, 2018 (Successor) and as a component of other current liabilities and other long-term liabilities in the consolidated balance sheet as of December 31, 2018 (Successor). In 2018 (Successor), the Company recognized a liability of $4.5 million for estimated severance costs in connection with the corporate office integration. The estimated costs were included as transaction and integration costs in the consolidated statement of operations for the year ended December 31, 2018 (Successor) and the unpaid severance was included as a component of accrued payroll and benefits in the consolidated balance sheet as of December 31, 2018 (Successor).

15. Segment Reporting

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 ancillary services and the operation of optical services. The surgical facility services segment consists of the operation of ASCs and surgical hospitals, and includes anesthesia services. The ancillary services segment consists of a diagnostic laboratory and multi-specialty physician practices. The optical services segment consists of an optical products group purchasing organization, and until October 2018, an optical laboratory that manufactured eyewear.

"All other" primarily consists of the Company's corporate general and administrative functions. Prior to 2017, the all other component was disaggregated and presented below the reportable operating segments in the Adjusted EBITDA reconciliation table. The Company has conformed the prior periods to align to the current year presentation. These changes had no effect on the Company's reportable operating segments, which are presented consistent with prior periods.

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

	Successor		*Predecessor*	
	Year Ended December 31,	September 1 to December 31,	January 1 to August 31,	Year Ended December 31,
	2018	2017	2017	2016
Revenues:				
Surgical facility services	$ 1,682,278	$ 564,458	$ 688,725	$ 1,042,097
Ancillary services	79,633	24,660	52,261	90,836
Optical services	9,545	3,486	7,629	12,505
Total	$ 1,771,456	$ 592,604	$ 748,615	$ 1,145,438
Adjusted EBITDA:				
Surgical facility services	$ 309,513	$ 103,760	$ 125,912	$ 214,218
Ancillary services	3,008	(2,255)	(6,526)	12,685
Optical services	2,500	736	2,214	3,308
All other	(80,253)	(23,504)	(36,036)	(50,948)
Total	$ 234,768	$ 78,737	$ 85,564	$ 179,263
Cash purchases of property and equipment, net:				
Surgical facility services	$ 34,178	$ 9,334	$ 14,582	$ 29,157
Ancillary services	419	191	1,875	5,388
Optical services	46	83	73	351
All other	5,162	1,219	2,243	4,213
Total	$ 39,805	$ 10,827	$ 18,773	$ 39,109

A reconciliation of Adjusted EBITDA to income before income taxes included in the condensed consolidated statement of operations is as follows:

	Successor		Predecessor	
	Year Ended December 31, 2018	September 1 to December 31, 2017	January 1 to August 31, 2017	Year Ended December 31, 2016
Adjusted EBITDA	$ 234,768	$ 78,737	$ 85,564	$ 179,263
Net income attributable to non-controlling interests	110,080	39,634	42,087	75,630
Depreciation and amortization	(67,440)	(21,804)	(30,124)	(39,551)
Interest expense, net	(147,003)	(48,740)	(68,929)	(100,571)
Equity-based compensation	(9,344)	(1,887)	(3,697)	(2,021)
Contingent acquisition compensation expense	(1,510)	(1,982)	(5,057)	(5,092)
Transaction, integration and acquisition costs [1]	(33,856)	(9,330)	(7,677)	(11,617)
Gain on litigation settlement	(46,009)	8,740	3,794	14,101
Gain on acquisition escrow release	—	167	1,000	—
Loss on disposals and deconsolidations, net	(31,822)	(5)	(1,715)	(2,355)
Reserve adjustments [2]	(2,670)	—	—	—
Impairment charges	(74,359)	—	—	—
Gain on amendment to tax receivable agreement	—	1,098	15,294	—
Tax receivable agreement benefit (expense)	—	25,329	—	(3,733)
Loss on debt refinancing	—	—	(18,211)	(11,876)
(Loss) income before income taxes	$ (69,165)	$ 69,957	$ 12,329	$ 92,178

[1] This amount includes transaction and integration costs of $31.7 million for the year ended December 31, 2018 (Successor), $7.5 million for the four months ended December 31, 2017 (Successor), $5.6 million for the eight months ended August 31, 2017 (Predecessor), and $8.7 million for the year ended December 31, 2016 (Predecessor). This amount includes practice acquisition costs of $2.2 million for the year ended December 31, 2018 (Successor), $1.8 million for the four months ended December 31, 2017 (Successor), $2.1 million for the eight months ended August 31, 2017 (Predecessor), and $2.9 million for the year ended December 31, 2016 (Predecessor).

[2] This amount represents adjustments to revenue in connection with applying consistent policies across the combined company as a result of the integration of Surgery Partners and NSH.

	Successor	
	December 31, 2018	December 31, 2017
Assets:		
Surgical facility services	$ 4,204,344	$ 4,072,521
Ancillary services	52,733	104,274
Optical services	20,084	48,309
All other	399,106	397,669
Total assets	$ 4,676,267	$ 4,622,773

16. Quarterly Financial Information (Unaudited)

The following tables include a summary of certain information related to the Company's quarterly consolidated results of operations for each of the four quarters in the years ended December 31, 2018 and 2017. The timing of acquisitions and divestitures completed during the years presented affects the comparability of the quarterly financial information. The following should be read in conjunction with the audited consolidated financial statements included herein. The amounts are as follows (in thousands except per share amounts):

	2018			
	Successor			
	Q1	Q2	Q3	Q4
Revenues [1]	$ 411,332	$ 436,579	$ 432,377	$ 491,168
Cost of revenues	$ 327,312	$ 340,090	$ 334,289	$ 359,740
Net income (loss)	$ 5,125	$ 4,310	$ 2,019	$ (107,080)
Net income attributable to non-controlling interests	$ (22,646)	$ (23,772)	$ (23,000)	$ (40,662)
Net loss attributable to Surgery Partners, Inc.	$ (17,521)	$ (19,462)	$ (20,981)	$ (147,742)
Basic net loss per share attributable to common stockholders	$ (0.53)	$ (0.57)	$ (0.61)	$ (3.25)
Diluted net loss per share attributable to common stockholders	$ (0.53)	$ (0.57)	$ (0.61)	$ (3.25)

[1] Quarterly information herein reflects changes related to adoption of ASU 2014-09 as discussed in Note 1. "Organization and Summary of Accounting Policies.

	2017				
	Predecessor			*Successor*	
	Q1	Q2	Q3[2]	Q3[2]	Q4
Revenues	$ 286,183	$ 288,353	$ 174,079	$ 132,258	$ 460,346
Cost of revenues	$ 211,948	$ 216,452	$ 143,772	$ 102,924	$ 338,704
Net income (loss)	$ 14,422	$ 11,627	$ 4,369	$ (2,648)	$ 966
Net income attributable to non-controlling interests	$ (17,176)	$ (16,098)	$ (8,813)	$ (6,492)	$ (33,142)
Net loss attributable to Surgery Partners, Inc.	$ (2,754)	$ (4,471)	$ (4,444)	$ (9,140)	$ (32,176)
Basic net loss per share attributable to common stockholders [3]	$ (0.06)	$ (0.09)	$ (0.09)	$ (0.57)	$ (0.83)
Diluted net loss per share attributable to common stockholders [3]	$ (0.06)	$ (0.09)	$ (0.09)	$ (0.57)	$ (0.83)

[2] The Predecessor period for Q3 includes the two months ended August 31, 2017. The Successor period for Q3 includes the one month ended September 30, 2017.

[3] Beginning in the Successor period, per share amounts include the impact of amounts allocated to participating securities. Refer to Note 9. "Earnings Per Share" for further discussion.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

SURGERY PARTNERS, INC.

By: /s/ Wayne S. DeVeydt
Wayne S. DeVeydt
Chief Executive Officer
(Principal Executive Officer)

Date: March 15, 2019

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

SIGNATURES	TITLE	DATE
/s/ Wayne S. DeVeydt Wayne S. DeVeydt	Chief Executive Officer, Director (Principal Executive Officer)	March 15, 2019
/s/ Thomas F. Cowhey Thomas F. Cowhey	Executive Vice President and Chief Financial Officer (Principal Financial and Accounting Officer)	March 15, 2019
/s/ T. Devin O'Reilly T. Devin O'Reilly	Chairman, Director	March 15, 2019
/s/ Teresa DeLuca Teresa DeLuca	Director	March 15, 2019
/s/ Adam Feinstein Adam Feinstein	Director	March 15, 2019
/s/ Brent Turner Brent Turner	Director	March 15, 2019
/s/ Andrew Kaplan Andrew Kaplan	Director	March 15, 2019
/s/ Clifford G. Adlerz Clifford G. Adlerz	Director	March 15, 2019