# 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, 2005**

**OR**

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

**For the transition period from _____ to _____**

**Commission file number: 000-50574**

# Symbion, Inc.
(Exact Name of Registrant as Specified in its Charter)

| **Delaware** | **62-1625480** |
|---|---|
| (State or Other Jurisdiction of Incorporation or Organization) | (I.R.S. Employer Identification No.) |
| **40 Burton Hills Boulevard, Suite 500 Nashville, Tennessee** (Address Of Principal Executive Offices) | **37215** (Zip Code) |

**(615) 234-5900**
(Registrant's Telephone Number, Including Area Code)

Securities registered pursuant to Section 12(b) of the Act: **None**

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

| **Common Stock, $.01 par value** | **Preferred Stock Purchase Rights** |
|---|---|
| (Title of Class) | (Title of Class) |

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐ Accelerated filer ☑ Non-accelerated filer ☐

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 shares of the registrant's common stock (based upon the closing price of these shares on the Nasdaq National Market on June 30, 2005) held by non-affiliates as of June 30, 2005, was approximately $399,298,751.

As of February 28, 2006, 21,450,170 shares of the registrant's common stock were outstanding.

**DOCUMENTS INCORPORATED BY REFERENCE**

Portions of the definitive proxy statement for our annual meeting of stockholders to be held on May 9, 2006 are incorporated by reference into Part III of this report.

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## Cautionary Note Regarding Forward-Looking Statements

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

- our ability to attract and maintain good relationships with physicians who use our facilities;
- our ability to acquire and develop additional facilities on favorable terms and to integrate their business operations;
- our ability to enter into strategic alliances with health care systems and other health care providers that are leaders in their markets;
- our ability to negotiate favorable contracts on behalf of our facilities with managed care organizations or other third-party payors; and
- our ability to enhance operating efficiencies.

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

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

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

# PART I

## Item 1. *Business*

### Overview

We own and operate a network of surgery centers in 22 states. Our surgery centers provide non-emergency surgical procedures across many specialties. We offer services designed to meet the health care needs of the communities in which we operate and seek to develop strong relationships with physicians and other health care providers in these markets. We believe that one of our competitive advantages is the experience of our senior management team, with four of our executive officers having an average of over 25 years of experience in the health care industry, including senior management positions at public and private health care companies. The remaining six members of our senior management team have an average of over 20 years of experience in the health care industry. As of March 10, 2006, we owned and operated 52 surgery centers and managed nine additional surgery centers. Our surgery centers include three facilities that are licensed as hospitals, two of which we own and one of which we manage. In addition to our surgery centers, we also operate one diagnostic center and manage three physician networks, including two physician networks in markets in which we operate surgery centers.

On September 16, 2002, we reincorporated in Delaware. We were originally incorporated in Tennessee in January 1996 under the name UniPhy Healthcare, Inc. and focused on the development and management of physician networks. On June 25, 1999, we acquired Ambulatory Resource Centres, Inc., an owner and operator of surgery centers, and changed our name to Symbion, Inc. Since our acquisition of Ambulatory Resource Centres, we have focused on developing, acquiring and managing surgery centers, and have grown our operations from 14 to 61 surgery centers. Since acquiring Ambulatory Resource Centres, we have terminated all but three of our management agreements with physician networks and transferred our assets and liabilities relating to those terminated agreements to the physician networks in exchange for cash and our previously issued securities. We also modified our agreements with two of the remaining physician networks to require us to provide only management services. As a result of these actions, we now focus our business on developing, acquiring and managing surgery centers and it may be difficult to compare our historical operating results from period to period.

**Surgery Center Industry**

Outpatient surgery has experienced tremendous growth since 1970, when the first surgery center opened in the United States, according to the Federated Ambulatory Surgery Association ("FASA"), a nonprofit association representing the interests of ambulatory surgery centers. Surgery centers are facilities where physicians can perform surgical procedures that generally do not require the patient to stay overnight. According to FASA, about 4,300 Medicare-certified outpatient surgery centers were operating in the United States as of May 2005.

We believe that the following factors have contributed to the growth in surgery centers and outpatient surgical procedures:

- *Physician and Patient Preference for Surgery Centers.* Physicians often prefer to operate in surgery centers, as compared to acute care hospitals, because of the efficiency and convenience that surgery centers afford. Procedures performed at surgery centers are typically non-emergency, so physicians can schedule their time more efficiently and increase the number of procedures that they can perform in a given period. Surgery centers also provide physicians with greater scheduling flexibility, more consistent nurse staffing and faster turnaround time between cases, as compared to acute care hospitals. In addition, we believe patients prefer the comfort of a less institutional setting and the more convenient process for scheduling and registration available in surgery centers, as compared to acute care hospitals.

- *Lower Cost Alternative.* Based upon our management's experience in the health care industry, we believe that surgeries performed in surgery centers are generally less expensive than those performed in acute care hospitals because of lower facility development costs, the focus on non-emergency procedures and more efficient staffing and work flow processes. We believe that cost-conscious payors are attracted to the lower costs afforded by surgery centers, as compared to acute care hospitals.

- *Advanced Technology and Improved Anesthesia.* Advancements in medical technology such as lasers, arthroscopy, fiber optics and enhanced endoscopic techniques have reduced the trauma of surgery and the amount of recovery time required by patients following a surgical procedure. Improvements in anesthesia also have shortened the recovery time for many patients and have reduced post-operative side effects such as pain, nausea and drowsiness. These medical advancements have enabled more patients to undergo surgery without an overnight stay and reduced the need for hospitalization following surgery.

With an estimated 4,300 Medicare-certified outpatient surgery centers operating in the United States as of May 2005, we believe significant opportunities exist for consolidation in this industry. The five largest national operators of outpatient surgery centers by number of centers represented an aggregate of less than 11% of the total number of outpatient surgery centers in the United States as of August 2005, according to Verispan, L.L.C., an independent health care market research and information firm. We believe that the surgery center industry will continue to consolidate because of the increasing complexity of the regulatory and managerial aspects of health care delivery, the growing influence of managed care, the rising cost of technology and the need for capital. We believe there are many surgery center owners that are seeking to affiliate with experienced operators of facilities with access to capital, management expertise and other resources.

## Our Strategy

We intend to expand our network of surgery centers in attractive markets throughout the United States by acquiring established centers and developing new centers while enhancing the performance of our existing centers. We also seek to provide patients with high-quality surgical services across many specialties. When attractive opportunities arise, we may acquire or develop other types of facilities, including diagnostic centers. The key components of our strategy are to:

- *Identify, recruit and retain leading surgeons and other physicians for our surgery centers.* We believe that establishing and maintaining strong relationships with surgeons and other physicians is a key factor to our success in acquiring, developing and operating surgery centers. We identify and partner with surgeons and other physicians that we believe have established reputations for clinical excellence in their communities. We believe that we have had success in recruiting and retaining physicians because of the ownership structure of our surgery centers and our staffing, scheduling and clinical systems that are designed to increase physician productivity, promote physicians' professional success and enhance the quality of patient care. We also believe that forming relationships with health care systems and other health care providers can enhance our ability to recruit physicians. We currently have strategic relationships with six health care systems.

- *Capitalize on our experienced management team to pursue multiple growth opportunities in the surgery center market.* We believe that the experience and capabilities of our senior management team provide a strategic advantage in improving the operations of our surgery centers, attracting physicians and identifying new development and acquisition opportunities. Four of our executive officers have an average of over 25 years of experience in the health care industry, including senior management positions at public and private health care companies. The remaining six members of our senior management team have an average of over 20 years of experience in the health care industry. Our management's broad industry experience has allowed it to establish strong relationships with participants throughout the health care industry. These relationships are helpful in forming leads for acquisitions, and in making decisions about expanding into new markets and services. The experience and capabilities of our management team also enable us to pursue multiple growth strategies in the surgery center market, including acquisitions of established surgery centers, de novo developments in attractive markets, strategic relationships with prominent hospitals and other health care providers and turnaround opportunities in connection with underperforming facilities. We have successfully executed each of these growth strategies, and intend to pursue each of them in the future.

- *Pursue a disciplined strategy of acquiring and developing surgery centers.* Since January 1999, we have acquired 41 surgery centers and developed 16 surgery centers, including five surgery centers that we subsequently divested. We anticipate acquiring about three to four centers and developing three to four centers annually during the next three to five years. We seek to acquire and develop both single and multi-specialty surgery centers that meet our criteria, including prominence and quality of physician partners, specialty mix, opportunities for growth, level of competition in the local market, level of managed care penetration and our ability to access managed care organization contracts. Our acquisition and development team conducts extensive due diligence and applies a financial model that targets a threshold return on invested capital over a period of five years. Once we acquire a surgery center, our team establishes a strategic plan to improve the center's operating systems, physician recruitment, facilities, and capitalize on the center's competitive strengths. We have historically targeted majority ownership in our facilities and currently hold majority ownership interests in 67% of the surgery centers in which we own an interest. Majority ownership allows us to make and execute managerial decisions which we believe provides greater opportunity for growth and higher returns. We also believe that by starting with majority ownership of a center, we can benefit by capturing a greater share of the value we create in managing and improving the center. We intend to continue to target majority ownership in our facilities. However, when attractive opportunities arise, we may acquire minority interests in surgery centers. When appropriate, we also may reduce our interest in majority owned surgery centers.

- *Increase revenues and profitability of existing surgery centers through operational focus.* We seek to increase revenues, profitability and return on our invested capital at all of our centers by focusing on operations. We have a dedicated team that is responsible for implementing best practices, cost controls and overall efficiencies at each of our surgery centers. Our centers benefit from our network of facilities by

sharing best practices and participating in group purchasing agreements designed to reduce the cost of supplies and equipment. We intend to continue to recruit additional physicians and expand the range of services offered at our surgery centers to increase the number and types of surgeries performed in our centers. We are committed to enhancing programs and services for our physicians and patients by providing advanced technology, quality care, cost-effective service and convenience.

## Operations

### *Surgery Center Operations*

As of March 10, 2006, we owned and operated 52 surgery centers and managed nine additional surgery centers. Three of our facilities are licensed as hospitals, two of which we own and one of which we manage. Our typical surgery center is a freestanding facility with about 14,000 square feet of space and four fully equipped operating rooms, two treatment rooms and ancillary areas for preparation, recovery, reception and administration. Our surgery centers provide non-emergency surgical procedures among many specialties, including orthopedic, gynecology, general surgery, ear, nose and throat, pain management, gastrointestinal, plastic surgery and ophthalmology. Our facilities that are licensed as hospitals may also provide additional services such as diagnostic imaging, pharmacy, laboratory and obstetrical services. In certain markets where we believe it is appropriate, we operate surgery centers that focus on a single specialty.

Our surgery centers are generally located in close proximity to physicians' offices. Each facility typically employs a staff of about 30, depending on its size, the number of cases and the type of services provided. Our staff at each center generally includes a center administrator, a business manager, a medical director, registered nurses, operating room technicians and clerical workers. At each of our surgery centers, we have arrangements with anesthesiologists to provide anesthesiology services. We also provide each of our surgery centers 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 centers in developing relationships with managed care providers and negotiating managed care contracts.

All of our surgery centers are Medicare certified. To ensure that a high level of care is provided, we implement quality assurance procedures at each of our surgery centers. Each of our surgery centers is available for use only by licensed physicians who have met professional credentialing requirements established by the center's medical advisory committee. In addition, each center's medical director supervises and is responsible for the quality of medical care provided at the center.

### *Surgery Center Ownership Structure*

We own and operate our surgery centers through partnerships or limited liability companies. Local physicians or physician groups also own an interest in most of our surgery centers. In some cases, a hospital system may own an interest in our surgery center. One of our wholly-owned subsidiaries typically serves as the general partner or majority member of our surgery centers. We generally own a majority interest in our surgery centers, or otherwise have sufficient control over the centers to be able to consolidate the financial results of operations of the centers with ours. In some instances, we will acquire an ownership interest in a surgery center with the prior owners retaining an ownership interest, and, in some cases, we offer new ownership interests to other physicians or hospital partners. We own a majority interest in 35 of the 52 surgery centers in which we own an interest. We typically guarantee all of the debts of these partnerships and limited liability companies, even though we do not own all of the ownership interests in the surgery centers. We also have a management agreement with each of the surgery centers, under which we provide day-to-day management services for a management fee, which is typically based on a percentage of the revenues of the center.

Each of the partnerships and limited liability companies through which we own and operate our surgery centers is governed by a partnership or operating agreement. These partnership and operating agreements typically provide, among other things, for voting rights and limited transfer of ownership interests. The partnership and operating agreements also provide for the distribution of available cash to the owners. In addition, the agreements typically restrict the physician owners from owning an interest in a competing surgery center during the period in which the physician owns an interest in our center and for one year after that period. The partnership and operating agreements

for our centers typically provide that the centers will purchase all of the physicians' ownership interests if certain adverse regulatory events occur, such as it becoming illegal for the physicians to own an interest in a surgery center, refer patients to a center or receive cash distributions from a surgery center. The purchase price that we would be required to pay for these ownership interests is based on pre-determined formulas, typically either a multiple of the center's EBITDA, as defined in our partnership and operating agreements, or the fair market value of the ownership interests as determined by a third-party appraisal. Some of these agreements require us to make a good faith effort to restructure our relationships with the physician investors in a manner that preserves the economic terms of the relationship prior to purchasing these interests. See Item 1A. "Risk Factors" and "— Government Regulation." In certain circumstances, we have the right to purchase a physician's ownership interests, including upon a physician's breach of the noncompetition provisions of a partnership or operating agreement. In some cases, we have the right to require the physician owners to purchase our ownership interest in the event our management agreement with a center is terminated. In one center, the physician owners have the right to purchase our ownership interest upon a change in our control.

We currently manage seven surgery centers without owning an interest in them through a strategic alliance with a hospital system located in the Memphis, Tennessee area. We also manage a surgery center licensed as a hospital located in Kansas City, Kansas in which we have no ownership interest. In addition, we own an interest in a limited liability company which assisted in the development of a surgery center in Lynbrook, New York and which provides administrative services to the surgery center.

*Surgery Centers*

The following table sets forth information regarding each of our surgery centers as of March 10, 2006:

| Facility | City | Number of Operating Rooms | Number of Treatment Rooms | Symbion Percentage Ownership |
|---|---|---|---|---|
| **Alabama** | | | | |
| Birmingham Endoscopy Center | Birmingham | 3 | 3 | 80%(1) |
| North River Surgical Center | Tuscaloosa | 2 | 2 procedure rooms | 80%(1) |
| **California** | | | | |
| Specialty Surgical Center of Beverly Hills/Brighton Way | Beverly Hills | 3 | 1 minor procedure room | 55%(1) |
| Specialty Surgical Center of Beverly Hills/Wilshire Boulevard | Beverly Hills | 4 | 2 minor procedure rooms | 55%(1) |
| Specialty Surgical Center of Encino | Encino | 4 | 2 minor procedure rooms | 54%(1) |
| Specialty Surgical Center of Irvine | Irvine | 4 | 1 minor procedure room | 21% |
| Specialty Surgical Center of Arcadia | Arcadia | 3 | 1 minor procedure room | 19% |
| **Colorado** | | | | |
| Dry Creek Surgery Center | Denver | 6 | 2 | 51%(1) |
| **Florida** | | | | |
| Deland Surgery Center | Deland | 3 | 2 | 79%(1) |
| West Bay Surgery Center | Largo | 4 | 4 | 51%(1) |
| Jacksonville Beach Surgery Center | Jacksonville | 4 | 1 | 81%(1) |
| Cape Coral Ambulatory Surgery Center | Cape Coral | 5 | 2 | 10% |
| Lee Island Coast Surgery Center | Fort Myers | 5 | 3 | 50%(1) |
| Orlando Surgery Center | Orlando | 5 | 1 minor procedure room | 66%(1) |
| Tampa Bay Regional Surgery Center | Largo | 1 | 2 | 51%(1) |
| The Surgery Center of Ocala | Ocala | 4 | 2 | 51%(1) |
| **Georgia** | | | | |
| Premier Surgery Center | Brunswick | 3 | 1 | 58%(1) |
| Atlanta Center for Reconstructive Foot and Ankle Surgery Center | Sandy Springs | 2 | — | 53%(1) |
| Roswell Center for Foot and Ankle Surgery Center | Roswell | 2 | — | 23% |
| Savannah Outpatient Foot and Ankle Surgery Center | Savannah | 2 | — | 80%(1) |
| The Surgery Center | Columbus | 4 | 2 | 68%(1) |
| **Illinois** | | | | |
| Valley Ambulatory Surgery Center | St. Charles | 6 | 1 minor procedure room | 40%(1) |
| **Indiana** | | | | |
| Vincennes Surgery Center | Vincennes | 3 | 1 minor procedure room | 51%(1) |
| New Albany Outpatient Surgery | New Albany | 3 | 1 | 70%(1) |
| **Kansas** | | | | |
| Heartland Specialty Surgical Hospital(2) | Kansas City | 7 | 3<br>19 hospital rooms | —(3) |
| Cypress Surgery Center | Wichita | 6 | 2 procedure rooms | 54%(1) |
| **Kentucky** | | | | |
| DuPont Surgery Center | Louisville | 5 | — | 61%(1) |
| **Louisiana** | | | | |
| Greater New Orleans Surgery Center | Metairie | 2 | — | 30%(1) |
| Physicians Surgical Specialty Hospital(2) | Houma | 5 | 3<br>10 hospital rooms<br>2 procedure rooms | 57%(1) |
| Surgery Center of Hammond | Hammond | 4 | 1 cysto room | 87%(1) |
| **Massachusetts** | | | | |
| Worcester Surgery Center | Worcester | 4 | 1 minor procedure room | 77%(1) |

| | | | | |
|---|---|---|---|---|
| Worcester ENT | Worcester | 1 | — | 51%(1) |

| Facility | City | Number of Operating Rooms | Number of Treatment Rooms | Symbion Percentage Ownership |
|---|---|---|---|---|
| **Missouri** | | | | |
| Central Missouri Medical Park Surgical Center | Jefferson City | 4 | 2 | 40%(1) |
| The Surgery Center of Kirkwood | Kirkwood | 3 | 1 minor procedure room | 50%(1) |
| **Mississippi** | | | | |
| Desoto Surgery Center | Desoto | 2 | 1 procedure room | —(3) |
| Physicians Outpatient Center | Oxford | 4 | 2 | —(3) |
| **New York** | | | | |
| South Shore Ambulatory Surgery Center | Lynbrook | 4 | 1 | —(4) |
| **North Carolina** | | | | |
| Orthopaedic Surgery Center of Asheville | Asheville | 3 | — | 61%(1) |
| Wilmington SurgCare | Wilmington | 7 | 3 minor procedure rooms | 87%(1) |
| **Ohio** | | | | |
| Physicians Ambulatory Surgery Center | Circleville | 2 | — | 61%(1) |
| Valley Surgical Center | Steubenville | 3 | 1 minor procedure room | 59%(1) |
| **Oklahoma** | | | | |
| Lakeside Women's Hospital(2) | Oklahoma City | 3 | 16 hospital rooms<br>1 procedure room | 42% |
| **Pennsylvania** | | | | |
| Village SurgiCenter | Erie | 5 | 1 | 73%(1) |
| **Rhode Island** | | | | |
| Bayside Endoscopy Center | Providence | — | 6 | 75%(1) |
| **Tennessee** | | | | |
| Baptist Germantown Surgery Center | Memphis | 6 | 1<br>3 overnight rooms | —(3) |
| Maury Regional Surgery Center | Columbia | 2 | 1 | 35% |
| Cool Springs Surgery Center | Franklin | 5 | 1<br>1 overnight room | 35% |
| East Memphis Surgery Center | Memphis | 6 | 1<br>4 overnight rooms | —(3) |
| Midtown Surgery Center | Memphis | 4 | — | —(3) |
| Southwind GI | Memphis | 1 | — | 100%(1) |
| Union City Center | Union City | 2 | 1 | —(3) |
| UroCenter | Memphis | 3 | 1 | —(3) |
| University Ambulatory Surgical Center | Knoxville | 6 | 1<br>2 overnight rooms | 25% |
| **Texas** | | | | |
| Central Park Surgery Center | Austin | 5 | 1<br>3 overnight rooms | 43%(1) |
| Clear Fork Surgery Center | Fort Worth | 3 | 1<br>4 overnight rooms | 33%(1) |
| East Houston Surgery Center | Houston | 4 | 2<br>1 overnight room | 47%(1) |
| Northeast Baptist Surgery Center | San Antonio | 4 | 3<br>1 overnight room | 49%(1) |
| NorthStar Surgical Center | Lubbock | 6 | 4<br>2 overnight rooms | 46%(1) |
| Surgery Center of Duncanville | Duncanville | 4 | 1<br>2 overnight rooms | 41%(1) |
| Texarkana Surgery Center | Texarkana | 4 | 3<br>2 overnight rooms | 66%(1) |
| **Washington** | | | | |
| Bellingham Surgery Center | Bellingham | 4 | — | 85%(1) |

(1) We consolidate these surgery centers for financial reporting purposes.

(2) This facility is licensed as a hospital.

(3) We manage these facilities, but do not have an ownership interest in them.

(4) We hold a 57% ownership interest in the limited liability company which provides administrative services to this surgery center. Due to regulatory restrictions in the State of New York, we cannot directly own an interest in the facility.

*Case Mix*

The following table sets forth the percentage of cases in each specialty performed in 2005 and 2004 at surgery centers in which we owned an interest as of December 31, 2005 and December 31, 2004:

| | Year Ended December 31, 2005 | Year Ended December 31, 2004 |
|---|---|---|
| **Specialty** | | |
| Ear, nose and throat | 7% | 8% |
| Gastrointestinal | 24 | 22 |
| General surgery | 5 | 5 |
| Obstetrics/gynecology | 3 | 3 |
| Ophthalmology | 12 | 13 |
| Orthopedic | 15 | 16 |
| Pain management | 15 | 16 |
| Plastic surgery | 4 | 4 |
| Other | 15 | 13 |
| Total | 100% | 100% |

*Case Growth*

The following table sets forth information from facilities in which we owned an interest and managed throughout the years ended December 31, 2005 and 2004, respectively:

| | Year Ended December 31, 2005 | Year Ended December 31, 2004 |
|---|---|---|
| Consolidated: | | |
| Cases | 171,592 | 166,886 |
| Cases growth | 2.8% | N/A |
| Net patient service revenue per case | $ 1,169 | $ 1,141 |
| Net patient service revenue per case growth | 2.5% | N/A |
| Number of same store surgery centers | 31 | N/A |
| | | |
| Consolidated centers and non-consolidated centers: | | |
| Cases | 196,239 | 189,467 |
| Cases growth | 3.6% | N/A |
| Net patient service revenue per case | $ 1,148 | $ 1,120 |
| Net patient service revenue per case growth | 2.5% | N/A |
| Number of same store surgery centers | 35 | N/A |

The following table sets forth information from facilities that we consolidate for financial reporting purposes (which includes surgery centers we have acquired or developed since January 1, 2004) for the years ended December 31, 2005 and 2004, respectively:

| | Year Ended December 31, 2005 | Year Ended December 31, 2004 |
|---|---|---|
| Cases | 209,429 | 176,483 |
| Cases growth | 18.7% | N/A |
| Net patient service revenue per case | $ 1,209 | $ 1,148 |
| Net patient service revenue per case growth | 5.3% | N/A |
| Number of surgery centers operated as of end of the period (1) | 59 | 54 |
| Number of consolidated surgery centers | 43 | 40 |

(1) Includes surgery centers that we manage but in which we do not have an ownership interest.

*Payor Mix*

The following table sets forth by type of payor the percentage of our patient service revenues generated in 2005 and 2004 for surgery centers in which we owned an interest as of December 31, 2005 and 2004:

| | Year Ended December 31, 2005 | Year Ended December 31, 2004 |
|---|---|---|
| **Payor** | | |
| Private Insurance | 76% | 76% |
| Government | 19 | 20 |
| Self-pay | 4 | 3 |
| Other | 1 | 1 |
| Total | 100% | 100% |

*Strategic Relationships*

When attractive opportunities arise, we may develop, acquire or operate surgery centers through strategic alliances with health care systems and other health care providers. We believe that forming a relationship with a health care system can enhance our ability to recruit physicians and access managed care contracts for our facilities in that market. We currently have strategic relationships with:

- Vanderbilt Health Services, Inc., with which we own and operate a surgery center in Franklin, Tennessee;
- Vanguard Health Systems, Inc., with which we own and operate a surgery center in San Antonio, Texas;
- Baptist Memorial Health Services, Inc., for which we manage seven surgery centers in Memphis, Tennessee and surrounding areas;
- University Health System, Inc., with which we own and operate a surgery center in Knoxville, Tennessee;
- Harris Methodist Ft. Worth, with which we own and operate a surgery center in Fort Worth, Texas; and
- Maury Regional Healthcare System, with which we own and operate a surgery center in Columbia, Tennessee.

The strategic relationships through which we own and operate surgery centers are governed by partnership and operating agreements that are generally comparable to the partnership and operating agreements of the other surgery centers in which we own an interest. The primary difference between the structure of these strategic relationships and the other surgery centers in which we own an interest is that, in the strategic relationships, a health care system holds an ownership interest in the surgery center, in addition to physician investors. For a general description of the

terms of our partnership and operating agreements, see "— Operations — Surgery Center Ownership Structure." In each of these strategic relationships, we have also entered into a management agreement under which we provide day-to-day management services for a management fee based on a percentage of the revenues of the surgery center. The terms of those management agreements are comparable to the terms of our management agreements with other surgery centers in which we own an interest.

We manage seven surgery centers owned by Baptist Memorial Health Services, Inc. ("Baptist Memorial") under management agreements with Baptist Memorial, in exchange for a management fee based on a percentage of the revenues of these surgery centers. The management agreements terminate on various dates from March 2006 to June 2008 and may be terminated earlier by either party for material breach after notice and an opportunity to cure. We have also entered into a development agreement with Baptist Memorial under which we are to provide development support for new surgery centers that may be developed by Baptist Memorial in exchange for a development fee negotiated for each developed center.

***Acquisition and Development of Surgery Centers***

We intend to expand our presence in the surgery center market by making strategic acquisitions of existing surgery centers and by developing new surgery centers in cooperation with local physician partners and, when appropriate, with hospital systems and other strategic partners.

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

We believe there are numerous acquisition opportunities that would pass our general screening criteria. We carefully evaluate each of our acquisition opportunities through an extensive due diligence process to determine which facilities have the greatest potential for growth and profitability improvements under our operating structure. In many cases, the acquisition team identifies specific opportunities to enhance a center's productivity post-acquisition. For example, we may renovate or construct additional operating or treatment rooms in existing facilities to meet anticipated demand for procedures based on analysis of local market characteristics. Our team may also identify opportunities to recruit additional physicians to increase the acquired facility's revenues and profitability. Once we decide to proceed with an acquisition proposal, we use a pricing strategy that targets a threshold return on invested capital over a period of five years. We have acquired 41 surgery centers since January 1999 and anticipate acquiring about three to four centers annually during the next three to five years.

*Development Program.* We develop surgery centers in markets in which we identify substantial interest by physicians and payors. We have experience in developing both single and multi-specialty surgery centers. When we develop a new surgery center, 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 facilities. Before and during the development phase of a new center, 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 center and identifying appropriate equipment to purchase or lease. After the surgery center is developed, we generally provide startup operational support, including information systems, equipment procurement and financing. We have developed 16 surgery centers since January 1999 and anticipate developing about three to four centers annually during the next three to five years.

Development and construction of a surgery center generally takes us from 12 to 18 months, depending on whether we are building the facility or improving available space. Estimated construction costs generally total from $1.0 million to $2.5 million for improving existing space. Equipment and other furnishing costs generally range from $1.0 million to $3.0 million. In addition, working capital of approximately $1.0 million to $1.5 million is generally required to sustain operations for the initial six to 12 months of operations. We historically financed these costs through capital contributions from investors in the center, borrowings under our facility loan agreements and

long-term facility lease agreements. We expect to finance these costs in the future with borrowings under our senior credit facility and capital contributions from investors in the centers. See "Management's Discussion and Analysis of Financial Condition and Results of Operations."

**Other Services**

Although our business is primarily focused on owning and operating surgery centers, we also provide other services that complement our core surgery center business.

***Diagnostic Centers***

We operate Dry Creek Imaging Center, a diagnostic imaging center that is adjacent to our surgery center in the Denver, Colorado market. We own a 90% interest in the diagnostic imaging center through a joint venture with Touchstone Medical Imaging, LLC. Dry Creek Imaging Center currently provides MRI, CT, ultrasound and mammography procedures. Touchstone and Dry Creek Imaging Center have entered into a management agreement, under which Touchstone provides daily management and administrative services to the diagnostic center in exchange for a percentage of the diagnostic center's net revenues. The initial term of the management agreement expires in 2006, and may be renewed for additional renewal terms of one year each. We believe the services provided by this diagnostic center complement and support the services provided by our surgery center in this market.

We may explore the possibility of selectively purchasing and developing additional diagnostic centers in the markets in which we operate surgery centers.

***Physician Networks***

We currently manage physician networks in Memphis, Tennessee, Johnson City, Tennessee and Louisville, Kentucky. Each of these physician networks has entered into an agreement with us, which provides, among other things, that we will provide billing, financial services and other business management services in exchange for a management fee. One of the physician networks is an independent practice association, or IPA, of health care providers located in the greater Louisville, Kentucky area (the "Louisville IPA"). Subsequent to December 31, 2005, the Louisville IPA informed us that it was dissolving its association. We believe the decreased revenue as a result of the dissolution of the Louisville IPA will be immaterial to our statement of operations and financial condition. Income before the provision for income taxes provided by the Louisville IPA was less than 1.1% for each of the years ended December 31, 2005 and 2004.

**Information Systems and Controls**

Each of our surgery centers uses a standard financial reporting system that provides information to our corporate office to track financial performance on a timely basis. In addition, each of our facilities uses an operating system to manage its business that provides critical support in areas such as scheduling, billing and collection, accounts receivable management, purchasing and other essential operational functions. We have implemented a standardized system to support all of our facilities and to enable us to access more easily information about our centers on a timely basis. The information system has been installed in all of our surgery centers, except for those facilities we acquired recently.

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

It is our policy to collect co-payments and deductibles prior to providing services. It is also our policy to verify a patient's insurance 72 hours prior to the patient's procedure. Because our services are non-emergency, our facilities

have the ability to control these processes. We do not track exceptions to these policies, but we believe that they occur infrequently and involve insignificant amounts. When they do occur, we require patients whose insurance coverage is not verified to assume full responsibility for the fees prior to services being rendered and we seek prompt payment of co-payments and deductibles and verification of insurance following the procedure.

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

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

**Marketing**

Our sales and marketing efforts are directed primarily at physicians, who are responsible for referring patients to our facilities. Marketing activities directed at physicians and other health care providers are coordinated locally by the individual facility and are supplemented by dedicated corporate personnel. These activities generally emphasize the benefits offered by our surgery centers compared to other facilities in the market, such as the proximity of our 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 surgery centers are important sources of recommendations to other physicians regarding the benefits of using our facilities. Each facility administrator develops a target list of physicians and we continually review these marketing lists and the facility administrator's progress in contacting and successfully attracting additional local physicians.

We also market our surgery centers directly to payors, such as HMOs, 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 facilities, and are focused on making each facility an approved provider under local managed care plans.

**Competition**

In each market in which we operate a surgery center, we compete with hospitals and operators of other surgery centers to attract physicians and patients. We believe that the competitive factors that affect our centers' ability to compete for physicians are convenience of location of the surgery center, access to capital and participation in managed care programs. We believe that our centers attract patients based upon our quality of care, the specialties and reputations of the physicians who operate in our centers, participation in managed care programs, ease of access and convenient scheduling and registration procedures.

In developing or acquiring existing surgery centers, we compete with other public and private surgery center and hospital companies. Several large national companies own and/or manage surgery centers and surgical hospitals, including HEALTHSOUTH Corporation, HCA Inc., Universal Health Services, Inc., AmSurg Corp. and United Surgical Partners International, Inc. In general, these companies have greater resources and access to capital than we do. We also face competition from local hospitals, physician groups and other providers who may compete with us in the ownership and operation of surgery centers.

**Employees**

At December 31, 2005, we had about 2,600 employees, of which about 1,700 were full-time employees. None of our employees are represented by a collective bargaining agreement. We believe that we have a good relationship with our employees.

**Environmental**

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

**Insurance**

We maintain liability insurance in amounts that we believe are appropriate for our operations. Currently, we maintain professional and general liability insurance that provides coverage on a claims made basis of $1.0 million per occurrence and $3.0 million in annual aggregate coverage per 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 $20.0 million. Coverage under certain of these policies is contingent upon the policy being in effect when a claim is made regardless of when the events which caused the claim occurred. The cost and availability of such coverage has varied widely in recent years. While we believe that our insurance policies are adequate in amount and coverage for our anticipated operation, 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.

**Reimbursement**

Payments under the Medicare program to ambulatory surgery centers are made under a system whereby the Secretary of Health and Human Services determines payment amounts prospectively for various categories of medical services performed in ambulatory surgery centers, subject to an inflation adjustment. The various state Medicaid programs also pay us a fixed payment for our services, which amount varies from state to state. About 18% of our patient service revenues during 2005 were attributable to Medicare and Medicaid payments.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, commonly referred to as the Medicare Modernization Act, limits increases in Medicare reimbursement rates for ambulatory surgery centers. Under the Medicare Modernization Act, the 2% increase in Medicare reimbursement rates for ambulatory surgery centers that became effective on October 1, 2003 was limited beginning April 1, 2004 to an amount equal to the increase in the Consumer Price Index for all urban consumers as estimated by the Secretary of the Department of Health and Human Services for the 12-month period ended March 31, 2003, minus 3.0 percentage points. The Medicare Modernization Act also provides that there will be no increase in these rates during the years 2005 through 2009. The Medicare Modernization Act also directs the General Accounting Office to conduct a study comparing the cost of procedures in surgery centers to the cost of procedures performed in hospital outpatient departments. The General Accounting Office is directed to submit the results of its study to the Centers for Medicare and Medicaid Services, or CMS, by no later than January 1, 2005. However, no report has been publicly released to date. CMS is directed to develop a new ambulatory surgery center payment system based upon the Medicare hospital outpatient department payment system so that it is effective on or after January 1, 2006 and no later than January 1, 2008. The Medicare Modernization Act provides that, in the year that the new payment system is implemented, it must be designed to result in the same aggregate amount of expenditures for surgical services provided at ambulatory surgery centers as would be made if the new system were not adopted. The rate changes mandated by the Medicare Modernization Act could have an adverse effect on the revenues of our centers, but we cannot predict at this time the full effect of the payment rate revisions.

A rule proposed by CMS would make substantial changes to the rate-setting methodology, payment rates, payment policies and the list of covered surgical procedures for ambulatory surgery centers. Among the proposed changes is a shift from eight payment groups to 105 ambulatory payment classifications. A federal statute allows the payment methodology to be phased in for ambulatory surgery centers over four years beginning as early as January 1, 2002. To date, CMS has not implemented this payment methodology, and in light of the payment study mandated by the Medicare Modernization Act, it is uncertain whether this proposed surgery center payment methodology will be implemented. If implemented in its proposed form, the change in payment methodology could reduce our Medicare revenues, depending on the volume and type of procedures performed at a particular facility. The proposed rule does not apply to our facilities licensed as hospitals.

The Medicare Payment Advisory Commission, or MedPAC, and the Office of the Inspector General of the Department of Health and Human Services, or OIG, have both recently recommended changes to the Medicare payment methodology for ambulatory surgery centers. MedPAC is a congressional advisory board charged with advising Congress on Medicare payment issues, while the OIG is a governmental agency responsible for investigating and monitoring Medicare, Medicaid and other Department of Health and Human Services programs. Generally, MedPAC and the OIG have recommended that reimbursement levels for ambulatory surgery center procedures be reduced.

On February 1, 2006, Congress passed the Deficit Reduction Act of 2005. Section 5103 of the Deficit Reduction Act contains a provision that models surgery center reimbursement on the methodology and payment rates applicable to surgical services furnished in hospital outpatient departments. Specifically, for procedures furnished on or after January 1, 2007, but before the implementation of a revised payment system for ambulatory surgery centers, a surgery center cannot recoup more than the hospital outpatient department rate for a specific procedure, even if the standard overhead amount of the procedure exceeds the hospital outpatient department rate. This change does not apply to our facilities licensed as hospitals. Our revenues and profitability could be affected by this change. We are unable to predict the full effect of this change in the law.

Furthermore, the Ambulatory Surgical Center Payment Modernization Act was introduced in 2005. This legislation would also model surgery center reimbursement on the methodology and payment rates applicable to surgical services furnished in hospital outpatient departments. This legislation, which has not yet been passed into law, adopts the recommendation of MedPAC that the ambulatory surgery center procedures list be modified and that ambulatory surgical centers be permitted to perform and receive Medicare facility payment for any surgical service, except for those services: (1) that the Department of Health and Human Services Secretary designates, after consultation with specified organizations, as posing a significant risk to beneficiary safety when furnished in an ambulatory surgery center; or (2) that require an overnight stay. This legislation would require that by January 1, 2008, CMS reimburse surgery centers on the basis of a uniform percentage of the rates paid to hospital outpatient departments for the same service. If this legislation is enacted, our revenue and profitability could be affected. We are unable to predict the full effect this legislation would have on our revenues. These recommended changes do not apply to our facilities licensed as hospitals.

Three of our facilities, including one managed facility, are licensed as hospitals. The Medicare program pays hospitals on a prospective payment system for acute inpatient services. Under this prospective payment system, a hospital receives a fixed amount for inpatient hospital services based on each patient's final diagnosis. These payments do not consider a specific hospital's costs, but are national rates adjusted for area wage differentials and case-mix index. For several years, the percentage increases to the prospective payment rates have been generally lower than the percentage increases in the costs of goods and services by hospitals. Most outpatient services provided by hospitals are reimbursed by Medicare under the outpatient prospective payment system. The Balanced Budget Act of 1997 mandated the implementation of the prospective payment system for Medicare outpatient services. This outpatient prospective payment system is based on a system of Ambulatory Payment Categories. Each Ambulatory Payment Category represents a bundle of outpatient services, and each Ambulatory Payment Category has been assigned a fully prospective reimbursement rate.

Most private third-party payors pay a facility fee to freestanding surgery centers for the use of the facility in addition to paying professional fees directly to the physicians performing the medical services. Most third-party payors pay pursuant to a written contract with our centers, but in cases where our centers do not have written

contracts prior to providing services, commonly known as "out-of-network" services, third-party payors have traditionally paid our centers at a percentage of the surgery centers' charges. There has been a growing trend in recent years for third-party payors to implement out-of-network fee schedules, which are more comparable to our contracted rates. Approximately 15% of our patient service revenues in 2005 was derived from "out-of-network" services. Market and cost factors affecting the fee structure, cost containment and utilization decisions of third-party payors and other payment factors over which we have no control may affect the revenues of our centers.

Our centers also provide services to injured workers and receive payment from workers' compensation payors pursuant to the workers' compensation laws of the various states. Historically, workers' compensation payors have paid surgery centers a percentage of the surgery centers' charges. However, workers' compensation payment amounts are subject to legislative, regulatory, and other payment changes over which we have no control. In recent years, there has been a trend for states to implement workers' compensation fees schedules with rates generally lower than what our centers have historically been paid for the same services. A reduction in workers' compensation payment amounts could have a material adverse effect on the revenues of our centers.

We cannot predict what further legislation may be enacted or what regulations or guidelines may be established concerning third-party reimbursement by state, federal or private programs. Reductions or changes in these programs could have a material adverse affect on our business.

**Governmental Regulation**

*General*

The health care industry is highly regulated, and we cannot assure you that the regulatory environment in which we operate will not change significantly in the future or that we will be able to successfully address changes in the regulatory environment. In addition to extensive, existing government health care regulation, there continue to be numerous initiatives on the federal and state levels affecting the payment for and availability of health care services. We believe that these health care initiatives will continue during the foreseeable future. Some of the reform initiatives proposed in the past, such as further reductions in Medicare and Medicaid payments and additional prohibitions on physician ownership of facilities to which they refer patients, could, if adopted, adversely affect us and our business.

Every state imposes licensing requirements on individual physicians and health care facilities. In addition, federal and state laws regulate HMOs and other managed care organizations. Many states require regulatory approval, including certificates of need, before establishing certain types of health care facilities, including surgery centers, offering certain services, including services we offer, or making expenditures in excess of statutory thresholds for health care equipment, facilities or programs. We believe that outpatient surgery and diagnostic services will continue to be subject to intense regulation at the federal and state levels.

Our ability to operate profitably will depend in part upon all of our facilities obtaining and maintaining all necessary licenses, certificates of need and other approvals and operating in compliance with applicable health care regulations. If we fail to obtain any necessary licenses or certifications or fail to maintain our existing licenses and certifications, it could have a material adverse effect on our business.

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

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

We are unable to predict what additional government regulations, if any, affecting our business may be enacted in the future or how existing or future laws and regulations might be interpreted. If we or any of our facilities fail to comply with applicable laws, it might have a material adverse effect on our business.

*Licensure and Certificates of Need*

Capital expenditures for the construction of new facilities, the addition of beds or the acquisition of existing 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 health care facilities and the expansion of existing facilities and services. In these states, approvals are required for capital expenditures exceeding amounts that involve certain facilities or services, including surgery centers.

State certificate of need laws generally provide that, prior to the addition of new beds, the construction of new facilities or the introduction of new services, a designated state health planning agency must determine that a need exists for those beds, facilities or services. The certificate of need process is intended to promote comprehensive health care planning, assist in providing high quality health care at the lowest possible cost and avoid unnecessary duplication by ensuring that only those health care facilities that are needed will be built.

Typically, the provider of services submits an application to the appropriate agency with information concerning the area and population to be served, the anticipated demand for the facility or service to be provided, the amount of capital expenditure, the estimated annual operating costs, the relationship of the proposed facility or service to the overall state health plan and the cost per patient day for the type of care contemplated. The issuance of a certificate of need is based upon a finding of need by the agency in accordance with criteria set forth in certificate of need laws and state and regional health facilities plans. If the proposed facility or service is found to be necessary and the applicant to be the appropriate provider, the agency will issue a certificate of need containing a maximum amount of expenditure and a specific time period for the holder of the certificate of need to implement the approved project.

Our health care facilities are also subject to state licensing requirements for medical providers. Our surgery centers have licenses to operate as ambulatory surgery centers in the states in which they operate, except for one facility in Kansas, one facility in Louisiana and one facility in Oklahoma that are licensed as hospitals. Even though these facilities licensed as hospitals provide surgical services, they must meet all applicable requirements for general hospital licensure. Our surgery centers that are licensed as ambulatory surgery centers must meet all applicable requirements for ambulatory surgery centers. To assure continued compliance with these regulations, governmental and other authorities periodically inspect our facilities. The failure to comply with these regulations could result in the suspension or revocation of a facility's license.

*Medicare and Medicaid Participation*

The majority of our revenues are expected to continue to be received through third-party reimbursement programs, including state and federal programs, such as Medicare and Medicaid, and private health insurance programs. Medicare is a federally funded and administered health insurance program, primarily for individuals entitled to social security benefits who are 65 or older or who are disabled. Medicaid is a health insurance program jointly funded by state and federal governments that provides medical assistance to qualifying low income persons. Each state Medicaid program covers in-patient hospital services and has the option to provide payment for surgery center services. The Medicaid programs of all of the states in which we currently operate cover surgery center services; however, these states may not continue to cover surgery center services and states into which we expand our operations may not cover or continue to cover surgery center services.

To participate in the Medicare program and receive Medicare payment, our facilities must comply with regulations promulgated by the Department of Health and Human Services. Among other things, these regulations, known as "conditions of participation," relate to the type of facility, its equipment, its personnel and its standards of medical care, as well as compliance with state and local laws and regulations. Our facilities must also satisfy the conditions of participation in order to be eligible to participate in the Medicaid program. 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 facilities will continue to qualify for participation.

Three of our facilities, including one managed facility, are licensed as hospitals. The Medicare program pays hospitals on a prospective payment system for acute inpatient services. Under this prospective payment system, a hospital receives a fixed amount for inpatient hospital services based on each patient's final diagnosis. These payments do not consider a specific hospital's costs, but are national rates adjusted for area wage differentials and case-mix index. For several years, the percentage increases to the prospective payment rates have been generally lower than the percentage increases in the costs of goods and services by hospitals. Most outpatient services provided by hospitals are reimbursed by Medicare under the outpatient prospective payment system. The Balanced Budget Act of 1997 mandated the implementation of the prospective payment system for Medicare outpatient services. This outpatient prospective payment system is based on a system of Ambulatory Payment Categories. Each Ambulatory Payment Category represents a bundle of outpatient services, and each Ambulatory Payment Category has been assigned a fully prospective reimbursement rate.

Payments under the Medicare program to ambulatory surgery centers are made under a system whereby the Secretary of Health and Human Services determines payment amounts prospectively for various categories of medical services performed in ambulatory surgery centers, subject to an inflation adjustment. The various state Medicaid programs also pay us a fixed payment for our services, which amount varies from state to state. About 18% of our patient service revenues during 2005 were attributable to Medicare and Medicaid payments.

We cannot predict what further legislation may be enacted or what regulations or guidelines may be established concerning third party reimbursement by state, federal or private programs. Reductions or changes in these programs could have a material adverse affect on our business.

*Antitrust Laws*

Federal and state antitrust laws prohibit price fixing among competitors. Independent physicians who are not economically integrated through a group practice or some other method of sharing substantial financial risk may be considered "competitors" under antitrust laws and subject to prohibitions on price fixing. Price fixing is considered a per se violation of federal antitrust laws. The Federal Trade Commission and the Department of Justice have the authority to bring civil and criminal enforcement actions against persons and entities that violate federal antitrust laws. Moreover, competitors and customers who are injured by activities that violate federal antitrust laws may bring civil actions against the alleged violator. In some cases, treble damages are available to an injured competitor or customer.

Networks of physicians, such as the IPA that we manage, involve price discussions among competitors, which create antitrust concerns. In recognition of the beneficial nature of these entities in a changing health care environment, the FTC and the Department of Justice have issued several joint policy statements regarding enforcement in the health care industry that set forth "antitrust safety zones" in which a network may safely operate.

The IPA that we manage may not fit within a safety zone. However, the policy statements issued by the Department of Justice and the FTC provide that the failure of an IPA to meet all of the requirements of a safety zone will not render the activities of the IPA per se illegal. The government will examine IPA arrangements on a case by case or "rule of reason" basis to determine if the IPA can demonstrate that its members are economically or clinically integrated and that the pro-competitive aspects of the IPA outweigh the anti-competitive aspects. If there are sufficient pro-competitive aspects to the IPA, it should not be held to be illegal. The FTC and the Department of Justice will provide advisory opinions regarding the compliance of physician network arrangements with the antitrust statutes; however, we have not sought such an opinion.

Subsequent to December 31, 2005, the Louisville IPA informed us that it was dissolving its association. We believe the decreased revenue as a result of the dissolution of the Louisville IPA will be immaterial to our financial position and results of operations. Income before the provision for income taxes provided by the Louisville IPA was less than 1.1% for each of the years ended December 31, 2005 and 2004.

*Medicare Fraud and Abuse and Anti-Referral Laws*

The Social Security Act includes provisions addressing false statements, illegal remuneration and other fraud. These provisions are commonly referred to as the Medicare Fraud and Abuse Laws, and include the statute commonly referred to as the federal anti-kickback statute. The federal 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 a service or item covered by a federal health care program or ordering or arranging for or recommending the order of any covered service or item. Violations of the federal anti-kickback statute are punishable by a fine of up to $50,000 or imprisonment for each violation, as well as damages up to three times the total amount of remuneration.

In addition, the Medicare Patient and Program Protection Act of 1987, as amended by the Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, and the Balanced Budget Act of 1997, imposes civil monetary penalties for a violation of the Medicare Fraud and Abuse Laws, as well as exclusion from federal health care programs. Pursuant to the enactment of HIPAA, as of June 1, 1997, the Secretary of Health and Human Services may, and in some cases must, exclude individuals and entities from participating in any government health care program that the Secretary determines have "committed an act" in violation of the Medicare Fraud and Abuse Laws or have improperly filed claims in violation of the Medicare Fraud and Abuse Laws. HIPAA also expanded the Secretary's authority to exclude a person involved in fraudulent activity from participation in a program providing health benefits, whether directly or indirectly, which is funded directly, in whole or in part, by the U.S. government.

Because physician-investors in our surgery centers are in a position to generate referrals to the centers, the distribution of available cash to those investors could come under scrutiny under the federal anti-kickback statute. The U.S. Court of Appeals for the Third Circuit has held that the federal anti-kickback statute is violated if one purpose (as opposed to a primary or sole purpose) of a payment to a provider is to induce referrals. Other federal circuit courts have followed this decision. None of these cases involved a joint venture such as those owning and operating our surgery centers and 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 surgery center may not vary with the number of his or her referrals to the surgery center, and we comply with this prohibition.

In a case involving a physician-owned joint venture, the U.S. Court of Appeals for the Ninth Circuit held that the federal anti-kickback statute is violated when a person or entity (1) knows that the statute prohibits offering or paying remuneration to induce referrals and (2) engages in prohibited conduct with the specific intent to violate the law. In that case, the joint venture was determined to have violated the law because its agent solicited prospective limited partners by implying that eligibility to purchase shares in the limited partnership was dependent on an agreement to refer business to it, told prospective limited partners that the number of shares they would be permitted to purchase would depend on the volume of business they referred, and stated that partners who did not refer business would be pressured to leave the partnership. The joint venture was vicariously liable for the actions of its agents, notwithstanding that the agent's actions were contrary to the principal's stated policy.

Further, under HIPAA, individuals who hold a direct or indirect ownership or controlling interest in an entity that is found to violate the Medicare Fraud and Abuse Laws may also be excluded from the Medicare and Medicaid programs if the individual knew or should have known of the activity leading to the conviction or exclusion of the entity, or where the individual is an officer or managing employee of the entity. Under HIPAA, the term "should know" means that a person acts in deliberate ignorance or reckless disregard of the truth or falsity of the information. This standard does not require that specific intent to defraud be proven by the OIG.

Under regulations issued by the OIG, certain categories of activities are deemed not to violate the federal anti-kickback statute. 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 federal anti-kickback statute. The safe harbors do not make conduct illegal, but instead outline standards that, if complied with, protect conduct that might otherwise be deemed in violation of the federal anti-kickback statute.

One earlier safe harbor protects profit distributions to investors in small entity joint ventures, such as limited partnerships, if certain conditions are met. However, we believe that our ownership and operation of our facilities

will not satisfy this safe harbor for small entity joint ventures, because this safe harbor requires that no more than 40% of the value of each class of investment interests be held by investors in a position to make or influence referrals or to generate business for the entity, and we anticipate that our facilities will not meet this requirement.

The OIG published an expanded listing of safe harbors under the federal anti-kickback statute on November 19, 1999. The expanded provisions include a safe harbor designed to protect distributions to physician investors in ambulatory surgery centers who refer patients directly to the center and personally perform the procedures as an extension of their practice. The safe harbor for surgery center ownership protects four categories of investors, including facilities owned by general surgeons, single-specialty physicians, multi-specialty physicians and hospital/physician ventures, provided that certain requirements are satisfied.

The requirements include the following:

1. The center must be an ambulatory surgery center certified to participate in the Medicare program and its operating and recovery room space must be dedicated exclusively to the surgery center and not a part of a hospital (although such space may be leased from a hospital if such lease meets the requirements of the safe harbor for space rental).

2. Each investor must be either (a) a physician who derived at least one-third of his or her medical practice income for the previous fiscal year or 12-month period from performing procedures on the list of Medicare-covered procedures for ambulatory surgery centers, (b) a hospital, or (c) a person or entity not in a position to make or influence referrals to the center, nor to provide items or services to the center, nor employed by the center or any investor.

3. Unless all physician-investors are members of a single specialty, each physician-investor must perform at least one-third of his or her procedures at the center each year. (This requirement is in addition to the requirement that the physician-investor has derived at least one-third of his or her medical practice income for the past year from performing procedures.)

4. Physician-investors must have fully informed their referred patients of the physician's investment interest.

5. The terms on which an investment interest is offered to an investor are not related to the previous or expected volume of referrals, services furnished or the amount of business otherwise generated from that investor to the entity.

6. Neither the center nor any other investor may loan funds to or guarantee a loan for an investor if the investor uses any part of such loan to obtain the investment interest.

7. The amount of payment to an investor in return for the investment interest is directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.

8. All physician-investors, any hospital-investor and the center agree to treat patients receiving medical benefits or assistance under the Medicare or Medicaid programs.

9. All ancillary services performed at the center for beneficiaries of federal health care programs must be directly and integrally related to primary procedures performed at the center, and may not be billed separately.

10. No hospital-investor may include on its cost report or any claim for payment from a federal health care program any costs associated with the center.

11. The center 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 equipment rental safe harbor and such services are provided in accordance with a contract that complies with the personal services and management contracts safe harbor.

12. 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 surgery centers will not fully satisfy this safe harbor for investment interests in ambulatory surgery centers because, among other reasons, we or one of our subsidiaries generally will be an investor in each surgery center and provide management services to the surgery center. We cannot assure you that the OIG would view our activities favorably even though they are intended to achieve compliance with the remaining elements of this safe harbor. In addition, although we expect each physician-investor to utilize the surgery center as an extension of his practice, we cannot assure you that all physician-investors will perform one-third of their procedures at the surgery center or inform their referred patients of their investment interests.

We own an interest in one surgery center in which a physician group that includes primary care physicians who do not use the center also owns an interest. In OIG Advisory Opinion 03-5 (February 6, 2003), the OIG declined to grant a favorable opinion to a proposed ambulatory surgery center structure that would be jointly owned by a hospital and a multi-specialty group practice composed of a substantial number of primary care physicians who would not personally use the center. According to the opinion, the fact that interests in the center would be indirectly owned by physicians who would not personally practice at the center precluded the OIG from determining that the proposed arrangement poses a minimal risk of fraud and abuse. The OIG concluded that the proposed structure could potentially generate prohibited remuneration under the federal anti-kickback statute. We believe that the ownership of our center complies with the federal anti-kickback statute because the physician group that owns an interest in our center is structured to fit within the definition of a unified group practice under the federal law prohibiting physician self-referrals, commonly known as the Stark law, and the income distributions of the group practice comply with the Stark law's acceptable methods of income distribution. No physician in the group practice receives an income distribution that is based directly on his or her referrals to the center. We believe that the group's ownership of the center is no different than its ownership of other ancillary services common in physician practices. Nevertheless, there can be no assurance that the proposed arrangement will not be determined to be in violation of the law.

We have entered into management agreements to manage many of our surgery centers, as well as three physician networks. 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, this safe harbor requires, among other things, that the aggregate compensation paid to the manager over the term of the agreement be set in advance. Because our management fee may be based on a percentage of revenues, it does not meet this requirement. However, we believe that our management arrangements satisfy the other requirements of the safe harbor for personal services and management contracts and that they comply with the federal anti-kickback statute. The OIG has taken the position that percentage-based management agreements are not protected by a safe harbor, and consequently, may violate the federal anti-kickback statute. On April 15, 1998, the OIG issued Advisory Opinion 98-4 which reiterates this proposition. This opinion focused on areas the OIG considers problematic in a physician practice management context, including financial incentives to increase patient referrals, no safeguards against overutilization and incentives to increase the risk of abusive billing. The opinion reiterated that proof of intent to violate the federal anti-kickback statute is the central focus of the OIG. We have implemented formal compliance programs designed to safeguard against overbilling and otherwise assure compliance with the federal anti-kickback statute and other laws, but we cannot assure you that the OIG would find our compliance programs to be adequate.

We typically guarantee a surgery center's debt financing and 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 referrals and that such failure would result in a violation of the federal 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 guarantee and that the failure of the physician investors to enter into similar guarantees does not create a material risk of violating the federal 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 federal 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 facilities, violate the federal anti-kickback statute, we, our subsidiaries, our officers, our directors and each surgery center investor could be subject, individually, to substantial monetary liability, prison sentences and/or exclusion from participation in any health care program funded in whole or in part by the U.S. government, including Medicare, CHAMPUS or state health care programs.

*Federal Anti-Referral Laws*

Physician self-referral laws have been enacted by the U.S. Congress and many states prohibiting certain self-referrals for health care services. The federal prohibition prohibits a practitioner, including a physician, dentist or podiatrist, from referring patients for certain "designated health services" provided by an entity with which the practitioner or a member of his immediate family has a "financial relationship" if those services are paid in whole or in part by Medicare or Medicaid unless an exception exists. 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 rendered through a prohibited referral. If an entity is paid for services rendered through a prohibited referral, it may be required to refund the payments. Violations of the Stark law may also result in damages of three times the amount claimed, civil penalties of up to $15,000 per prohibited claim and $100,000 per prohibited scheme and exclusion from participating in Medicare and Medicaid. "Designated health services" include:

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

The list of designated health services includes imaging services and other diagnostic services provided by our diagnostic center. However, the Stark law is implicated only if the referring physician or a member of his immediate family has a financial relationship with the provider of designated health services. There is no physician ownership (or physician family member ownership) in our diagnostic center. Any compensation relationships between our diagnostic center and physicians are set forth in writing, provide for a fair market value compensation and are otherwise structured to fit within applicable exceptions to the Stark law.

The list of designated health services does not include surgical services provided in an ambulatory surgery center. Furthermore, in final Stark law regulations published by the Department of Health and Human Services on January 4, 2001, the term "designated health services" was defined to not include services that are reimbursed by Medicare as part of a composite rate, such as services provided in an ambulatory surgery center.

However, if designated health services are provided by an ambulatory surgery center and separately billed, referrals to the surgery center by a physician investor would be prohibited by the Stark law. Because our facilities that are licensed as ambulatory surgery centers 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 surgery centers in which the physician has a beneficial interest, our business and financial results would be adversely affected.

Additionally, the physician networks we manage must comply with the "in-office ancillary services exception" of the Stark law. We believe that these physician networks operate in compliance with the language of statutory exceptions to the Stark law, including the exceptions for services provided by physicians within a group practice or in-office ancillary services.

Three of our facilities, including one managed facility, are licensed as hospitals. The Stark law includes an exception relating to physician ownership of a hospital, provided that the physician's ownership interest is in the whole hospital and the physician is authorized to perform services at the hospital. Physician investment in our facilities licensed as hospitals meet this requirement. However, the Medicare Modernization Act amended the Stark law to provide that an exception in the Stark law relating to physician ownership in hospitals did not apply to specialty hospitals for a period of 18 months following November 18, 2003. The 18-month moratorium expired on June 8, 2005. Specialty hospitals were defined in the Medicare Modernization Act as hospitals that are primarily or exclusively engaged in the care and treatment of (1) patients with a cardiac condition, (2) patients with an orthopedic condition, (3) patients receiving a surgical procedure or (4) any other specialized category of services that the Secretary of the Department of Health and Human Services designates as inconsistent with the purpose of the hospital ownership exception. The 18-month moratorium did not apply to specialty hospitals that were in existence or under development on November 18, 2003, as long as: (a) the total number of physician investors in the hospital did not increase from the number of physician investors on November 18, 2003; (b) the hospital did not change the type of specialty services that it provides from the types that it provided on November 18, 2003; and (c) the hospital did not increase its number of beds by more than 5% or five beds, whichever is greater.

The Stark moratorium expired on June 8, 2005. Prior to the moratorium's expiration, Senators Charles Grassley and Max Baucus introduced a bill, the Hospital Fair Competition Act of 2005, which would have made the moratorium permanent. The Hospital Fair Competition Act of 2005 did not pass prior to the expiration of the original Stark moratorium. However, the Centers for Medicare and Medicaid Services ("CMS") adopted a policy that had the same practical effect as an extension of the Stark moratorium. CMS announced on June 9, 2005 that it was imposing a six-month Medicare enrollment moratorium on specialty hospitals. As part of that moratorium, CMS directed its fiscal intermediaries to refuse to process Medicare enrollment applications for specialty hospitals. Even though the Medicare Modernization Act never defined exactly what thresholds had to be met for a hospital to be considered to be "primarily or exclusively" engaged in specialty services, CMS determined that those hospital applicants that estimate they will provide at least 45% of their initial year's inpatient services in cardiac, orthopedic or surgical DRG categories should be deemed to be specialty hospitals and therefore subject to the enrollment moratorium.

On February 1, 2006, Congress passed the Deficit Reduction Act of 2005. Section 5006 of the Deficit Reduction Act contains significant restrictions on specialty hospitals, including a provision preventing specialty hospitals from enrolling in Medicare for the next six and possibly eight months. The Deficit Reduction Act also raises the specter of further Congressional and regulatory restrictions. The Deficit Reduction Act specialty hospital provisions require the Secretary of Health and Human Services to develop a strategic plan to address physician-owned specialty hospital issues such as proportionality of investment return, methods for determining bona fide investments, disclosure of investment interests and the provision of Medicaid and charity care by specialty hospitals. The Secretary is directed to issue a report to Congress no later than six months (or eight months, if the Secretary applies for a two-month extension) after the date of the enactment of the Deficit Reduction Act. The Secretary's report will include recommendations for such specialty hospital legislative and administrative actions that the Secretary considers appropriate to address the issues identified in the Deficit Reduction Act.

It is not certain what types of regulatory revisions CMS will make to address the perceived issues with specialty hospitals, or what recommendations it will make to Congress for future legislative action.

If future legislation were to be enacted that prohibits all physician referrals to specialty hospitals in which the physicians own an interest, even if those facilities already exist, our specialty hospitals could be materially adversely affected.

*False and Other Improper Claims*

The U.S. government is authorized to impose criminal, civil and administrative penalties on any person or entity that files a false claim for payment from the Medicare or Medicaid programs. 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. While the criminal statutes are generally reserved for instances of fraudulent intent, the U.S. government is applying its criminal, civil and administrative penalty statutes in an ever-expanding range of circumstances. For example, the government has taken the position that a pattern of claiming reimbursement for unnecessary services violates these statutes if the claimant merely should have known the services were unnecessary, even if the government cannot demonstrate actual knowledge. The government has also taken the position that claiming payment for low-quality services is a violation of these statutes if the claimant should have known that the care was substandard. In addition, some courts have held that a violation of the Stark law can result in liability under the federal False Claims Act.

Over the past several years, the U.S. government has accused an increasing number of health care providers of violating the federal False Claims Act. The False Claims Act prohibits a person from knowingly presenting, or causing to be presented, a false or fraudulent claim to the U.S. government. The statute defines "knowingly" to include not only actual knowledge of a claim's falsity, but also reckless disregard for or intentional ignorance of the truth or falsity of a claim. Because our facilities perform hundreds of similar procedures a year for which they are paid by Medicare, and there is a relatively long statute of limitations, a billing error or cost reporting error could result in significant civil or criminal penalties.

Under the *qui tam*, or whistleblower, provisions of the False Claims Act, private parties may bring actions on behalf of the U.S. government. These private parties, often referred to as relators, are entitled to share in any amounts recovered by the government through trial or settlement. Both direct enforcement activity by the government and whistleblower lawsuits have increased significantly in recent years and have increased the risk that a health care company, like us, will have to defend a false claims action, pay fines or be excluded from the Medicare and Medicaid programs as a result of an investigation resulting from a whistleblower case. Although we believe that our operations materially comply with both federal and state laws, they may nevertheless be the subject of a whistleblower lawsuit, or may otherwise be challenged or scrutinized by governmental authorities. A determination that we have violated these laws could have a material adverse effect on us.

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 centers were to waive an out-of-network co-payment or other patient responsibility amounts without fully disclosing the waiver on the claim submitted to the payor. While some of our centers waive the out-of-network portion of patient co-payment amounts when providing services to patients whose health insurance is covered by a payor with which the enters are not contracted, our centers fully disclose waivers in the claims submitted to the payors. We believe that our surgery centers are in compliance with all state insurance laws and regulations regarding the submission of claims. We cannot assure you, however, that none of our centers' 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.

*Health Information Practices*

There are currently numerous laws at the state and federal levels addressing patient privacy concerns. Federal regulations issued pursuant to HIPAA contain, among other measures, provisions that require many organizations, including us, to implement very significant and potentially expensive new computer systems, employee training programs and business procedures. The federal regulations are intended to encourage electronic commerce in the healthcare industry.

On August 17, 2000, the Department of Health and Human Services finalized regulations requiring us to use standard data formats and code sets established by the rule when electronically transmitting information in connection with several transactions, including health claims and equivalent encounter information, health care payment and remittance advice and health claim status. On February 20, 2003, the Department of Health and Human Services issued final modifications to these regulations. We have implemented or upgraded computer systems, as appropriate, at our facilities and at our corporate headquarters to comply with the new transaction and code set regulations and have tested these systems with several of our payors. If we or our payors are unable to exchange information in connection with the specified transactions because of an inability to comply fully with the regulations, we are required to exchange the information using paper. If we are forced to submit paper claims to payors, it will significantly increase our costs associated with billing and could delay payment of claims. Although compliance with the transaction and code set regulations was required on October 16, 2003, CMS announced on September 23, 2003 that it would implement a contingency plan to accept noncompliant electronic transactions after the October 16, 2003 deadline. On February 27, 2004, CMS announced a modification to its claims payment policies that will significantly increase the payment waiting period for electronic claims that are submitted in a non-HIPAA compliant format. Effective July 1, 2004, only claims that are submitted electronically in a HIPAA compliant format are eligible for payment 14 days after the claim is received. All other claims are not eligible for payment until 27 days after the claim is received.

HIPAA requires the Department of Health and Human Services to issue regulations establishing standard unique health identifiers for individuals, employers, health plans and health care providers to be used in connection with standard electronic transactions.

On May 31, 2002, the Department of Health and Human Services issued a final rule that calls for using the Employer Identification Number (the taxpayer identifying number for employers that is assigned by the Internal Revenue Service) as the standard unique health identifier for employers. Most health care organizations, including us, had to comply with this final rule by July 30, 2004. Health plans, health care clearinghouses and providers must use this identifier, among other uses, in connection with the standard electronic transactions standards.

On January 23, 2004, the Department of Health and Human Services published a final rule that adopted the National Provider Identifier, or NPI, as the standard unique health identifier for health care providers. When the NPI is implemented, health care providers, including our facilities, must use only the NPI to identify themselves in connection with electronic transactions. Legacy numbers, such as Medicaid numbers, CHAMPUS numbers and Blue Cross-Blue Shield numbers, will not be permitted. Health care providers will no longer have to keep track of multiple numbers to identify themselves in the standard electronic transactions with one or more health plans. The NPI will be a 10-digit all numeric number that will be assigned to eligible health care providers, including our facilities, by the National Provider System, or NPS, an independent government contractor. Under the final rule, all health care providers may begin applying for NPIs on May 23, 2005 with the NPS. All health care providers, including our facilities, must obtain and start using NPIs in connection with the standard electronic transactions no later than May 23, 2007.

The Department of Health and Human Services has not yet issued proposed rules that establish the standard for unique health identifiers for health plans or individuals. Once these regulations are issued in final form, we expect to have about two years to become fully compliant.

On February 20, 2003, the Department of Health and Human Services finalized a rule that establishes, in part, standards to protect the confidentiality, availability and integrity of health information by health plans, health care clearinghouses and health care providers that receive, store, maintain or transmit health and related financial information in electronic form, regardless of format. These security standards require us to establish and maintain

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

On December 28, 2000, the Department of Health and Human Services published a final rule establishing standards for the privacy of individually identifiable health information. The final rule establishing the privacy standards became effective on April 14, 2001, with compliance required by April 14, 2003. On August 14, 2002, the Department of Health and Human Services published final revisions to the privacy rule. The final revisions did not alter the compliance date of April 14, 2003 for the majority of the requirements in the privacy regulations. These privacy standards apply to all health plans, all health care clearinghouses and health care providers that transmit health information in an electronic form in connection with the standard transactions. We are a covered entity under the final rule. The 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. They 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. In addition, our facilities will continue to remain subject to any state laws that are more restrictive than the privacy regulations issued under HIPAA. These state laws vary by state and could impose additional penalties.

A violation of these regulations could result in civil money penalties of $100 per incident, up to a maximum of $25,000 per person per year per standard. HIPAA also provides for criminal penalties of up to $50,000 and one year in prison for knowingly and improperly obtaining or disclosing protected health information, up to $100,000 and five years in prison for obtaining protected health information under false pretenses, and up to $250,000 and ten years in prison for obtaining or disclosing protected health information with the intent to sell, transfer or use such information for commercial advantage, personal gain or malicious harm.

Compliance with these standards requires significant commitment and action by us. We have appointed members of our management team to direct our compliance with these standards. Implementation will require us to engage in extensive preparation and make significant expenditures. At this time we have appointed a privacy officer, prepared privacy policies, trained our workforce on these policies and entered into business associate agreements with the appropriate vendors. Because some of the regulations are proposed regulations, we cannot predict the total financial impact of the regulations on our operations.

*Health Care Regulations Affecting Our New York Operations*

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

**Available Information**

Our website is *www.symbion.com*. We make available free of charge on this website under "Investor Relations – SEC Filings" our periodic and other reports and amendments to those reports filed with or furnished to the Securities

and Exchange Commission ("SEC") as soon as reasonably practicable after we electronically file or furnish such materials.

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

The following are some of the risks and uncertainties that could cause our actual financial condition, results of operations, business and prospects to differ materially from those contemplated by the forward-looking statements contained in this report or our other filings with the SEC. These risks and uncertainties are also factors that an investor should consider before investing in our common stock. If any of the following risks actually occurred, our business, financial condition and operating results could suffer, and the trading price of our common stock could decline.

**Risks Related to Our Business and Industry**

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

We are dependent upon private and governmental third-party sources of payment for the services provided to patients in our surgery centers and other facilities and the physician networks we manage. The amount that our centers, facilities and networks receive in payment for their services may be adversely affected by market and cost factors as well as other factors over which we have no control, including Medicare, Medicaid and state regulations and the cost containment and utilization decisions and reduced reimbursement schedules of third-party payors. For the year ended December 31, 2005, payments from government payors represented about 19% of our patient service revenues from surgery centers that we consolidate for financial reporting purposes.

Medicare's system of paying for covered procedures performed in a surgery center or its rates for surgery center procedures may change in the near future. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, commonly referred to as the Medicare Modernization Act, limits increases in Medicare reimbursement rates for ambulatory surgery centers. Under the Medicare Modernization Act, the 2% increase in Medicare reimbursement rates for ambulatory surgery centers that became effective October 1, 2003 is limited to an amount equal to the increase in the Consumer Price Index for all urban consumers as estimated by the Secretary of the Department of Health and Human Services for the 12-month period ended March 31, 2003, minus 3.0 percentage points. The Medicare Modernization Act also provides that there will be no increase in these rates during the years 2005 through 2009. The Medicare Modernization Act also directs the General Accounting Office to conduct a study comparing the cost of procedures in surgery centers to the cost of procedures performed in hospital outpatient departments. The General Accounting Office was directed to submit the results of its study to the Centers for Medicare and Medicaid Services, or CMS, by no later than January 1, 2005. However, no report had been publicly released as of March 1, 2006. CMS is directed to develop a new ambulatory surgery center payment system based upon the Medicare hospital outpatient department payment system so that it is effective on or after January 1, 2006 and no later than January 1, 2008. The Medicare Modernization Act provides that, in the year that the new payment system is implemented, it must be designed to result in the same aggregate amount of expenditures for surgical services provided at ambulatory surgery centers as would be made if the new system were not adopted. The rate changes mandated by the Medicare Modernization Act could have an adverse effect on the revenues of our centers, but we cannot predict at this time the full effect of the payment rate revisions.

Previously, the Department of Health and Human Services proposed a rule which would increase the number of surgical procedure payment groups from eight to 105 and the number of surgical procedures covered by the Medicare program to about 2,500. All of the procedures paid at a particular rate would constitute a payment group. Each of the procedures would be paid at one of the 105 prospectively determined payment rates. To date, CMS has not implemented the proposed surgery center methodology, and in light of the payment study mandated by the Medicare Modernization Act, it is uncertain whether this proposed surgery center payment methodology will be implemented. If implemented in its proposed form, the change in payment methodology could reduce our Medicare revenues, depending on the volume and type of procedures performed at a particular facility. States in which we perform Medicaid procedures could also change their payment methodology in the future, and these changes may reduce the payments we receive for our services from state Medicaid programs. In addition, the Medicare Payment

Advisory Commission, or MedPAC, and the Office of the Inspector General of the Department of Health and Human Services, or OIG, have both recently recommended changes to the Medicare payment methodology for surgery centers. MedPAC is a congressional advisory board charged with advising Congress on Medicare payment issues, while the OIG is a governmental agency responsible for investigating and monitoring Medicare, Medicaid and other Department of Health and Human Services programs. Generally, MedPAC and the OIG have recommended that reimbursement levels for surgery center procedures be reduced. These proposed changes do not apply to our facilities licensed as hospitals.

On February 1, 2006, Congress passed the Deficit Reduction Act of 2005. Section 5103 of the Deficit Reduction Act contains a provision that models surgery center reimbursement on the methodology and payment rates applicable to surgical services furnished in hospital outpatient departments. Specifically, for procedures furnished on or after January 1, 2007, but before the implementation of a revised payment system for ambulatory surgery centers, a surgery center cannot recoup more than the hospital outpatient department rate for a specific procedure, even if the standard overhead amount of the procedure exceeds the hospital outpatient department rate. This change does not apply to our facilities licensed as hospitals. Our revenue and profitability could be affected by this change. We are unable to predict the full effect of this change in the law.

Furthermore, recent legislation, entitled "The Ambulatory Surgical Center Payment Modernization Act", was introduced in 2005. This legislation would also model surgery center reimbursement on the methodology and payment rates applicable to surgical services furnished in hospital outpatient departments. This legislation, which has not yet been passed into law, adopts the recommendation of MedPAC that the ambulatory surgery center procedures list be modified and that ambulatory surgical centers be permitted to perform and receive Medicare facility payment for any surgical service, except for those services: (1) that the Department of Health and Human Services Secretary designates, after consultation with specified organizations, as posing a significant risk to beneficiary safety when furnished in an ambulatory surgery center; or (2) that require an overnight stay. This legislation would require that, by January 1, 2008, CMS reimburse surgery centers on the basis of a uniform percentage of the rates paid to hospital outpatient departments for the same service. If this legislation is enacted, our revenue and profitability could be affected. We are unable to predict the full effect of this legislation on our financial position and results of operations. These recommended changes do not apply to our facilities licensed as hospitals.

We cannot predict what further legislation may be enacted or what regulations or guidelines may be established concerning third party reimbursement by state, federal or private programs. Reductions or changes in these programs could have a material adverse affect on our financial position and results of operations.

***If future government regulatory interpretations prohibit our centers from providing 23 hour stay services, our revenues could decrease.***

Medicare regulations prohibit ambulatory surgery centers from performing surgical procedures on Medicare patients if it is anticipated that the patient will require overnight recovery. Historically, however, CMS has permitted ambulatory surgery centers to keep non-Medicare patients for up to 23 hours. On March 11, 2004, CMS issued a Memorandum to State Survey Agency Directors stating that an ambulatory surgery center that routinely provides 23 hour recovery services to non-Medicare patients will jeopardize the facility's Medicare certification. CMS is expected to clarify or revise this new interpretation of the Medicare ambulatory surgery center regulations. If CMS does not modify this interpretation, our centers would be unable to routinely offer services to patients requiring extended recovery time, and it could have a material adverse effect on our revenues.

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

Payments from private third-party payors represented about 76% of our patient service revenues in 2005. Most of these payments came from third-party payors with which our centers have contracts. Managed care companies such as health maintenance organizations, or HMOs, and preferred provider organizations, or PPOs, which offer prepaid and discounted medical service packages, represent a growing segment of private third-party payors. If we fail to enter into favorable contracts and maintain satisfactory relationships with managed care organizations, our revenues may decrease. Cost containment measures, such as fixed fee schedules, capitation payment arrangements,

reductions in reimbursement schedules by third-party payors and closed provider networks, could also cause a reduction of our revenues in the future and cause our profit margins to decline.

Some of our payments from third-party payors in the past year came from third-party payors with which our centers did not have a written contract. In those cases, commonly known as "out-of-network" services, we generally charge the patients the same co-payment or other patient responsibility amounts that we would have charged had our center had a contract with the payor. We also submit a claim for the services to the payor along with full disclosure that our center has charged the patient an in-network patient responsibility amount. Historically, those third-party payors who do not have contracts with our centers have typically paid our claims at higher than comparable contracted rates. However, there is a growing trend for third-party payors to adopt out-of-network fee schedules, which are more comparable to our contracted rates, or to take other steps to discourage their enrollees from seeking treatment at out-of-network surgery centers. If this trend continues, and if we are not able to successfully negotiate favorable contracts with these payors, this could have a material adverse effect on our financial position and results of operations.

Payments from workers' compensation payors represented approximately 13% of our patient service revenues in 2005. Traditionally, workers' compensation payors have paid surgery centers a percentage of the surgery centers' charges. Several states have recently implemented workers' compensation provider fee schedules, and other states have considered or have begun the process of developing a state workers' compensation fee schedule for providers. In some cases, the fee schedule rates contain lower rates than our surgery centers have historically been paid for the same services. If the trend of states adopting lower workers' compensation fee schedules continues, it could have a material adverse effect on our centers' financial position and results of operations.

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

Our strategy is to increase our revenues and earnings by continuing to focus on existing facilities and continuing to acquire and develop additional surgery centers. Since January 1999, we have acquired or developed 57 surgery centers, including five centers that we no longer own. We may be unable to identify suitable acquisition and development opportunities and to negotiate and complete acquisitions and new projects on favorable terms. In addition, our acquisition and development program requires substantial capital resources, and we may need to obtain additional capital or financing, from time to time, to fund these activities. As a result, we may take actions that could have a detrimental effect on our results of operations or the price of our common stock, including incurring substantial debt or issuing equity securities or convertible debt securities that would dilute our existing stockholders' ownership percentage. Sufficient capital or financing may not be available to us on satisfactory terms, if at all.

***We may encounter numerous business risks in acquiring and developing additional surgery centers, and may have difficulty operating and integrating those surgery centers.***

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

In addition, we may acquire surgery centers with unknown or contingent liabilities, including liabilities for failure to comply with health care laws and regulations. Although we maintain professional and general liability insurance, we do not currently maintain insurance specifically covering any unknown or contingent liabilities that

may have occurred prior to the acquisition of companies and surgery centers. In some cases, our right to indemnification for these liabilities may be subject to negotiated limits.

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

***Efforts to regulate the construction, acquisition or expansion of health care facilities could prevent us from acquiring additional surgery centers or other 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 health care facilities or expansion of the services the facilities offer. In giving approval, these states consider the need for additional or expanded health care facilities or services. In 11 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. Other 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 facilities or services in the future. In addition, at the time we acquire a 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 surgery centers or other facilities, expand health care services we provide at these facilities or replace or expand acquired facilities.

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

Our business depends upon the efforts and success of the physicians who provide medical services at our facilities and the strength of our relationships with these physicians. These physicians are not employees of our facilities and are not contractually required to use our facilities. We generally do not enter into contracts with physicians who use our facilities, other than partnership and operating agreements with physicians who own interests in our surgery centers, provider agreements with anesthesiology groups that provide anesthesiology services in our surgery centers, medical director agreements and pain clinic agreements. Physicians who use our 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 surgery centers. In recent years, pain management and gastrointestinal procedures have been performed increasingly in an office-based setting. Although physicians who own an interest in our centers are subject to agreements restricting ownership of competing facilities, these agreements may not restrict procedures performed in a physician office. Also, these agreements restricting ownership of competing facilities are difficult to enforce, and we may be unsuccessful in preventing physicians who own an interest in our centers from acquiring an interest in a competing facility.

In addition, the physicians who use our facilities may choose not to accept patients who pay for services through certain third-party payors, which could reduce our revenues. In nine of the surgery centers in which we own an interest, a single physician performed over 25% of the total number of cases performed at the center during 2005. From time to time, we may have disputes with physicians who use our facilities and/or own interests in our centers or our company. Our revenues and profitability could be significantly reduced if we lost our relationship with one or more key physicians or groups of physicians or if a key physician or group ceased or reduced his or its use of our 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 facilities could damage our reputation, subject us to liability and significantly reduce our revenues. We also manage three physician networks that accounted for about 2% of our revenues during the year ended December 31, 2005. The termination of any of our contracts to manage our physician networks would have an immaterial effect on our financial position and results of operations. Subsequent to December 31, 2005, the Louisville IPA informed us that it was dissolving its association. We believe the decreased revenue as a result of the dissolution of the Louisville IPA will be immaterial

to our financial position and results of operations. Income before the provision for income taxes provided by the Louisville IPA was less than 1.1% for each of the years ended December 31, 2005 and 2004.

***We have a limited history operating many of our centers.***

Since January 1999, we have acquired 41 surgery centers and developed 16 surgery centers, including five surgery centers that we subsequently divested. Several of these centers have been acquired or developed in the past few years and we have limited experience in operating the facilities. As a result, we have a limited history of operations upon which you can evaluate us or our prospects. Forecasts of our future revenues, expenses and operating results may not be as accurate as they would be if we had a longer history of operations.

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

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, mandates the adoption of security and integrity standards related to patient information. HIPAA also standardizes the method for identifying providers, employers, health plans and patients. Final rules implementing the security and integrity portion of HIPAA were adopted February 20, 2003 with a mandatory implementation date of April 20, 2005. We believe that we are in compliance with the HIPAA regulations. However, if we fail to comply with the requirements of HIPAA, we could be subject to civil penalties of up to $25,000 per calendar year for each provision contained in the privacy, security and transaction regulations that is violated and criminal penalties of up to $250,000 per violation for certain other violations.

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

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

- qualification of medical and support persons;
- pricing of services by health care providers;
- the adequacy of medical care, equipment, personnel, operating policies and procedures;
- maintenance and protection of records; and
- environmental protection, health and safety.

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

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

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

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

In July 1991, the Department of Health and Human Services issued final regulations defining various "safe harbors." Business arrangements that meet the requirements of the safe harbors are deemed to be in compliance with the federal anti-kickback statute. Business arrangements that do not meet the safe harbor requirements do not necessarily violate the federal anti-kickback statute, but may be subject to scrutiny by the federal government to determine compliance. Two of the safe harbors issued in 1991 apply to business arrangements similar to those used in connection with our surgery centers: 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 facilities, as well as our business arrangements involving physician networks, do not satisfy all of the requirements of either safe harbor.

In November 1999, the Department of Health and Human Services issued final regulations creating additional safe harbor provisions, including a safe harbor that applies to physician ownership of, or investment interests in, surgery centers. These regulations do not apply to our facilities licensed as hospitals. The surgery center safe harbor protects four types of investment arrangements. 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 surgery centers typically consist of one or more of our subsidiaries being an investor in each partnership or limited liability company that owns the surgery center, in addition to providing management and other services to the surgery center. As a result of these and other aspects of our business arrangements, including those relating to the composition of physician groups that own an interest in our facilities, these arrangements do not comply with all the requirements of the surgery center safe harbor and, therefore, are not immune from government review or prosecution.

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

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

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

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

The federal physician self-referral law, commonly referred to as the Stark law, prohibits a physician from making a Medicare or Medicaid reimbursed referral for a "designated health service" to an entity if the physician or a member of the physician's immediate family has a "financial relationship" with the entity. "Designated health services" include a number of services, including clinical laboratory services, radiology and certain other imaging services and inpatient and outpatient hospital services. Under the current Stark law and related regulations, services provided at a surgery center are not covered by Stark, even if those services include imaging, laboratory services or other Stark designated health services, provided that the surgery center does not bill for these services separately. However, services provided at our facilities licensed as hospitals are covered by the Stark law.

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 large civil monetary penalties and exclusion from participation in the Medicare and Medicaid programs. Exclusion of our surgery centers from these programs through future judicial or agency interpretation of existing laws or additional legislative restrictions on physician ownership or investments in health care entities could result in a significant loss of reimbursement revenues.

***The Deficit Reduction Act of 2005, as well as new pending legislation, could restrict our ability to operate new hospitals and could adversely impact our reimbursement revenues.***

On February 1, 2006, Congress passed the Deficit Reduction Act of 2005. Section 5006 of the Deficit Reduction Act contains significant restrictions on specialty hospitals, including a provision preventing new specialty hospitals from enrolling in Medicare for the next six and possibly eight months. The Deficit Reduction Act also raises the specter of further Congressional and regulatory restrictions. The Deficit Reduction Act specialty hospital provisions require the Secretary of Health and Human Services to develop a strategic plan to address physician-owned specialty hospital issues such as proportionality of investment return, methods for determining bona fide investments, disclosure of investment interests and the provision of Medicaid and charity care by specialty hospitals. The Secretary is directed to issue a report to Congress no later than six months (or eight months, if the Secretary applies for a two-month extension) after the date of the enactment of the Deficit Reduction Act. The Secretary's report will include recommendations for such specialty hospital legislative and administrative actions that the Secretary considers appropriate to address the issues identified in the Deficit Reduction Act.

It is not certain what types of regulatory revisions CMS will make to address the perceived issues with specialty hospitals, or what recommendations it will make to Congress for future legislative action. If future legislation were to be enacted that prohibits all physician referrals to specialty hospitals in which the physicians own an interest, even if those facilities already exist, the financial position and results of operations of our specialty hospitals could be materially adversely affected.

Section 5103 of the Deficit Reduction Act contains a provision that models surgery center reimbursement on the methodology and payment rates applicable to surgical services furnished in hospital outpatient departments. Specifically, for procedures furnished on or after January 1, 2007, but before the implementation of a revised payment system for ambulatory surgery centers, a surgery center cannot recoup more than the hospital outpatient department rate for a specific procedure, even if the standard overhead amount of the procedure exceeds the hospital outpatient department rate. This change does not apply to our facilities licensed as hospitals. Our revenue and profitability could be affected by this change. We are unable to predict the full effect of this change in the law.

Furthermore, the Ambulatory Surgical Center Payment Modernization Act was introduced in 2005. This legislation would also model surgery center reimbursement on the methodology and payment rates applicable to surgical services furnished in hospital outpatient departments. This legislation, which has not yet been passed into law, adopts the recommendation of MedPAC that the ambulatory surgery center procedures list be modified and that ambulatory surgical centers be permitted to perform and receive Medicare facility payment for any surgical service, except for those services: (1) that the Department of Health and Human Services Secretary designates as posing a significant risk to beneficiary safety when furnished in an ambulatory surgery center; or (2) that require an overnight stay. This legislation would require that by January 1, 2008, CMS reimburse surgery centers on the basis of a uniform percentage of the rates paid to hospital outpatient departments for the same service. If this legislation is enacted, our revenue and profitability could be affected. We are unable to predict the full effect of this legislation on our revenues. These recommended changes do not apply to our facilities licensed as hospitals.

We cannot predict what further legislation may be enacted or what regulations or guidelines may be established concerning third party reimbursement by state, federal or private programs. Reductions or changes in these programs could have a material adverse affect on our financial position and results of operations.

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

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

The U.S. government is authorized to impose criminal, civil and administrative penalties on any person or entity that files a false claim for payment from the Medicare or Medicaid programs. 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. While the criminal statutes are generally reserved for instances of fraudulent intent, the U.S. government is applying its criminal, civil and administrative penalty statutes in an ever-expanding range of circumstances. For example, the government has taken the position that a pattern of claiming reimbursement for unnecessary services violates these statutes if the claimant merely should have known the services were unnecessary, even if the government cannot demonstrate actual knowledge. The government has also taken the position that claiming payment for low-quality services is a violation of these statutes if the claimant should have known that the care was substandard. In addition, some courts have held that a violation of the Stark law can result in liability under the federal False Claims Act.

Over the past several years, the U.S. government has accused an increasing number of health care providers of violating the federal False Claims Act. The False Claims Act prohibits a person from knowingly presenting, or causing to be presented, a false or fraudulent claim to the U.S. government. The statute defines "knowingly" to include not only actual knowledge of a claim's falsity, but also reckless disregard for or intentional ignorance of the truth or falsity of a claim. Because our facilities perform hundreds of similar procedures a year for which they are paid by Medicare, and there is a relatively long statute of limitations, a billing error or cost reporting error could result in significant civil or criminal penalties.

Under the *qui tam*, or whistleblower, provisions of the False Claims Act, private parties may bring actions on behalf of the U.S. government. These private parties, often referred to as relators, are entitled to share in any

amounts recovered by the government through trial or settlement. Both direct enforcement activity by the government and whistleblower lawsuits have increased significantly in recent years and have increased the risk that a health care company, like us, will have to defend a false claims action, pay fines or be excluded from the Medicare and Medicaid programs as a result of an investigation resulting from a whistleblower case. Although we believe that our operations comply with both federal and state laws, they may nevertheless be the subject of a whistleblower lawsuit, or may otherwise be challenged or scrutinized by governmental authorities. A determination that we have violated these laws could have a material adverse effect on us.

We are also subject to various state insurance statutes and regulations that prohibit us from submitting inaccurate, incorrect or misleading claims. We believe that our surgery centers are in material compliance with all state insurance laws and regulations regarding the submission of claims. We cannot assure you, however, that none of our centers' 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 practice in violation, which could have an adverse effect on our business and operating results, and we could be subject to fines and criminal penalties.

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

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

***We are liable for debts and other obligations of the partnerships and limited liability companies that own and operate some of our surgery centers.***

We own and operate our surgery centers through 26 limited partnerships, 25 limited liability companies and one general partnership. Local physicians, physician groups and hospitals also own an interest in all but one of these partnerships and limited liability companies. In the partnerships in which we are the general partner, we are liable for 100% of the debts and other obligations of the partnership, even if we do not own all of the partnership interests. We also guarantee the debts and other obligations of many of the partnerships and limited liability companies in which we own an interest. Our senior credit facility allows us to borrow up to $150.0 million, including funds that we can lend to the partnerships and limited liability companies in which we own an interest. The physicians and physician groups that own an interest in these partnerships and limited liability companies do not guarantee a pro rata amount of this debt or the other obligations of these partnerships and limited liability companies.

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

We own an interest in a limited liability company which provides administrative services to a surgery center located in New York. New York law requires that, in order to be approved by the New York Department of Health as licensed health care facilities, corporations must have natural persons as stockholders. Accordingly, we are not able to own interests in a partnership or limited liability company that owns an interest in a New York health care facility. New York law also prohibits the delegation of certain management functions by a licensed health care facility. The law does permit a licensed facility to obtain various services from non-licensed entities; however, it is not clear what types of delegation constitute a violation. Although we believe that our operations and relationships in New York are in compliance with these laws, if New York regulatory authorities or a third party asserts a contrary position we may be unable to continue or expand our operations in New York.

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

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 interests of the physician investors in most of the partnerships or limited liability companies that own and operate our surgery centers. The purchase price that we would be required to pay for these ownership interests is typically based on either a multiple of the center's EBITDA, as defined in our partnership and operating agreements with these centers, or the fair market value of the ownership interests as determined by a third-party appraisal. The physician investors in some of our surgery centers 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 surgery centers 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 surgery centers 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 surgery centers would be illegal; or
- make illegal the ownership by the physician investors of interests in the partnerships or limited liability companies through which we own and operate our surgery centers.

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 interests, 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 position and results of operations.

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

In recent years, physicians, hospitals and other health care providers have become subject to an increasing number of legal actions alleging malpractice, product liability or related legal theories. Many of these actions involve large monetary claims and significant defense costs. We maintain liability insurance in amounts that we believe are appropriate for our operations. Currently, we maintain professional and general liability insurance that provides coverage on a claims made basis of $1.0 million per occurrence and $3.0 million in annual aggregate coverage per 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 $20.0 million. However, this insurance coverage may not cover all claims against us. Insurance coverage may not continue to be available at a cost allowing us to maintain adequate levels of insurance. If one or more successful claims against us were not covered by or exceeded the coverage of our insurance, our financial position and results of operations could be adversely affected.

***Significant indebtedness could limit our ability to operate our business and pursue business opportunities.***

As of March 10, 2006, we had outstanding debt under our senior credit facility of about $103.0 million that we incurred to finance our acquisitions and developments and for other general corporate purposes. Our senior credit facility allows us to borrow up to $150.0 million. Our significant indebtedness could have important consequences, including the following:

- we may be required to dedicate a substantial portion of our cash flows from operations to the payment of principal and interest on our indebtedness, reducing the funds available to fund working capital, capital expenditures and other general corporate purposes;

- some of our borrowings are at variable rates of interest and we are vulnerable to increases in interest rates;
- our flexibility in planning for, or reacting to, changes in our business and the industry in which we operate may be limited;
- we may be at a disadvantage to our competitors who are less leveraged;
- we may be more vulnerable to a downturn in our business or the economy generally;
- our senior credit facility contains numerous financial and other restrictive covenants, including restrictions on paying dividends, incurring additional indebtedness and buying or selling assets; and
- our senior credit facility requires us to pledge the capital stock or other equity interests of our subsidiaries to the bank group as collateral security.

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

The health care business is highly competitive. We compete with other health care providers, primarily hospitals and other surgery centers, in recruiting physicians to utilize our facilities and in contracting with managed care payors in each of our markets. There are unaffiliated hospitals in each market in which we operate. These hospitals have established relationships with physicians and payors. In addition, other companies either are currently in the same or similar business of developing, acquiring and operating surgery centers and other 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 may also compete with some of these companies for entry into strategic relationships with health care systems and health care professionals. In addition, many physician groups develop surgery centers without a corporate partner, utilizing consultants who perform services for a fee and do not take an equity interest in the ongoing operations of the center. 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 surgery center or hospital. 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.

***A large number of our surgery centers are located in Texas and Florida, which makes us particularly sensitive to regulatory, economic and other conditions in those states. In addition, four of our surgery centers account for a significant portion of our patient service revenues.***

Our revenues are particularly sensitive to regulatory, economic and other conditions in the states of Texas and Florida. As of March 10, 2006, we operated seven surgery centers in Texas and eight surgery centers in Florida. The surgery centers in Texas represented about 20.2% of our patient service revenues during 2005 and the surgery centers in Florida represented about 14.4% of our patient service revenues during 2005. In addition, Physicians Surgical Specialty Hospital in Houma, Louisiana, NorthStar Surgical Center in Lubbock, Texas, The Surgery Center of Kirkwood in Kirkwood, Missouri and Wilmington SurgCare in Wilmington, North Carolina, generated about 6.6%, 6.6%, 5.5% and 5.3%, respectively, of our patient service revenues during 2005. If these facilities are adversely affected by regulatory, economic and other conditions, or if these facilities do not perform effectively, our operating results will be adversely affected. None of our remaining surgery centers accounted for more than 5.0% of our revenues during 2005.

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

We are highly dependent on our senior management, including Richard E. Francis, Jr., our chairman of the board and chief executive officer, and Clifford G. Adlerz, our president and chief operating officer. We have entered into employment agreements with Messrs. Francis and Adlerz and William V.B. Webb, our chief development officer.

The initial term of each of these agreements is three years, which is automatically extended so that the term is three years until terminated. We may terminate each employment agreement for cause. In addition, either party may terminate the employment agreement at any time by giving prior written notice to the other party. We do not maintain "key man" life insurance policies on any of our officers. Because our senior management has contributed greatly to our growth since inception, the loss of key management personnel or our inability to attract, retain and motivate sufficient numbers of qualified management personnel could have a material adverse effect on our financial position and results of operations.

***We face risks related to compliance with corporate governance laws and financial reporting standards.***

The Sarbanes-Oxley Act of 2002, as well as related new rules and regulations implemented by the Securities and Exchange Commission, Nasdaq and the Public Company Accounting Oversight Board, required changes in the corporate governance practices and financial reporting standards for public companies. These new laws, rules and regulations, including compliance with Section 404 of the Sarbanes-Oxley Act of 2002 relating to internal control over financial reporting ("Section 404"), have materially increased our legal and financial compliance costs and made some activities more time-consuming and more burdensome. We became a public company in February 2004 and we were required to comply with the provisions of Section 404 commencing with our fiscal year ended December 31, 2005. We believe that we are in compliance with Section 404. Failure to be fully compliant with these rules and regulations could materially adversely affect our financial position and results of operations.

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

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

**Risks Related to Our Corporate Structure**

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

Our ownership interests in surgery centers generally are held through limited partnerships or limited liability companies in which we maintain an ownership interest along with physicians or physician practice groups. As general partner or manager of these entities, we may have a special responsibility, known as a fiduciary duty, to manage these entities in the best interests of the other interest holders. 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 interest holders and our responsibility to our stockholders. For example, we have entered into management agreements to provide management services to our surgery centers in exchange for a fee. Disputes may arise as to the nature of the services to be provided or the amount of the fee to be paid. In these cases, we are obligated to exercise reasonable, good faith judgment to resolve the disputes and may not be free to act solely in our own best interests or the interests of our stockholders. Disputes may also arise between us and our physician investors with respect to a particular business decision or regarding the interpretation of the provisions of the applicable limited partnership agreement or operating agreement. We seek to avoid these disputes but have not implemented any measures to resolve these conflicts if they arise. If we are unable to resolve a dispute on terms favorable or satisfactory to us, our financial position and results of operations may be adversely affected.

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

We are a holding company and our ability to service our debt and pay dividends, if any, is dependent upon the earnings from the business conducted by our subsidiaries. The distributions of those earnings or advances or other distributions of funds by these subsidiaries to us, all of which are contingent upon the subsidiaries' earnings, are

subject to various business considerations. In addition, distributions by subsidiaries could be subject to statutory restrictions, including state laws requiring that the subsidiary be solvent, or contractual restrictions.

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

All of the surgery centers in which we have ownership interests are held through partnerships or limited liability companies. We typically own, directly or indirectly, the general partnership or majority member interests in these entities. The partnership and operating agreements for these entities provide for distribution of available cash, in some cases on a quarterly basis. If we are unable to cause sufficient revenues to be distributed from one or more of these entities, our relationships with the physicians who also own an interest in these entities may be damaged and we could be adversely affected. We may not be able to resolve favorably any dispute regarding revenue distribution or other matters with a health care system with which we share control of the distributions made by these entities. Further, the failure to resolve a dispute with these health care systems could cause an entity in which we own an interest to be dissolved.

***Our stockholder rights plan, provisions of our certificate of incorporation and bylaws and Delaware law could prevent or discourage a change in our management or a takeover you may consider favorable.***

We have adopted a stockholder rights plan. The rights plan may discourage, delay or prevent a merger or acquisition that you may consider favorable. The rights plan may also entrench our management by making it more difficult for a potential acquirer to replace or remove our management or board of directors.

In addition, some of the provisions of our certificate of incorporation and bylaws may discourage, delay or prevent a merger or acquisition that you may consider favorable or the removal of our current management. These provisions:

- authorize the issuance of "blank check" preferred stock;
- provide for a classified board of directors with staggered, three-year terms;
- prohibit cumulative voting in the election of directors;
- prohibit our stockholders from acting by written consent without the approval of our board of directors;
- limit the persons who may call special meetings of stockholders; and
- establish advance notice requirements for nominations for election to the board of directors or for proposing matters to be approved at meetings of stockholders.

Our certificate of incorporation and bylaws also prohibit the amendment of many of the provisions in the certificate of incorporation and bylaws by our stockholders unless the amendment is approved by the holders of at least 67% of our shares of common stock. In addition, Delaware law may discourage, delay or prevent a change in our control by prohibiting us from engaging in a business combination with an "interested stockholder" for a period of three years after the person becomes an interested stockholder.

***Because our management and their affiliates together own a large percentage of our common stock, they will be able to exert significant influence over all matters submitted to our stockholders for approval, regardless of the preferences of our other stockholders.***

As of December 31, 2005, our officers, directors and their affiliates together beneficially owned about 12.9% of our outstanding common stock. Accordingly, these stockholders are able to exert significant influence over:

- the election of our board of directors;
- our management and policies; and

- the outcome of any corporate transaction or other matter submitted to our stockholders for approval, including mergers, consolidations and the sale of all or substantially all of our assets.

Our officers, directors and their affiliates are also able to exert significant influence over a change in our control or an amendment to our certificate of incorporation or bylaws. In addition, we granted registration rights to these stockholders covering all shares of our stock that they own. Their interests may conflict with the interests of other holders of common stock and they may take actions affecting us with which you disagree.

**Risks Related to Our Common Stock**

***Because we have not paid dividends and do not anticipate paying dividends on our common stock in the foreseeable future, you should not expect to receive dividends on shares of our common stock.***

We currently anticipate that we will retain all future earnings, if any, to finance the growth and development of our business and do not anticipate paying cash dividends on our common stock in the foreseeable future. Any payment of cash dividends will depend upon our financial condition, capital requirements, earnings and other factors deemed relevant by our board of directors. Further, under the terms of our senior credit facility, we are restricted from paying cash dividends and making other distributions to our stockholders.

***Our stock price is likely to be highly volatile.***

Before February 6, 2004, there was no public market for our common stock. The stock market has, from time to time, experienced extreme price and volume fluctuations. Many factors may cause the market price for our common stock to decline, perhaps substantially, including:

- our failure or delay in meeting our development and acquisition plans;
- our revenues and operating results failing to meet the expectations of securities analysts or investors in any quarter;
- changes in laws and regulations governing health care and the surgery center industry;
- proposed or enacted changes in reimbursement by governmental and other third-party payors;
- changes in securities analysts' financial estimates or recommendations;
- investor perception of our industry or our prospects; and
- general economic trends and market conditions, including factors unrelated to our operating performance.

In the past, other companies in the health care industry have experienced volatility in the market price of their stock and have been the subject of securities class action litigation. We may be involved in securities class action litigation in the future which could divert our management's attention and resources and could have a material adverse effect on our financial position and results of operations.

**Item 1B.** ***Unresolved Staff Comments***

None.

**Item 2.** ***Properties***

Our corporate headquarters are located in Nashville, Tennessee in 43,772 square feet of leased office space, under a ten-year lease that commenced on November 1, 2002. We sublease 1,827 square feet of the 43,772 square feet to a third party.

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

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

**Item 3.** ***Legal Proceedings***

We are, from time to time, subject to claims and suits arising in the ordinary course of business, including claims for damages for personal injuries, breach of management contracts and employment related claims. In certain of these actions, plaintiffs request payment for damages, including punitive damages, that may not be covered by insurance.

As disclosed in our 2004 Annual Report on Form 10-K filed March 28, 2005, MediSphere Health Partners, Inc. filed a breach of contract action against Symbion Ambulatory Resource Centres, Inc., one of our subsidiaries, in the Chancery Court for Davidson County, Tennessee on February 4, 2005. MediSphere seeks in the lawsuit to recover $1,062,857 (plus attorneys' fees), which it claims to be due pursuant to the terms of a Stock Purchase Agreement between Symbion Ambulatory Resource Centres, Inc. and MediSphere dated November 4, 2003. On March 21, 2005, Symbion Ambulatory Resource Centres, Inc. filed an answer to the complaint. In the answer, we denied that any amounts are due under the terms of the Stock Purchase Agreement, and asserted a counterclaim against MediSphere. In the counterclaim, we seek to recover in excess of $3.0 million in damages out of MediSphere's breach of certain of the representations and warranties contained in the Stock Purchase Agreement, and MediSphere's intentional concealment and misrepresentation of facts material to the Stock Purchase Agreement and the November 17, 2003 closing of the transactions contemplated therein. We have also asserted a counterclaim against certain of MediSphere's preferred shareholders. We dispute MediSphere's claims that any amounts are due under the terms of the Stock Purchase Agreement and intend to defend the case vigorously.

**Item 4.** ***Submission of Matters to a Vote of Security Holders***

No matters were submitted to a vote of the stockholders during the fourth quarter ended December 31, 2005.

## PART II

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

*Market for Common Stock.* Until February 6, 2004, there was no established public trading market for our common stock. On February 6, 2004, our common stock commenced trading on the Nasdaq National Market under the symbol "SMBI." The following table sets forth for the periods indicated the high and low bid prices per share of our common stock as reported on the Nasdaq National Market.

| | High | Low |
|---|---|---|
| **2005** | | |
| First Quarter | $22.95 | $18.39 |
| Second Quarter | 23.97 | 21.04 |
| Third Quarter | 27.72 | 22.20 |
| Fourth Quarter | 26.79 | 21.95 |

| | High | Low |
|---|---|---|
| **2004** | | |
| February 6, 2004 to March 31, 2004 | $20.66 | $16.98 |
| Second Quarter | 18.01 | 15.85 |
| Third Quarter | 19.30 | 15.83 |
| Fourth Quarter | 21.95 | 15.43 |

On February 28, 2006, the last reported sales price for our common stock on the Nasdaq National Market was $23.58 per share. At February 28, 2006, there were approximately 174 stockholders of record.

*Dividends.* We have never declared or paid dividends on our common stock. We intend to retain future earnings to finance the growth and development of our business and, accordingly, do not currently intend to declare or pay any dividends on our common stock. Our board of directors will evaluate our future earnings, results of operations, financial condition and capital requirements in determining whether to declare or pay cash dividends. Delaware law prohibits us from paying any dividends unless we have capital surplus or net profits available for this purpose. In addition, our credit facility imposes restrictions on our ability to pay dividends. See "Management's Discussion and Analysis of Financial Condition and Results of Operations — Liquidity and Capital Resources."

*Recent Sales of Unregistered Securities.* During the three months ended December 31, 2005, we issued the following securities that were not registered under the Securities Act of 1933, as amended (the "Securities Act"). The transaction described below was conducted in reliance upon the exemptions from registration provided in Sections 3(b) and 4(2) of the Securities Act and Regulation D and the other rules and regulations promulgated thereunder. This issuance was made without the use of an underwriter, and the certificate and other documentation evidencing the securities issued in connection with this transaction bears a restrictive legend permitting transfer of the securities only upon registration under the Securities Act or pursuant to an exemption from registration.

- On October 5, 2005, we issued 252 shares of our common stock to an individual who holds an ownership interest in one of our surgery centers upon a cashless exercise of warrants.

**Item 6.** ***Selected Financial Data***

The following selected consolidated financial and other data should be read in conjunction with "Management's Discussion and Analysis of Financial Condition and Results of Operations" and our audited consolidated financial statements and the related notes included elsewhere in this report. The selected consolidated statement of operations data set forth below for each of the three years in the period ended December 31, 2005, and the selected consolidated balance sheet data set forth below at December 31, 2005 and 2004, are derived from our audited consolidated financial statements that are included elsewhere in this report. The selected consolidated statement of operations data set forth below for the years ended December 31, 2002 and 2001, and the selected consolidated balance sheet data set forth below at December 31, 2003, 2002 and 2001, are derived from our audited consolidated financial statements that are not included in this report.

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

| | Year Ended December 31, | | | | |
|---|---|---|---|---|---|
| | 2005 | 2004 | 2003 | 2002 | 2001 |
| | (dollars in thousands, except per share amounts) | | | | |
| **Consolidated Statement Of Operations Data:** | | | | | |
| Revenues | $ 265,744 | $ 216,325 | $ 176,269 | $ 144,688 | $ 104,704 |
| Cost of revenues | 166,610 | 141,765 | 117,305 | 93,692 | 75,783 |
| General and administrative expense | 21,993 | 18,449 | 15,874 | 14,328 | 12,407 |
| Depreciation and amortization | 13,277 | 10,927 | 9,295 | 7,836 | 7,743 |
| Provision for doubtful accounts | 4,215 | 3,989 | 2,748 | 4,843 | 1,055 |
| Loss (income) on equity investments | (1,273) | (1,272) | (402) | (541) | 192 |
| Impairment and loss on disposal of long-lived assets | 1,541 | 271 | 437 | 492 | 385 |
| Gain on sale of long-lived assets | (1,785) | (250) | (571) | (457) | (2,346) |
| Total operating expenses | 204,578 | 173,879 | 144,686 | 120,193 | 95,219 |
| Operating income | 61,166 | 42,446 | 31,583 | 24,495 | 9,485 |
| Minority interests in income of consolidated subsidiaries | (25,871) | (15,549) | (10,447) | (7,353) | (1,909) |
| Interest expense, net | (4,851) | (4,862) | (5,782) | (4,625) | (2,600) |
| Income before income taxes | 30,444 | 22,035 | 15,354 | 12,517 | 4,976 |
| Provision (benefit) for income taxes | 11,389 | 8,483 | (2,170) | 215 | 287 |
| Net income | $ 19,055 | $ 13,552 | $ 17,524 | $ 12,302 | $ 4,689 |
| Net income per share: | | | | | |
| Basic | $ 0.90 | $ 0.69 | $ 1.66 | $ 1.19 | $ 0.47 |
| Diluted | $ 0.86 | $ 0.67 | $ 1.38 | $ 1.01 | $ 0.45 |
| Shares used to compute net income per share: | | | | | |
| Basic | 21,285,211 | 19,736,722 | 10,536,745 | 10,349,568 | 9,908,447 |
| Diluted | 22,028,591 | 20,347,385 | 12,658,620 | 12,144,140 | 10,341,085 |
| **Cash Flow Data:** | | | | | |
| Net cash provided by operating activities | $ 41,903 | $ 28,087 | $ 20,807 | $ 21,770 | $ 8,438 |
| Net cash used in investing activities | (68,840) | (104,852) | (66,974) | (21,592) | (5,821) |
| Net cash provided by (used in) financing activities | 32,095 | 82,383 | 43,177 | 5,235 | (3,423) |
| **Other Data:** | | | | | |
| EBITDA (1) | $ 48,572 | $ 37,824 | $ 30,431 | $ 24,978 | $ 15,319 |
| EBITDA as a % of revenues | 18.3% | 17.5% | 17.3% | 17.3% | 14.6% |
| Number of surgery centers operated as of the end of period(2) | 59 | 54 | 44 | 34 | 24 |

| | As of December 31, | | | | |
|---|---|---|---|---|---|
| | 2005 | 2004 | 2003 | 2002 | 2001 |
| | | | (in thousands) | | |

| | | | | | |
|---|---|---|---|---|---|
| **Consolidated Balance Sheet Data:** | | | | | |
| Working capital | $ 48,784 | $ 41,455 | $ 25,979 | $ 24,839 | $ 21,706 |
| Total assets | 436,378 | 365,761 | 252,784 | 188,888 | 100,799 |
| Total long-term debt, less current maturities | 101,969 | 69,747 | 101,037 | 57,738 | 39,983 |
| Total stockholders' equity | 260,058 | 237,998 | 104,015 | 86,677 | 41,610 |

(1) When we use the term "EBITDA," we are referring to net income plus (a) income tax expense (provision), (b) interest expense, net and (c) depreciation and amortization. Minority interest expense represents the interests of third parties, such as physicians, hospitals and other health care providers, that own interests in surgery centers that we consolidate for financial reporting purposes. We consolidate for financial reporting purposes the financial results of 43 of the 50 surgery centers in which we owned an interest as of December 31, 2005. Our operating strategy involves sharing ownership of our surgery centers with physicians, physician groups and hospitals. These third parties own an interest in all but one of the centers in which we own an interest. We believe that it is preferable to present EBITDA because it excludes the portion of net income attributable to these third-party interests and clarifies for investors our portion of EBITDA generated by our surgery centers and other operations.

We use EBITDA as a measure of liquidity. We have included it because we believe that it provides investors with additional information about our ability to incur and service debt and make capital expenditures. We also use EBITDA, with some variation in the calculation, to determine our compliance with some of the covenants under our senior credit facility, as well as to determine the interest rate and commitment fee payable under the senior credit facility.

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

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

| | Year Ended December 31, | | | | |
|---|---|---|---|---|---|
| | 2005 | 2004 | 2003 | 2002 | 2001 |
| | | | (in thousands) (unaudited) | | |
| EBITDA | $ 48,572 | $ 37,824 | $ 30,431 | $24,978 | $15,319 |
| Depreciation and amortization | (13,277) | (10,927) | (9,295) | (7,836) | (7,743) |
| Interest expense, net | (4,851) | (4,862) | (5,782) | (4,625) | (2,600) |
| Income taxes | (11,389) | (8,483) | 2,170 | (215) | (287) |
| Net income | 19,055 | 13,552 | 17,524 | 12,302 | 4,689 |
| Depreciation and amortization | 13,277 | 10,927 | 9,295 | 7,836 | 7,743 |
| Impairment and loss on disposal of long-lived assets | 1,541 | 271 | 437 | 492 | 385 |
| Gain on sale of long-lived assets | (1,785) | (250) | (571) | (457) | (2,346) |
| Minority interests in income of consolidated subsidiaries | 25,871 | 15,549 | 10,447 | 7,353 | 1,909 |
| Distributions to minority partners | (23,225) | (14,420) | (10,690) | (6,177) | (2,186) |
| Loss (income) on equity investments | (1,273) | (1,272) | (402) | (541) | 192 |
| Provision for bad debts | 4,215 | 3,989 | 2,748 | 4,843 | 1,055 |
| Changes in operating assets and liabilities, net of effects of acquisitions and dispositions: | | | | | |
| Accounts receivable | (4,929) | (5,274) | (3,537) | (5,694) | (1,052) |
| Other current assets | 414 | 1,465 | (7,016) | (3,080) | (2,424) |
| Other current liabilities | 8,742 | 3,550 | 2,572 | 4,893 | 473 |
| Net cash provided by operating activities | $ 41,903 | $ 28,087 | $ 20,807 | $21,770 | $ 8,438 |

(2) Includes surgery centers that we manage but in which we do not have an 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 "Selected Financial Data" and our audited consolidated financial statements and related notes included elsewhere in this report. This discussion contains forward-looking statements that involve risks and uncertainties. For additional information regarding some of the risks and uncertainties that affect our business and the industry in which we operate, please read Item 1A. "Risk Factors" found elsewhere in this report. Our actual results may differ materially from those estimated or projected in any of these forward-looking statements.

### Executive Overview

*Our Company*

We own and operate a network of surgery centers in 22 states. As of March 10, 2006, we owned and operated 52 surgery centers and managed nine additional surgery centers. We own a majority interest in 35 of the 52 surgery centers in which we own an interest, and consolidate 44 of these centers for financial reporting purposes. However, one of the majority-owned and consolidated surgery centers was acquired after December 31, 2005 and one of our newly-developed surgery centers began operations after December 31, 2005; therefore, the results of these two surgery centers are not included in our discussion of 2005 results. Our surgery centers include three facilities that are licensed as hospitals, two of which we own and one of which we manage. In addition to our surgery centers, we also operate one diagnostic center and manage three physician networks, including two physician networks in markets in which we operate surgery centers.

Much of our growth during 2005 occurred through acquisitions and same store growth. Since December 31, 2004, we have acquired six surgery centers and developed one additional surgery center. Of the newly-acquired and developed surgery centers, we consolidate and have a majority interest in four of the seven facilities for financial reporting purposes. We also began the initial development of three additional surgery centers. We used a mixture of cash from operations and proceeds from our senior credit facility to acquire these interests. We believe that our continued growth and success depends not only on acquiring surgery centers, but also on the improved performance of facilities that we already own and operate. Our same store facility revenues increased during 2005 as a result of increases in the number of cases and a shift to a more favorable payor mix. However, during the third quarter of 2005, our case volumes in Louisiana, Texas and North Carolina were adversely impacted by several hurricanes. Facilities located in Hammond, Houma and Metairie, Louisiana and facilities located in Texas and North Carolina were temporarily shut down as a result of the hurricanes. The facilities located in Hammond and Houma, Louisiana and the facilities located in Texas and North Carolina reopened during the third quarter of 2005 and showed improved case volume during the fourth quarter 2005. Our surgery center located in Metairie, Louisiana reopened late in the fourth quarter of 2005. We estimate that we lost approximately $1.7 million in revenue during the year ended December 31, 2005, as a result of the closure of the facilities affected by the hurricanes during the third and fourth quarters. We carry business interruption insurance that may compensate us for our losses related to the closure of facilities because of the hurricanes.

We anticipate acquiring about three to four centers and developing three to four centers annually during the next three to five years. A typical surgery center costs us between $3.0 million and $7.0 million to develop and equip, excluding costs of real estate. This cost varies depending on the range of specialties that will be provided at the facility and the number of operating and treatment rooms. We typically fund about 70% of the development costs of a new surgery center with borrowings under our senior credit facility, and the remainder with equity contributed by us and the other owners of the center. Our ownership interests in surgery centers that we have developed range from 23% to 81%, although we anticipate that we will own primarily majority interests in future developments. The remaining owners are typically local physicians, physician groups or hospitals. We expect that our acquisition and development program will require substantial capital resources, which we estimate to range from $35.0 million to $75.0 million per year over the next three years. In addition, the operations of our existing facilities will require ongoing capital expenditures. We expect that our capital needs will be financed through a combination of cash flow from operations, bank debt and the issuance of debt and equity securities.

*Revenues*

We generate revenue and cash primarily through patient service revenues. We also generate revenue and cash, although to a lesser extent, through physician service revenues and other service revenues. Patient service revenues are revenues from surgical or diagnostic procedures performed in each of the surgery centers that we consolidate for financial reporting purposes. The fee charged for a procedure varies depending on the procedure, but usually includes all charges for usage of an operating room, a recovery room, special equipment, supplies, nursing staff and medications. The fee does not include professional fees charged by the patient's surgeon, anesthesiologist or other attending physician, which are billed directly by such physicians to the patient or third-party payor. Patient service revenues are recognized on the date of service, net of estimated contractual adjustments and discounts for third-party payors, including Medicare and Medicaid. Changes in estimated contractual adjustments and discounts are recorded in the period of change.

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

Other service revenues consists of management and administrative service fees derived from the non-consolidated facilities that we account for under the equity method, management of surgery centers 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 following table summarizes our revenues by service type as a percentage of revenues for the periods indicated:

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2005 | 2004 | 2003 |
| Patient service revenues | 95% | 94% | 90% |
| Physician service revenues | 2 | 2 | 2 |
| Other service revenues | 3 | 4 | 8 |
| Total | 100% | 100% | 100% |

*Operating Trends*

We intend to increase revenues by increasing the number of cases performed at each surgery center. We also intend to increase revenues by acquiring additional surgery centers and developing new surgery centers. As a result of the increased revenues, we expect our EBITDA margin to increase due to operating efficiencies and economies of scale as a result of leveraged general and administrative expenses. Our success in the future will be determined by the continued success of our current surgery centers as well as our ability to acquire and integrate new facilities.

**Acquisitions, Developments and Divestitures**

*Acquisitions and Developments*

During 2005, we acquired six surgery centers and developed one additional surgery center. We have a majority interest in and consolidate four of the surgery centers for financial reporting purposes. We entered into management agreements with each of these centers. In addition, we began the initial development of three additional surgery centers. Our investment related to these centers was about $50.4 million We paid for these investments using cash from operations and funds available under our senior credit facility.

During 2004, we acquired six surgery centers and two other surgery centers we intended to develop through syndication, renovation and expansion. We also opened one imaging center and entered into a management agreement for one additional surgery center. We entered into management agreements with each of these centers. One of our newly-developed surgery centers was developed through a partnership with one of our existing physician networks. Our investment related to these centers was about $66.3 million. We paid for these investments using cash from operations and funds available under our senior credit facility.

During 2003, we acquired five surgery centers. We entered into management agreements with each of these surgery centers and have a majority ownership interest in four of these centers. Our investment related to these centers was about $45.6 million. We paid for these investments using primarily funds available under our senior credit facility. In addition, we issued warrants to purchase 14,101 shares of our common stock.

In addition, during 2003, we acquired an additional 39% ownership interest in Dry Creek Imaging Center, a diagnostic imaging center that is adjacent to our surgery center in the Denver, Colorado market, for about $1.5 million in cash. We now own 90% of the center. We also acquired an additional 16.4% ownership interest in Village SurgiCenter in Erie, Pennsylvania, for about $1.0 million in cash. As of December 31, 2005, we own a 73% interest in the center.

*Divestitures*

During 2005, the Company sold its 51% ownership interest in the Erie Imaging Center, located in Erie, Pennsylvania, to Touchstone Medical Imaging, LLC ("Touchstone") for $100,000 in cash and a $1.0 million promissory note payable to the Company by Touchstone on August 31, 2005. The Company received payment in full for the promissory note during the third quarter of 2005. The Company recorded a loss of approximately $725,000 related to the sale. Before the sale, Touchstone was the minority partner and manager of the Erie Imaging Center. Also during 2005, the Company closed a surgery center located in Edmond, Oklahoma and sold the surgery center's land and building. The Company evaluated the current market and growth opportunities of the surgery center and decided the best strategy for the Company was to close the surgery center. Patient service revenues for the Edmond facility were less than 1% of the Company's consolidated patient service revenues for each of the twelve months ended December 31, 2005, 2004 and 2003. In connection with the closure of the surgery center, including the sale of the real estate, the Company recorded a net pre-tax loss of approximately $600,000 during 2005.

During 2004, after purchasing the outstanding ownership interests from our prior physician and hospital partners, we restructured our Physicians SurgiCenter of Houston partnership in Houston, Texas, creating a joint venture with the American Institute of Gastric Banding, Ltd. a privately-held single procedure focused surgical company based in Dallas, Texas ("AIGB"). In connection with the restructuring, we retained a 10% ownership in the surgery center and we no longer managed or consolidated the surgery center for financial reporting purposes. During 2005, we sold our remaining 10% ownership in the surgery center to AIGB for an immaterial gain.

Effective May 20, 2003, the surgery center we managed in Knoxville, Tennessee closed following the opening of the new surgery center in this market that we developed with the same organization, University Health System, Inc. We have a 25% ownership interest in the new surgery center.

**Critical Accounting Policies**

Our accounting policies are described in Note 2 of our consolidated financial statements included elsewhere in this report. In preparing our consolidated financial statements in conformity with accounting principles generally accepted in the United States, our management must make estimates and assumptions that affect the reported amounts of assets and liabilities and related disclosures at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Certain accounting estimates are particularly sensitive because of their complexity and the possibility that future events affecting them may differ materially from our current judgments and estimates. Our actual results could differ from those estimates. We believe that the following critical accounting policies are important to the portrayal of our financial condition and results of

operations, and require our management's subjective or complex judgment because of the sensitivity of the methods, assumptions and estimates used. This listing of critical accounting policies is not intended to be a comprehensive list of all of our accounting policies. In many cases, the accounting treatment of a particular transaction is specifically dictated by generally accepted accounting principles in the United States, with no need for management's judgment regarding accounting policy.

*Consolidation and Control*

Our consolidated financial statements include our accounts and those of our wholly-owned subsidiaries, as well as our interests in facilities that we control through our ownership of a majority voting interest or other rights granted to us by contract as the sole general partner or manager to manage and control the business. The rights of the limited partners or minority members in these surgery centers are generally limited to those that protect their ownership interests, including the right to approve of the issuance of new ownership interests, and those that protect their financial interests, including the right to approve the acquisition or divestiture of significant assets or the incurrence of debt that physician limited partners or members are required to guarantee on a pro rata basis based upon their respective ownership interests or that exceeds 20% of the fair market value of the center's assets. All significant intercompany balances and transactions, including management fees from consolidated centers, are eliminated in consolidation.

We also hold non-controlling interests in some surgery centers over which we exercise significant influence. Significant influence includes financial interests ranging from 19% to 42% and duties, rights and responsibilities for the day-to-day management of the surgery center. These non-controlling interests are accounted for under the equity method.

In addition, on December 31, 2003, as a result of Interpretation No. 46, "Consolidation of Variable Interest Entities ("VIEs"), an Interpretation of Accounting Research Bulletin No. 51" ("FIN 46"), we consolidated for financial reporting purposes a surgery center in which we do not own an interest. Under FIN 46, the surgery center is considered a VIE and we are the primary beneficiary. Therefore, under FIN 46 we are required to consolidate this surgery center for financial reporting purposes. The consolidation of this surgery center does not have a material impact on our results of operations.

*Revenue Recognition*

Our revenues are comprised of patient service revenues, physician service revenues and other service revenues. Our patient service revenues relate to fees charged for surgical or diagnostic procedures performed at facilities that we consolidate for financial reporting purposes. These fees are billed either to the patient or a third-party payor. Our fees vary depending on the procedure, but usually include all charges for usage of an operating room, a recovery room, equipment, supplies, nursing staff and medications. Our fees do not include professional fees charged by the patient's surgeon, anesthesiologist or other attending physician, which are billed directly by the physicians to the patient or third-party payor. We recognize patient service revenues when the related procedures are performed.

Our physician service revenues relate to fees we derive from managing physician networks for which we also have a contractual obligation to provide capital and additional assets. Currently we have such an obligation to only one group of six physicians included in one of the three physician networks we manage. We expect our physician service revenues to decline as a percentage of our total revenues as we continue to focus on our surgery center business. Physician service revenues consist of reimbursed expenses and a percentage of the amount by which each physician network's revenues exceed its expenses, as defined by our management agreement with each physician network. We recognize physician service revenues in the period in which reimbursable expenses are incurred and the period in which we have rights to a percentage of the amount by which a physician network's revenues exceed its expenses.

Our other service revenues are comprised of management and administrative service fees we derive from non-consolidated facilities that we account for under the equity method, management of surgery centers in which we do not own an interest and management services we provide to physician networks for which we are not required to provide capital or additional assets. The fees we derive from these management arrangements are based on a pre-

determined percentage of the revenues of each surgery center and physician network. We recognize other service revenues in the period in which services are rendered.

*Allowance for Contractual Adjustments and Doubtful Accounts*

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

We estimate our allowances for bad debts using similar information and analysis. While we believe that our allowances for contractual adjustments and bad debts are adequate, if the actual write-offs are significantly different from our estimates, our results of operations may, in turn, be significantly impacted. Because we have the ability to verify a patient's insurance coverage before services are rendered and because we have entered into contracts with third-party payors which account for a majority of our total revenue, the out-of-period contractual adjustments are minimal. Our net accounts receivable reflected allowances for doubtful accounts of $19.1 million and $13.7 million at December 31, 2005 and 2004, respectively.

We derive all of our physician service revenues from physician networks with which we have service agreements. Physician service revenues from physician networks consist of reimbursable expenses plus participation in the excess of revenue over expenses of the physician networks as provided for in the service agreements. Reimbursed expenses include the costs of our personnel, supplies and other expenses incurred to provide the management services to the physician networks. We recognize physician service revenues in the period in which reimbursable expenses are incurred and in the period in which we have rights to a percentage of the amount by which a physician network's revenues exceed its expenses. The participation component of physician service revenues is based on net billings of the physician network. Changes in estimated contractual adjustments and bad debts are reflected in physician service revenues in subsequent periods. Our physician service revenues would be impacted by changes in estimated contractual adjustments and bad debts recorded by the physician networks.

The following table summarizes our day's sales outstanding as of the dates indicated:

| | As of December 31, | | |
|---|---|---|---|
| | 2005 | 2004 | 2003 |
| Day's sales outstanding | 43 | 41 | 45 |

Our target for day's sales outstanding related to patient service revenues ranges from 40 days to 50 days. Our day's sales outstanding for the dates presented in the table above are within the target range.

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

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

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

Our accounts receivable aging, net of contractual adjustments but before our allowance for doubtful accounts, for consolidated surgery centers as of December 31 was (dollars in thousands):

| | 2005 | | 2004 | |
|---|---|---|---|---|
| | Amount | % of Total | Amount | % of Total |
| Current | $18,291 | 35% | $14,717 | 35% |
| 31 to 60 days | 10,207 | 20 | 7,880 | 18 |
| 61 to 90 days | 5,506 | 11 | 4,004 | 9 |
| 91 to 120 days | 3,433 | 7 | 2,660 | 6 |
| 121 to 150 days | 2,460 | 5 | 2,054 | 5 |
| Over 150 days | 11,678 | 22 | 11,316 | 27 |
| Total | $51,575 | 100% | $42,631 | 100% |

We recognize that final reimbursement of outstanding accounts receivable is subject to final approval by each third-party payor. However, because we have contracts with our third-party payors and we verify the insurance coverage of the patient before services are rendered, the amounts that are pending approval from third-party payors are minimal. Amounts are classified outside of self-pay if we have an agreement with the third-party payor or we have verified a patient's coverage prior to services rendered. It is our policy to collect co-payments and deductibles prior to providing services. It is also our policy to verify a patient's insurance 72 hours prior to the patient's procedure. Because our services are non-emergency, our surgery centers have the ability to control these procedures. Our patient service revenues from self-pay as a percentage of total revenues for 2005, 2004 and 2003 were approximately 4%, 3% and 3%, respectively.

*Income Taxes*

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

*Long-lived Assets, Goodwill and Intangible Assets*

When events, circumstances or operating results indicate that the carrying values of certain long-lived assets and the related identifiable intangible assets might be impaired, we assess whether the carrying value of the assets will be recovered through undiscounted future cash flows expected to be generated from the use of the assets and their eventual disposition. If the assessment indicates that the recorded cost will not be recoverable, that cost will be reduced to estimated fair value. Estimated fair value will be determined based on a discounted future cash flow analysis. During 2005 and 2004, we recorded an impairment charge of approximately $69,000 and $271,000, respectively, primarily related to the write

down of obsolete medical equipment. During 2003, we recorded an impairment charge of $275,000 related to software that we purchased but no longer intended to use. We believe that there has been no other impairment.

Goodwill represents the excess of the purchase price over the fair value of net tangible and identifiable intangible assets acquired. Goodwill and indefinite lived intangible assets are tested for impairment at least annually using a fair value method. Impairment is measured at the reporting unit level using a discounted cash flows model to determine the fair value of the reporting units. We will perform a goodwill impairment test whenever events or

changes in facts or circumstances indicate that impairment may exist, or at least annually during the fourth quarter each year. During the fourth quarter of 2005, the Company completed its annual impairment test and there was no indication of impairment.

*Professional and General Liability Risks*

We are subject to claims and legal actions in the ordinary course of our business, including claims relating to patient treatment, employment practices and personal injuries. To cover these claims, we maintain general and professional liability insurance in excess of self-insured retentions through a third-party commercial insurance carrier in amounts we believe to be sufficient for its operations. We expense the costs under the self-insured retention exposure for general and professional liability claims which relate to (i) deductibles on claims made during the policy period, and (ii) an estimate of claims incurred but not yet reported. Reserves and provisions for professional liability are based upon actuarially determined estimates. These estimates are based on various assumptions. Based on historical results and data currently available, we do not believe a change in one or more of these assumptions will have a material impact on our financial position or results of operations. These balances for professional liability represent the estimated costs of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The reserves are estimated using individual case-basis valuations and actuarial analysis. Changes to the estimated reserve amounts are included in current operating results.

**Results of Operations**

The following table summarizes certain statements of operations items for each of the three years ended December 31, 2005, 2004 and 2003. The table also shows the percentage relationship to total revenues for the periods indicated:

| | Year Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2005 | | 2004 | | 2003 | |
| | Amount | % of Revenues | Amount | % of Revenues | Amount | % of Revenues |
| | (dollars in thousands) | | | | | |
| Revenues | $265,744 | 100.0% | $216,325 | 100.0% | $176,269 | 100.0% |
| Cost of revenues | 166,610 | 62.7 | 141,765 | 65.5 | 117,305 | 66.5 |
| General and administrative expense | 21,993 | 8.3 | 18,449 | 8.5 | 15,874 | 9.0 |
| Depreciation and amortization | 13,277 | 5.0 | 10,927 | 5.0 | 9,295 | 5.3 |
| Provision for doubtful accounts | 4,215 | 1.6 | 3,989 | 1.8 | 2,748 | 1.6 |
| Income on equity investments | (1,273) | (0.5) | (1,272) | (0.5) | (402) | (0.2) |
| Impairment and loss on disposal of long-lived assets | 1,541 | 0.6 | 271 | 0.1 | 437 | 0.2 |
| Gain on sale of long-lived assets | (1,785) | (0.7) | (250) | 0.0 | (571) | (0.3) |
| Total operating expenses | 204,578 | 77.0% | 173,879 | 80.4% | 144,686 | 82.1% |
| Operating income | 61,166 | 23.0 | 42,446 | 19.6 | 31,583 | 17.9 |
| Minority interests in income of consolidated subsidiaries | (25,871) | (9.7) | (15,549) | (7.2) | (10,447) | (5.9) |
| Interest expense, net | (4,851) | (1.8) | (4,862) | (2.2) | (5,782) | (3.3) |
| Income before income taxes | 30,444 | 11.5 | 22,035 | 10.2 | 15,354 | 8.7 |
| Provision (benefit) for income taxes | 11,389 | 4.3 | 8,483 | 3.9 | (2,170) | (1.2) |
| Net income | $ 19,055 | 7.2% | $ 13,552 | 6.3% | $ 17,524 | 9.9% |

**Year Ended December 31, 2005 Compared to Year Ended December 31, 2004**

*Overview.* In 2005, our revenues increased 22.8% to $265.7 million from $216.3 million for 2004. Net income increased 40.4% to $19.1 million for 2005 from $13.6 million for 2004. Our financial results in 2005 were driven by the addition of six newly-acquired surgery centers and one newly-developed surgery center. We also began development of three additional surgery centers during 2005. Our results were also impacted by the organic growth at existing centers. Patient service revenues at same store surgery centers increased 5.3% for 2005 as compared to 2004. For purposes of this management's discussion of our consolidated financial results, we consider same store

facilities as those centers that we consolidate for financial reporting purposes for both the twelve months ended December 31, 2005 and 2004.

*Revenues.* Revenues for the year ended December 31, 2005 as compared to the year ended December 31, 2004 were as follows (dollars in thousands):

| | 2005 | 2004 | Dollar Variance | Percent Variance |
|---|---|---|---|---|
| Patient service revenues: | | | | |
| Same store revenues | $200,573 | $190,483 | $10,090 | 5.3% |
| Revenue from surgery centers acquired or developed | 52,607 | 12,195 | 40,412 | — |
| Total patient service revenues | 253,180 | 202,678 | 50,502 | 24.9 |
| Physician service revenues | 4,325 | 4,040 | 285 | 7.1 |
| Other service revenues | 8,239 | 9,607 | (1,368) | (14.2) |
| Total revenues | $265,744 | $216,325 | $49,419 | 22.8% |

The increase in same store revenues was primarily the result of a 2.8% increase in the number of cases during 2005. The remaining increase in patient service revenues is related to surgery centers acquired or developed since January 1, 2004.

*Cost of Revenues.* Cost of revenues for the year ended December 31, 2005 as compared to the year ended December 31, 2004 were as follows (dollars in thousands):

| | 2005 | 2004 | Dollar Variance | Percent Variance |
|---|---|---|---|---|
| Same store cost of revenues | $129,057 | $124,260 | $ 4,797 | 3.9% |
| Cost of revenues from surgery centers acquired or developed | 37,553 | 17,505 | 20,048 | — |
| Total cost of revenues | $166,610 | $141,765 | $24,845 | 17.5% |

The increase in same store cost of revenues was primarily the result of the increase in the number of cases performed during 2005 as compared to 2004. This increase was partially offset by lower general and professional liability expense during 2005 as compared to 2004. The general and professional liability expense includes reserves for an estimate of losses limited to deductibles and self-insured retention related to claims incurred and reported in the policy period and an estimate for unlimited losses related to claims incurred but not yet reported during the policy period. We based our accrual for general and professional liability expense on management's analysis of independent actuarial studies that were performed during 2005 and 2004 by Casualty Actuarial Consultants, Inc. The decrease in our general and professional liability expense was due to a favorable claims history and improved industry data used in the 2005 study. The remaining $20.0 million increase in cost of revenues was the result of surgery centers acquired or developed since January 1, 2004. As a percentage of revenues, total cost of revenues decreased to 62.7% for 2005 from 65.5% for 2004. We adopted Statement of Financial Accounting Standards No. 123(R), *Share-Based Payment*, on January 1, 2006. We estimate increasing cost of revenues of approximately $210,000 during 2006 as a result of additional compensation expense related to stock options granted prior to December 31, 2005 that will vest during 2006.

*General and Administrative Expenses.* General and administrative expenses increased 19.6% to $22.0 million for 2005 from $18.4 million for 2004. The increase in general and administrative expense was primarily related to the overall growth in the number of surgery centers and costs associated with our compliance with the Sarbanes-Oxley Act of 2002. As a percentage of revenues, general and administrative expense decreased to 8.3% for 2005 from 8.5% for 2004. This decrease was primarily the result of improved economies of scale. We estimate increasing general and administrative expenses of approximately $2.8 million during 2006 as a result of additional compensation expense related to stock options granted prior to December 31, 2005 that will vest during 2006.

*Depreciation and Amortization.* Depreciation and amortization expense for the year ended December 31, 2005 as compared to the year ended December 31, 2004 were as follows (dollars in thousands):

| | 2005 | 2004 | Dollar Variance | Percent Variance |
|---|---|---|---|---|
| Same store depreciation and amortization | $10,992 | $10,038 | $ 954 | 9.5% |
| Depreciation and amortization from surgery centers acquired or developed | 2,285 | 889 | 1,396 | — |
| Total depreciation and amortization | $13,277 | $10,927 | $ 2,350 | 21.5% |

As a percentage of revenues, depreciation and amortization expense remained constant at 5.0% for 2005 and 2004.

*Provision for Doubtful Accounts.* Provision for doubtful accounts increased 5.0% to $4.2 million for 2005 from $4.0 million for 2004. This increase is primarily attributed to the surgery centers acquired or developed since January 1, 2004. As a percentage of revenues, the provision for doubtful accounts decreased to 1.6% for 2005 from 1.8% for 2004.

*Income on Equity Investments.* Income on equity investments represents the net income of certain investments we have in surgery centers. These surgery centers are not consolidated for financial reporting purposes. Income on equity investments remained constant at $1.3 million for the year of 2005 compared to 2004.

*Loss on Disposal of Long-Lived Assets.* Loss on disposal of long-lived assets for 2005 primarily represents the loss related to our closing of a surgery center located in Edmond, Oklahoma and the loss on the disposal of our ownership interest in an imaging center located in Erie, Pennsylvania.

*Gain on Sale of Long-Lived Assets.* Gain on sale of long-lived assets for the 2005 and 2004 primarily represents the gain we recognized on the sale of a portion of our ownership interests in certain surgery centers.

*Operating Income.* Operating income increased $18.8 million to $61.2 million for 2005 from $42.4 million for 2004. The increase in operating income is primarily attributable to surgery centers acquired or developed since January 1, 2004. Same store operating income increased for 2005 as a result of an increase in cases and improved economies of scale. As a percentage of revenues, operating income increased to 23.0% for 2005 from 19.6% for 2004.

*Minority Interests in Income of Consolidated Subsidiaries.* Minority interests in income of consolidated subsidiaries for the year ended December 31, 2005 as compared to the year ended December 31, 2004 were as follows (dollars in thousands):

| | 2005 | 2004 | Dollar Variance | Percent Variance |
|---|---|---|---|---|
| Same store minority interests | $19,038 | $14,999 | $ 4,039 | 26.9% |
| Minority interests from surgery centers acquired or developed | 6,833 | 550 | 6,283 | — |
| Total minority interests | $25,871 | $15,549 | $10,322 | 66.4% |

Minority interests in income of consolidated subsidiaries for same store facilities increased as a result of improved profitability at the same store facilities. Minority interest expense represents the portion of the surgery center's net income that is attributable to the surgery center's minority owners. Consequently, as the net income of the surgery centers increase, the corresponding minority interest expense will increase. As a percentage of revenues, minority interests in income from consolidated subsidiaries increased to 9.7% for 2005 from 7.2% for 2004.

*Interest Expense, Net of Interest Income.* Interest expense, net of interest income, remained constant at $4.9 million for 2005 and 2004. Our interest expense was affected by our increased borrowing levels during 2005 as compared to 2004. However, our overall interest expense remained constant due to our lower interest rates during 2005 as compared to 2004.

*Provision for Income Taxes.* The provision for income taxes increased $2.9 million to $11.4 million for 2005 as compared to $8.5 million for 2004. This increase in the provision for income taxes was due to the increase in income before income taxes. The effective tax rate for 2005 was 37.4% as compared to an effective rate of 38.5% for 2004. Our effective tax rate changed because of a change in our deferred tax assets and liabilities. Also, our effective tax rate changed due to favorable rate changes in certain states in which we operate.

*Net Income.* Net income increased $5.5 million to $19.1 million for 2005 from $13.6 million for 2004. This increase was primarily the result of the increase in net income resulting from surgery centers acquired or developed since January 1, 2004 and an increase in cases performed in 2005 compared to 2004 at same store facilities. As a percentage of revenues, net income increased to 7.2% in 2005 from 6.3% for 2004.

**Year Ended December 31, 2004 Compared to Year Ended December 31, 2003**

*Overview.* In 2004, our revenues increased 22.7% to $216.3 million from $176.3 million for 2003. Net income decreased 22.3% to $13.6 million for 2004 from $17.5 million for 2003. Our financial results in 2004 were driven by the addition of six newly-acquired surgery centers, three newly-developed surgery centers and one newly-developed diagnostic center. Our results were also impacted by the organic growth at existing centers. Results for 2003 included a benefit for income taxes of approximately $2.2 million, which primarily related to the recognition of deferred tax assets of approximately $3.1 million. The 2003 results also included the impact of higher interest expense and prepayment penalties incurred in connection with the refinancing of outstanding indebtedness, which was completed in the third quarter of 2003. We paid off the higher cost indebtedness with the proceeds from our initial public offering completed in February 2004. For purposes of this management's discussion of our consolidated financial results, we consider same store facilities as those centers that we consolidate for financial reporting purposes for both the twelve months ended December 31, 2004 and 2003.

*Revenues.* Revenues for the year ended December 31, 2004 as compared to the year ended December 31, 2003 were as follows (dollars in thousands):

| | 2004 | 2003 | Dollar Variance | Percent Variance |
|---|---|---|---|---|
| Patient service revenues: | | | | |
| Same store revenues | $166,093 | $152,946 | $13,147 | 8.5% |
| Revenue from surgery centers acquired or developed | 36,585 | 5,175 | 31,410 | — |
| Total patient service revenues | 202,678 | 158,121 | 44,557 | 28.2 |
| Physician service revenues | 4,040 | 3,796 | 244 | 6.4 |
| Other service revenues | 9,607 | 14,352 | (4,745) | (33.1) |
| Total revenues | $216,325 | $176,269 | $40,056 | 22.7% |

The increase in same store revenues was primarily the result of a 5.0% increase in the number of cases during 2004. The remaining increase in patient service revenues is related to surgery centers acquired or developed since January 1, 2003. In addition, the $13.1 million increase in same store patient service revenues was also the result of $4.8 million from the consolidation of the variable interest entity, which was recorded as other service revenues during 2003. Other service revenues decreased $4.8 million for 2004 compared to 2003 primarily as a result of the consolidation of the variable interest entity pursuant to FIN 46(R). If we had adopted FIN 46(R) effective January 1, 2003, same store revenues would have increased 7.6% from $154.4 million for 2003 to $166.1 million for 2004. If we had adopted FIN 46(R) effective January 1, 2003, total revenues would have increased 23.1% from $175.7 million for 2003 to $216.3 million for 2004.

*Cost of Revenues.* Cost of revenues for the year ended December 31, 2004 as compared to the year ended December 31, 2003 were as follows (dollars in thousands):

| | 2004 | 2003 | Dollar Variance | Percent Variance |
|---|---|---|---|---|
| Same store cost of revenues | $119,212 | $114,303 | $ 4,909 | 4.3% |
| Cost of revenues from surgery centers acquired or developed | 22,553 | 3,002 | 19,551 | — |
| Total cost of revenues | $141,765 | $117,305 | $24,460 | 20.9% |

The increase in same store cost of revenues was primarily the result of the increase in the number of cases performed during 2004 as compared to 2003. This increase was partially offset by lower general and professional liability expense during 2004 as compared to 2003. The general and professional liability expense includes reserves for an estimate of losses limited to deductibles and self-insured retention related to claims incurred and reported in the policy period and an estimate for unlimited losses related to claims incurred but not yet reported during the policy period. We based our accrual for general and professional liability expense on management's analysis of independent actuarial studies performed during 2004 and 2003 by Casualty Actuarial Consultants, Inc. The remaining $19.6 million increase in cost of revenues was the result of surgery centers acquired or developed since January 1, 2003. As a percentage of revenues, total cost of revenues decreased to 65.5% for 2004 from 66.5% for 2003. If we had adopted FIN 46(R) effective January 1, 2003, total cost of revenues would have increased 19.1% to $141.8 million for 2004 from $119.1 million for 2003. In addition, as a percentage of revenues, cost of revenues would have decreased to 65.5% for 2004 from 67.8% for 2003.

*General and Administrative Expenses.* General and administrative expenses increased 15.7% to $18.4 million for 2004 from $15.9 million for 2003. The increase in general and administrative expense was primarily related to the overall growth in the number of surgery centers. As a percentage of revenues, general and administrative expense decreased to 8.5% for 2004 from 9.0% for 2003. This decrease was primarily the result of improved economies of scale.

*Depreciation and Amortization.* Depreciation and amortization expense for the year ended December 31, 2004 as compared to the year ended December 31, 2003 were as follows (dollars in thousands):

| | 2004 | 2003 | Dollar Variance | Percent Variance |
|---|---|---|---|---|
| Same store depreciation and amortization | $ 9,410 | $9,051 | $ 359 | 4.0% |
| Depreciation and amortization from surgery centers acquired or developed | 1,517 | 244 | 1,273 | — |
| Total depreciation and amortization | $10,927 | $9,295 | $ 1,632 | 17.6% |

As a percentage of revenues, depreciation and amortization expense decreased to 5.0% for 2004 from 5.3% for 2003.

*Provision for Doubtful Accounts.* Provision for doubtful accounts increased $1.3 million to $4.0 million for 2004 from $2.7 million for 2003. This increase was primarily attributed to the surgery centers acquired or developed since January 1, 2003. As a percentage of revenues, the provision for doubtful accounts increased to 1.8% for 2004 from 1.6% for 2003.

*Income on Equity Investments.* Income on equity investments represents the net income of certain investments we have in surgery centers. These surgery centers are not consolidated for financial reporting purposes. The increase was primarily attributable to investments we made in surgery centers during 2004 and the fourth quarter of 2003.

*Operating Income.* Operating income increased $10.8 million to $42.4 million for the year ended December 31, 2004 from $31.6 million for the year ended December 31, 2003. The increase in operating income was primarily attributable to surgery centers acquired or developed since January 1, 2003. Same store operating income increased $4.1 million for 2004 as a result of an increase in cases and improved economies of scale. This increase in same

store operating income was partially offset by a $2.5 million increase in general and administrative expenses during 2004. As a percentage of revenues, operating income increased to 19.6% for 2004 from 17.9% for 2003.

*Minority Interests in Income of Consolidated Subsidiaries.* Minority interests in income of consolidated subsidiaries for the year ended December 31, 2004 as compared to the year ended December 31, 2003 were as follows (dollars in thousands):

| | 2004 | 2003 | Dollar Variance | Percent Variance |
|---|---|---|---|---|
| Same store minority interests | $13,304 | $10,944 | $ 2,360 | 21.6% |
| Minority interests from surgery centers acquired or developed | 2,245 | (497) | 2,742 | — |
| Total minority interests | $15,549 | $10,447 | $ 5,102 | 48.8% |

Minority interests in income of consolidated subsidiaries for same store facilities increased as a result of improved operations at the same store facilities and as a result of the consolidation of the variable interest entity pursuant to FIN 46 (R). Minority interest expense represents the portion of the surgery center's net income that is attributable to the surgery center's minority owners. Consequently, as the net income of the surgery centers increase, the corresponding minority interest expense will increase. As a percentage of revenues, minority interests in income from consolidated subsidiaries increased to 7.2% for 2004 from 5.9% for 2003.

*Interest Expense, Net of Interest Income.* Interest expense, net of interest income, decreased 15.5% to $4.9 million for 2004 from $5.8 million for 2003. The decrease in interest expense was primarily the result of higher interest expense and prepayment penalties incurred in connection with our senior subordinated notes we issued to refinance outstanding indebtedness during 2003. We paid off the senior subordinated notes in the first quarter of 2004 with proceeds from our initial public offering completed in February 2004.

*Provision (Benefit) for Income Taxes.* The provision (benefit) for income taxes increased to a $8.5 million provision for 2004 as compared to a $2.2 million benefit for 2003. The 2003 results included the recognition of deferred tax assets of approximately $3.1 million.

*Net Income.* Net income decreased $3.9 million to $13.6 million for 2004 from $17.5 million for 2003. This decrease was primarily the result of the $2.2 million benefit for income taxes recorded during 2003. The change in the effective income tax rate in 2004 as compared to 2003 was partially offset by the increase in net income resulting from surgery centers acquired or developed since January 1, 2003 and an increase in cases performed in 2004 compared to 2003. As a percentage of revenues, net income decreased to 6.3% in 2004 from 9.9% for 2003.

**Quarterly Results of Operations**

The following tables present a summary of our unaudited quarterly consolidated results of operations for each of the four quarters in 2005 and 2004. The unaudited financial statements include all adjustments, consisting of normal recurring adjustments, necessary for a fair statement of such information when read in conjunction with our audited consolidated financial statements and related notes. Our quarterly operating results have varied in the past, may continue to do so and are not necessarily indicative of results for any future period.

| | 2005 | | | |
|---|---|---|---|---|
| | First Quarter | Second Quarter | Third Quarter | Fourth Quarter |
| | (dollars in thousands) (unaudited) | | | |
| **Consolidated Statement of Operations Data:** | | | | |
| Revenues | $62,179 | $64,653 | $66,422 | $72,490 |
| Operating expenses: | | | | |
| Salaries and benefits | 16,008 | 15,851 | 17,762 | 18,132 |
| Supplies | 11,453 | 11,802 | 12,006 | 13,408 |
| Professional and medical fees | 3,319 | 3,487 | 3,510 | 3,564 |
| Rent and lease expense | 3,830 | 4,077 | 4,488 | 4,817 |
| Other operating expenses | 4,588 | 5,035 | 4,515 | 4,958 |
| Cost of revenues | 39,198 | 40,252 | 42,281 | 44,879 |
| General and administrative expenses | 5,402 | 5,904 | 5,069 | 5,616 |
| Depreciation and amortization | 3,146 | 3,114 | 3,359 | 3,658 |
| Provision for doubtful accounts | 714 | 1,068 | 1,378 | 1,055 |
| Income on equity investments | (284) | (325) | (233) | (431) |
| Impairment and loss on disposal of long-lived assets | 109 | 745 | 664 | 21 |
| Gain on sale of long-lived assets | (241) | (782) | (758) | — |
| Total operating expenses | 48,044 | 49,976 | 51,760 | 54,798 |
| Operating income | 14,135 | 14,677 | 14,662 | 17,692 |
| Minority interests in income of consolidated subsidiaries | (5,969) | (5,863) | (6,453) | (7,586) |
| Interest expense, net | (1,034) | (880) | (1,408) | (1,529) |
| Income before income taxes | 7,132 | 7,934 | 6,801 | 8,577 |
| Provision for income taxes | 2,746 | 3,054 | 2,619 | 2,970 |
| Net income | $ 4,386 | $ 4,880 | $ 4,182 | $ 5,607 |
| **Other Data:** | | | | |
| Number of surgery centers operated as of the end of period(1) | 56 | 56 | 59 | 59 |

| | 2004 | | | |
|---|---|---|---|---|
| | First Quarter | Second Quarter | Third Quarter | Fourth Quarter |
| | (dollars in thousands) (unaudited) | | | |
| **Consolidated Statement of Operations Data:** | | | | |
| Revenues | $51,947 | $52,727 | $52,031 | $59,620 |
| Operating expenses: | | | | |
| Salaries and benefits | 13,581 | 13,738 | 13,717 | 15,359 |
| Supplies | 10,283 | 10,563 | 10,324 | 11,586 |
| Professional and medical fees | 2,598 | 2,708 | 2,849 | 3,338 |
| Rent and lease expense | 3,157 | 3,282 | 3,420 | 3,808 |
| Other operating expenses | 4,370 | 4,556 | 4,378 | 4,150 |
| Cost of revenues | 33,989 | 34,847 | 34,688 | 38,241 |
| General and administrative expenses | 4,544 | 4,633 | 4,496 | 4,776 |
| Depreciation and amortization | 2,712 | 2,746 | 2,846 | 2,623 |
| Provision for doubtful accounts | 697 | 832 | 995 | 1,465 |
| Income on equity investments | (121) | (366) | (374) | (411) |
| Impairment and loss on disposal of long-lived assets | 16 | — | — | 255 |
| Gain on sale of long-lived assets | (80) | (77) | — | (93) |
| Total operating expenses | 41,757 | 42,615 | 42,651 | 46,856 |
| Operating income | 10,190 | 10,112 | 9,380 | 12,764 |
| Minority interests in income of consolidated subsidiaries | (3,420) | (3,538) | (3,246) | (5,345) |
| Interest expense, net | (2,577) | (696) | (718) | (871) |
| Income before income taxes | 4,193 | 5,878 | 5,416 | 6,548 |
| Provision for income taxes | 1,614 | 2,263 | 2,084 | 2,522 |
| Net income | $ 2,579 | $ 3,615 | $ 3,332 | $ 4,026 |
| **Other Data:** | | | | |
| Number of surgery centers operated as of the end of period(1) | 44 | 45 | 51 | 54 |

(1) Includes surgery centers that we manage but in which we do not have an ownership interest.

**Liquidity and Capital Resources**

*Overview*

On February 11, 2004, we received net proceeds of $115.5 million, after deducting underwriting discounts and commissions, from our initial public offering of 8,280,000 shares of common stock, which included 1,080,000 shares attributable to the underwriters' exercise of their over-allotment option. We used the net proceeds to repay indebtedness and to pay holders of Series A and Series B convertible preferred stock in connection with the conversion of those shares to common stock upon the completion of the offering.

During 2005, we acquired six surgery centers and developed one additional surgery center. We have a majority interest in four of the surgery centers. We entered into management agreements with each of these centers. Our investment related to these centers was about $50.4 million. We paid for these investments using cash from operations and funds available under our senior secured credit facility. We also began development of three additional surgery centers during 2005.

During 2004, we acquired six centers and two other surgery centers we intended to develop through syndication, renovation and expansion. We also opened one imaging center and entered into a management agreement with one additional surgery center. We entered into management agreements with each of these centers. One of our newly-developed surgery centers was developed through a partnership with one of our existing physician networks. Our investment related to these centers was about $66.3 million. We paid for these investments using cash from operations and funds available under our senior credit facility.

We have used capital during the past three years primarily to acquire and develop surgery centers. Our cash is used primarily to acquire centers, develop centers and pay operating expenses. We anticipate acquiring about three to four centers and developing three to four centers annually during the next three to five years. We expect that our acquisition and development program will require substantial capital resources, which we estimate to range from $35.0 million to $75.0 million per year over the next three years. In addition, the operations of our existing facilities will require ongoing capital expenditures. A typical surgery center costs us between $3.0 million and $7.0 million to develop and equip, excluding costs of real estate. This cost varies depending on the range of specialties that will be provided at the facility and the number of operating and treatment rooms. We typically fund about 70% of the development costs of a new surgery center with borrowings under our senior credit facility and cash from operations, and the remainder with equity contributed by us and the other owners of the center. In the past, our ownership interests in surgery centers that we have developed range from 23% to 81%, although we anticipate that we will own primarily majority interests in future developments. We expect that our capital needs will be financed through a combination of cash flow from operations, bank debt and the issuance of debt and equity securities.

*Cash Flow Statement Information*

During 2005, we generated operating cash flow of $41.9 million. The $41.9 million includes distributions to minority interest holders of $23.2 million. Net cash used in investing activities during 2005 was $68.8 million, including $69.2 million of payments related to capital expenditures which consisted of payments for facilities acquired and developed and the acquisition of additional ownership interests in existing centers. Our net cash provided by financing activities during 2005 was $32.1 million, primarily related to $61.9 million of proceeds from borrowings under our senior credit facility. The proceeds from our long-term borrowing were partially offset by $34.4 million of principal payments on long-term debt.

During 2004, we generated operating cash flow of $28.1 million. The $28.1 million included distributions to minority interest holders of $14.4 million. Net cash used in investing activities during 2004 was $104.9 million, including $106.3 million of payments related to capital expenditures which consisted of payments for facilities acquired and developed and the acquisition of additional ownership interests in existing centers. The $106.3 million includes $31.8 million related to our Series A convertible preferred stock and Series B convertible preferred stock which converted into common stock and the right to receive cash upon the completion of our initial public offering. Our net cash provided by financing activities during 2004 was $82.4 million, primarily related to $115.5 million of net proceeds from our initial public offering and $83.0 million of proceeds from borrowings under our senior credit facility. The proceeds from our initial public offering and long-term borrowing were partially offset by $118.8 million of principal payments on long-term debt.

*Long-Term Debt*

In March 2005, we amended and restated our senior credit facility to allow us to borrow up to $150.0 million from a group of lenders for acquisitions, developments of new centers and working capital. The amendment and restatement of the senior credit facility has also lowered our interest costs and extended the maturity date of the senior credit facility until 2010. At December 31, 2005, we had outstanding indebtedness under our senior credit facility of $96.0 million. At our option, loans under the senior credit facility bear interest at Bank of America's base rate or the Eurodollar rate in effect on the applicable borrowing date, plus an applicable margin. The applicable margin will vary depending upon the ratio of our consolidated funded indebtedness to consolidated EBITDA. As of December 31, 2005, the interest rate for this debt ranged from 5.42% to 5.89% per year based on the borrowing date. During 2005, we entered into an interest rate swap agreement. The interest rate swap protects us against certain interest rate fluctuations of the LIBOR rate on $50.0 million of the Company's variable rate debt under the senior credit facility. The effective date of the interest rate swap was August 26, 2005, and it expires on March 21, 2010. The interest rate swap effectively fixes our LIBOR interest rate on the $50.0 million of variable debt at a rate of 4.49%. The senior credit facility contains various financial and non-financial covenants and restrictions. We believe that we are in compliance with these covenants and restrictions. The obligations under the senior credit facility and the related documents are secured by a first priority lien on substantially all of our wholly-owned subsidiaries' real and personal property, a pledge of all the capital stock or other ownership interests in each of our wholly-owned subsidiaries, and a pledge of our ownership interests in substantially all of our majority-owned subsidiaries. Our obligations under the senior credit facility are guaranteed by all of our wholly-owned subsidiaries with assets with a fair market value of greater than $100,000.

As of December 31, 2005, we had outstanding indebtedness to Synergy Bank in an aggregate amount of about $4.8 million. The notes payable to Synergy Bank are collateralized by the real estate owned by the surgery centers to which the loans were made. The notes mature in 2008 and bear interest at a rate of 6.7% per year. The notes contain various covenants to maintain certain financial ratios and also restrict encumbrance of assets, creation of indebtedness, investing activities and payment of distributions.

We believe that existing funds, cash flows from operations and borrowings under our senior credit facility will provide sufficient liquidity for the next 12 to 18 months. We will need to incur additional debt or issue additional equity or debt securities in the future to fund our acquisitions and development projects. We cannot assure you that capital will be available on acceptable terms, if at all. If we are unable to obtain funds when needed or on acceptable terms, we will be required to curtail our acquisition and development program. Our ability to meet our funding needs could be adversely affected if we suffer adverse results from our operations, or if we violate the covenants and restrictions to which we are subject under our senior credit facility and senior subordinated notes.

**Contractual Obligations and Commercial Commitments**

The following table summarizes our contractual obligations by period as of December 31, 2005 on a historical basis:

| | Payments Due by Period | | | | |
|---|---|---|---|---|---|
| Contractual Obligation | Total | Less than 1 Year | 1-3 Years | 4-5 Years | After 5 Years |
| | | | (in thousands) | | |
| Long-term debt | $102,006 | $ 823 | $ 1,804 | $ 99,379 | $ — |
| Capital lease obligations | 1,310 | 524 | 697 | 89 | — |
| Operating leases | 117,388 | 14,687 | 28,505 | 24,941 | 49,255 |
| Other long-term obligations | — | — | — | — | — |
| Total | $220,704 | $16,034 | $31,006 | $124,409 | $49,255 |

The following table summarizes our other commercial commitments related to unconsolidated entities by period as of December 31, 2005 on a historical basis:

| | Amount of Commitment Expiration Per Period | | | | |
|---|---|---|---|---|---|
| Other Commercial Commitments Related to Unconsolidated Entities | Total Amounts Committed | Less than 1 Year | 1-3 Years | 4-5 Years | After 5 Years |
| | | | (in thousands) | | |
| Operating lease guarantees | $ 1,030 | $ 263 | $ 551 | $ 216 | $ — |

**Inflation**

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

**Recently Issued Accounting Pronouncements**

In December 2004, the FASB issued SFAS No. 153, *Exchange of Non-monetary Assets — an amendment of APB Opinion No. 29*. The guidance in APB Opinion No. 29, *Accounting for Non-monetary Transactions*, is based on the principle that exchanges of non-monetary assets should be measured based on the fair value of the assets exchanged. The guidance in that Opinion, however, included certain exceptions to that principle. SFAS No. 153 amends Opinion No. 29 to eliminate the exception for non-monetary assets that do not have commercial substance. A non-monetary exchange has commercial substance if the future cash flows of the entity are expected to change significantly as a result of the exchange. SFAS No. 153 is effective for non-monetary asset exchanges occurring in fiscal periods beginning after June 15, 2005. The adoption of SFAS No. 153 did not have a material impact on our financial position or results of operations.

In May 2005, the FASB issued SFAS No. 154, *Accounting Changes and Error Corrections*, which replaces APB Opinion No. 20, *Accounting Changes*, and SFAS No. 3, *Reporting Accounting Changes in Interim Financial Statements*. SFAS No. 154 changes the requirements for the accounting for and reporting of a change in accounting principle. It requires retrospective application to prior periods' financial statements of changes in accounting principle, unless it is impracticable to determine either the period-specific effects or the cumulative effect of the change. This statement is effective for accounting changes and corrections of errors made in fiscal years beginning after December 15, 2005. The adoption of SFAS No. 154 will not have a material impact on our financial position or results of operations.

In June 2005, the FASB issued Emerging Issues Task Force ("EITF") Issue No. 04-5, *Determining Whether a General Partner, or the General Partners as a Group, Controls a Limited Partnership or Similar Entity When the Limited Partners Have Certain Rights*. EITF No. 04-5 provides a framework for determining whether a general partner controls, and should consolidate, a limited partnership or a similar entity. EITF No. 04-5 is effective for all limited partnerships formed after June 29, 2005 and for any limited partnerships in existence on June 29, 2005 that modify their partnership agreements after that date. EITF No. 04-5 is effective for all of the Company's partnerships beginning January 1, 2006. We have evaluated all of our existing partnership agreements and determined the adoption of EITF No. 04-5 will not have a material effect on our financial position or results of operations.

In December 2004, FASB issued SFAS No. 123(R), *Share-Based Payment*. SFAS No. 123(R) is a revision of SFAS No. 123 and supersedes APB No. 25. Among other items, SFAS No. 123(R) eliminates the use of the intrinsic value method of accounting. Instead, companies will be required to recognize in financial statements the cost of employee services received in exchange for awards of equity instruments, based on the fair value of those awards. When SFAS No. 123(R) was issued, the effective date was the first reporting period beginning after June 15, 2005. In April 2005, the Securities and Exchange Commission modified the effective date to be the beginning of the first fiscal year beginning after June 15, 2005, which would be January 1, 2006 for us. Early adoption of SFAS No. 123(R) is allowed using either a "modified prospective" method, or a "modified retrospective" method. Under the "modified prospective" method, compensation cost is recognized utilizing SFAS No. 123(R) beginning with the effective date for all share-based payments granted or modified after that date, but is based on the requirements of SFAS No. 123 for all unvested awards granted prior to the effective date of SFAS No. 123(R). The requirements are the same under the "modified retrospective" method, but companies are permitted to restate financial statements of previous periods based on pro forma disclosures made in accordance with SFAS No. 123.

We adopted SFAS No. 123(R) effective January 1, 2006. We will use the modified prospective method of adoption and will continue to use the Black-Scholes pricing method to value any future awarded options. The adoption of SFAS No. 123(R) will have a material impact on our statement of operations. We currently estimate the impact on our 2006 results of operations of adopting SFAS No. 123(R) to be approximately $3.0 million before applying the estimated applicable tax rate. Of the estimated $3.0 million to be recorded in 2006 upon adoption of SFAS No. 123(R), approximately $214,000 is expected to be recorded as salaries and benefits and approximately $2.8 million is expected to be recorded as general and administrative expense. We are estimating the effect of our

stock based compensation for options granted prior to December 31, 2005 will be $0.09 per diluted share for 2006. Our estimate can vary in the future depending on many factors, including levels of options and awards granted in the future, forfeitures and when option or award holders exercise these awards.

**Item 7A.** ***Quantitative and Qualitative Disclosures About Market Risk***

We are exposed to market risk related to changes in prevailing interest rates. Historically, we have not held or issued derivative financial instruments other than the use of a variable-to-fixed interest rate swap for a portion of our senior credit facility. We do not use derivative instruments for speculative purposes. Our outstanding debt to commercial lenders is generally based on a predetermined percentage above LIBOR or the lenders' prime rate. At December 31, 2005, $96.0 million of our total long-term debt was subject to variable rates of interest, while the remaining $7.3 million of our total long-term debt was subject to fixed rates of interest. A hypothetical 100 basis point increase in market interest rates would result in additional annual interest expense of $960,000. The fair value of our long-term debt, based on a discounted cash flow analysis, approximates its carrying value as of December 31, 2005.

**Item 8.** ***Financial Statements and Supplementary Data***

Information with respect to this Item is contained in our consolidated financial statements beginning with the Index 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***

(a) ***Evaluation of Disclosure Controls and Procedures.*** We carried out an evaluation, under the supervision and with the participation of management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of our disclosure controls and procedures as of the end of the period covered by this report pursuant to Exchange Act Rule 13a-15. Based upon that evaluation, the Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective in ensuring that information required to be disclosed by us (included in our consolidated subsidiaries) in reports that we file or submit under the Securities Exchange Act of 1934, as amended, is recorded, processed, summarized and reported in a timely basis.

(b) ***Management's Report on Internal Control over Financial Reporting.*** Management is responsible for establishing and maintaining adequate internal control over financial reporting, as defined in Exchange Act Rule 13a-15(f). Our internal control system was designed to provide reasonable assurance to our management and Board of Directors regarding the preparation and fair presentation of published financial statements.

Management has assessed the effectiveness of our internal control over financial reporting using the criteria set forth in "Internal Control — Integrated Framework" issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Based on management's assessment and those criteria, management believes that our internal control over financial reporting was effective as of December 31, 2005.

During 2005, we acquired an ownership interest in entities that own and operate the following surgery centers and equity method investments: Specialty Surgical Center of Beverly Hills/Brighton Way, Specialty Surgical Center of Beverly Hills/Wilshire Boulevard, Specialty Surgical Center of Encino, Specialty Surgical Center of Irvine and Specialty Surgical Center of Arcadia. Related to these acquisitions, our consolidated balance sheet includes $11.4 million and $3.1 million of total assets, excluding goodwill, and net assets, respectively, as of December 31, 2005, and our consolidated statement of operations includes $13.2 million and $2.0 million of total revenues and net income, respectively, for the year ended December 31, 2005. We have excluded these acquisitions from management's assessment of internal control over financial reporting.

Management's assessment of the effectiveness of internal control over financial reporting has been audited by Ernst & Young LLP, an independent registered public accounting firm. Ernst & Young's attestation report is included below.

**Report of Independent Registered Public Accounting Firm**

**The Board of Directors and Stockholders of Symbion, Inc.**

We have audited management's assessment, included in the accompanying Management's Report on Internal Control Over Financial Reporting, that Symbion, Inc. ("the Company") maintained effective internal control over financial reporting as of December 31, 2005, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). 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. Our responsibility is to express an opinion on management's assessment and an opinion on the effectiveness of the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, evaluating management's assessment, testing and evaluating the design and operating effectiveness of internal control, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

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.

As indicated in the accompanying Management's Report on Internal Control Over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Specialty Surgical Center of Beverly Hills/Brighton Way, Specialty Surgical Center of Beverly Hills/Wilshire, Specialty Surgical Center of Encino, Specialty Surgical Center of Irvine and Specialty Surgical Center of Arcadia (collectively, the "California Centers") which are included in the 2005 consolidated financial statements of the Company and constituted $11.4 million and $3.1 million of total assets, excluding goodwill, and net assets, respectively, as of December 31, 2005, and $13.2 million and $2.0 million of total revenues and net income, respectively, for the year then ended. Our audit of internal control over financial reporting of the Company also did not include an evaluation of the internal control over financial reporting of the California Centers.

In our opinion, management's assessment that the Company maintained effective internal control over financial reporting as of December 31, 2005, is fairly stated, in all material respects, based on the COSO criteria. Also, in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2005, based on the COSO criteria.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Symbion, Inc. as of December 31, 2005 and 2004, and the related consolidated statements of operations, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2005, and our report dated March 10, 2006 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

March 10, 2006
Nashville, Tennessee

(c) ***Changes in Internal Control Over Financial Reporting.*** There has been no change in our internal control over financial reporting that occurred during the fourth quarter of 2005 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

**Limitations on the Effectiveness of Controls**

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

**Item 9B.** ***Other Information***

None.

## PART III

### Item 10. *Directors and Executive Officers of the Registrant*

**Directors and Executive Officers**

Information about our directors and executive officers is incorporated by reference to the information contained under the captions "Election of Directors," "Corporate Governance" and "Executive Officers" included in our proxy statement relating to our annual meeting of stockholders to be held on May 9, 2006.

**Code of Business Conduct and Ethics**

We have adopted a Code of Business Conduct and Ethics. This code of ethics is posted on our website located at *www.symbion.com* under the heading "Corporate Governance — Code of Business Conduct and Ethics."

**Compliance with Section 16(a) of the Exchange Act**

Information with respect to compliance with Section 16(a) of the Securities Exchange Act of 1934 is incorporated by reference to the information contained under the caption "Security Ownership of Certain Beneficial Owners and Management — Section 16(a) Beneficial Ownership Reporting Compliance" included in our proxy statement relating to our annual meeting of stockholders to be held on May 9, 2006.

### Item 11. *Executive Compensation*

This information is incorporated by reference to the information contained under the captions "Corporate Governance — Compensation of Directors" and "Executive Compensation" included in our proxy statement relating to our annual meeting of stockholders to be held on May 9, 2006. The Comparative Performance Graph and the Compensation Committee Report on Executive Compensation also included in the proxy statement are expressly not incorporated herein by reference.

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

Information about the security ownership of certain beneficial owners and management is incorporated by reference to the information contained under the captions "Security Ownership of Certain Beneficial Owners and Management" and "Executive Compensation – Equity Compensation Plan Information" included in our proxy statement relating to our annual meeting of stockholders to be held on May 9, 2006.

### Item 13. *Certain Relationships and Related Transactions*

This information is incorporated by reference to the information contained under the caption "Executive Compensation – Certain Transactions" included in our proxy statement relating to our annual meeting of stockholders to be held on May 9, 2006.

### Item 14. *Principal Accountant Fees and Services*

This information is incorporated by reference to the information contained under the caption "Ratification of Appointment of Independent Registered Public Accounting Firm" included in our proxy statement relating to our annual meeting of stockholders to be held on May 9, 2006.

## PART IV

**Item 15.** ***Exhibits and Financial Statement Schedules***

**(a) Index to Consolidated Financial Statements, Financial Statement Schedules and Exhibits**

(1) ***Consolidated Financial Statements***

The consolidated financial statements required to be included in Part II, Item 8, are indexed on Page F-1 and submitted as a separate section of this report.

(2) ***Consolidated Financial Statement Schedules***

All schedules are omitted because they are not applicable or not required, or because the required information is included in the consolidated financial statements or notes in this report.

(3) ***Exhibits***

| No. | Description |
|---|---|
| 2.1 | — Agreement and Plan of Merger, dated as of March 7, 2002, among Symbion, Inc., Symbion Acquisition Sub, Inc. and Physicians Surgical Care, Inc. (a) |
| 2.2 | — Purchase Agreement, dated as of November 11, 2004, by and among the members of Surgery Center Partners, L.L.C., Symbion Ambulatory Resource Centres, Inc. and SMBIMS Kirkwood, Inc. (b) |
| 2.3 | — Purchase Agreement, dated as of July 27, 2005, by and among Members of Specialty Surgical Center, LLC, Specialty Surgical Center of Encino, LLC, Specialty Surgical Center of Irvine, LLC, Specialty Surgical Center of Arcadia, LLC, Symbion Ambulatory Resource Centres, Inc. and Affiliates of Symbion Ambulatory Resource Centres, Inc. (c) |
| 3.1 | — Certificate of Incorporation (d) |
| 3.2 | — Certificate of Amendment to Certificate of Incorporation (c) |
| 3.3 | — Certificate of Retirement of Stock (f) |
| 3.4 | — Certificate of Designation of Rights and Preferences of Series A Convertible Preferred Stock and Series B Convertible Preferred Stock (d) |
| 3.5 | — Certificate of Designation of Series A Junior Participating Preferred Stock (e) |
| 3.6 | — Bylaws (d) |
| 4.1 | — Form of Common Stock Certificate (d) |
| 4.2 | — Amended and Restated Investors' Rights Agreement, dated as of June 25, 1999, among Symbion, Inc. and the security holders named therein (a) |
| 4.3 | — Amendment No. 1 to Amended and Restated Investors' Rights Agreement, dated as of August 11, 1999, among Symbion, Inc. and the security holders named therein (a) |
| 4.4 | — Amendment No. 2 to Amended and Restated Investors' Rights Agreement, dated as of April 1, 2002, among Symbion, Inc. and the security holders named therein (a) |
| 4.5 | — Form of Warrant for the purchase of shares of Symbion, Inc. common stock (a) |

| No. | Description |
|---|---|

4.6 — Rights Agreement, dated as of February 6, 2004, between Symbion, Inc. and SunTrust Bank (g)

10.1 — Amended and Restated Executive Employment Agreement, dated May 16, 2002, between Symbion, Inc. and Richard E. Francis, Jr. (a) (n)

10.2 — Amended and Restated Executive Employment Agreement, dated May 16, 2002, between Symbion, Inc. and Clifford G. Adlerz (a) (n)

10.3 — Amended and Restated Executive Employment Agreement, dated May 16, 2002, between Symbion, Inc. and William V. B. Webb (a) (n)

10.4 — Securities Purchase Agreement, dated as of July 18, 2003, among Symbion, Inc. and DLJ Investment Partners II, L.P. and its affiliates (d)

10.5 — Form of 14¾% Senior Subordinated Note due 2008 (d)

10.6 — Credit Agreement, dated as of July 18, 2003, among Symbion, Inc., various lenders party thereto, Bank of America, N.A., as Administrative Agent and as Issuing Bank, Credit Suisse First Boston as Syndication Agent, Key Corporate Capital, Inc. as Documentation Agent, and Banc of America Securities, LLC, as sole Lead Arranger and Sole Book Manager (d)

10.7 — First Amendment to Credit Agreement, dated January 30, 2004, among Symbion, Inc., various lenders party thereto and Bank of America, N.A., as Administrative Agent and as Issuing Bank (d)

10.8 — Amended and Restated Credit Agreement, dated as of March 21, 2005, among Symbion, Inc., the subsidiaries of Symbion identified therein, Bank of America, N.A., as Administrative Agent, Swing Line Lender and L/C Issuer, Credit Suisse First Boston, as Syndication Agent, KeyBank National Association, as Documentation Agent and the other lenders party thereto (h)

10.9 — Lease Agreement, dated June 26, 2001, between Burton Hills IV Partners and Symbion, Inc. (a)

10.10 — First Amendment to Lease Agreement, dated February 9, 2004, between Burton Hills IV Partners and Symbion, Inc. (f)

10.11 — Amended and Restated Ambulatory Resource Centres, Inc. 1997 Stock Option Plan (a) (n)

10.12 — Ambulatory Resource Centres, Inc. Nonqualified Initial Option Plan (a) (n)

10.13 — Symbion Stock Incentive Plan (a) (n)

10.14 — Form of Incentive Stock Option Agreement under the Stock Incentive Plan (i) (n)

10.15 — Form of Nonqualified Stock Option Agreement under the Stock Incentive Plan (i) (n)

10.16 — Form of Restricted Stock Agreement under the Stock Incentive Plan (j) (n)

10.17 — Symbion Non-Employee Directors Stock Option Plan (a) (n)

10.18 — Form of Nonqualified Stock Option Agreement under the Non-Employee Directors Stock Option Plan (i) (n)

10.19 — Symbion Employee Stock Purchase Plan (a) (n)

| No. | Description |
|---|---|

10.20 — First Amendment to Symbion Employee Stock Purchase Plan (a) (n)

10.21 — Second Amendment to Symbion Employee Stock Purchase Plan (k) (n)

10.22 — Third Amendment to Symbion Employee Stock Purchase Plan (n)

10.23 — Executive Change in Control Severance Plan, dated December 11, 1997 (a) (n)

10.24 — Supplemental Executive Retirement Plan (l) (n)

10.25 — Form of Deferred Stock Purchase Program Agreement (l) (n)

10.26 — Management Rights Purchase Agreement, dated as of July 27, 2005, by and among Parthenon Management Partners, LLC, Andrew A. Brooks, M.D., Randhir S. Tuli and SymbionARC Management Services, Inc. (c)

10.27 — 2005 Bonus Plan (n)

10.28 — Summary of Director Compensation (n)

10.29 — Executive Officer Compensation and 2006 Bonus Plan (m) (n)

21.1 — Subsidiaries of Registrant

23.1 — Consent of Ernst & Young LLP

23.2 — Consent of Casualty Actuarial Consultants, Inc. (2005 report)

23.3 — Consent of Casualty Actuarial Consultants, Inc. (2004 report) (b)

23.4 — Consent of Casualty Actuarial Consultants, Inc. (2003 report) (f)

31.1 — Certification of Chief Executive Officer pursuant to Rule 13a-14(a) of the Securities Exchange Act of 1934, as amended, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

31.2 — Certification of Chief Financial Officer pursuant to Rule 13a-14(a) of the Securities Exchange Act of 1934, as amended, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

32.1 — Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

32.2 — Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

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(a) Incorporated by reference to exhibits filed with the Registrant's Registration Statement on Form S-1 (Registration No. 333-89554).

(b) Incorporated by reference to exhibits filed with the Registrant's Annual Report on Form 10-K for the year ended December 31, 2004 (File No. 000-50574).

(c) Incorporated by reference to exhibits filed with the Registrant's Current Report on Form 8-K filed August 2, 2005 (File No. 000-50574).

(d) Incorporated by reference to exhibits filed with the Registrant's Registration Statement on Form S-1 (Registration No. 333-110555).

(e) Incorporated by reference to exhibits filed with the Registrant's Registration Statement on Form S-8 (Registration No. 333-113272).

(f) Incorporated by reference to exhibits filed with the Registrant's Annual Report on Form 10-K for the year ended December 31, 2003 (File No. 000-50574).

(g) Incorporated by reference to exhibits filed with the Registrant's Registration Statement on Form 8-A filed with the Securities and Exchange Commission on February 6, 2004 (Registration No. 000-50574).

(h) Incorporated by reference to exhibits filed with the Registrant's Current Report on Form 8-K filed March 25, 2005 (File No. 000-50574).

(i) Incorporated by reference to exhibits filed with the Registrant's Current Report on Form 8-K filed December 14, 2004 (File No. 000-50574).

(j) Incorporated by reference to exhibits filed with the Registrant's Current Report on Form 8-K filed January 11, 2005 (File No. 000-50574).

(k) Incorporated by reference to exhibits filed with the Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2005 (File No. 000-50574).

(l) Incorporated by reference to exhibits filed with the Registrant's Quarterly Report on Form 10-Q for the quarter ended March 31, 2005 (File No. 000-50574).

(m) Incorporated by reference to exhibits filed with the Registrant's Current Report on Form 8-K filed February 28, 2006 (File No. 000-50574).

(n) Compensation plan or arrangement.

## INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

## Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders of Symbion, Inc.

We have audited the accompanying consolidated balance sheets of Symbion, Inc. as of December 31, 2005 and 2004, and the related consolidated statements of operations, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2005. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Symbion, Inc. at December 31, 2005 and 2004, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2005, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the effectiveness of Symbion, Inc.'s internal control over financial reporting as of December 31, 2005, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated March 10, 2006 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

March 10, 2006
Nashville, Tennessee

## SYMBION, INC.

## CONSOLIDATED BALANCE SHEETS
**(dollars in thousands, except per share amounts)**

| | December 31, 2005 | December 31, 2004 |
|---|---|---|
| **ASSETS** | | |
| Current assets: | | |
| Cash and cash equivalents | $ 28,434 | $ 23,276 |
| Accounts receivable, less allowance for doubtful accounts of $19,088 and $13,738, respectively | 32,487 | 28,893 |
| Inventories | 7,572 | 6,068 |
| Prepaid expenses and other current assets | 8,002 | 7,246 |
| Total current assets | 76,495 | 65,483 |
| Property and equipment: | | |
| Land | 1,625 | 1,694 |
| Buildings and improvements | 46,322 | 35,881 |
| Furniture and equipment | 68,579 | 59,764 |
| Computers and software | 7,561 | 7,041 |
| | 124,087 | 104,380 |
| Less accumulated depreciation | (50,677) | (36,587) |
| Property and equipment, net | 73,410 | 67,793 |
| Goodwill | 268,312 | 215,533 |
| Other intangible assets, net | 650 | 950 |
| Investments in and advances to affiliates | 13,770 | 12,927 |
| Other assets | 3,741 | 3,075 |
| Total assets | $436,378 | $365,761 |
| **LIABILITIES AND STOCKHOLDERS' EQUITY** | | |
| Current liabilities: | | |
| Accounts payable | $ 6,727 | $ 5,237 |
| Accrued payroll and benefits | 8,680 | 7,985 |
| Other accrued expenses | 10,957 | 9,186 |
| Current maturities of long-term debt | 1,347 | 1,620 |
| Total current liabilities | 27,711 | 24,028 |
| Long-term debt, less current maturities | 101,969 | 69,747 |
| Other liabilities | 17,845 | 10,350 |
| Minority interests | 28,795 | 23,638 |
| Stockholders' equity: | | |
| Common stock, 225,000,000 shares, $0.01 par value, authorized at December 31, 2005 and at December 31, 2004; 21,444,463 shares issued and outstanding at December 31, 2005, 21,032,777 shares issued and outstanding at December 31, 2004 | 214 | 210 |
| Additional paid-in-capital | 206,418 | 203,797 |
| Stockholder notes receivable | (228) | (287) |
| Accumulated other comprehensive income | 321 | — |
| Retained earnings | 53,333 | 34,278 |
| Total stockholders' equity | 260,058 | 237,998 |
| Total liabilities and stockholders' equity | $436,378 | $365,761 |

See accompanying notes.

## SYMBION, INC.

## CONSOLIDATED STATEMENTS OF OPERATIONS
**(dollars in thousands, except per share amounts)**

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2005 | 2004 | 2003 |
| Revenues | $ 265,744 | $ 216,325 | $ 176,269 |
| Operating expenses: | | | |
| Salaries and benefits | 67,753 | 56,395 | 46,275 |
| Supplies | 48,669 | 42,756 | 35,099 |
| Professional and medical fees | 13,880 | 11,493 | 9,889 |
| Rent and lease expense | 17,212 | 13,667 | 10,891 |
| Other operating expenses | 19,096 | 17,454 | 15,151 |
| Cost of revenues | 166,610 | 141,765 | 117,305 |
| General and administrative expense | 21,993 | 18,449 | 15,874 |
| Depreciation and amortization | 13,277 | 10,927 | 9,295 |
| Provision for doubtful accounts | 4,215 | 3,989 | 2,748 |
| Income on equity investments | (1,273) | (1,272) | (402) |
| Impairment and loss on disposal of long-lived assets | 1,541 | 271 | 437 |
| Gain on sale of long-lived assets | (1,785) | (250) | (571) |
| Total operating expenses | 204,578 | 173,879 | 144,686 |
| Operating income | 61,166 | 42,446 | 31,583 |
| Minority interests in income of consolidated subsidiaries | (25,871) | (15,549) | (10,447) |
| Interest expense, net | (4,851) | (4,862) | (5,782) |
| Income before income taxes | 30,444 | 22,035 | 15,354 |
| Provision (benefit) for income taxes | 11,389 | 8,483 | (2,170) |
| Net income | $ 19,055 | $ 13,552 | $ 17,524 |
| Net income per share: | | | |
| Basic: | $ 0.90 | $ 0.69 | $ 1.66 |
| Diluted: | $ 0.86 | $ 0.67 | $ 1.38 |
| Weighted average number of common shares outstanding and common equivalent shares: | | | |
| Basic: | 21,285,211 | 19,736,722 | 10,536,745 |
| Diluted: | 22,028,591 | 20,347,385 | 12,658,620 |

See accompanying notes.

## SYMBION, INC.

## CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
**(dollars in thousands, except per share amounts)**

| | Symbion, Inc. Series A and Series B Convertible Preferred Stock | | Symbion, Inc. Common Stock | | Additional Paid-In Capital | Stockholder Notes Receivable | Accumulated Other Comprehensive Income | Retained Earnings (Deficit) | Total Stockholders' Equity |
|---|---|---|---|---|---|---|---|---|---|
| | Shares | Amount | Shares | Amount | | | | | |
| Balance at December 31, 2002 | 6,946,316 | $ 21,742 | 10,570,565 | $ 106 | $ 62,008 | $ (381) | $ — | $ 3,202 | $ 86,677 |
| Issuance of warrants and common stock, net of repurchases, and other | — | — | 42,122 | — | (262) | 76 | — | — | (186) |
| Net income | — | — | — | — | — | — | — | 17,524 | 17,524 |
| Balance at December 31, 2003 | 6,946,316 | $ 21,742 | 10,612,687 | $ 106 | $ 61,746 | $ (305) | $ — | $ 20,726 | $ 104,015 |
| Public offering of common stock | — | — | 8,280,000 | 83 | — | — | — | — | 83 |
| Conversion of Preferred Stock at time of public offering | (6,946,316) | (21,742) | 1,789,341 | 18 | 24,795 | — | — | — | 3,071 |
| Other initial public offering activity | — | — | — | — | 111,764 | — | — | — | 111,764 |
| Issuance of warrants and common stock, net of repurchases, and other | — | — | 350,749 | 3 | 5,492 | 18 | — | — | 5,513 |
| Net income | — | — | — | — | — | — | — | 13,552 | 13,552 |
| Balance at December 31, 2004 | — | $ — | 21,032,777 | $ 210 | $ 203,797 | $ (287) | $ — | $ 34,278 | $ 237,998 |
| Issuance of warrants and common stock, net of repurchases, and other | — | — | 411,686 | 4 | 2,558 | 59 | — | — | 2,621 |
| Amortized compensation expense related to restricted stock | — | — | — | — | 63 | — | — | — | 63 |
| Unrealized gain on interest rate swap, net of taxes | — | — | — | — | — | — | 321 | — | 321 |
| Net income | — | — | — | — | — | — | — | 19,055 | 19,055 |
| Balance at December 31, 2005 | — | $ — | 21,444,463 | $ 214 | $ 206,418 | $ (228) | $ 321 | $ 53,333 | $ 260,058 |

See accompanying notes.

## SYMBION, INC.

## CONSOLIDATED STATEMENTS OF CASH FLOWS
(dollars in thousands)

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2005 | 2004 | 2003 |
| **Cash flows from operating activities:** | | | |
| Net income | $ 19,055 | $ 13,552 | $ 17,524 |
| Adjustments to reconcile net income to net cash provided by operating activities: | | | |
| Depreciation and amortization | 13,277 | 10,927 | 9,295 |
| Impairment and loss on disposal of long-lived assets | 1,541 | 271 | 437 |
| Gain on sale of long-lived assets | (1,785) | (250) | (571) |
| Minority interests | 25,871 | 15,549 | 10,447 |
| Distributions to minority partners | (23,225) | (14,420) | (10,690) |
| Income on equity investments | (1,273) | (1,272) | (402) |
| Provision for doubtful accounts | 4,215 | 3,989 | 2,748 |
| Changes in operating assets and liabilities, net of effects of acquisitions and dispositions: | | | |
| Accounts receivable | (4,929) | (5,274) | (3,537) |
| Other assets | 414 | 1,465 | (7,016) |
| Other liabilities | 8,742 | 3,550 | 2,572 |
| Net cash provided by operating activities | 41,903 | 28,087 | 20,807 |
| **Cash flows from investing activities:** | | | |
| Payments for acquisitions, net of cash acquired | (55,479) | (95,198) | (48,940) |
| Purchases of property and equipment, net | (13,751) | (11,086) | (13,826) |
| Change in other assets | 390 | 1,432 | (4,208) |
| Net cash used in investing activities | (68,840) | (104,852) | (66,974) |
| **Cash flows from financing activities:** | | | |
| Principal payments on long-term debt | (34,353) | (118,820) | (62,106) |
| Proceeds from debt issuances | 61,938 | 83,000 | 100,419 |
| Proceeds from capital contributions by minority partners | 3,630 | 1,364 | 3,348 |
| Proceeds from initial public offering, net | — | 115,506 | — |
| Change in other long-term liabilities | (1,570) | 432 | 1,516 |
| Net proceeds from issuance of common stock | 2,450 | 901 | — |
| Net cash provided by financing activities | 32,095 | 82,383 | 43,177 |
| Net increase (decrease) in cash and cash equivalents | 5,158 | 5,618 | (2,990) |
| Cash and cash equivalents at beginning of period | 23,276 | 17,658 | 20,648 |
| Cash and cash equivalents at end of period | $ 28,434 | $ 23,276 | $ 17,658 |
| **Supplemental cash flow information:** | | | |
| Cash paid for interest | $ 6,059 | $ 6,436 | $ 5,442 |

See accompanying notes.

SYMBION, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2005
(dollars in thousands, except per share amounts)

## 1. Organization

Symbion, Inc. (the "Company"), through its wholly-owned subsidiaries, owns interests in partnerships and limited liability companies which own and operate surgery centers in joint-ownership with physicians and physician groups, hospitals and hospital networks. As of December 31, 2005, the Company owned and operated 50 surgery centers and managed nine additional surgery centers in 22 states. The Company owns a majority interest in 34 of the 50 surgery centers and consolidates 43 of these centers for financial reporting purposes. The Company's surgery centers include three facilities that are licensed as hospitals, two of which are owned and one of which is managed. The Company also owns one diagnostic imaging center, which is located in a market in which the Company currently owns and operates a surgery center. In addition to the surgery centers and the diagnostic center, the Company manages three physician networks, including two physician networks in markets in which the Company also operates surgery centers. The Company also provides management and administrative services on a contract basis to surgery centers in which it does not own an interest.

## 2. Significant Accounting Policies and Practices

### Basis of Presentation and Use of Estimates

The accompanying consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles. The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the accompanying consolidated financial statements and notes. Examples include, but are not limited to, estimates of accounts receivable allowances, professional and general liabilities and the estimate of deferred tax assets or liabilities. In the opinion of management, all adjustments considered necessary for a fair presentation have been included. All adjustments are of a normal, recurring nature. Actual results could differ from those estimates.

### Principles of Consolidation

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 ownership of a majority voting interest or other rights granted to the Company by contract to manage and control the affiliate's business. The physician limited partners and minority members of the entities that we control 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, gross negligence or bankruptcy. These protective rights do not preclude consolidation of the respective partnerships and limited liability companies. The consolidated financial statements also include the accounts of a variable interest entity in which the Company is the primary beneficiary. The variable interest entity is a surgery center located in the state of New York. The accompanying consolidated balance sheet as of December 31, 2005 and 2004 includes assets of $4,988 and $5,137, respectively, and liabilities of $156 and $132, respectively, related to the variable interest entity. All significant intercompany balances and transactions are eliminated in consolidation.

### Fair Value of Financial Instruments

In estimating fair value disclosures for cash, accounts receivable and accounts payable, the carrying amounts reported in the accompanying consolidated balance sheets approximate fair value because of their short-term nature. For long-term debt and capitalized leases, the carrying amounts reported in the accompanying consolidated balance sheets approximate fair value based upon the borrowing rates available to the Company.

**Cash and Cash Equivalents**

The Company considers all highly liquid investments with a maturity of three months or less when purchased to be cash equivalents. Approximately $1,083 of the Company's 2005 cash and cash equivalents represent an escrow amount for indemnifications related to the 2005 purchase of the Company's interest in surgery centers in California. The Company maintains its cash and cash equivalent balances at high credit quality financial institutions.

**Accounts Receivable**

Accounts receivable consist of receivables from federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies, employers and patients. The Company recognizes that revenues and receivables from government agencies are significant to its operations, but it does not believe that there are significant credit risks associated with these government agencies. Concentration of credit risk with respect to other payors is limited because of the large number of such payors. Accounts receivable are recorded net of contractual adjustments and allowances for doubtful accounts to reflect accounts receivable at net realizable value. Accounts receivable at December 31 were as follows:

| | 2005 | 2004 |
|---|---|---|
| Surgery centers | $31,903 | $28,393 |
| Physician networks | 584 | 500 |
| Total | $32,487 | $28,893 |

The following table sets forth by type of payor the percentage of the Company's accounts receivable for consolidated surgery centers as of December 31:

| Payor | 2005 | 2004 |
|---|---|---|
| Private insurance | 70% | 63% |
| Government | 10 | 14 |
| Self-pay | 14 | 17 |
| Other | 6 | 6 |
| Total | 100% | 100% |

Collection periods vary by payor class. During the year ended December 31, 2005, the collection period for private insurance payors generally ranged from 21 to 45 days, the collection period for government payors generally ranged from 21 to 35 days and the collection period for self-pay generally ranged from 75 to 80 days.

The Company's policy is to review the standard aging schedule, by facility, to determine the appropriate provision for doubtful accounts. This review is supported by an analysis of the actual net revenues, contractual adjustments and cash collections received. If the Company's internal collection efforts are unsuccessful, the Company manually reviews the patient accounts. An account is written-off only after the Company has pursued collection with legal or collection agency assistance or otherwise deemed an account to be uncollectible.

**Allowance for Doubtful Accounts**

The amount of the provision for doubtful accounts is based upon management's assessment of historical and expected net collections. Management reviews the results of detailed analysis of historical write-offs and recoveries at the surgery centers as a primary source of information in estimating the collectability of accounts receivable.

Changes in the allowance for doubtful accounts and the amounts charged to revenues, costs and expenses were as follows:

| | Allowance Balance at Beginning of Period | Charged to Revenues, Costs and Expenses | Charged to Other Accounts(1) | Write-offs | Allowance Balance at End of Period |
|---|---|---|---|---|---|
| Year ended December 31: | | | | | |
| 2003 | $ 11,632 | $ 2,748 | $ 1,362 | $ 3,210 | $ 12,532 |
| 2004 | 12,532 | 3,989 | 437 | 3,220 | 13,738 |
| 2005 | 13,738 | 4,215 | 5,002 | 3,867 | 19,088 |

(1) Relates to allowances for doubtful accounts recorded under the purchase method of accounting for acquired entities.

**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.

**Property and Equipment**

Property and equipment are stated at cost or, if obtained through acquisition, at fair value determined on the date of acquisition, and depreciated on a straight-line basis over the useful lives of the assets, generally three to five years for computers and software and five to seven years for furniture and equipment. Leasehold improvements are depreciated on a straight-line basis over the shorter of the lease term or the estimated useful life of the assets. Routine maintenance and repairs are charged to expenses as incurred, while expenditures that increase capacities or extend useful lives are capitalized. When events or circumstances indicate that the carrying value of certain property and equipment might be impaired, the Company prepares an expected undiscounted cash flow projection. If the projection indicates that the recorded amounts of the property and equipment are not expected to be recovered, these amounts are reduced to estimated fair value. The cash flow estimates and discount rates incorporate management's best estimates, using appropriate and customary assumptions and projections at the date of evaluation. For the year ended December 31, 2005 and 2004, the Company recorded impairment charges of $69 and $271, respectively, primarily related to a charge for obsolete medical equipment. For the year ended December 31, 2003, the Company recorded impairment charges of $275 related to software that the Company purchased but did not use.

Depreciation expense, including the amortization of assets under capital leases, was $12,980, $10,855 and $9,224 for the years ended December 31, 2005, 2004 and 2003, respectively.

**Goodwill and Indefinite Lived Intangible Assets**

Goodwill represents the excess of the purchase price over the fair value of net tangible and identifiable intangible assets acquired. Goodwill and other indefinite lived intangible assets are no longer amortized, but are tested at least annually through an impairment test using a fair value method. Impairment is tested using a discounted cash flows model to determine fair value. The Company will perform a goodwill impairment test whenever events or changes in facts or circumstances indicate that impairment may exist, or at least annually during the fourth quarter each year. Goodwill resulting from acquisitions is deductible for tax purposes over a 15-year period. There was no impairment related to goodwill for the years ended December 31, 2005, 2004 and 2003. See Note 6 for further disclosure on goodwill.

**Service Agreement Rights**

Service agreement rights represent the exclusive right to operate the Louisville, Kentucky physician network during the 20-year term of the agreement. Originally, the service agreement right was amortized over 20 years. Amortization expense increased during 2005 because the term of the service agreement was decreased from the

original 20-year term to an approximately 3-year term. Service agreement rights are recorded as other intangible assets on the accompanying consolidated balance sheets and had unamortized balances of $650 and $950 at December 31, 2005 and 2004, respectively. Amortization expense was $297 for the year ended December 31, 2005 and $72 for each of the two years ended December 31, 2004 and 2003. See Note 6 for further disclosure on service agreement rights. Subsequent to December 31, 2005, the Louisville, Kentucky independent practice association notified the Company that it would be dissolving. The Company will continue to manage the independent practice association through June 30, 2006.

**Minority Interests**

The consolidated financial statements include all assets, liabilities, revenues and expenses of surgery centers in which the Company has a majority ownership interest or has other rights sufficient to allow the Company to consolidate the center. The Company has recorded minority interests in the earnings (losses) of such surgery centers.

**Investments in and Advances to Affiliates**

The Company holds non-controlling interests in certain surgery centers in which it exercises significant influence. The Company accounts for such investments under the equity method. Investments in and advances to affiliates at December 31, 2005 and 2004 include approximately $3,471 and $4,835, respectively, of advances to, net investments in and a note receivable from a surgery center that the Company manages which are secured by substantially all of the assets of the related surgery center.

**Other Assets**

Other assets at December 31, 2005 and 2004 included approximately $1,998 and $2,081, respectively, related to deferred financing costs. Deferred financing costs, which primarily relate to the Company's senior credit facility, consist of prepaid interest, loan fees and other costs of financing that are amortized over the term of the related financing agreements. The deferred financing costs are amortized as interest expense on the accompanying consolidated statements of operations.

Other assets at December 31, 2005 also included approximately $528 related to the fair value of the Company's interest rate swap. During the third quarter of 2005, the Company entered into an interest rate swap to reduce the interest rate risk associated with the interest rate on the Company's senior credit facility. See Note 8 for further disclosure on the Company's interest rate swap.

**Comprehensive Income**

The Company reports other comprehensive income as a measure of changes in stockholders' equity that result from recognized transactions and other economic events of the period from nonowner sources. Other comprehensive income of the Company results from adjustments due to the fluctuation of the value of the Company's interest rate swap accounted for under Statement of Financial Accounting Standards ("SFAS") No. 133, *Accounting for Derivative Instruments and Hedging Activities*, as amended. The Company entered into the interest rate swap during the third quarter of 2005. The value of the interest rate swap was an asset of $528, net of taxes of approximately $207, at December 31, 2005 and is recorded as accumulated other comprehensive income in the accompanying consolidated balance sheet. See Note 8 for further discussion of the Company's interest rate swap. For the years ended December 31, 2004 and 2003, the Company had no items of comprehensive income recorded directly to stockholders' equity.

**Revenues**

Revenues consist of the following for the years ended December 31:

| | 2005 | 2004 | 2003 |
|---|---|---|---|
| Patient service revenues | $253,180 | $202,678 | $158,121 |
| Physician service revenues | 4,325 | 4,040 | 3,796 |
| Other service revenues | 8,239 | 9,607 | 14,352 |
| Total revenues | $265,744 | $216,325 | $176,269 |

*Patient Service Revenues*

Patient service revenues are recorded at the time health care services are provided at estimated amounts due from patients and third-party payors. A fee is charged for surgical procedures performed in each of the Company's surgery centers. The fee varies depending on the procedure, but usually includes all charges for usage of an operating room, a recovery room, special equipment, supplies, nursing staff and medications. The fee does not include professional fees charged by the patient's surgeon, anesthesiologist or other attending physician, which are billed directly by such physicians to the patient or third-party payor. The Medicare program and most other payors pay surgery centers in accordance with a fee schedule that is prospectively determined. Accordingly, there is no retroactive cost report settlement process. Revenues from surgery centers are recognized on the date of service, net of estimated contractual adjustments and discounts from third-party payors, including Medicare and Medicaid. Changes in estimated contractual adjustments and discounts are recorded in the period of change.

The following table sets forth by type of payor the percentage of our patient service revenues generated in 2005, 2004 and 2003 for surgery centers in which we owned an interest as of December 31:

| Payor | 2005 | 2004 | 2003 |
|---|---|---|---|
| Private insurance | 76% | 76% | 76% |
| Government | 19 | 20 | 19 |
| Self-pay | 4 | 3 | 3 |
| Other | 1 | 1 | 2 |
| Total | 100% | 100.0% | 100.0% |

*Physician Service Revenues*

The Company derives all of its physician service revenues from physician networks with which it has service agreements. Physician service revenues from physician networks consist of reimbursable expenses, plus participation in the excess of revenue over expenses of the physician networks, as provided for in the service agreements. Reimbursed expenses include the costs of personnel, supplies and other expenses incurred to provide the management services to the physician networks. The Company recognizes physician service revenues in the period in which reimbursable expenses are incurred and in the period in which the Company has the right to receive a percentage of the amount by which a physician network's revenues exceed its expenses. The participation component of physician service revenues is based on net billings. Changes in estimated contractual adjustments and bad debts are reflected in physician service revenues in the period of change. The Company's physician service revenues would be impacted by changes in estimated contractual adjustments and bad debts recorded by the physician networks. As required by the service agreements, the Company purchases patient accounts receivable on a monthly basis from the physician networks at estimated net realizable value (i.e., net of estimated contractual adjustments and bad debts) to provide liquidity to the physician networks and collects amounts from the responsible payor as described under Accounts Receivable in Note 2. As of December 31, 2005, the Company had such an obligation to only one group of three physicians included in one of the three physician networks the Company manages. Such activity is reflected as cash flows from operating activities in the accompanying consolidated statements of cash flows. Accounts receivable are a function of clinic revenues generated by the physician networks, rather than physician service revenues of the Company.

Physician service revenues consist of the following amounts for the years ended December 31:

| | 2005 | 2004 | 2003 |
|---|---|---|---|
| Professional services revenues | $12,619 | $11,028 | $10,028 |
| Contractual adjustments and bad debt expense | (5,680) | (4,924) | (4,235) |
| Clinic revenue | 6,939 | 6,104 | 5,793 |
| Medical group retainage | (2,614) | (2,064) | (1,997) |
| Physician service revenues | $ 4,325 | $ 4,040 | $ 3,796 |

*Other Service Revenues*

Other service revenues consist of management and administrative service fees derived from the non-consolidated facilities that the Company accounts for under the equity method, management of surgery centers in which the Company does not own an interest and management services the Company provides to physician networks for which the Company is not required to provide capital or additional assets.

**Stock-Based Compensation**

The Company has elected to record cost for stock-based compensation in accordance with Accounting Principles Board ("APB") Opinion No. 25, *Accounting for Stock Issued to Employees*, and related interpretations thereof and, accordingly, recognizes no compensation expense for options granted when the exercise price is equal to or less than the market price of the underlying stock on the date of grant (the "intrinsic value method"). SFAS No. 123, *Accounting for Stock-Based Compensation*, encourages, but does not require, companies to record compensation cost for stock-based employee compensation plans at "fair value." SFAS No. 123 permits the use of the Black-Scholes method to estimate fair value. An expense for restricted stock awards is recognized in the statement of operations based on the value of the stock on the grant date and applied over the vesting period of the award.

Had the Company used Black-Scholes estimates to determine the fair value of options granted under SFAS No. 123, and recorded a compensation expense, net income and net income per share attributable to common stockholders would have been reduced to the following pro forma amounts (in thousands, except per share amounts):

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2005 | 2004 | 2003 |
| Net income as reported | $19,055 | $13,552 | $17,524 |
| Add: Total compensation expense for stock option grants included in net income, net of taxes | 40 | — | — |
| Pro forma compensation expense for stock option grants | (2,385) | (1,842) | (2,122) |
| Pro forma net income | $16,710 | $11,710 | $15,402 |
| Basic earnings per share: | | | |
| As reported | $ 0.90 | $ 0.69 | $ 1.66 |
| Pro forma | 0.79 | 0.59 | 1.46 |
| Diluted earnings per share: | | | |
| As reported | $ 0.86 | $ 0.67 | $ 1.38 |
| Pro forma | 0.76 | 0.58 | 1.22 |

On January 5, 2005, the Company granted restricted stock awards of 132,500 shares with a market value per share of $19.26 on that date. The Company is amortizing the expense related to the awards according to their vesting schedule. The amount of $40, included above in the 2005 reported net income, represents the expense of the restricted stock awards, net of income taxes, for the twelve months ended December 31, 2005.

The Black-Scholes option valuation model was developed for use in estimating the fair value of traded options, which have no vesting restrictions and are fully transferable. In addition, option valuation models require the input of highly subjective assumptions including the expected stock price volatility and the expected exercise patterns of the option holders.

In December 2004, the Financial Accounting Standards Board ("FASB") issued SFAS No. 123(R), *Share-Based Payment*. SFAS No. 123(R) is a revision of SFAS No. 123 and supersedes APB No. 25. Among other items, SFAS No. 123(R) eliminates the use of the intrinsic value method of accounting. Instead, companies will be required to recognize in financial statements the cost of employee services received in exchange for awards of equity instruments, based on the fair value of those awards. When SFAS No. 123(R) was issued, the effective date was the first reporting period beginning after June 15, 2005. In April 2005, the Securities and Exchange Commission modified the effective date to be the beginning of the first fiscal year beginning after June 15, 2005, which would be January 1, 2006 for the Company. Early adoption of SFAS No. 123(R) is allowed using either a "modified prospective" method, or a "modified retrospective" method. Under the "modified prospective" method, compensation cost is recognized utilizing SFAS No. 123(R) beginning with the effective date for all share-based

payments granted or modified after that date, but is based on the requirements of SFAS No. 123 for all unvested awards granted prior to the effective date of SFAS No. 123(R). The requirements are the same under the "modified retrospective" method, but companies are permitted to restate financial statements of previous periods based on pro forma disclosures made in accordance with SFAS No. 123.

The Company has adopted SFAS No. 123(R) effective January 1, 2006. The Company will use the modified prospective method of adoption and will continue to use Black-Scholes pricing method to value any future awarded options. The adoption of SFAS No. 123(R) will have a material impact on the Company's results of operations. The Company currently estimates the impact on the Company's 2006 results of operations of adopting SFAS No. 123(R) to be approximately $2,967 before applying the estimated applicable tax rate. Of the estimated $2,967 to be recorded in 2006 upon adoption of SFAS No. 123(R), $214 is expected to be recorded as salaries and benefits and $2,753 is expected to be recorded as general and administrative expense. The Company's estimate can vary in the future depending on many factors, including levels of options and awards granted in the future, forfeitures and when option or award holders exercise these awards. Had the Company adopted SFAS No. 123(R) in prior periods, the Company believes the impact of that standard would have approximated the impact of SFAS No. 123 as described above in the pro forma net income and earnings per share. See Note 9 and Note 15 for further information on the Company's stock-based compensation.

**Income Taxes**

Income taxes are computed based on the asset and liability method of accounting whereby deferred tax assets and liabilities are determined based upon differences between the financial reporting and tax basis of assets and liabilities and are measured using the enacted tax rates and laws that will be in effect when the differences are expected to reverse. From time to time, the Company enters into transactions whereby the tax treatment of such transactions under the Internal Revenue Code or applicable state tax law is uncertain. The Company recognizes the tax treatment of these transactions in accordance with SFAS No. 5, "Accounting for Contingencies." See Note 11 for further information on income taxes.

**Non-Cash Investing Activities**

During 2005, the Company issued 21,649 shares of its common stock to various physician owners of our surgery centers in cashless exercises of warrants. During 2004, the Company recorded $3,652 of goodwill related to 204,500 shares of the Company's common stock that were issued to the former stockholders of Physicians Surgical Care, Inc. The earn-out was based on the 2003 financial results of one of the surgery centers the Company acquired from Physicians Surgical Care, Inc. in April 2002.

**Recently Issued Accounting Pronouncements**

In December 2004, the FASB issued SFAS No. 153, *Exchange of Non-monetary Assets -- an amendment of APB Opinion No. 29*. The guidance in APB Opinion No. 29, *Accounting for Non-monetary Transactions*, is based on the principle that exchanges of non-monetary assets should be measured based on the fair value of the assets exchanged. The guidance in that Opinion, however, included certain exceptions to that principle. SFAS No. 153 amends Opinion No. 29 to eliminate the exception for non-monetary assets that do not have commercial substance. A non-monetary exchange has commercial substance if the future cash flows of the entity are expected to change significantly as a result of the exchange. SFAS No. 153 is effective for non-monetary asset exchanges occurring in fiscal periods beginning after June 15, 2005. The adoption of SFAS No. 153 did not have a material impact on the Company's financial position or results of operations.

In May 2005, the FASB issued SFAS No. 154, *Accounting Changes and Error Corrections*, which replaces APB Opinion No. 20, *Accounting Changes*, and SFAS No. 3, *Reporting Accounting Changes in Interim Financial Statements*. SFAS No. 154 changes the requirements for the accounting for and reporting of a change in accounting principle. It requires retrospective application to prior periods' financial statements of changes in accounting principle, unless it is impracticable to determine either the period-specific effects or the cumulative effect of the change. This statement is effective for accounting changes and corrections of errors made in fiscal years beginning after December 15, 2005. The adoption of SFAS No. 154 will not have a material impact on the Company's financial position or results of operations.

In June 2005, the FASB issued Emerging Issues Task Force ("EITF") Issue No. 04-5, *Determining Whether a General Partner, or the General Partners as a Group, Controls a Limited Partnership or Similar Entity When the Limited Partners Have Certain Rights*. EITF No. 04-5 provides a framework for determining whether a general partner controls, and should consolidate, a limited partnership or a similar entity. EITF No. 04-5 is effective for all limited partnerships formed after June 29, 2005 and for any limited partnerships in existence on June 29, 2005 that modify their partnership agreements after that date. EITF No. 04-5 is effective for all of the Company's partnerships beginning January 1, 2006. The Company evaluated all of its existing partnership agreements and determined the adoption of EITF No. 04-5 did not have a material effect on our financial position or results of operations.

**Reclassifications**

Certain reclassifications have been made to the prior year financial statements to conform to the 2005 presentation. The reclassifications had no impact on the Company's financial position or results of operations.

**3. Reverse Stock Split and Initial Public Offering**

On February 5, 2004, the Company's Board of Directors approved a 1-for-4.4303 reverse stock split of the Company's common stock in connection with its initial public offering. All information related to common stock, options to purchase common stock, warrants to purchase common stock and earnings per share data presented in the accompanying consolidated financial statements and related notes have been restated to reflect the effect of the reverse stock split of the Company's common stock.

On February 11, 2004, the Company completed an initial public offering of 8,280,000 shares of its common stock at a price of $15.00 per share, including 1,080,000 shares sold following exercise in full by the underwriters of an option granted to them by the Company to purchase the additional shares to cover over-allotments. The Company received net proceeds of approximately $115,506 in the offering, after deducting underwriting discounts and commissions. The Company used the net proceeds to repay indebtedness and to pay holders of the Company's Series A and Series B convertible preferred stock in connection with the conversion of those shares to common stock upon the completion of the offering.

**4. Acquisitions and Developments**

During 2005, the Company acquired six surgery centers and developed one additional surgery center. The Company also began development of three additional surgery centers. During 2004, the Company acquired six surgery centers and two other surgery centers the Company intended to develop through syndication, renovation and expansion. During 2003, the Company acquired five surgery centers. The following table summarizes the allocation of the aggregate purchase price of acquisitions for the years ended December 31:

| | 2005 | 2004 | 2003 |
|---|---|---|---|
| Fair value of assets acquired | $ 62,425 | $ 77,582 | $49,925 |
| Liabilities assumed | (11,983) | (11,271) | (4,284) |
| Common stock, preferred stock and warrants issued | — | — | (49) |
| Net cash used for acquisitions | $ 50,442 | $ 66,311 | $45,592 |

The cash for the acquisitions was funded primarily through the Company's senior credit facility with the remainder funded from the operations of the Company.

These acquisitions were accounted for under the purchase method of accounting and, accordingly, the results of operations of the acquired businesses are included in the accompanying consolidated financial statements from their respective dates of acquisitions. These acquisitions placed the Company in new markets or expanded the Company's presence in current markets.

During 2004, the Company issued 204,500 shares of the Company's common stock to the former stockholders of Physicians Surgical Care, Inc. ("PSC") pursuant to an earn-out provision in the Company's merger agreement with PSC. The earn-out was based on the 2003 financial results of one of the surgery centers acquired from PSC in April 2002. The earn-out is reflected in goodwill in the accompanying consolidated balance sheets in the amount of

$3,652, which represents the fair value of the shares issued. The Company paid $263 during 2003 in additional consideration related to surgery centers acquired in 2002, which are reflected as additions to goodwill in the accompanying consolidated balance sheets.

Included in the acquisitions discussed above were the following individually significant transactions:

*2005 Significant Acquisitions*

During the first quarter of 2005, the Company acquired a majority interest in Atlanta Center for Reconstructive Foot and Ankle Surgery, LLC and acquired a minority interest in Roswell Center for Foot and Ankle Surgery, LLC, a *de novo* surgery center that opened in February 2005. The Company acquired its ownership interests in these two surgery centers for an aggregate of approximately $5,700, using funds from operations and funds available under the Company's senior credit facility. Both the Atlanta Center for Reconstructive Foot and Ankle Surgery and the Roswell Center for Foot and Ankle Surgery have two operating rooms. Both surgery centers are single-specialty surgery centers and are located in the northern suburbs of Atlanta, Georgia.

During August 2005, the Company completed its acquisition of interests in five surgery centers in Southern California for approximately $49,200. As part of this transaction, the Company acquired a majority interest in three surgery centers and acquired a minority interest in two *de novo* surgery centers that opened in June 2004 and October 2004, respectively. In addition to the five surgery centers, the Company also acquired a minority interest in a *de novo* surgery center that is currently under development.

The following represents the unaudited pro forma results of consolidated operations as if the 2005 acquisitions discussed above had occurred on January 1, 2005, after the effects of certain pro forma adjustments:

| | Year Ended December 31, 2005 |
|---|---|
| Revenues | $ 284,357 |
| Income before income taxes | 32,346 |
| Earnings per share: | |
| Basic | $ 0.95 |
| Diluted | $ 0.92 |

The acquisition purchase prices are preliminary and are subject to finalized purchase adjustments.

*2004 Significant Acquisitions*

In May 2004, the Company acquired a minority interest in Valley Ambulatory Surgery Center, L.P. for approximately $6,480, using cash from operations. In November 2004, the Company purchased the capital stock of the general partner of the center for an additional $7,028. Subsequent to the investment during the fourth quarter, the Company's total ownership of this center was 40.0% and the Company began consolidating this facility. The center has six operating suites and one minor procedure room. The center is a multi-specialty ambulatory surgery center located in a suburb of Chicago, Illinois.

During the third quarter of 2004, the Company acquired a majority ownership in four additional surgery centers for a total of approximately $12,648, using cash from operations and funds available under the Company's senior credit facility. The Company acquired a surgery center located in Savannah, Georgia. The Savannah surgery center is a single-specialty surgery center with one operating suite, and the Company plans to develop this facility through syndication, renovation and expansion. The Savannah surgery center is a newly-developed facility that began operations in the months before the Company purchased the surgery center. The Company also acquired a surgery center located in Steubenville, Ohio. The Steubenville surgery center is a multi-specialty surgery center with three operating suites and one minor procedure room. In addition, the Company acquired a surgery center located in New Albany, Indiana. The New Albany surgery center is a multi-specialty surgery center with four operating suites and one minor procedure room. Finally, the Company acquired a surgery center located in Hammond, Louisiana. The Hammond surgery center is a multi-specialty surgery center with four operating suites and two minor procedure rooms. The Company entered into management agreements with all four of these centers.

During the fourth quarter of 2004, the Company acquired a majority ownership interest in two surgery centers in Alabama and one surgery center in Missouri. The Birmingham Surgery Center, located in Birmingham, Alabama, is a single-specialty surgery center with three operating rooms. The Company converted this center to a multi-specialty surgery center and syndicated ownership in 2005. The North River Surgical Center, located in Tuscaloosa, Alabama, is a multi-specialty surgery center with two operating rooms, and the Company plans to develop this facility through syndication, renovation and expansion. The Surgery Center of Kirkwood, located in Kirkwood, Missouri, is a multi-specialty surgery center with three operating rooms and one minor procedure room. The Company acquired ownership interests in these three centers for an aggregate of approximately $40,155 in cash.

The following represents the unaudited pro forma results of consolidated operations as if the 2004 acquisitions discussed above had occurred on January 1, 2004, after the effects of certain pro forma adjustments:

| | Year Ended December 31, 2004 |
|---|---|
| Revenues | $ 248,397 |
| Income before income taxes | 24,150 |
| Earnings per share: | |
| Basic | $ 0.75 |
| Diluted | $ 0.73 |

*2003 Significant Acquisitions*

On November 17, 2003, the Company acquired three surgery centers from MediSphere Health Partners, Inc. One of these facilities is licensed as a hospital. The Company paid approximately $7,938 in cash, issued $49 in warrants and incurred $422 in acquisition costs in connection with the acquisition of these centers. The purchase price was also subject to additional settlements related to working capital and indemnification holdbacks that were finalized in 2004. On December 1, 2003, in separate transactions, the Company purchased two additional surgery centers for $37,402 in cash. The Company incurred $227 in acquisition costs related to these centers. The purchase price of each transaction was subject to additional settlements related to working capital and other adjustments that were finalized during 2004. During 2004, as a result of these settlements, the Company recorded an additional amount of $1,308 to goodwill. The purchase price allocated to the acquired assets and liabilities assumed on the purchase dates is as follows:

| | |
|---|---|
| Working capital | $ 3,253 |
| Property and equipment | 4,050 |
| Goodwill | 37,563 |
| Other long-term assets | 4,544 |
| Long-term debt | (1,748) |
| Minority interests | (1,624) |
| Total purchase price | $46,038 |

In 2003, the Company also made individually insignificant acquisitions of additional ownership interests in certain of its consolidated surgery centers in exchange for $3,348 in cash, which resulted in additions to goodwill of $1,594 and additions to investments in and advances to affiliates of $750.

The pro forma effect of the Company's 2003 acquisitions on its results of operations for the periods prior to the respective acquisition dates was not significant.

*Developments and Other*

During 2005, the Company executed an agreement to develop, operate and own a minority interest in Cape Coral Ambulatory Surgery Center, LLC, a multi-specialty *de novo* center located in Cape Coral, Florida. The center is expected to be a five operating room surgery center and is projected to open during 2006.

During 2004, the Company opened a newly-developed surgery center in Memphis, Tennessee. The Memphis surgery center is a single-specialty surgery center with one minor procedure room. The Memphis surgery center was developed through a partnership with one of our existing physician networks. Also, during 2004, the Company

opened the newly-developed Erie Imaging Center in Erie, Pennsylvania. Erie Imaging Center is a diagnostic imaging center and is located in a market in which the Company owns and operates a surgery center. During 2005, the Company disposed of the Erie Imaging Center. In addition, the Company signed an agreement to manage the DeSoto Surgery Center in DeSoto, Mississippi. The DeSoto Surgery Center is an affiliate of Baptist Memorial Health Services, Inc.

During 2003, the Company opened a newly-developed surgery center located in Columbia, Tennessee. The Columbia surgery center is a multi-specialty surgery center with two operating rooms and one treatment room.

**5. Dispositions**

During 2005, the Company sold its 51% ownership interest in the Erie Imaging Center, located in Erie, Pennsylvania, to Touchstone Medical Imaging, LLC ("Touchstone") for $100 in cash and a $1,000 promissory note payable to the Company by Touchstone on August 31, 2005. The Company received payment in full for the promissory note during the third quarter of 2005. The Company recorded a loss of approximately $725 related to the sale. Before the sale, Touchstone was the minority partner and manager of the Erie Imaging Center.

Also during 2005, the Company closed a surgery center located in Edmond, Oklahoma and sold the surgery center's land and building. The Company evaluated the current market and growth opportunities of the surgery center and decided the best strategy for the Company was to close the surgery center. Patient service revenues for the Edmond facility were less than 1% of the Company's consolidated patient service revenues for each of the twelve months ended December 31, 2005, 2004 and 2003. In connection with the closure of the surgery center, including the sale of the real estate, the Company recorded a net pre-tax loss of approximately $600 during 2005.

During 2004, after purchasing the outstanding ownership interests from the Company's prior physician and hospital partners, the Company restructured its Physicians SurgiCenter of Houston partnership in Houston, Texas, creating a joint venture with the American Institute of Gastric Banding, Ltd. ("AIGB"), a privately-held single procedure focused surgical company based in Dallas, Texas. In connection with the restructuring, the Company retained a 10% ownership in the surgery center. The Company no longer manages or consolidates the surgery center for financial reporting purposes. During 2005, the Company sold its remaining 10% ownership interest in the surgery center $500 to AIGB.

During 2003, the Company sold ownership interests in certain consolidated surgery centers for $1,659 in cash. The Company recorded an impairment and loss on disposal of long-lived assets of $162 and a gain on sale of long-lived assets of $571 in connection with these transactions.

**6. Goodwill and Intangible Assets**

Changes in the carrying amount of goodwill are as follows:

| | |
|---|---|
| Balance at December 31, 2003 | $116,654 |
| Purchase price allocations | 97,433 |
| Finalized purchase price allocations | 1,446 |
| Balance at December 31, 2004 | 215,533 |
| Purchase price allocations | 49,366 |
| Finalized purchase price allocations | 3,233 |
| Balance at December 31, 2005 | $268,312 |

The purchase price allocation of $49,366 for 2005 relates to the Company's purchase of surgery centers during 2005. See Note 4 for more disclosure on the Company's 2005 acquisitions. The purchase price allocation of $97,433 for 2004 includes approximately $31,800 related to the Company's Series A convertible preferred stock and Series B convertible preferred stock which converted into common stock and the right to receive cash upon completion of the Company's initial public offering. The purchase price allocation of $97,433 also includes $3,652 of goodwill related to 204,500 shares of the Company's common stock that were issued to the former stockholders of PSC pursuant to an earn-out provision in the Company's purchase agreement with PSC. The earn-out was based on the 2003 financial results of one of

the surgery centers acquired from PSC in March 2002. In addition, the purchase price allocation of $97,433 includes approximately $62,112 primarily related to new surgery centers the Company acquired during 2004. The finalized purchase price allocation of $3,233 and $1,446 for 2005 and 2004, respectively, includes settlements related to working capital and other adjustments that were made for acquisitions in prior years.

Information regarding the Company's other intangible assets is as follows:

| | Gross Carrying Amount | Accumulated Amortization |
|---|---|---|
| Amortized intangible assets: | | |
| As of December 31, 2004 | | |
| Service agreement rights | $ 1,370 | $ (420) |
| As of December 31, 2005 | | |
| Service agreement rights | 1,370 | (717) |

Amortization expense for the years ended December 31, 2005, 2004 and 2003was $297, $72 and $72, respectively. During 2005, the Company renegotiated the service agreement rights. As a result of this renegotiation, the 2005 amortization expense for 2005 was increased to $297.

**7. Operating Leases**

The Company leases office space and equipment for its surgery centers, including surgery centers under development. The lease agreements generally require the lessee to pay all maintenance, property taxes, utilities, and insurance costs.

The future minimum lease payments under non-cancelable operating leases at December 31, 2005 are as follows:

| | |
|---|---|
| 2006 | $ 14,687 |
| 2007 | 14,230 |
| 2008 | 14,275 |
| 2009 | 13,122 |
| 2010 | 11,819 |
| Thereafter | 49,255 |
| Total minimum lease payments | $117,388 |

Total rent and lease expense was $18,704, $15,055 and $12,089 for the years ended December 31, 2005, 2004 and 2003, respectively. The Company incurred rental expense of $4,606, $4,019 and $3,143 under operating leases with physician investors and an entity that is an affiliate of one of the Company's former directors for the years ended December 31, 2005, 2004 and 2003, respectively.

**8. Long-Term Debt**

The Company's long-term debt is summarized as follows:

| | December 31, | |
|---|---|---|
| | 2005 | 2004 |
| Senior credit facility | $ 96,000 | $64,000 |
| Notes payable to banks | 4,752 | 5,055 |
| Secured term loans | 1,254 | 788 |
| Capital lease obligations | 1,310 | 1,524 |
| | 103,316 | 71,367 |
| Less current maturities | (1,347) | (1,620) |
| | $101,969 | $69,747 |

**Senior Credit Facility**

In March 2005, the Company amended and restated its senior credit facility with a syndicate of financial institutions led by Bank of America, N.A. The Company is the borrower under the senior credit facility and all of its active wholly-owned subsidiaries are guarantors. Under the terms of the senior credit facility, entities that become wholly-owned subsidiaries must also guarantee the debt.

The senior credit facility provides senior secured financing of up to $150,000 through a revolving credit line. Up to $2,000 of the senior credit facility is available for the issuance of standby letters of credit, and up to $5,000 of the senior credit facility is available for swing line loans. The swing line loans are made available by Bank of America as the swing line lender on a same-day basis in minimum purchase amounts of $100. The Company is required to repay each swing line loan in full upon the demand of the swing line lender. The senior credit facility terminates and is due and payable on March 21, 2010. At December 31, 2005 and December 31, 2004, the Company had $96,000 and $64,000, respectively, of outstanding debt under the senior credit facility. At the Company's option, loans under the senior credit facility bear interest at Bank of America's base rate or the Eurodollar rate in effect on the applicable borrowing date, plus an applicable Eurodollar rate margin. Both the applicable base rate margin and applicable Eurodollar rate margin will vary depending upon the ratio of the Company's consolidated funded indebtedness to consolidated EBITDA. At December 31, 2005, the interest rate on the borrowings, which consists of LIBOR plus the applicable Eurodollar rate margin, under the senior credit facility ranged from 5.42% to 5.89%.

During 2005, the Company entered into an interest rate swap agreement. The interest rate swap protects the Company against certain interest rate fluctuations of the LIBOR rate on $50,000 of the Company's variable rate debt under the senior credit facility. The effective date of the interest rate swap was August 26, 2005, and it expires on March 21, 2010. The interest rate swap effectively fixes the Company's LIBOR interest rate on the $50,000 of variable debt at a rate of 4.49%. The Company has recognized the fair value of the interest rate swap as a long-term asset of approximately $528 at December 31, 2005.

At December 31, 2005, the Company was in compliance with all material covenants required by each long-term debt agreement.

**Notes Payable to Banks**

A subsidiary of the Company has outstanding indebtedness to Synergy Bank (the "Mortgage Notes"). The Mortgage Notes are collateralized by the real estate owned by the surgery centers to which the loans were made. The Mortgage Notes mature in 2008 and bear interest at a rate of 6.7% per year. The aggregate outstanding principal balance under the Mortgage Notes was $4,752 and $5,055 at December 31, 2005 and December 31, 2004, respectively. The Mortgage Notes contain various covenants to maintain certain financial ratios and also restrict encumbrance of assets, creation of indebtedness, investing activities and payment of distributions.

**Capital Lease Obligations**

The Company is liable to various vendors for several equipment leases. The outstanding balance related to these capital leases at December 31, 2005 and 2004 was $1,310 and $1,524, respectively. The leases have interest rates ranging from 3% to 11% per year and mature beginning in 2006 through 2009. The carrying value of property and equipment under capital leases at December 31, 2005 and 2004 was $1,987 and $2,029, respectively.

**Other Long-Term Debt Information**

Scheduled maturities of obligations as of December 31, 2005 are as follows:

| | Long-term Debt | Capital Lease Obligations | Total |
|---|---|---|---|
| 2006 | $ 823 | $ 556 | $ 1,379 |
| 2007 | 1,002 | 635 | 1,637 |
| 2008 | 802 | 153 | 955 |
| 2009 | 588 | 109 | 697 |
| 2010 | 98,791 | — | 98,791 |
| Thereafter | — | — | — |
| | 102,006 | 1,453 | 103,459 |
| Less current maturities | (823) | (524) | (1,347) |
| Amounts representing interest | — | (143) | (143) |
| | $ 101,183 | $ 786 | $101,969 |

**9. Stockholders' Equity**

**Capital**

The holders of common stock are entitled to one vote per share on all matters on which stockholders are entitled to vote and do not have cumulative voting rights. The holders of common stock have no preemptive, conversion, redemption or sinking fund rights.

As of December 31, 2005 and 2004, the Company had outstanding warrants to purchase 75,585 and 293,029, respectively, shares of common stock of the Company at exercise prices ranging from $6.77 to $13.87 per share. The decrease in outstanding warrants from December 31, 2004 to December 31, 2005 is primarily the result of the Company's buyback of 132,475 physician held warrants for $1,382. These warrants were scheduled to expire during the first and second quarter of 2005. All warrants outstanding at December 31, 2005 were exercisable and expire beginning in 2008 through 2009.

**Stock Options**

The aggregate maximum number of shares of the Company's common stock authorized for issuance pursuant to the Stock Incentive Plan, the Non-Employee Directors Stock Option Plan, the Ambulatory Resource Centres Non-Qualified Initial Plan and the Ambulatory Resource Centres 1997 Stock Option Plan was 3,500,196 as of December 31, 2005. The maximum number of shares is calculated as the lesser of (i) the lesser of 6,348,328 or 12.5% of common stock outstanding on a fully diluted basis for the Stock Incentive Plan, (ii) the lesser of 380,899 or 0.75% of common stock outstanding on a fully diluted basis for the Non-Employee Directors Stock Option Plan, (iii) 168,192 shares of common stock for the Ambulatory Resource Centres Non-Qualified Initial Plan and (iv) 29,601 shares of common stock for the Ambulatory Resource Centres 1997 Stock Option Plan. All options have been granted at exercise prices that equaled the fair value of the stock on the date of grant and vest over a one-year to four-year period. The exercise periods for the three stock option plans are ten years.

The estimated weighted average fair values of the options at the date of grant in 2005, 2004 and 2003 were $7.27, $6.75 and $9.48 per share, respectively. The fair values of the options were derived using the Black-Scholes option-pricing model and requirements as discussed in SFAS No. 123. In applying the Black-Scholes model, the Company assumed the following:

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2005 | 2004 | 2003 |
| Weighted average risk-free interest rate | 3.8% | 3.8% | 4.1% |
| Expected volatility | 31.8% | 31.8% | 70% |
| Expected life, in years | 6 | 5 | 7 |
| Expected dividend yield | — | — | — |
| Expected forfeiture rate | 3% | 3% | 3% |

*Weighted average risk-free interest rate*

The risk-free interest 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 stock 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. SFAS No. 123 recommended companies such as Symbion, whose common stock has only recently become publicly traded, to use average volatilities of similar entities. As a result, the Company has used the average volatilities of some of its competitors as an estimate in determining stock option fair values. As the Company becomes more familiar with the fluctuations in its own stock price and more history of the Company's stock price can be compiled, the Company intends to use its own stock price volatility in the future for its stock option fair value pricing.

*Expected life, in years*

SFAS No. 123 requires that companies incorporate the expected life of the stock option. A clear distinction is made between the expected life of the option and the contractual term of the option. The expected life of the option is considered the amount of time, in years, the option is expected to be outstanding before it is exercised. Whereas, the contractual term of the stock option is the term the option is valid before it expires.

*Expected dividend yield*

Since issuing dividends will affect the fair value of a stock option, SFAS No. 123 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. Therefore, the Company has used an expected dividend yield of zero.

*Expected forfeiture rate*

The Company has reviewed the forfeiture patterns of the Company's option holders since the Company's stock has been publicly traded and determined that 3% is a reasonable assumption to use in estimating the fair value of the Company's stock options.

The following is a summary of option transactions since December 31, 2002:

| | Number of Shares | Weighted Average Exercise Price |
|---|---|---|
| December 31, 2002 | 1,434,383 | $ 10.06 |
| Granted | 476,322 | 14.96 |
| Exercised | (84,627) | 0.66 |
| Expired | (107,603) | 10.35 |
| December 31, 2003 | 1,718,475 | $ 11.87 |
| Granted | 305,000 | 19.37 |
| Exercised | (101,788) | 9.85 |
| Expired | (59,137) | 12.82 |
| December 31, 2004 | 1,862,550 | $ 13.17 |
| Granted | 463,950 | 19.46 |
| Exercised | (327,846) | 9.59 |
| Expired | (45,438) | 15.95 |
| December 31, 2005 | 1,953,216 | $ 15.19 |

At December 31, 2005, options to purchase 721,541 shares of common stock were available for grant.

At December 31, 2005, 2004 and 2003, options to purchase 919,796 shares, 911,087 shares and 761,978 shares of common stock, respectively, were exercisable.

The following table summarizes information regarding the options outstanding at December 31, 2005:

| Options Outstanding | | | | Options Exercisable | |
|---|---|---|---|---|---|
| Range of Exercise Prices | Outstanding as of December 31, 2005 | Weighted-Average Remaining Contractual Life | Weighted-Average Exercise Price | Exercisable as of December 31, 2005 | Weighted-Average Exercise Price |
| $ 0.00 — $ 7.58 | 135,419 | 1.8 | $ 0.54 | 134,081 | $ 0.54 |
| $ 7.58 — $10.10 | 42,852 | 4.2 | $ 7.79 | 44,190 | $ 7.58 |
| $10.10 — $12.63 | 933 | 0.5 | $ 10.69 | 933 | $ 10.69 |
| $12.63 — $15.15 | 1,021,612 | 7.9 | $ 14.32 | 653,507 | $ 14.21 |
| $15.15 — $19.70 | 731,150 | 9.5 | $ 19.31 | 87,085 | $ 19.31 |
| $19.70 — $23.68 | 21,250 | 9.5 | $ 23.64 | — | $ — |
| | 1,953,216 | 5.8 | $ 15.19 | 919,796 | $ 12.38 |

Since the Company's shares have become publicly traded, all options granted have an exercise price of the Company's share price on the date of grant.

**10. Earnings Per Share**

Basic and diluted income per share are based on the weighted average number of common shares outstanding and the dilutive impact of outstanding options and warrants to purchase shares.

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2005 | 2004 | 2003 |
| Numerator for basic and diluted income per share: | | | |
| Net income | $ 19,055 | $ 13,552 | $ 17,524 |
| Denominator: | | | |
| Denominator for basic income per share weighted-average shares outstanding | 21,285,211 | 19,736,722 | 10,536,745 |
| Effect of dilutive securities: | | | |
| Employee stock options | 698,382 | 353,432 | 301,903 |
| Warrants | 44,998 | 109,514 | 189,527 |
| Preferred stock | — | 140,712 | 1,567,910 |
| Common stock held in escrow | — | 7,005 | 62,535 |
| Denominator for diluted income per share — adjusted weighted-average shares outstanding | 22,028,591 | 20,347,385 | 12,658,620 |
| Basic net income per share | $ 0.90 | $ 0.69 | $ 1.66 |
| Diluted net income per share | $ 0.86 | $ 0.67 | $ 1.38 |

The effects of 20,250, 265,000 and 450,928 employee stock options for 2005, 2004 and 2003, respectively, and 19,568 warrants for 2003 were not included in the computation of diluted earnings per share because their effects would have been anti-dilutive. The decrease in preferred stock outstanding is a result of those shares converting to common shares at the date of the initial public offering as discussed in Note 3.

**11. Income Taxes**

The Company and its subsidiaries file a consolidated federal income tax return. The partnerships and limited liability companies 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 the taxable income of the Company. The remaining income or loss of each

partnership and limited liability company is allocated to the limited partners. During 2005, the Company paid approximately $2,938 related to income taxes.

Income tax expense is comprised of the following for the years ended December 31:

| | 2005 | 2004 | 2003 |
|---|---|---|---|
| Current: | | | |
| Federal | $ 6,609 | $ 337 | $ 272 |
| State | 1,121 | 582 | 666 |
| Deferred | 3,659 | 7,564 | (3,108) |
| Income tax expense (benefit) | $11,389 | $8,483 | $(2,170) |

The effective income tax rate differed from the federal statutory rate as follows for the years ended December 31:

| | 2005 | 2004 | 2003 |
|---|---|---|---|
| Tax at U.S. statutory rates | $10,648 | $7,712 | $ 5,374 |
| State income taxes, net of federal tax benefit | 268 | 225 | 249 |
| Change in valuation allowance | 152 | 261 | (8,207) |
| Other | 321 | 285 | 414 |
| | $11,389 | $8,483 | $(2,170) |

The components of temporary differences and the approximate tax effects that give rise to the Company's net deferred tax liability are as follows at December 31:

| | 2005 | 2004 |
|---|---|---|
| Deferred tax assets: | | |
| Amortization | $ — | $ 5,264 |
| Accrued vacation | 195 | 391 |
| Net operating loss carryforward | 3,767 | 2,887 |
| Deferred project costs | 115 | 194 |
| Other deferred assets | 3,336 | 2,304 |
| Total gross deferred tax assets | 7,413 | 11,040 |
| Less: Valuation allowance | (3,728) | (3,162) |
| Total deferred tax assets | 3,685 | 7,878 |
| Deferred tax liabilities: | | |
| Depreciation on property and equipment | (608) | (5,951) |
| Amortization on intangible assets | (203) | — |
| Basis differences of partnerships and joint ventures | (10,953) | (5,658) |
| Other liabilities | (36) | (725) |
| Total deferred tax liabilities | (11,800) | (12,334) |
| Net deferred tax liability | $ (8,115) | $ (4,456) |

The Company has state net operating losses of $64,634 at December 31, 2005. These losses expire from December 31, 2011 through 2025. During 2005, the valuation allowance increased by $566, including the $152 increase presented above, as a result of changes in net operating and net capital loss carryforwards. The valuation allowance also increased $414 as a result of changes in the Company's state net operating losses, which is presented as a component of state income taxes. The Company has credited the benefit for stock option exercises to stockholder's equity, totaling $431 and $230, for 2005 and 2004, respectively.

**12. Employee Benefit Plans**

**Symbion, Inc. 401(k) Plan**

The Symbion, Inc. 401(k) Plan (the "Symbion Plan") is a defined contribution plan whereby employees who have completed six months of service in which they have worked a minimum of 1,000 hours and are age 21 or older are eligible to participate. Employees may enroll in the plan on either January 1 or July 1 of each year. The Symbion Plan allows eligible employees to make contributions of varying percentages of their annual compensation, up to the maximum allowed amounts by the Internal Revenue Service. Eligible employees may or may not receive a match by the Company of their contributions. The match varies by surgery center and is determined prior to the start

of each plan year. Generally, employer contributions vest 20% after two years of service and continue vesting at 20% per year until fully vested. The Company's matching expense for 2005, 2004 and 2003 was $563, $804 and $513, respectively.

**Employee Stock Purchase Plan**

The Company adopted an Employee Stock Purchase Plan ("Stock Purchase Plan") to provide substantially all the Company's full-time and part-time employees an opportunity to purchase shares of its common stock in amounts not to exceed 10% of eligible compensation, 5,642 shares of common stock or $25 of common stock each calendar year. To be eligible to enroll in the Stock Purchase Plan, employees must: (i) have been employed six consecutive months by the Company, (ii) be scheduled to work at least twenty hours per week, (iii) be regularly scheduled to work more than five months during the year and (iv) not own 5% or more of the Company's common stock. Under the Stock Purchase Plan, as amended during 2005, the participant's September 30 account balance is used to purchase shares of stock at a 5% discount of the fair market value of shares on September 30. At December 31, 2005 and 2004, the Company had recorded a $73 and $231, respectively, commitment related to the Stock Purchase Plan in accrued payroll and benefits in the accompanying consolidated balance sheets. A total of 372,435 shares are available for purchase under the plan. The Stock Purchase Plan became effective on the date of the Company's completion of its initial public offering as discussed in Note 3.

**Supplemental Retirement Savings Plan**

The Company adopted the supplemental retirement savings plan (the "SERP") in May 2005. The SERP provides supplemental retirement 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 the 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. Compensation expense recorded by the Company related to the Company's contribution to the SERP was $149 for 2005.

**13. Commitments and Contingencies**

**Debt and Lease Guaranty on Unconsolidated Entities**

The Company has guaranteed $1,030 of operating lease payments of a surgery center in which it owns a 35% interest. The lease expires in 2009.

**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. To cover these types of claims, the Company maintains general liability and professional liability insurance in excess of self-insured retentions through a commercial insurance carrier in amounts that the Company believes to be sufficient for its operations, although, potentially, some claims may exceed the scope of coverage in effect. This insurance coverage is on a claims-made basis. Plaintiffs in these matters may request punitive or other damages that may not be covered by insurance. The Company is not aware of any such proceedings that would have a material adverse effect on the Company's business, financial condition or results of operations. The Company expenses the costs under the self-insured retention exposure for general and professional liability claims which relate to (i) deductibles on claims made during the policy period, 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 for professional liability are based upon actuarially determined estimates. The reserves are estimated using individual case-basis valuations and actuarial analysis. Based on historical results and data currently available, the Company does not believe a change in one or more of these assumptions will have a material impact on the Company's consolidated financial position or results of operations. As of December 31, 2005 and 2004, the Company's professional and general liability accrual for the estimate of self-insured retentions was $3,495

and $3,774, respectively, and is included in other liabilities in the accompanying consolidated balance sheets as of December 31, 2005 and 2004, respectively.

**Current Operations**

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare, Medicaid and other federal health care programs. From time to time, governmental regulatory agencies will conduct inquiries of the Company's practices. It is the Company's current practice and future intent to cooperate fully with such inquiries. The Company is not aware of any such inquiry that would have a material adverse effect on the Company's consolidated financial position or results of operations.

**Acquired Centers**

The Company, through its wholly-owned subsidiaries or controlled partnerships and limited liability companies, has acquired and will continue to acquire surgical and diagnostic centers with prior operating histories. Such centers 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 itself that no such liabilities exist and obtains indemnification from prospective sellers covering such matters and institutes 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 health care providers or have materially adverse effects on its business or revenues arising from such future actions. The Company believes, however, that it will be able to adjust its operations so as to be in compliance with any regulatory or statutory provision as may be applicable.

**Potential Physician Investor Liability**

Each physician investor in the partnerships and limited liability companies which operate the Company's surgery centers carries general and professional liability insurance on a claims-made basis. Each investee may, however, be liable for damages to persons or property arising from occurrences at the surgery centers. Although the various physician investors and other surgeons generally are required to obtain general and professional liability insurance with tail coverage, such individual may not be able to obtain coverage in amounts sufficient to cover all potential liability. Since most insurance policies contain exclusions, the physician investor 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.

**14. Selected Quarterly Financial Data (Unaudited)**

The following is selected quarterly financial data for each of the four quarters in 2005 and 2004. Quarterly results are not necessarily representative of operations for a full year. The sum of the quarterly per share amounts may not equal the annual totals due to rounding.

| | 2005 | | | |
|---|---|---|---|---|
| | First Quarter | Second Quarter | Third Quarter | Fourth Quarter |
| | (unaudited) | | | |
| Revenues | $62,179 | $64,653 | $66,422 | $72,490 |
| Cost of Revenues | 39,198 | 40,252 | 42,281 | 44,879 |
| Net Income | 4,386 | 4,880 | 4,182 | 5,607 |
| Net income per share: | | | | |
| Basic | 0.21 | 0.23 | 0.20 | 0.26 |
| Diluted | 0.20 | 0.22 | 0.19 | 0.25 |

| | 2004 | | | |
|---|---|---|---|---|
| | First Quarter | Second Quarter | Third Quarter | Fourth Quarter |
| | (unaudited) | | | |
| Revenues | $51,947 | $52,727 | $52,031 | $59,620 |
| Cost of Revenues | 33,989 | 34,847 | 34,688 | 38,241 |
| Net Income | 2,579 | 3,615 | 3,332 | 4,026 |
| Net income per share: | | | | |
| Basic | 0.16 | 0.17 | 0.16 | 0.19 |
| Diluted | 0.15 | 0.17 | 0.16 | 0.19 |

**15. 2005 Subsequent Event**

Subsequent to December 31, 2005, the Company's Compensation Committee granted 428,100 options to certain employees of the Company. The exercise price of the options was $23.80, which is the closing price of the Company's common stock on February 27, 2006, the grant date. The Company estimates the compensation expense related to these options and all options granted prior to December 31, 2005 to decrease diluted earnings per share by approximately $0.11 for 2006.

On March 1, 2006, the Company acquired a majority interest in Cypress Surgery Center, LLC, for approximately $9,900. Cypress Surgery Center is located in Wichita, Kansas. Cypress Surgery Center is a multi-specialty surgery center with six operating rooms and two special procedure rooms.

## 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, in the City of Nashville, State of Tennessee, on March 14, 2006.

SYMBION, INC.

By: /s/ Richard E. Francis, Jr.
Richard E. Francis, Jr.
*Chairman and Chief Executive Officer*

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

| Signature | Title | Date |
|---|---|---|
| /s/ Richard E. Francis, Jr.<br>Richard E. Francis, Jr. | Chairman of the Board, Chief Executive Officer,<br>Director (principal executive officer) | March 14, 2006 |
| /s/ Kenneth C. Mitchell<br>Kenneth C. Mitchell | Chief Financial Officer, Senior Vice President of Finance<br>(principal financial and accounting officer) | March 14, 2006 |
| /s/ Clifford G. Adlerz<br>Clifford G. Adlerz | President, Chief Operating Officer,<br>Director | March 14, 2006 |
| /s/ William V. B. Webb<br>William V. B. Webb | Chief Development Officer,<br>Director | March 14, 2006 |
| /s/ Frederick L. Bryant<br>Frederick L. Bryant | Director | March 14, 2006 |
| /s/ Donald W. Burton<br>Donald W. Burton | Director | March 14, 2006 |
| /s/ Eve M. Kurtin<br>Eve M. Kurtin | Director | March 14, 2006 |
| /s/ Jack Tyrrell<br>Jack Tyrrell | Director | March 14, 2006 |
| /s/ David M. Wilds<br>David M. Wilds | Director | March 14, 2006 |

## EXHIBIT INDEX

| No. | Description |
|---|---|
| 2.1 | Agreement and Plan of Merger, dated as of March 7, 2002, among Symbion, Inc., Symbion Acquisition Sub, Inc. and Physicians Surgical Care, Inc. (a) |
| 2.2 | Purchase Agreement, dated as of November 11, 2004, by and among the members of Surgery Center Partners, L.L.C., Symbion Ambulatory Resource Centres, Inc. and SMBIMS Kirkwood, Inc. (b) |
| 2.3 | Purchase Agreement, dated as of July 27, 2005, by and among Members of Specialty Surgical Center, LLC, Specialty Surgical Center of Encino, LLC, Specialty Surgical Center of Irvine, LLC, Specialty Surgical Center of Arcadia, LLC, Symbion Ambulatory Resource Centres, Inc. and Affiliates of Symbion Ambulatory Resource Centres, Inc. (c) |
| 3.1 | Certificate of Incorporation (d) |
| 3.2 | Certificate of Amendment to Certificate of Incorporation (e) |
| 3.3 | Certificate of Retirement of Stock (f) |
| 3.4 | Certificate of Designation of Rights and Preferences of Series A Convertible Preferred Stock and Series B Convertible Preferred Stock (d) |
| 3.5 | Certificate of Designation of Series A Junior Participating Preferred Stock (e) |
| 3.6 | Bylaws (d) |
| 4.1 | Form of Common Stock Certificate (d) |
| 4.2 | Amended and Restated Investors' Rights Agreement, dated as of June 25, 1999, among Symbion, Inc. and the security holders named therein (a) |
| 4.3 | Amendment No. 1 to Amended and Restated Investors' Rights Agreement, dated as of August 11, 1999, among Symbion, Inc. and the security holders named therein (a) |
| 4.4 | Amendment No. 2 to Amended and Restated Investors' Rights Agreement, dated as of April 1, 2002, among Symbion, Inc. and the security holders named therein (a) |
| 4.5 | Form of Warrant for the purchase of shares of Symbion, Inc. common stock (a) |
| 4.6 | Rights Agreement, dated as of February 6, 2004, between Symbion, Inc. and SunTrust Bank (g) |
| 10.1 | Amended and Restated Executive Employment Agreement, dated May 16, 2002, between Symbion, Inc. and Richard E. Francis, Jr. (a) (n) |
| 10.2 | Amended and Restated Executive Employment Agreement, dated May 16, 2002, between Symbion, Inc. and Clifford G. Adlerz (a) (n) |
| 10.3 | Amended and Restated Executive Employment Agreement, dated May 16, 2002, between Symbion, Inc. and William V. B. Webb (a) (n) |
| 10.4 | Securities Purchase Agreement, dated as of July 18, 2003, among Symbion, Inc. and DLJ Investment Partners II, L.P. and its affiliates (d) |

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| No. | Description |
|---|---|
| 10.5 | — Form of 14¾% Senior Subordinated Note due 2008 (d) |
| 10.6 | — Credit Agreement, dated as of July 18, 2003, among Symbion, Inc., various lenders party thereto, Bank of America, N.A., as Administrative Agent and as Issuing Bank, Credit Suisse First Boston as Syndication Agent, Key Corporate Capital, Inc. as Documentation Agent, and Banc of America Securities, LLC, as sole Lead Arranger and Sole Book Manager (d) |
| 10.7 | — First Amendment to Credit Agreement, dated January 30, 2004, among Symbion, Inc., various lenders party thereto and Bank of America, N.A., as Administrative Agent and as Issuing Bank (d) |
| 10.8 | — Amended and Restated Credit Agreement, dated as of March 21, 2005, among Symbion, Inc., the subsidiaries of Symbion identified therein, Bank of America, N.A., as Administrative Agent, Swing Line Lender and L/C Issuer, Credit Suisse First Boston, as Syndication Agent, KeyBank National Association, as Documentation Agent and the other lenders party thereto (h) |
| 10.9 | — Lease Agreement, dated June 26, 2001, between Burton Hills IV Partners and Symbion, Inc. (a) |
| 10.10 | — First Amendment to Lease Agreement, dated February 9, 2004, between Burton Hills IV Partners and Symbion, Inc. (f) |
| 10.11 | — Amended and Restated Ambulatory Resource Centres, Inc. 1997 Stock Option Plan (a) (n) |
| 10.12 | — Ambulatory Resource Centres, Inc. Nonqualified Initial Option Plan (a) (n) |
| 10.13 | — Symbion Stock Incentive Plan (a) (n) |
| 10.14 | — Form of Incentive Stock Option Agreement under the Stock Incentive Plan (i) (n) |
| 10.15 | — Form of Nonqualified Stock Option Agreement under the Stock Incentive Plan (i) (n) |
| 10.16 | — Form of Restricted Stock Agreement under the Stock Incentive Plan (j) (n) |
| 10.17 | — Symbion Non-Employee Directors Stock Option Plan (a) (n) |
| 10.18 | — Form of Nonqualified Stock Option Agreement under the Non-Employee Directors Stock Option Plan (i) (n) |
| 10.19 | — Symbion Employee Stock Purchase Plan (a) (n) |
| 10.20 | — First Amendment to Symbion Employee Stock Purchase Plan (a) (n) |
| 10.21 | — Second Amendment to Symbion Employee Stock Purchase Plan (k) (n) |
| 10.22 | — Third Amendment to Symbion Employee Stock Purchase Plan (n) |
| 10.23 | — Executive Change in Control Severance Plan, dated December 11, 1997 (a) (n) |
| 10.24 | — Supplemental Executive Retirement Plan (l) (n) |
| 10.25 | — Form of Deferred Stock Purchase Program Agreement (l) (n) |

| No. | Description |
|---|---|

10.26 — Management Rights Purchase Agreement, dated as of July 27, 2005, by and among Parthenon Management Partners, LLC, Andrew A. Brooks, M.D., Randhir S. Tuli and SymbionARC Management Services, Inc. (c)

10.27 — 2005 Bonus Plan (n)

10.28 — Summary of Director Compensation (n)

10.29 — Executive Officer Compensation and 2006 Bonus Plan (m) (n)

21.1 — Subsidiaries of Registrant

23.1 — Consent of Ernst & Young LLP

23.2 — Consent of Casualty Actuarial Consultants, Inc. (2005 report)

23.3 — Consent of Casualty Actuarial Consultants, Inc. (2004 report) (b)

23.4 — Consent of Casualty Actuarial Consultants, Inc. (2003 report) (f)

31.1 — Certification of Chief Executive Officer pursuant to Rule 13a-14(a) of the Securities Exchange Act of 1934, as amended, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

31.2 — Certification of Chief Financial Officer pursuant to Rule 13a-14(a) of the Securities Exchange Act of 1934, as amended, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

32.1 — Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

32.2 — Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

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(a) Incorporated by reference to exhibits filed with the Registrant's Registration Statement on Form S-1 (Registration No. 333-89554).

(b) Incorporated by reference to exhibits filed with the Registrant's Annual Report on Form 10-K for the year ended December 31, 2004 (File No. 000-50574).

(c) Incorporated by reference to exhibits filed with the Registrant's Current Report on Form 8-K filed August 2, 2005 (File No. 000-50574).

(d) Incorporated by reference to exhibits filed with the Registrant's Registration Statement on Form S-1 (Registration No. 333-110555).

(e) Incorporated by reference to exhibits filed with the Registrant's Registration Statement on Form S-8 (Registration No. 333-113272).

(f) Incorporated by reference to exhibits filed with the Registrant's Annual Report on Form 10-K for the year ended December 31, 2003 (File No. 000-50574).

(g) Incorporated by reference to exhibits filed with the Registrant's Registration Statement on Form 8-A filed with the Securities and Exchange Commission on February 6, 2004 (Registration No. 000-50574).

(h) Incorporated by reference to exhibits filed with the Registrant's Current Report on Form 8-K filed March 25, 2005 (File No. 000-50574).

(i) Incorporated by reference to exhibits filed with the Registrant's Current Report on Form 8-K filed December 14, 2004 (File No. 000-50574).

(j)

Incorporated by reference to exhibits filed with the Registrant's Current Report on Form 8-K filed January 11, 2005 (File No. 000-50574).

(k) Incorporated by reference to exhibits filed with the Registrant's Quarterly Report on Form 10-Q for the quarter ended September 30, 2005 (File No. 000-50574).

(l) Incorporated by reference to exhibits filed with the Registrant's Quarterly Report on Form 10-Q for the quarter ended March 31, 2005 (File No. 000-50574).

(m) Incorporated by reference to exhibits filed with the Registrant's Current Report on Form 8-K filed February 28, 2006 (File No. 000-50574).

(n) Compensation plan or arrangement.