NOVAMED INC
Form 10-K
March 16, 2011

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2010

o 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: 0-26625

NOVAMED, INC.

(Exact name of registrant as specified in its charter)

Delaware	**36-4116193**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

333 West Wacker Drive, Suite 1010, Chicago, Illinois 60606

(Address of principal executive offices) (zip code)

Registrant s telephone number, including area code: **(312) 664-4100**

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

Title of each class	**Name of each exchange on which registered**
Common Stock, par value $.01 per share	The NASDAQ Stock Market, LLC

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

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

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 o No x

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

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

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. x

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

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

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

The aggregate market value of the registrant s shares of voting stock held by non-affiliates of the registrant, based upon the last reported sale price of the registrant s Common Stock on June 30, 2010 was $59,037,435. The number of shares outstanding of the registrant s Common Stock, par value $.01 per share, as of March 7, 2011 was 7,952,004.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant s Definitive Proxy Statement to be filed within 120 days after December 31, 2010 are incorporated by reference into Part III of this Annual Report on Form 10-K.

PART I

This Annual Report on Form 10-K (the Form 10-K) contains, and incorporates by reference, certain forward-looking statements (as such term is defined in Section 21E of the Securities Exchange Act of 1934, as amended) that involve risks and uncertainties and reflect our current expectations regarding our future results of operations, performance and achievements. These forward-looking statements are made pursuant to the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. We have tried, wherever possible, to identify these forward-looking statements by using words such as anticipates, believes, estimates, expects, plans, intends and similar expressions. These statements involve risks and uncertainties and reflect our current beliefs and are based on information currently available to us. Accordingly, these statements are subject to certain risks, uncertainties and contingencies that could cause our actual results, performance or achievements in 2011 and beyond to differ materially from those expressed in, or implied by, such statements. These risks and uncertainties include: the current state of the economy, including higher unemployment levels; our current and future debt levels and ability to refinance; our ability to access capital on a cost-effective basis to continue to successfully implement our growth strategy; reduced prices and reimbursement rates for surgical procedures; our ability to acquire, develop or manage a sufficient number of profitable surgical facilities; our ability to maintain successful relationships with the physicians who use our surgical facilities; our ability to grow and manage effectively our increasing number of surgical facilities; competition from other companies in the acquisition, development and operation of surgical facilities; and uncertainty around the impact of health reform law, and the application of existing or proposed government regulations, or the adoption of new laws and regulations, that could limit our business operations, reduce our reimbursements, increase our costs, require us to incur significant expenditures or limit our ability to relocate our facilities if necessary. These factors and others are more fully set forth under Item 1A Risk Factors. You should not place undue reliance on any forward-looking statements. We undertake no obligation to update or revise any such forward-looking statements that may be made to reflect events or circumstances after the date of this Annual Report on Form 10-K or to reflect the occurrence of unanticipated events.

Unless the context requires otherwise, you should understand all references to we, us and our to include NovaMed, Inc. and its consolidated subsidiaries.

Item 1. Business

General

NovaMed, Inc. is a health care services company and an owner and operator of ambulatory surgery centers (ASCs). Our primary focus and strategy is to operate, develop and acquire ASCs in joint ownership with physicians throughout the United States. As of March 15, 2011, we own and operate 37 ASCs located in 19 states. Historically, most of our ASCs were single-specialty ophthalmic surgical facilities where ophthalmologists perform surgical procedures primarily cataract surgery. Over time, however, we have evolved into other specialties such as orthopedics (including podiatry), pain management, gastroenterology, urology, otolaryngology (ENT), plastic surgery and gynecology. This expansion into other specialties has been accomplished through both the acquisition of new ASCs and the addition of new specialties to our existing ASCs. As of March 15, 2011, 13 of our 37 ASCs offer surgical services in specialties other than ophthalmology. We continue to explore opportunities to acquire ASCs offering differing types of medical specialties. We also continue to explore ways to efficiently add new specialties to our existing ASCs.

As of March 15, 2011, we owned a majority interest in 35 of our ASCs, with the noncontrolling interests generally being held by physicians. We own 100% of the equity interests in two of our ASCs.

We also own and operate optical laboratories, an optical products purchasing organization, and a marketing products and services business.

In addition to our surgical facilities and optical products businesses, we provide management services to two eye care practices pursuant to long-term service agreements. Under these service agreements, we provide business, information technology, administrative and financial services to these practices in exchange for a management fee. These management services are provided to an optometric practice with an optical retail store located in the Chicago market and an ophthalmology practice with multiple locations in Atlanta, Georgia.

We were originally organized as a Delaware limited liability company in March 1995 under the name NovaMed Eyecare Management, LLC. In connection with a venture capital investment made in November 1996, NovaMed Holdings Inc., an Illinois corporation, was formed to serve as a holding company, with NovaMed Eyecare Management, LLC as our principal operating subsidiary. In May 1999, NovaMed Holdings Inc. reincorporated as a Delaware corporation and changed its name to NovaMed Eyecare, Inc. In August 1999, we consummated our initial public offering of common stock.

In March 2004, we changed our name to NovaMed, Inc. We also changed the name of our principal operating subsidiary to NovaMed Management Services, LLC.

Agreement and Plan of Merger

On January 20, 2011, we entered into an Agreement and Plan of Merger (the Merger Agreement) with Surgery Center Holdings, Inc., a Delaware corporation (Surgery Partners), and Wildcat Merger Sub, Inc., a Delaware corporation and a wholly-owned subsidiary of Surgery Partners (Merger Sub), providing for the merger (the Merger) of Merger Sub with and into us, with our company surviving the Merger as a wholly-owned subsidiary of Surgery Partners. Surgery Partners is an affiliate of H.I.G. Capital, L.L.C. (H.I.G.). The merger consideration is $13.25 per share (the Merger Consideration), net to the seller in cash, without interest thereon and subject to applicable withholding taxes. Upon completion of the Merger, each share outstanding immediately prior to the effective time of the Merger (excluding those shares that are held by Surgery Partners, Merger Sub or us or any of our subsidiaries and stockholders who have perfected and not withdrawn a demand for appraisal rights under Delaware law) will be automatically canceled and converted into the right to receive the Merger Consideration in cash (without interest and subject to applicable withholding taxes). At the effective time of the Merger, (i) each of our stock options, whether vested or unvested, will be entitled to receive an amount in cash equal to the excess, if any, of the Merger Consideration over the exercise price per share multiplied by the number of shares of our common stock subject to such stock option and (ii) each unvested restricted share of our common stock that is outstanding immediately prior to the effective time of the Merger will be canceled, with the holder of such unvested restricted share of common stock becoming entitled to receive an amount in cash equal to the Merger Consideration multiplied by the maximum number of shares of common stock subject to such restricted share. Our board of directors and a special committee of the board of directors composed entirely of independent directors unanimously approved the Merger Agreement.

Completion of the Merger is subject to customary conditions, including (i) the expiration of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and (ii) the absence of any law, order or injunction prohibiting the Merger or any pending legal proceeding that seeks to prohibit, prevent, enjoin, restrain or materially delay the Merger. Further, the transaction is subject to the approval of the Merger Agreement by holders of a majority of the outstanding shares of our common stock.

Jefferies Finance LLC and THL Credit, Inc. have provided committed debt financing for the transaction. Surgery Partners has also obtained equity financing commitments for the transactions contemplated by the Merger Agreement. The aggregate proceeds of such debt and equity commitments will be sufficient for Surgery Partners to pay the aggregate Merger Consideration and all related fees and expenses, including any required refinancings or repayments of existing indebtedness. In addition, an investment fund affiliated with H.I.G. has provided us with a limited guarantee in our favor, guaranteeing the payment of certain monetary obligations that may be owed pursuant to the Merger Agreement, including any reverse termination fee that may become payable.

The Merger Agreement contains customary termination provisions for us and Surgery Partners and provides that, in connection with the termination of the Merger Agreement under specified circumstances involving competing transactions or a change in our board of directors recommendation, we may be required to pay Surgery Partners a termination fee of $4.368 million. The Merger Agreement also provides that Surgery Partners will be required to pay us a reverse termination fee of (i) $6.552 million if Surgery Partners fails to close the Merger because it does not receive financing to consummate the Merger after all other conditions have been satisfied and it is not otherwise in breach or (ii) $10.920 million if Surgery Partners terminates the Merger Agreement in its discretion or otherwise fails to close the Merger after all conditions to closing have been satisfied.

The foregoing description of the Merger Agreement has been provided solely to inform investors of its terms. The representations, warranties, and covenants contained in the Merger Agreement were made only for the purposes of such agreement and as of specific dates, were made solely for the benefit of the parties to the Merger Agreement and may be intended not as statements of fact, but rather as a way of allocating risk

to one of the parties if those statements prove to be inaccurate. In addition, such representations, warranties, and covenants may have been qualified by certain disclosures not reflected in the text of the Merger Agreement, and may apply standards of materiality in a way that is different from what may be viewed as material by shareholders of, or other investors in, NovaMed. Our shareholders and other investors are not third-party beneficiaries under the Merger Agreement and should not rely on the representations, warranties, and covenants or any descriptions thereof as characterizations of the actual state of facts or conditions of NovaMed, Surgery Partners, Merger Sub, or any of their respective subsidiaries or affiliates. We acknowledge that, notwithstanding the inclusion of the foregoing cautionary statements, we are responsible for considering whether additional specific disclosures of material information regarding material contractual provisions are required to make the statements in this Form 10-K not misleading.

Information Available

Our corporate offices are located at 333 West Wacker Drive, Suite 1010, Chicago, Illinois 60606 and 100 Mansell Court East, Suite 650, Roswell, Georgia 30076. Our website is *www.novamed.com*. Information contained on our website is not part of, and is not incorporated into, this Annual Report on Form 10-K. We file annual, quarterly, and current reports, proxy statements, and other documents with the Securities and Exchange Commission (the SEC) under the Securities Exchange Act of 1934, as amended (the Exchange Act). The public may read and copy any materials that we file with the SEC at the SEC s public reference facilities at Room 1580, 100 F Street, N.E., Washington, D.C. 20549. Also, the SEC maintains an Internet website that contains reports, proxy and information statements, and other information regarding issuers, including us, that file their Exchange Act documents electronically with the SEC. The public can obtain any documents that we file with the SEC at *http://www.sec.gov*.

We also make available free of charge on or through our Internet website (*http://www.novamed.com*) our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act as soon as reasonably practicable after we electronically file such materials with, or furnish them to, the SEC.

Industry Overview

Ambulatory Surgery Center Industry

The term ambulatory surgery refers to medical procedures performed on a nonhospitalized patient who is able to return home the same day. Since the inception of outpatient surgery centers in the early 1970s, the ASC industry has grown consistently, with approximately 5,300 Medicare-certified ASCs as of December 31, 2010, according to the Centers for Medicare and Medicaid Services (CMS). Improved surgical techniques and technologies have significantly expanded the number of surgical procedures that can be performed in an ASC. Lasers, enhanced endoscopic techniques and fiber optics have reduced the trauma and recovery time associated with many surgical procedures. Improved anesthesia has minimized post-operative side effects such as nausea and drowsiness, resulting in shorter recovery times and in many cases eliminating the need for overnight hospitalization.

We also believe that the convenience and efficiencies offered by an ASC have also contributed to the growth in ASC procedures. We believe that many physicians prefer an ASC to a hospital because of greater scheduling flexibility, faster turnaround time between cases and more efficient nurse staffing. Patients prefer the experience of a surgical facility dedicated to their specialized surgery that is free from disruptions or scheduling conflicts that often arise in hospitals due to emergency procedures or more complex surgical procedures that take longer than expected.

In addition to these technological advancements and operating efficiencies, we believe that public and private third party payors recognize the cost-effective benefits of ASCs. We believe that surgery performed at an ASC is generally less expensive than hospital-based outpatient surgery because of lower facility costs, more efficient staffing and space utilization and a specialized operating environment focused on cost containment.

Optical Products and Services Industry

The eye care market consists of a large, diverse group of services and products. The eye care services market includes routine eye examinations as well as diagnostic and surgical procedures that address complex eye and vision conditions. The most common conditions addressed by eye care professionals are nearsightedness, farsightedness and astigmatism. Other frequently treated conditions include cataracts, glaucoma, macular degeneration and diabetic retinopathy. Eye and vision conditions are typically treated with surgery, pharmaceuticals, prescription glasses, contact lenses or some combination of these treatments. Additional services offered by eye care professionals include research services for eye care devices or pharmaceuticals being developed or tested in clinical trials. The optical products market consists of the manufacture, distribution and sale of optical goods, including corrective lenses, eyeglasses, frames, contact lenses and other optical products and accessories.

While the number of patient choices for vision correction has increased with improved surgical vision correction technologies and techniques, the market for basic optical goods, including corrective lenses, eyeglass frames, contact lenses and other optical products and accessories, remains a significant market. Eyeglass lenses and frames are typically sold through retail optical outlets located in optometrist and ophthalmologist clinics, as well as through retail stores.

Our Business Model

We are focused primarily on operating, developing and acquiring ASCs within new and existing markets. We believe that our experience in operating ASCs, when coupled with our management services experience in working with physicians, will provide our physician-partners with an efficient operating environment to maximize quality patient care. Our business was founded in the eye care setting, but we have expanded into other specialties and expect to continue to acquire and develop ASCs in varying specialties.

Surgical Facilities

As of March 15, 2011, we own and operate 37 ASCs, each of which is a state-licensed and Medicare-certified ASC. Physicians perform a variety of surgical procedures in our ASCs, including ophthalmology, orthopedics (including podiatry), pain management, gastroenterology, urology, ENT, plastic surgery and gynecology. Fifty-five percent (55%) of the surgical procedures performed in our facilities in 2010 were ophthalmic procedures, with pain management, orthopedics, gastroenterology, ENT and urology comprising 19%, 10%, 5%, 4% and 2%, respectively. Elective plastic surgery (*i.e.* surgery not covered by third party payors) is approximately 1% of our total procedures.

We generally own and operate our surgical facilities through joint ownership arrangements in which we own a majority interest in the facility with the noncontrolling equity interests being owned by the physicians that perform surgeries in the ASC and live in the ASC s local community. Each facility is generally owned and operated through a separate limited liability company, with one of our wholly owned subsidiaries generally serving as the manager of the entity. In certain instances, we may own the facility through a limited partnership with one of our wholly owned subsidiaries serving as the general partner.

Product Sales

We own and operate an optical laboratory business that specializes in surfacing, finishing and distributing corrective lenses and eyeglass lenses. Our laboratories have in excess of 275 active customers, including ophthalmologists, optometrists, opticians and optical retail chains. Our optical products purchasing organization allows health care professionals to purchase optical and medical products through us from more than 275 suppliers. We expanded our purchasing organization in December 2007 when we acquired an optical products purchasing organization based in Minneapolis, Minnesota. With this acquisition, we now process consolidated monthly billing for over 2,300 customers. A customer of these businesses includes a former affiliated practice which is a party to a multi-year optical supply agreement with us pursuant to which our group purchasing organization and optical laboratories are the primary providers of optical products and supplies to this practice. Unless the parties agree on an extension, this supply agreement will expire in December 2012. The product sales revenue generated from this customer in 2010 constituted six and one-half percent of our total product sales revenue.

In addition, our marketing products and services business provides eye care professionals and vendors with a range of products and services including brochures, videos, advertising and website design, education and training programs, and consulting services.

We also have a long-term service agreement with an optometric practice located in Illinois. The optometric practice also has a retail optical outlet that sells eyeglasses and other products to patients. We provide all of the services, facilities and equipment necessary to operate this optometric practice under a 25-year service agreement ending in 2027. The services include:

- billing, collection and cash management services
- procuring and maintaining all office space, equipment and supplies
- subject to federal and state law, recruiting, employing, supervising and training all non-professional personnel
- assisting in recruiting additional doctors
- all administrative and support services
- information technology services

Other

We also have a 40-year service agreement, ending in 2040, in place with an ophthalmology practice with multiple locations in Atlanta, Georgia. We provide all of the services, facilities and equipment necessary to operate this medical practice, including services identical in nature to those described above with respect to our Illinois affiliated optometric practice.

For a further discussion regarding these segments and their respective financial information, please see Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations.

Our Growth Strategy

Surgical Facilities

We are focused on operating, developing and acquiring ASCs. Historically, our emphasis was primarily on eye surgical services. Over time, however, we have expanded into other specialties such as orthopedics (including podiatry), pain management, gastroenterology, urology, ENT, plastic surgery and gynecology. This expansion into other specialties has been through both the acquisition of new facilities and the addition of specialties to our existing centers. While ophthalmology is still our largest specialty and a key part of our growth strategy, we are actively evaluating and pursuing opportunities in other specialties. The key elements of our growth strategy are:

- Increasing the revenue and profitability of our existing ASCs;
- Acquiring equity interests in ASCs in partnership with physicians; and
- Developing newly constructed ASCs through joint ownership arrangements with physicians.

Increasing Revenue and Profitability of our Existing ASCs

The revenue generated by our ASCs is driven by the surgical procedures performed by physicians. Revenue growth in our existing ASCs is expected to be derived from an increase in surgical procedures performed at each facility, with this increase attributable to existing physicians or new physicians utilizing the facility. All of our ASCs currently have the capacity to handle additional procedures. Given this capacity, we introduce the benefits of our facilities to new physicians who may be using other less efficient and convenient facilities. We believe the efficiency and convenience of an ASC, and the opportunity to work in facilities affiliated with a national ASC operator with significant management expertise, are appealing to physicians and their patients and provides a more attractive setting than hospitals. We employ sales people in several of our markets who are working on a full-time basis to market our ASCs to potential physicians. We also work with our

physicians to identify new procedures, technologies or equipment to integrate into our facilities and expand the scope of surgical services offered in a cost-effective manner. Moreover, as we continue to expand the number of multi-specialty ASCs within our portfolio, reimbursements from private third party payors will likely increase as an overall percentage of our surgical facility revenue. Thus, we will continue to evaluate opportunities to maximize our managed care panel participation and reimbursement levels.

With some of our existing centers that currently provide only eye-related surgical services, we continue to explore efficient ways to add new surgical specialties. We are often required to obtain state licensure approval to add other specialties to our existing centers. The likelihood of our success in receiving these approvals will vary by state.

Staffing and medical supply costs are generally an ASC s two largest expense categories. We analyze staffing schedules and work with physicians to schedule surgeries in a manner that maximizes staff efficiency and optimizes staffing costs. We also have negotiated purchasing contracts with many of our largest vendors and we educate our physicians on lower cost supply alternatives while maintaining high patient care standards.

Acquiring Equity Interests in ASCs

We have a development staff that is responsible for identifying, evaluating and negotiating the acquisition of majority interests in ASCs in new or existing markets. In certain instances, we may also consider acquiring a minority, rather than a majority, equity interest. The acquisition of a well-established ASC is an attractive means of entry into a new market, particularly in states that require a certificate of need (CON) for development. In analyzing potential transactions, the evaluation of our prospective physician-partners is a critical factor. We recognize that the success of our ASCs is tied directly to the success of our physician-

partners and their practices. We believe our management services experience from our history as a physician practice management company greatly enhances our physician evaluation process.

We also assess the target facility s potential for future growth. We identify opportunities to add new physicians or surgical procedures, or to improve managed care participation. We also examine the opportunities to reduce expenses through improved staff efficiency, better physician scheduling and reduced supply costs. Our development staff and operations personnel work closely with our physician partners to formulate a growth strategy for each newly acquired facility to maximize our return on investment.

Developing Newly Constructed ASCs

Our development staff is also responsible for identifying potential opportunities to build new ASCs with physician-partners. These projects involve partnering with one or more physicians in a local community that is either underserved from a facility standpoint, or involve physicians who do not have the resources, productivity or expertise to construct a facility on their own and seek an experienced partner to help finance, structure and oversee the project. Generally, development of a new ASC can be an attractive alternative in states that do not require a CON to build a new center. We have developed two of our 37 ASCs as of March 15, 2011. In addition, in 2009, we relocated one of our ASCs from Altamonte Springs, Florida into a newly constructed and expanded facility with four operating rooms in Orlando, Florida.

Product Sales

We believe there are opportunities to grow our products sales business by adding customers, as well as offering a broader range of products and services. In 2007, we added to our optical products group purchasing organization by purchasing another purchasing organization based in Minneapolis, Minnesota. In August 2008, we supplemented our marketing products and services business by acquiring MDnetSolutions, a call center and marketing solutions company serving primarily the bariatric market. In June 2010, we sold the MDnetSolutions business back to its previous owner.

Competition

Surgical Facilities

In operating, developing and acquiring our ASCs, our principal competitors are corporations, physicians and hospitals. There are several publicly held and private companies actively engaged in the acquisition, development and operation of ASCs. Some of these companies may acquire and develop multi-specialty ASCs, practice-based ASCs focusing on varying specialties, or a combination of the two. Moreover, some of these companies have the acquisition and development of ASCs as their core business, while other competitors are larger companies that have subsidiaries or divisions engaged in this business. Many of these competitors have greater resources than us. In recent years, we have seen hospitals becoming much more active in competing with us for the acquisition and development of ASCs. Hospitals are also becoming much more active in employing physicians and/or purchasing medical practices. In each of our local markets, we compete with hospitals and other ASCs in attracting physicians to utilize our ASCs, for patients and for managed care contracting opportunities.

Product Sales

Our two optical laboratories face a variety of national, regional and local competitors. We compete in the optical laboratory market on the bases of quality and breadth of service, reputation and price.

In the market for providing optical group purchasing services, we primarily compete with national and regional buying groups, as well as large vendors. Competition in this market is based upon service, price and the strength of the purchasing organization, including the ability to negotiate discounts with suppliers.

Our marketing products and services business competes in a fragmented market, with no dominant competitors that have significant market share.

Other

Our management services are provided to eye care professionals through long-term affiliations. The market for these management services is fragmented, and we do not face any single, dominant national competitor. Eye care professionals may seek a corporate partner to assist them in the growth and development of their practices, as well as with the day-to-day management and

administration of their businesses. Factors that may influence an eye care professional s decision to retain a corporate partner to provide management services are the corporate partner s experience and scope and quality of services offered, the eye care professional s need for these services, and price.

Employees

As of March 1, 2011, we had approximately 772 employees, 503 of whom are full-time employees. We are not a party to any collective bargaining agreements and we consider our relations with our employees to be good.

Many of our ASCs are located adjacent to a physician practice. In some instances, our ASCs may lease from the physician practice some or all of the individuals who provide services in the ASC on our behalf. This is typically only done when the ASC provides surgical services on a limited schedule. This leasing model allows us to staff these centers in a more cost-effective manner.

Governmental Regulation

As a participant in the health care industry, our operations are subject to extensive and increasing regulation by governmental entities at the federal, state and local levels. Many of these laws and regulations are subject to varying interpretations, and in many areas, we believe courts and regulatory authorities generally have provided limited clarification. Moreover, state and local laws and interpretations vary from jurisdiction to jurisdiction. As a result, we may not always be able to accurately predict interpretations of applicable law regulating our businesses.

We believe our business practices comply in all material respects with applicable federal, state and local laws and regulations. If the legal compliance of any of our activities were challenged, however, we might have to divert substantial time, attention and resources from running our business to defend against these challenges regardless of their merit. In such circumstances, if we do not successfully defend these challenges, we might face a variety of adverse consequences including losing our ASC licenses, losing our eligibility to participate in Medicare, Medicaid or other federal or state health care programs, or losing other contracting privileges and, in some instances, civil or criminal fines. Any of these consequences could have a material adverse effect on our business, financial condition and results of operations.

The regulatory environment in which we operate may change significantly in the future. Numerous legislative proposals have been introduced in the U.S. Congress and in various state legislatures over the past several years that could cause major reforms of the U.S. health care system. In addition, several sets of regulations have been recently adopted that may require substantial changes in the way health care providers operate during the coming years. In response to new or revised laws, regulations or interpretations, we could be required to revise the structure of our legal arrangements, repurchase noncontrolling equity interests in our ASCs that are owned by physicians, incur substantial legal fees, fines or other costs, or curtail our business activities, reducing the potential profit to us of some of our legal arrangements, any of which could have a material adverse effect on our business, financial condition and results of operations.

The following is a summary of the principal health care regulatory issues affecting our operations and us.

Federal Law

Anti-Kickback Statute. The federal anti-kickback statute prohibits the knowing and willful offer, payment, solicitation or receipt of any form of remuneration in return for, or in order to induce, (i) the referral of a person for services, (ii) the furnishing or arranging for the furnishing of items or services, or (iii) the purchase, lease or order or arranging or recommending purchasing, leasing or ordering any item or service, in each case, reimbursable under Medicare, Medicaid or other federal health care programs. Recent revisions to the anti-kickback statute passed as part of the Health Reform Law now provide that knowledge of the anti-kickback statute or the intent to violate the anti-kickback statute is not required. Other revisions now provide that submission of a claim for services or items generated in violation of the anti-kickback statute constitutes a false or fraudulent claim and may be subject to additional penalties under the Federal Civil False Claims Act. Violations of the anti-kickback statute may result in criminal penalties, including imprisonment or criminal fines of up to $25,000 per violation, civil penalties of up to $50,000 per violation plus up to three times the amount of the underlying remuneration, and exclusion from federal or state programs including Medicare or Medicaid.

The anti-kickback statute is broadly written as to encompass many legitimate, harmless and pro-competitive arrangements. Consequently, Congress has enacted a series of statutory exceptions to the anti-kickback statute, and the Inspector General for the U.S. Department of Health and Human Services (DHHS) has promulgated a series of regulatory safe harbors. When possible, we have attempted to structure our business operations within a safe harbor. However, some aspects of our business either do not meet the

prescribed safe harbor standards, or relate to practices for which no safe harbor standards exist. Because there is no legal requirement that relationships fit within a safe harbor, a business arrangement that does not comply with the relevant safe harbor, or for which a safe harbor does not exist, does not necessarily violate the anti-kickback statute, and is not necessarily illegal *per se*.

Included among the safe harbors to the anti-kickback statute are certain safe harbors for investment interests in general, and for investment interests in ASCs, specifically. As of March 15, 2011, we co-own 35 of our ASCs with one or more physicians, and we will likely co-own with physicians most of the ASCs that we will acquire in the future. We will also likely be selling noncontrolling interests in our existing wholly owned ASCs to physicians in the near- to intermediate-term. It is unlikely that our co-ownership will meet all of the parameters of the general investment interest safe harbors or the ASC investment interest safe harbors. As discussed above, however, an arrangement that does not fit squarely within a safe harbor is not *per se* unlawful under the anti-kickback statute. If a practice does not fit within a safe harbor, however, no guarantee can be given that the practice will be exempt from prosecution or the imposition of civil monetary penalties; it will be viewed under the totality of the facts and circumstances. It is our intent to structure all such co-ownership arrangements in a manner that complies with as many of the safe harbor components as possible, that meets the objectives of the anti-kickback statute, and that follows the other available regulatory guidance regarding ASC co-ownership arrangements to the greatest extent possible.

The applicable regulatory authorities have provided limited guidance regarding ASC ownership arrangements that are permissible under the anti-kickback statute. Based on the guidance that is available, we believe that our joint ownership arrangements comply with the anti-kickback law based on, among other things, the following factors: all of the jointly owned ASCs are Medicare certified; patients referred to an ASC by an investor are informed of the referring physician s investment interest in the ASC; the terms on which an investment interest in the ASC is offered to an investor are not related to the previous or expected volume of referrals or services by, or other business with, the investor; neither any of the investors (including us) nor the ASC entity will loan money to any investors or guarantee debt of any investors incurred to purchase the investment interest; the return on investment in the ASC is directly proportional to the investors investment interests; the ASCs treat federal health program beneficiaries in a non-discriminatory manner; and Medicare- recognized surgical procedures account for a significant portion of each investor-physician s medical practice income.

Self-Referral Law. Subject to limited exceptions, the federal physician self-referral law, known as the Stark Law, prohibits physicians, optometrists, dentists, chiropractors, and podiatrists from referring their Medicare or Medicaid patients for the provision of designated health services (DHS) to any entity with which they or their immediate family members have a financial relationship. The Stark Law also prohibits the recipient of a prohibited referral from billing Medicare for the DHS provided pursuant to that referral. Financial relationships include both compensation and ownership relationships. Designated health services include clinical laboratory services, radiology and ultrasound services, durable medical equipment and supplies, and prosthetics, orthotics and prosthetic devices, as well as seven other categories of services.

Generally speaking, the Stark Law does not prohibit referrals to ASCs from physicians with ownership or investment interests in those ASCs. Medicare regulations provide two exceptions that protect referrals to ASCs by physicians who have ownership or compensation relationships with those ASCs. The first exception expressly exempts items and services which are identified as designated health services for which payment is included in the ASC composite rate. Referrals made for these items and services by physicians with a financial relationship with the ASC do not violate the Stark Law when furnished in the ASC setting. Thus, when an intraocular lens, or IOL, used in cataract surgery, or another service or item that would otherwise qualify as a designated health service, is included in an ASC composite payment rate, the IOL (or other such service or item) will not be considered to be a designated health service. The second exception provides that prosthetics, prosthetic devices, and durable medical equipment implanted at a Medicare-certified ASC by the referring physician or a member of the referring physician s group practice also are specially excepted, even when the Medicare payment for these items is separate from *i.e.,* not bundled into the ASC payment.

Violating the Stark Law may result in denial of payment for the designated health services performed, civil fines of up to $15,000 for each service provided pursuant to a prohibited referral, a fine of up to $100,000 for participation in a circumvention scheme, and exclusion from the Medicare, Medicaid and other federal health care programs. The Stark Law is a strict liability statute. Any referral made where a financial relationship exists that fails to meet an exception constitutes a violation of the law.

Civil False Claims Act. The Federal Civil False Claims Act prohibits knowingly presenting or causing to be presented any false or fraudulent claim for payment by the government, or using any false or fraudulent record in order to have a false or fraudulent claim paid. Violations of the law may result in repayment of three times the damages suffered by the government and penalties from $5,500 to $11,000 per false claim. Collateral consequences of a violation of the False Claims Act include administrative penalties and

possible exclusion from participation in Medicare, Medicaid and other federal health care programs.

Health Insurance Portability and Accountability Act. In August 1996, Congress enacted the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Included within HIPAA s health care reform provisions are its administrative simplification provisions, which require that health care transactions be conducted in a standardized format, and that the privacy and security of certain individually identifiable health information be protected. Final rules for most of the administrative simplification subject areas have been published.

Final rules covering Standards for Electronic Transactions and Code Sets were published on August 17, 2000, and set forth the standardized billing codes and formats that we must use when conducting certain health care transactions and activities. Our ASCs are utilizing standard transactions and approved code sets, all in compliance with HIPAA.

On December 28, 2000, as modified on May 31, 2002 and August 14, 2002, the DHHS published final rules addressing Standards for Privacy of Individually Identifiable Health Information under HIPAA s administrative simplification provisions. Compliance with these rules was required by April 14, 2003. These rules create substantial compliance issues for all covered entities which include health care providers, health plans and health care clearinghouses that engage in regulated transactions and activities. Operations of our ASCs are covered by the final rules. We believe our ASCs are in substantial compliance with these final rules.

Final rules addressing the Security Standards under HIPAA s administrative simplification provisions were published on February 20, 2003. Compliance with these regulations was required by April 21, 2005. We believe our ASCs are in compliance.

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) part of the American Recovery and Reinvestment Act of 2009 (ARRA) broadened the scope of the HIPAA privacy and security regulations. On October 30, 2009, the US Department of Health and Human Services issued an Interim Final Rule implementing amendments to the enforcement regulations under HIPAA. We believe our ASCs are in substantial compliance with the HITECH Act requirements as well.

The HITECH Act provides a framework for security breach notification requirements to individuals affected by a breach and, in some cases, to HHS or to the media. This reporting obligation effective September 23, 2009 applies broadly to breaches involving unsecured protected health information. DHHS is currently in the process of finalizing regulations addressing security breach notification requirements. DHHS initially released an Interim Final Rule for breach notification requirements on August 24, 2009. DHHS then drafted a Final Rule, but the rule was subsequently withdrawn by DHHS on July 29, 2010. Currently, the Interim Final Rule remains in effect but the withdrawal suggests that when DHHS issues the Final Rule, which it has indicated it intends to do in the near future, the requirements for how covered entities should respond in the event of a potential security breach involving protected health information are likely to be more onerous than those contained in the Interim Final Rule. In addition, the HITECH Act extends the application of certain provisions of the security and privacy regulations to business associates and subjects them to civil and criminal penalties for violation of the regulations beginning February 17, 2010.

Violations of HIPAA s provisions may result in civil and criminal penalties, and the HITECH Act strengthened HIPAA s enforcement provisions, which may result in increased enforcement activity. For violations occurring on or after February 18, 2009, entities are subject to tiered ranges for civil money penalty amounts between $100 and $50,000 per violation based upon the increasing levels of culpability associated with violations, with an annual cap of $1.5 million for identical violations within a calendar year. An additional criminal monetary penalty and imprisonment may be imposed where a person knowingly obtains or discloses personal health information. DHHS recently imposed a $1 million fine against Massachusetts General Hospital, and a $4.3 million fine against Cignet Health in February 2011 for violations of the privacy rule, suggesting increased enforcement activity in this area.

In addition, the ARRA authorizes state attorney generals to bring civil actions seeking either injunction or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents. The ARRA also broadens the applicability of the criminal penalty provisions to employees of covered entities and requires DHHS to impose penalties for violations resulting from willful neglect. Further, under the ARRA, DHHS is now required to conduct periodic compliance audits of covered entities and their business associates.

Affordable Care Act. On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which was then amended a few days later by the Health Care and Education Reconciliation Act (HCERA). Together,

these two pieces of legislation are commonly referred to as the Affordable Care Act (ACA). The stated goal of the Obama Administration in enacting the ACA was to reform the U.S. healthcare system in order to expand access to health care, improve quality, and slow the growth of health care costs.

The ACA is a broad ranging health care law that includes many provisions to be phased in periodically over the next several years. This legislation will profoundly impact the market in which we operate and how we conduct our business.

One significant aim of the ACA is to reform the individual and group health care markets using a variety of legal mechanisms, including the individual mandate which, beginning in 2014, would require most uninsured Americans to purchase health insurance or pay a penalty. At the time the individual mandate becomes effective in 2014, the ACA provides that state Insurance Exchanges are to be operational across the United States in order to facilitate the purchase of health insurance at affordable premiums. Additionally, the ACA expands access to Medicaid and introduces a number of particular Medicare initiatives.

The ACA faces legal and political challenges and it is unknown whether and to what degree it may withstand these challenges. After the ACA was enacted, a number of plaintiffs, including many states, filed numerous lawsuits in various federal district courts challenging the ACA on a variety of grounds, including the constitutionality of the individual mandate. One especially significant development in the legal challenge to the ACA came in January 2011, when a federal district judge in the state of Florida ruled that the individual mandate is unconstitutional and that, as a result, the whole of the ACA is unconstitutional. It appears likely that the United States Supreme Court will ultimately determine whether the individual mandate and the ACA are constitutional, and whether the federal government and states continue to implement and enforce the law, but the time frames for when the matter could come before the Supreme Court and then when a decision might be issued are uncertain.

Additionally, the ACA is being challenged in Congress. Numerous bills have been introduced to repeal all or parts of the legislation, and one bill that would repeal the entire law, HR 2, was approved by the US House of Representatives in January 2011.

If the ACA is not struck down by courts or repealed by Congress, while the ultimate impact of the ACA is unknown, it has the potential to change the entire healthcare marketplace in unpredictable ways. The ACA could dramatically alter the current payor mix with more individuals receiving benefits through government as opposed to private payors, increasing our dependence on Medicare and Medicaid reimbursement regimes. Additionally, if provisions of the ACA lead to value-based purchasing or pay-for-performance programs being implemented for ASCs, this would impose additional burdens in the form of further quality reporting obligations accompanied by potentially lower reimbursements.

We are unable to predict whether pending legal and political challenges to the ACA will result in the ACA being struck down, or otherwise being modified, or becoming subject to repeal or defunding in whole or in part. Further, if the ACA does substantially survive pending legal and political challenges, we cannot predict the scope and impact of regulations on ASCs that will result directly and indirectly from the ACA, which will be implemented by CMS and other agencies. The many changes that could be brought about by the ACA and its related regulatory framework could reduce our revenues or increase our costs and could have a material adverse effect on our business, financial condition or results of operations.

State Law

Facility Licensure and Certificate of Need. We are required to obtain and maintain licenses from the state departments of health in states where we open, acquire and operate ASCs. We believe that we have obtained, and that we maintain, the necessary licenses in states where licenses are required. With respect to future expansion, we cannot assure you that we will be able to obtain the required licenses without unreasonable expense or delay. In addition, we cannot assure you that we will be able to maintain licenses for all of our operating ASCs. We believe our ASCs are in compliance with all applicable state licensure requirements, but we cannot guarantee that the state departments of health will continue to view our facilities as being in compliance.

Some states require a CON, prior to the construction or modification of an ASC or the purchase of specified medical equipment in excess of a dollar amount set by the state. We believe that we have obtained the necessary CONs in states where a CON is required. However, we believe courts and state regulatory authorities generally have provided little clarification as to some of the regulations governing the need for CONs. It is possible that a state regulatory authority could challenge our determination. With respect to our future development of new ASCs or expansion of existing ASCs, we cannot assure you that we will be able to acquire a CON in all states where a CON is required.

Anti-Kickback Laws. In addition to the federal anti-kickback law, a number of states have enacted laws that prohibit payment for referrals and other types of kickback arrangements. Some of these state laws apply to all patients regardless of their source of payment, while others limit their scope to patients whose care is paid for by particular payors.

Self-Referral Laws. In addition to the federal Stark Law, a number of states have enacted laws that require disclosure of or prohibit referrals by health care providers to entities in which the providers have an investment interest or with which the providers have a compensation relationship. In some states, these restrictions apply regardless of the patient s source of payment.

State Privacy Laws. Numerous states have enacted privacy laws that have similar objectives to the federal HIPAA privacy regulations. These laws, which vary from state to state, require that certain protective measures be taken in connection with the disclosure of a patient s identifying information.

State Security Breach Laws. The majority of states have enacted laws implementing specific requirements in the event that the personal information of a resident is compromised. Although these requirements vary from state to state, notification of security breaches to the state Attorney General and affected residents is often required. Notification may be costly and time consuming and a failure to comply with these requirements may result in civil or criminal penalties. To the extent to which we own or maintain personal information, we may be required to comply with various state security breach laws.

Corporate Practice of Medicine. A number of states have enacted laws that prohibit, or have common law that prohibits, the corporate practice of medicine. These laws are designed to prevent interference in the medical decision-making process by anyone who is not a licensed physician. Application of the corporate practice of medicine prohibition varies from state to state. Although we neither employ physicians nor provide professional medical services, we provide services to physicians in connection with their performance of surgical procedures through laser services agreements and through our remaining management services agreements. To the extent any act or service to be performed by us is construed by a court or enforcement agency to constitute the practice of medicine, we cannot be sure that a particular state court or enforcement agency may not construe our arrangements as violating that jurisdiction s corporate practice of medicine doctrine. In such an event, we may be required to redesign or reformulate our relationships with these physicians and there is a possibility that some provisions of our agreements may not be enforceable.

Fee-Splitting Laws. The laws of some states prohibit providers from dividing with anyone, other than providers who are part of the same group practice, any fee, commission, rebate or other form of compensation for any services not actually and personally rendered. Penalties for violating these fee-splitting statutes or regulations may include revocation, suspension or probation of a provider s license, or other disciplinary action. In addition, courts have refused to enforce contracts found to violate state fee-splitting prohibitions. The precise language and judicial interpretation of fee-splitting prohibitions varies from state to state. Courts in some states have interpreted fee-splitting statutes to prohibit all percentage of gross revenue and percentage of net profit management fee arrangements. Other state statutes only prohibit fee splitting in return for referrals. To the extent any of our contractual arrangements are construed by a court or enforcement agency to violate the jurisdiction s fee-splitting laws, we may be required to redesign or reformulate our arrangements and there is a possibility that some provisions of our agreements may not be enforceable.

Excimer Laser Regulation

Medical devices, including the excimer lasers used in our ASCs, are subject to regulation by the FDA. Medical devices may not be marketed for commercial sale in the U.S. until the FDA grants pre-market approval for the device.

Failure to comply with applicable FDA requirements could subject us or laser manufacturers to enforcement action, product seizures, recalls, withdrawal of approvals and civil and criminal penalties. Further, failure to comply with regulatory requirements, or any adverse regulatory action, could result in a limitation on or prohibition of our use of excimer lasers.

Government Regulation Management Services

Our management services business and the operations of our affiliated providers are also subject to extensive and continuing regulation by governmental entities at the federal, state and local levels. The following is a summary of the principal health care regulatory issues affecting our management services business, both with respect to our affiliated providers and us:

Federal Law

Anti-Kickback Statute. As discussed above, there are safe harbor regulations to the federal anti-kickback statute. When possible, we have attempted to structure our management services business and our relationships with our affiliated providers to meet most of the elements of the applicable safe harbor standards. Some aspects of our management services business, the business of our affiliated providers, and our relationships with our affiliated providers either do not meet the prescribed safe harbor standards, or relate to practices for which no safe harbor standards exist. Because there is no legal requirement that relationships fit within a safe harbor, a business arrangement that does not comply with the relevant safe harbor, or for which a safe harbor does not exist, does not necessarily violate the anti-kickback statute.

Self-Referral Law. Our affiliated providers provide limited categories of designated health services, specifically, diagnostic radiology services, including A-scans and B-scans, and prosthetic devices, including eyeglasses and contact lenses furnished to patients following cataract surgery. We believe the provision of these designated health services satisfies an exception to the Stark Law. In addition, compensation arrangements between our affiliated providers and their employers have historically been structured to comply with the Stark Law.

Civil False Claims Act. The Federal Civil False Claims Act prohibits knowingly presenting or causing to be presented any false or fraudulent claim for payment by the government, or using any false or fraudulent record in order to have a false or fraudulent claim paid.

Health Insurance Portability and Accountability Act. The operations of our affiliated providers are covered by HIPAA and the HITECH Act. We have taken actions to assist our remaining affiliated providers with their HIPAA and HITECH Act compliance efforts.

Affordable Care Act. The ACA is a broad ranging health care law that includes many provisions to be phased in over the next several years. We are unable to predict whether pending legal and political challenges to the ACA will result in the ACA being struck down on legal grounds, or otherwise being modified, or becoming subject to repeal or defunding in whole or in part. Further, if the ACA does substantially survive pending legal and political challenges, we cannot predict the scope and impact of regulations on ASCs that will result directly and indirectly from the ACA, which will be implemented by CMS and other agencies. The many changes that could be brought about by the ACA and its related regulatory framework could reduce our revenues or increase our costs and could have a material adverse effect on our business, financial condition or results of operations.

State Law

State Privacy Laws. State health information privacy laws may also apply to the activities of our affiliated providers. There is very little guidance regarding the application of these state privacy laws. We cannot be sure that the privacy measures taken by our affiliated providers will be construed as complying with these laws. In the event the privacy measures taken by these professionals are deemed not to comply with a particular state s health privacy laws, we may need to incur significant time, effort and expense to establish compliance.

State Security Breach Laws. The majority of state security breach laws impose requirements both for persons who own personal information and persons who maintain personal information for the benefit of another person or entity. To the extent that we own or maintain personal information, we will need to comply with state security breach laws governing its protection and any required procedures or notifications in the event that the personal information becomes compromised.

Corporate Practice of Medicine Laws. Although we neither employ doctors nor provide professional medical services, to the extent any portion of the comprehensive management services that we provide under our service agreements with our affiliated providers is construed by a court or enforcement agency to constitute the practice of medicine, our service agreements provide that our obligations to perform the act or service is waived. We cannot be sure that a particular state court or enforcement agency may not construe our arrangements as violating that jurisdiction s corporate practice of medicine doctrine. In such an event, we may be required to redesign or reformulate our relationships with our affiliated providers and there is a possibility that some provisions of our service agreements may not be enforceable.

Fee-Splitting Laws. We believe our management fee arrangements with our affiliated providers differ from those invalidated as unlawful fee splits because they establish a flat monthly fee that is subject to adjustment based on the degree to which actual practice revenues or expenses vary from budget. However, there is some risk that our arrangements could be construed by a state court or enforcement agency to run afoul of state fee-splitting prohibitions. Accordingly, all of our service agreements contain either a reformation provision or a mechanism establishing an alternative fee structure, or both.

Discontinued Operations

On June 17, 2010, our Board of Directors approved the sale of our MDnetSolutions business. Our Board determined that MDnetSolutions has been more negatively impacted than the Company s other businesses by the challenging economic environment experienced since its acquisition. The Board determined that the prospects for this business to become profitable were not sufficient to justify further investment and support of this business. For this reason, the Board determined to sell MDnetSolutions. On June 18, 2010, we sold the MDnetSolutions business back to its previous owner. The results of this business, and the after-tax loss generated by the sale, are classified as discontinued operations for all periods presented.

Item 1A. Risk Factors

The following factors should be considered in evaluating our Company and our business. These factors may have a significant impact on our business, operating results and financial condition.

Risks Relating to Our Proposed Merger

If the Merger contemplated by the Merger Agreement with Surgery Partners and Merger Sub does not occur, it could have a material adverse effect on our business, results of operations, and financial condition.

On January 20, 2011, we entered into a Merger Agreement with Surgery Partners and Merger Sub providing for the Merger of Merger Sub with and into us, with our company surviving the Merger as a wholly-owned subsidiary of Surgery Partners. Upon completion of the Merger, each share outstanding immediately prior to the effective time of the Merger (excluding those shares that are held by Surgery Partners, Merger Sub or us or any of our subsidiaries and stockholders who have perfected and not withdrawn a demand for appraisal rights under Delaware law) will be automatically canceled and converted into the right to receive $13.25 in cash (without interest and subject to applicable withholding taxes). The transaction is expected to close in the second quarter of 2011, subject to customary closing conditions, including customary antitrust and regulatory approvals. Further, the transaction is subject to the approval of the Merger Agreement by holders of a majority of the outstanding shares of our common stock.

We cannot predict whether the closing conditions for the Merger set forth in the Merger Agreement will be satisfied, and the transactions contemplated by the Merger Agreement may be delayed or even abandoned before completion if certain events occur. The Merger Agreement may be terminated by us, on the one hand, or Surgery Partners, on the other hand, under certain circumstances, and termination of the Merger Agreement may require us to pay a termination fee of approximately $4.368 million to Surgery Partners. If the conditions to the transactions set forth in the Merger Agreement are not satisfied or waived pursuant to the Merger Agreement, or if the transactions are not completed for any other reason, (i) the market price of our common stock could significantly decline; (ii) we will remain liable for the significant expenses that we have incurred related to the transaction, including legal and financial advisor fees, and may be required to pay the approximately $4.368 million termination fee; (iii) we may experience substantial disruption in our sales and operating activities, and the loss of key personnel, customers, suppliers, and other third-party relationships, any of which could materially and adversely affect us and our business, operating results, and financial condition; and (iv) we may have difficulty attracting and retaining key personnel.

Until the closing of the transactions, it is possible that the focus of our management team and employees may be diverted, and that there may be a negative reaction to the Merger on the part of our customers, employees, suppliers, or other third-party relationships. The Merger Agreement also contains certain limitations regarding our business operations prior to completion of the Merger.

Risks Relating to Our Business

Current economic conditions may adversely affect our business

The current economic conditions in the United States may adversely affect our results of operations, our financial condition and our ability to pursue our growth strategy. The current economic conditions and continuing levels of high unemployment could result in fewer procedures being performed at our ASCs because patients may delay or cancel treatments. Further increases in unemployment could also result in fewer individuals being covered by employer-sponsored health plans and more individuals being covered by lower paying government-sponsored programs such as Medicare and Medicaid. Adverse economic conditions may also increase pressure on federal and state governments to contain or reduce reimbursements from Medicare, Medicaid and other programs. To the extent that commercial payors are adversely affected by the economy, we may experience declines in commercial rates, a slow

down in collections and a reduction in the amounts we expect to collect.

In addition, our credit facility expires on December 15, 2011 unless we repay or refinance our convertible notes prior to this date in which case the expiration date will be extended to August 31, 2012. If the merger does not close, our plan is to negotiate an amendment to our credit facility to extend the term and provide for the ability to pay off our convertible debt in 2012 with borrowings from our amended credit facility. There is no assurance we will be successful.

The level of our current and future debt could adversely impact our business, financial condition and growth strategy, and could also dilute our current equity holders and limit our flexibility

Our acquisition and development program requires substantial capital resources and the operations of our existing ASCs also require ongoing capital expenditures. Our future capital requirements and the adequacy of our available funds will depend on many factors, including the timing and size of our acquisitions, development and expansion activities, the capital requirements associated with our ASCs, the future cost of medical equipment and our ability to generate cash flow. If we identify favorable acquisition and development opportunities that require additional resources, we may be required to incur additional indebtedness or issue equity securities in order to pursue these opportunities.

Our current debt levels may limit our ability to use indebtedness to fund our growth. As of December 31, 2010, we had $21.5 million outstanding under our credit facility which expires on December 15, 2011 unless we repay or refinance our convertible notes prior to this date in which case the expiration date will be extended to August 31, 2012. Our $80 million facility consists of a $50 million revolving credit facility and a $30 million term loan facility. We also have $75 million outstanding in 1.0% convertible senior subordinated notes due June 15, 2012, which we will need to repay or refinance prior to maturity. This high level of indebtedness, among other things, could limit our ability to borrow additional funds or refinance our existing credit facility on favorable terms, if at all. Our indebtedness could also cause us to dedicate a substantial portion of our cash flow from operations to the payment of principal and interest on our indebtedness, reducing the funds available for our operations and development activities. As our indebtedness has increased, the portion of our borrowings at variable interest rates has also increased, which leaves us vulnerable to interest rate increases. Our degree of leverage also places us at a competitive disadvantage compared to our competitors that have less debt. We could also fund our growth, or reduce our outstanding indebtedness, through the issuance of equity securities. To the extent any such equity financing is available to us, it may be dilutive to our current equity holders.

Under the current terms of our credit facility, as of December 31, 2010, we had approximately $49 million of potential availability under the $50 million revolving credit facility. As of December 31, 2010, the $30 million term loan facility requires quarterly payments of $1.25 million, which increase to $1.5 million commencing December 31, 2011. We are unable to borrow additional funds under the $30 million term loan facility; consequently, our borrowing availability under our existing credit facility is limited to the availability under the $50 million revolving credit facility. In addition, we are not able to use the final $10 million of availability for the purpose of acquisitions.

Reduced prices and reimbursement rates for surgical procedures as a result of competition or Medicare and other governmental and private third party payor cost containment efforts could reduce our revenue, profitability and cash flow

Government sponsored health care programs accounted for approximately 33% of our consolidated net revenue for the year ended December 31, 2010. The health care industry is continuing to experience a trend toward cost containment as government and private third-party payors seek to contain reimbursement and utilization rates and to negotiate reduced payment schedules with health care service providers. These trends may result in a reduction from historical levels in per patient revenue received by our ASCs. Changes in Medicare payment rates have, in the past, resulted in reduced payments to ASCs. Medicaid and other governmental and private insurance payments also could be affected to the extent

that these insurance programs use payment methodologies based on Medicare rates, or take actions independent of Medicare to revise payment methodologies.

On January 1, 2008, pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (referred to as the Medicare Modernization Act), the CMS began implementing a new methodology for determining Medicare payment rates for ASCs. When CMS implemented these revised rates, payment amounts for most procedures furnished by our ASCs changed, in some cases significantly. Payment for some high-volume procedures, such as cataract extraction, increased, while payment for others, such as YAG laser capsulotomy and gastroenterology procedures, decreased. CMS is implementing the new methodology over four years. During 2010, subject to transition year rules and other adjustments, ASCs generally were paid approximately 59 percent of what comparably situated hospitals were paid for the same service. In 2011, subject to transition year rules and other adjustments, ASCs generally will be paid approximately 56 percent of what comparably situated hospitals will be paid for the same service. Procedures

that were approved for payment in the ASC setting prior to 2008 are subject to transition rules, and as such may be paid more or less than the approximately 56 percent of the hospital rate. The percentage relationship between ASC and hospital payment rates will continue to fluctuate from year-to-year as CMS annually recalculates the conversion factors and applies budget neutrality and inflation adjustments. Consequently, we expect Medicare payments for most procedures furnished by our ASCs to fluctuate annually, and in some cases significantly. However, we also expect the overall gap between hospital and ASC rates to continue to widen. To the extent the amount that Medicare pays ASCs for procedures fluctuates, potential revenues likewise could fluctuate and decline. Many private payors utilize Medicare payment schedules or shadow price Medicare payments. Consequently, changes to Medicare payments also could negatively affect revenues available from non-Medicare patients.

In addition, payments for certain services commonly furnished in a physician office, or office-based procedures are capped at the amount Medicare pays physicians as a technical component when the services are furnished in the office setting. As such, payments for many procedures commonly furnished in our ASCs are well below the payment a hospital would receive for the same procedure. Approximately 350 procedures (10 percent of covered procedures) are currently designated as office-based. To the extent that we furnish a substantial number of office-based procedures, revenues could be negatively impacted.

The ACA now requires CMS to reduce the annual inflation update for ASC payments by making a productivity adjustment of 1.3 percentage points each year. As such, while the applicable inflation adjustment for 2011 for ASC payment rates is 1.5 percent, since the applicable productivity adjustment is 1.3 percent, the actual inflation adjustment for ASCs payments is a mere 0.2 percent for 2011. As a result of this productivity adjustment, we expect Medicare payments for ASC services to be increased only nominally from year to year.

Under current law, only procedures specifically designated by CMS will be covered when furnished in the ASC setting. As such, our facilities can receive a facility payment from Medicare only for ASC covered procedures. CMS develops and maintains the listing of ASC Covered Procedures (defined by HCPCS Code). At present, approximately 3,500 procedures are approved for payment in the ASC setting. CMS is required by law to update the list of ASC Covered Procedures every two years. Although CMS recently has updated the list of ASC Covered Procedures annually, CMS has occasionally disregarded this requirement and failed to update the list. There is a risk that CMS will continue to occasionally disregard this statutory requirement, and not update the list of ASC Covered Procedures as required by law. There also is a substantial risk that CMS could eliminate Medicare coverage for many surgical procedures. In November 2004, CMS proposed to delete 100 procedures from the list of ASC Covered Procedures, including many procedures that are commonly furnished in ASC settings. Although CMS ultimately decided in May 2005 to delete only five of the proposed 100 procedures, CMS could again propose and ultimately decide to substantially reduce the number of procedures for which Medicare will pay an ASC facility fee, a change that could affect the financial viability of our business. To the extent that any procedures performed at our ASCs are deleted from the list of ASC Covered Procedures, it could negatively and materially affect our revenue and business.

Considerable uncertainty surrounds the future determination of Medicare reimbursement levels for ambulatory surgical services. Services reimbursable under the Medicare program are subject to legislative change, administrative rulings, interpretations, discretion, governmental funding restrictions and requirements for utilization review. Such matters, as well as more general governmental budgetary concerns, may significantly reduce payments made to ASCs under this program, and there can be no assurance that future Medicare payment rates will be sufficient to cover the costs of, or cost increases in, providing services to Medicare patients. These uncertainties are compounded as a result of the unknown future of the ACA, which faces continuing legal and political challenges. We cannot predict the outcomes of court decisions that will affect the ACA, nor how legislative efforts to repeal, modify, dilute, or defund the ACA may impact our business. The outcome of court decisions and legislative battles and actions regarding the ACA could have a material adverse effect on the Company. See Government Regulation Federal Law Affordable Care Act.

Changes to Medicare reimbursements may also impact our revenue from private third party payors because many private third party payors tie their reimbursement levels to Medicare rates.

Revenue from laser vision correction procedures comprised approximately one percent of our surgical facilities net revenue for the year ended December 31, 2010. The market for providing laser vision correction and other refractive surgery procedures continues to be highly competitive. In response, many of our competitors are offering laser vision correction or other refractive surgery services at lower prices than the prices we charge. If price competition continues, however, we may choose or be forced to lower the facility fees we charge in our surgical facilities. If we lower our fees, we could experience reductions in our revenue, profitability and cash flow.

Our revenue and profitability could decrease if we are unable to maintain positive relationships with the physicians who perform surgical procedures at our ASCs

The success of our business depends on our relationship with, and the success and efforts of, the physicians who perform surgical procedures at our ASCs. Our physician partners may perform surgical procedures at other facilities or hospitals, are not required to use our ASCs and may choose not to perform procedures at our ASCs. Our revenue and profitability would decline if our relationship with key physicians deteriorated or those physicians reduced or eliminated their use of our ASCs. In addition, our business and reputation could be damaged if the physicians who use our ASCs fail to provide quality medical care or follow required professional guidelines at our facilities. Some individual physicians are responsible for a significant share of the procedure volume and revenue at some of our ASCs. The loss of one or more of these physicians could negatively impact the financial viability of an ASC.

In addition, co-owning ASCs with physicians may create additional regulatory risk. See Government Regulation Federal Law Anti-Kickback Statute.

Our failure to operate, acquire or develop a sufficient number of profitable surgical facilities could limit our profitability and revenue growth

Our growth strategy is focused on growing our existing ASCs and acquiring or developing new ASCs in a cost-effective manner. We may not experience an increase in surgical procedures at our existing or future ASCs. We may not be able to achieve the economies of scale and patient base, or provide the business, administrative and financial services required to grow or sustain profitability in our existing and future ASCs. Newly acquired or developed facilities may generate losses or experience lower operating margins than our more established facilities, or they may not generate returns that justify our investment.

The market for ASC acquisitions continues to be competitive, and most potential targets often have multiple bidders. This bidding process often results in increased purchase prices and less favorable transaction terms. We may not be able to identify suitable acquisition or development targets, successfully negotiate the acquisition or development of these facilities on satisfactory terms, or have the access to adequate capital to finance these endeavors.

We anticipate that we will fund the acquisition and development of future ASCs from cash generated from our operations and amounts borrowed under our credit facility. The maximum commitment available under our revolving credit facility is currently $50 million (the remaining $30 million is a term loan that is being paid down but under which we cannot borrow additional funds). Our current credit facility expires on December 15, 2011 unless we repay or refinance our convertible notes prior to this date in which case the expiration date will be extended to August 31, 2012. As of March 2, 2011, we have approximately $49 million of potential availability under our $50 million revolving credit facility. Our ability to pursue acquisition and development activity will be limited to the availability under our $50 million revolving credit facility and cash generated from our operations. In addition, we are not able to use the final $10 million of availability for acquisitions.

If we are unable to successfully implement our growth strategy or manage our growth effectively, our business, financial condition and results of operations could be adversely affected.

We will need cash to pay the principal portion of the conversion value of the Convertible Notes (as defined below), as required by the indenture governing the notes

Under the net share settlement feature of the Convertible Notes, we are required to repay the $75 million principal portion of the Convertible Notes in cash. It is unlikely that our cash flow from operations will be sufficient to make this payment so we will need other sources of debt or equity capital. Our business and growth strategy, including our ability to finance the acquisition and development of new ASCs, could be negatively impacted if we do not have sufficient financial resources, or are not able to arrange suitable financing, to pay the required amounts upon conversion or tender of the Convertible Notes.

Our operating margins and profitability could suffer if we are unable to manage effectively, and grow the revenue of, our increasing number of ASCs

Our growth strategy includes increasing our revenue and earnings by increasing the number of procedures performed at our ASCs. Because we do not anticipate price increases from third party payors and given that we may face further reimbursement pressures, our operating margins will be adversely affected if we do not increase the revenue and procedure volume of our existing

ASCs to offset increases in our operating costs. We seek to increase procedure volume and revenue at our ASCs by increasing the number of physicians performing procedures at our facilities, obtaining new or more favorable managed care contracts, improving patient flow at our centers and achieving operating efficiencies. We may not be successful in these endeavors.

We acquired ten ASCs in 2006, two ASCs in 2007, three ASCs in 2008 and no ASCs in 2009 and one ASC in 2010 (which we absorbed into our Orlando, Florida ASC). Despite making just one acquisition in 2009 and 2010, our business strategy contemplates us continuing to acquire and develop more ASCs in the future. Our growth has placed, and will continue to place, increased demands on our employees, business systems and other resources. Continued expansion of our operations will require substantial financial resources and management attention. To accommodate our past and anticipated future growth, we will need to continue to implement and improve the management and operation of our business systems and to expand, train, manage and motivate our employees. Our operating results could suffer if we do not properly manage our growth.

We may not compete effectively with other companies that have greater resources and experience than us or that may make it more difficult to maintain our licensure

Competitors with substantially greater financial, technical, managerial, marketing and other resources and experience may compete more effectively than us. We compete with other businesses, including ASC companies, hospitals, individual physicians, other ASCs, laser vision correction centers, eye care clinics and providers of retail optical products. Competitors with substantially greater resources and less debt than us may be more successful in acquiring and developing surgical facilities. In recent years, we have seen hospitals becoming much more active in competing with us for the acquisition and development of ASCs. Hospitals and other ASCs may also be more successful in attracting physicians to utilize their facilities. Hospitals are also becoming much more active in employing physicians and/or purchasing medical practices. Our optical laboratories and optical products purchasing organization also face competition on national, regional and local levels. Companies in other health care industry segments, including managers of hospital-based medical specialties or large group medical practices, may become competitors in providing ASCs and surgical equipment, as well as competitive eye care related services. Competition for retaining the services of highly qualified medical, technical and managerial personnel is significant.

We also face competitive pressures from local hospitals. In addition to competing for patients, physician relationships and ASC acquisition opportunities, ASCs are often required by Medicare and certain state laws to maintain a written transfer agreement with an area hospital. A transfer agreement provides that a hospital will accept an ASC s patient in the event of an emergency. Generally, we have not encountered problems obtaining transfer agreements from area hospitals. In limited instances, however, we have observed hospitals resisting entering into transfer agreements for what we believe to be competitive reasons. While there often are alternatives for ASCs to comply with federal and state regulations without a transfer agreement, competitive pressures from hospitals may make it more difficult and/or expensive for our ASCs to maintain their licensure and/or Medicare certification.

Changes in the interpretation of existing laws and regulations, or adoption of new laws or regulations, governing our business operations, including physician use and/or ownership of ASCs, could result in penalties to us, require us to incur significant expenditures, or force us to make changes to our business operations

We are subject to extensive government regulation and supervision under federal, state and local laws and regulations. Many of these laws and regulations are subject to varying interpretations, and courts and regulatory authorities generally have provided limited clarification. Moreover, state and local laws and interpretations vary from jurisdiction to jurisdiction. As a result, we may not always be able to accurately predict interpretations of applicable law, and federal and state authorities could challenge some of our activities, including our co-ownership of ASCs with physicians and other investors. If any of our activities are challenged, we may have to divert substantial time, attention and resources from running our business to defend our activities against these challenges, regardless of their merit. If we do not successfully defend these challenges, we may face a variety of adverse consequences, including:

- loss of use of our ASCs;

- losing our eligibility to participate in Medicare or Medicaid or losing other contracting privileges; or

- in some instances, civil or criminal fines or penalties.

Any of these results could impair our sources of revenue and our profitability and limit our ability to grow our business.

For example, the federal anti-kickback statute prohibits the knowing and willful solicitation, receipt, offer or payment of any direct or indirect remuneration in return for the referral of patients or the ordering or purchasing of items or services payable under Medicare, Medicaid or other federal health care programs. This statute is very broad and Congress directed the DHHS to develop regulatory exceptions, known as safe harbors, to the statute s referral prohibitions. While we have attempted to structure the ownership and operation of our ASCs within a safe harbor, we do not satisfy all of the requirements. Because there is no legal requirement that relationships fit within a safe harbor, a business arrangement that does not comply with the safe harbor, or for which a safe harbor does not exist, does not necessarily violate the anti-kickback statute.

Presently, despite the fact that we do not fit within a safe harbor, we believe that our ownership and operation of ASCs complies with the anti-kickback statute. However, existing interpretations or enforcement of the federal anti-kickback statute or other applicable federal or state laws and regulations could change. If so, violations of the anti-kickback statute or other laws may result in substantial civil and criminal penalties and exclusion from participation in Medicare, Medicaid and other federally funded programs.

On June 19, 2007, the Inspector General for the DHHS posted Advisory Opinion No. 07-05. In this Advisory Opinion, the Inspector General declined to grant a favorable opinion to an arrangement in which a hospital proposed to purchase a subset of the units held in the ASC by two of the largest users of the ASC. The Inspector General stated that while none of the elements of the arrangement necessarily indicated fraud or abuse, it could not conclude that the difference in the cost of capital acquisition between the hospital and the physician owners was not related to the business generated by the owners for the ASC or the hospital.

On July 25, 2008, the Inspector General posted Advisory Opinion No. 08-08. In this Advisory Opinion, the Inspector General granted a favorable opinion to a joint venture arrangement involving investment in an ASC by a group of surgeons and a hospital. The Inspector General stated that while this arrangement did not meet any specific safe harbor and could potentially generate prohibited remuneration under the anti-kickback statute, it would not impose sanctions under the federal anti-kickback statute.

Finally, on July 22, 2009, the Inspector General posted Advisory Opinion No. 09-09. In this Advisory Opinion, the Inspector General also granted a favorable opinion to an arrangement involving an ASC developed and operated by a hospital and seven orthopedic surgeons. The Inspector General concluded that while this arrangement did not qualify for safe harbor protection, it would not impose sanctions under the federal anti-kickback statute. However, the Inspector General also stated in a footnote, that there might be cause for concern if the valuation of the investor contributions were based on a cash flow analysis of the ASC as a going concern.

Although we cannot predict the ultimate application of these opinions and their impact on our business, based on the guidance that is available we believe that our joint ownership arrangements comply with the anti-kickback law.

In addition, there also is a material risk that Congress, CMS or the states could revise physician ownership and referral laws in a manner that could prohibit or limit physician ownership of ASCs. Recent revisions to the Stark Law enacted as part of the Health Reform Law have the practical effect of generally prohibiting physician ownership in new hospitals and freezing physician ownership levels in existing hospitals. While this legislation applies only to hospitals, and not to ASCs, future actions by either Congress or CMS could ban or limit physician ownership of ASCs. Additionally, several states are considering limits on physician ownership in and referrals to specialty hospitals, and a few are considering similar limitations on physician ownership in and referrals to ASCs. In New Jersey, a state court in November 2007 ruled that physicians who refer their patients to an ASC in which they have an ownership interest, violate the New Jersey Codey Act s ban against self-referrals. In response, the New Jersey legislature passed SB 787, which creates several exceptions for referrals made by physicians to ASCs in which they have a significant beneficial interest while at the same time creating more restrictions on ASC operations generally and establishing a moratorium on the establishment of future ASCs. To the extent that Congress, CMS or any of the states act to prohibit or limit physician ownership of ASCs, the investment structure of our ASCs could be significantly affected.

If certain laws and regulations change, or the interpretation and/or enforcement of such laws and regulations change, we may elect to purchase some or all of the equity interests in our ASCs owned by physicians. The regulatory changes that could trigger this repurchase include it becoming: (i) illegal for a physician to own an equity interest in one of our ASCs; (ii) illegal for physician-owners in our ASCs to refer Medicare or other patients to the facility; or (iii) substantially likely that the receipt by physician-owners of cash distributions from the limited liability company or partnership will be illegal. The cost of repurchasing these equity interests would be substantial. We may not have sufficient capital resources to fund these obligations, and it may trigger the need to procure additional debt or equity financing. To the extent any such financing was available to us, it may be on terms that reduce our earnings or are

dilutive to our current equity holders. While we attempt to structure these purchase obligations as favorable as possible to us, the triggering of these obligations could have a significantly negative effect on our financial condition and business prospects.

Furthermore, on October 30, 2008, CMS posted a final rule substantially revising the Medicare ASC Conditions for Coverage (CfCs). These changes took effect on May 18, 2009 and impose significant new regulatory burdens on ASCs which may constrain the range of services we offer and require us to incur additional cost and expense. Moreover, it is possible that changes to our facilities and operations may not be sufficient to be in compliance with new Medicare conditions, in which case some or all of our ASCs may be forced to disenroll from the Medicare program. Many governmental and private payors require Medicare certification as a condition to participate in their payment plans. Any ASC not enrolled in Medicare may likewise be precluded from enrolling in other governmental and private payor plans. Such exclusion would have a material negative effect on our business.

Adoption of new laws or regulations governing our business could significantly add to our cost of doing business.

Hospitals are currently obligated to periodically make mandatory quality reports to CMS. CMS has the authority to similarly require ASCs to file quality reports, and the agency has previously indicated its intent to use its rulemaking authority to establish a similar mandatory quality reporting obligation for ASCs at an unknown time in the future.

Provisions in the ACA initiate the process of connecting Medicare payments for a variety of health care services to quality of care processes and outcomes. Under the ACA, CMS is to begin implementing a value-based purchasing program for hospital services in 2013. For ASCs, the ACA requires that by January 2011, CMS develop a plan for a value-based purchasing program. As of February 2011, CMS had not yet issued its plan. Once the ASC plan is developed, however, it would not automatically be imposed on ASCs, because the ACA does not give CMS authority to implement a value-based purchasing program for ASCs. Unlike the hospital value-based purchasing program, which is authorized by the ACA, congressional action would be required before ASCs are subject to any value-based purchasing program. Accordingly, the linking of Medicare payments to quality of performance and outcomes for ASCs is unlikely to occur as rapidly as will be the case for hospitals.

It is likely that CMS will propose that ASCs be required to report quality data beginning as soon as 2012. Such a requirement could impose substantial new compliance burdens and costs on our facilities.

ASCs may become subject to a payment penalty based on acquired conditions that patients get from the ASC. Currently, Medicare s acquired conditions policy applies only to hospitals, which are subject to reduced Medicare reimbursements when hospital patients incur a secondary diagnosis, such as a surgical site infection, that was not present upon admission to the hospital. The ACA requires CMS to conduct a study by January 2012 on whether to expand Medicare s acquired conditions policy to provider types other than hospitals, including ASCs. It is unclear whether such a policy will be applied to ASCs; an acquired conditions policy could substantially impact Medicare reimbursements to our facilities.

According to its Work Plan for 2011, the Inspector General (IG) for the US Department of Health and Human Services has undertaken a review of the appropriateness of the current rate-setting methodology for ASCs, and the IG indicates it intends to provide the results of its review prior to October 2011. If the IG determines that the current ASC rate-setting methodology should be modified to incorporate value-based purchasing concepts, such an IG report could become a catalyst for legislators to require value-based purchasing for ASCs more quickly.

Regulation of the construction, acquisition or expansion of ASCs could prevent us from developing, acquiring, expanding or relocating facilities

Most states require licenses to own and operate ASCs, and some states require a CON to construct or modify an ASC. Several states recently have been revising licensure and CON laws in a manner that makes it more difficult to develop or relocate ASCs. If we are unable to procure the appropriate state licensure approvals, or if we are unable to obtain a CON in states with CON laws, then we may not be able to acquire or construct a sufficient number of ASCs, or to expand the scope of services offered in our existing ASCs, to achieve our growth strategy. Procuring these approvals could take considerable time, effort and expense, and may result in delays in opening new or modified facilities. Moreover, if we are unable to maintain good relations with the landlords of our ASCs, we may be forced to relocate a facility from time to time. If we are forced to relocate a facility, we may incur substantial costs in building out and furnishing our new location. In addition, depending on the state, we may also have difficulty obtaining the necessary state licensure and CON approvals to relocate the facility. See Government Regulation State Law.

The nature of being actively involved in acquiring ASCs could subject us to potential claims and material liabilities relating to these businesses

Although we conduct extensive due diligence prior to acquiring an ASC and are generally indemnified by the sellers, our acquisitions could subject us to claims, suits or liabilities relating to unknown or contingent liabilities or from incidents occurring prior to our acquisition of the facility. If we incur these liabilities and are not indemnified or insured for them, our operating results and financial condition could be adversely affected.

Rapid technological advances may reduce our sources of revenue and our profitability

Adoption of new technologies that may be comparable or superior to existing technologies for surgical equipment could reduce the amount of the facility fees we receive from physicians who use our surgical facilities, or the amount of revenue derived from our laser services agreements. Reduction of these sources of revenue could decrease our profitability. We also may have to expend significant capital resources to deploy new technology and related equipment to remain competitive. Our inability to provide access to new and improving technology could deter physicians from using our surgical facilities or equipment.

Loss of the services of key management personnel could adversely affect our business

Our success depends, in part, on the services of key management personnel, including Thomas S. Hall, our President, Chief Executive Officer and Chairman of the Board, Scott T. Macomber, our Executive Vice President and Chief Financial Officer, and Graham B. Cherrington, our Executive Vice President of Operations. We do not know of any reason why we might be likely to lose the services of any of these officers. However, in light of the role that each of these officers is expected to play in our future growth, if we lost the services of any of these officers, we believe that our business could be adversely affected.

The nature of our business could subject us to potential malpractice, product liability and other claims

The provision of surgical services entails the potentially significant risk of physical injury to patients and an inherent risk of potential malpractice, product liability and other similar claims. Our insurance may not be adequate to satisfy claims or protect us and this coverage may not continue to be available at acceptable costs. A partially or completely uninsured claim against us could reduce our earnings and working capital.

Our insurance policies are generally renewed on an annual basis. Although we believe we will be able to renew our current policies or otherwise obtain comparable professional liability coverage, we have no control over the potential costs to renew. Increases in professional liability and other insurance premiums will negatively affect our profitability.

If a change in events or circumstances causes us to write-off a portion of our intangible assets, our total assets could be reduced significantly and we could incur a substantial charge to earnings

Intangible assets, primarily in the form of goodwill, represent a significant portion of our total assets. At December 31, 2010, intangible assets represented approximately 81% of total assets and 199% of NovaMed, Inc. stockholders equity. The intangible asset value represents the excess of cost over the fair value of the separately identifiable net assets acquired in connection with our acquisitions and affiliations. The value of these assets may not be realized. We regularly, and at least annually, evaluate whether events and circumstances have occurred that indicate all or a portion of the carrying amount of the asset may exceed its fair value, in which case an impairment charge to earnings may become necessary. If, in the future, we determine that our intangible assets have suffered an impairment that requires us to write off a portion of the asset due to a change in events or circumstances, this write-off could significantly reduce our total assets and we could incur a substantial charge to earnings, as well as be in default under one or more covenants in our credit facility.

Becoming and remaining compliant with federal regulations enacted under the Health Insurance Portability and Accountability Act and the Health Information Technology for Economic and Clinical Health Act could require us to expend significant resources and capital, and could impair our profitability and limit our ability to grow our business

Numerous federal regulations have been adopted under HIPAA and the HITECH Act, which extends certain provisions of the security and privacy regulations to business associates. We have taken actions in an effort to establish our compliance with HIPAA s and the HITECH Act s privacy regulations, and we believe that we are in substantial compliance with HIPAA s and the HITECH Act s

privacy regulations. These actions include having our ASCs and affiliated providers implement new HIPAA-compliant policies and procedures, conducting employee HIPAA training, identifying business associates with whom we need to enter into new or amended HIPAA-compliant contractual arrangements and various other measures. Ongoing implementation and oversight of these measures involves significant time, effort and expense.

Other federal regulations adopted under HIPAA require that our affiliated providers and us be capable of conducting certain standardized health care transactions, including billing and other claims transactions. We have undertaken significant efforts, involving substantial time and expense, to assure that our ASCs and affiliated providers can submit transactions in compliance with HIPAA. We anticipate that continuing time and expense will be required to maintain the ability to submit HIPAA-compliant transactions, and to make sure that newly-acquired ASCs can submit HIPAA-compliant transactions.

In addition, compliance with the HIPAA security regulations require ASCs and other covered entities to implement reasonable technical, physical and administrative security measures to safeguard protected health information maintained, used and disclosed in electronic form. Moreover, the HITECH Act establishes a requirement for security breach notifications. We have taken actions in an effort to establish our compliance with HIPAA s and the HITECH Act s security regulations, and we believe that we are in substantial compliance with HIPAA s security regulations. Ongoing implementation and oversight of these measures involves significant time, effort and expense.

HIPAA and HITECH Act violations could expose us to civil penalties ranging between $100 and $50,000 per person per year for each violation with an annual cap of $1.5 million for identical violations within a calendar year. Additionally, criminal penalties include fines of up to $250,000 and/or up to 10 years in prison per violation.

Risks Relating to our Common Stock

Future sales of shares of our common stock could depress our stock price

After giving effect to the convertible note hedge and warrant transactions that we entered into in connection with our convertible note offering in June 2007, the conversion of some or all of our 1.0% convertible senior subordinated notes due June 15, 2012 may dilute the ownership interests of our existing stockholders. With the net share settlement feature of the Convertible Notes, upon conversion we will deliver cash instead of shares to repay the principal amount of the Convertible Notes. At the time of conversion we may elect to finance all or a portion of this $75 million through the issuance of equity securities which may be dilutive to our current equity holders and could adversely affect the market price of our common stock. If at the time of conversion our share price exceeds the conversion price of $19.113 per share, we have the option of funding such excess residual value with shares of our common stock or cash. Pursuant to the note hedge transaction, Deutsche Bank AG London is required to deliver to us those shares of our common stock necessary to cover the residual value of any excess over $19.113 per share. To the extent our share price exceeds $24.93 per share, then pursuant to the warrant transaction, we will be required to deliver shares of our common stock representing the value of the warrants in excess of $24.93 per share. In addition, if a qualifying fundamental change occurs prior to maturity of the Convertible Notes, the conversion rate will be increased by an additional number of shares of common stock as provided for in the indenture governing the Convertible Notes. This additional issuance of common stock pursuant to these warrants may also be dilutive to our current equity holders and could adversely affect the prevailing market prices of our common stock. In addition, the existence of the Convertible Notes and the related convertible note hedge and warrant transactions may encourage short selling by market participants because the conversion of the Convertible Notes could depress the price of our common stock.

The convertible note hedge and warrant transactions that we entered into in connection with the sale of the Convertible Notes may affect the trading price of our common stock

In connection with the issuance of the Convertible Notes, we entered into a privately negotiated convertible note hedge transaction with Deutsche Bank AG London, which is expected to reduce the potential dilution to our common stock upon any conversion of the Convertible Notes. We also entered into a warrant transaction with Deutsche Bank AG London with respect to our common stock pursuant to which we may issue shares of our common stock. In connection with hedging these transactions, Deutsche Bank AG London or its affiliates were expected to enter into various over-the-counter derivative transactions with respect to our common stock at, and possibly after, the pricing of the Convertible Notes and may have purchased or may purchase shares of our common stock in secondary market transactions following the pricing of the Convertible Notes. These activities could have had, or could have, the effect of increasing the price of our common stock. Deutsche Bank AG London or its affiliates are likely to modify their hedge positions from time to time prior to conversion or maturity of the Convertible Notes by purchasing and selling shares of our common stock, other of our securities or other instruments it may wish to use in connection with such hedging. The effect, if any, of any of these transactions and activities on the market price of our common stock or the Convertible Notes will depend in part on market

conditions and cannot be ascertained at this time, but any of these activities could adversely affect the value of our common stock (including during any period used to determine the amount of consideration deliverable upon conversion of the Convertible Notes).

Fluctuations in our quarterly operating results may make it difficult to predict our future results of operations and may cause volatility in our stock price

During 2010, the market price of our common stock was volatile, fluctuating from a high trading price of $16.41 to a low trading price of $7.71 per share. Our results of operations have varied and may continue to fluctuate from quarter to quarter. We have a high level of fixed operating costs, including compensation costs and rent. As a result, our profitability depends to a large degree on the volume of surgical procedures performed in, and on our ability to utilize the capacity of, our surgical facilities.

The timing and degree of fluctuations in our operating results will depend on several factors, including:

- general economic conditions;
- decreases in demand for non-emergency procedures due to severe weather;
- availability or sudden loss of the services of physicians who utilize our surgical facilities;
- availability or shortages of surgery-related products and equipment;
- the timing and relative size of acquisitions; and
- the recording of gains or losses on the sale of noncontrolling interests in our ASCs.

These kinds of fluctuations in quarterly operating results may make it difficult for you to assess our future results of operations and may cause a decline or volatility in our stock price.

Any return on your investment in our stock will depend on your ability to sell our stock at a profit

We have never declared or paid any dividends and our credit agreement prohibits payment of dividends on our common stock. We anticipate that we will not declare dividends at any time in the foreseeable future. Instead we will retain earnings for use in our business. As a result, your return on an investment in our stock likely will depend on your ability to sell our stock at a profit.

In addition, the stock market has, from time to time, experienced extreme price and volume fluctuations. These broad market fluctuations may adversely affect the market price of our common stock.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

We do not own any real property except for one of our ASCs, which owns the underlying real estate. We generally lease space for our corporate offices, our ASCs and our product sales operations, all of which are located in 21 states. As part of our management services business, we also lease the clinics of our affiliated providers. In some cases, these facilities are leased from related parties. See Item 13 Certain Relationships and Related Transactions. Our corporate offices currently consist of 11,367 square feet in Chicago, Illinois, 14,400 square feet in Roswell, Georgia, and 7,600 square feet in Des Plaines, Illinois.

The terms and conditions of our real property leases vary. The forms of lease range from modified triple net to gross leases, with terms generally ranging from month-to-month to nine years, with certain leases having multiple renewal terms exercisable at our option. Generally, our ASCs and eye care clinics are located in medical complexes, office buildings or free-standing buildings. The square footage of these offices range from 2,250 square feet to 13,100 square feet, and the terms of these leases have expiration dates ranging from October 31, 2011 to September 30, 2020. Depending on state licensing and certificate of need issues, relocating or

expanding the space in any of our ASCs may require state regulatory approval.

The following is a list of our 37 ASCs as of March 1, 2011:

Location	Number of Operating Rooms	Our Ownership Percentage	Specialty
Jonesboro, AR	2	51%	Ophthalmology
Whittier, CA	2	51%	Multispecialty
Colorado Springs, CO	2	64%	Ophthalmology
Denver, CO	1	51%	Ophthalmology
Gainesville, FL	2	51%	Ophthalmology
Lake Worth, FL	2	60%	Ophthalmology
Orlando, FL	4	62%	Orthopedic
Sebring, FL	2	56.25%	Multispecialty
Atlanta, GA	2	100%	Ophthalmology
Chicago, IL	1	69.5%	Ophthalmology
Maryville, IL	1	77%	Ophthalmology
Oak Lawn, IL	4	51%	Multispecialty
River Forest, IL	2	51%	Ophthalmology
Merrillville, IN	2	51%	Ophthalmology
New Albany, IN	2	51%	Ophthalmology