Original Application

Cumberland Behavioral Health, LLC

CN1806-022

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

ATTACCERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency, or Institution

Cumberland Behavioral Health, LLC
Name

300 Great Circle Road — Davidson
Street or Route — County

Nashville — TN — 37228
City — State — Zip Code

Website address: https://www.acadiahealthcare.com and www.sthealth.com

Note: The facility's name and address ***must be*** *the name and address of the project and* ***must be*** *consistent with the Publication of Intent.*

2. Contact Person Available for Responses to Questions

E. Graham Baker, Jr. — Attorney
Name — Title

Anderson and Baker — graham@grahambaker.net
Company Name — Email address

2120 Richard Jones Road — Nashville — TN — 37215
Street or Route — City — State — Zip Code

Attorney — 615-370-3380 — 615-383-3480
Association with Owner — Phone Number — Fax Number

NOTE: ***Section A*** is intended to give the applicant an opportunity to describe the project. ***Section B*** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, Contribution to the Orderly Development of Health Care, and Quality Measures.

Please answer all questions on ***8½" X 11" white paper, clearly typed and spaced, single or double-sided, in order and sequentially numbered. In answering, please type the question and the response.*** All questions must be answered. If an item does not apply, please indicate *"N/A" (not applicable).* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.***

3. SECTION A: EXECUTIVE SUMMARY

A. Overview

Please provide an overview not to exceed three pages in total explaining each numbered point.

1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;

Response: This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Cumberland Behavioral Health, LLC ("Applicant"), 300 Great Circle Road, Nashville (Davidson County), TN 37228, with the Applicant having an ownership type of limited liability company and owned by Saint Thomas Health and Acadia Nashville JV Holdings, LLC, and to be managed by Acadia Management Company, LLC, files this Certificate of Need application for the construction, development and establishment of a new psychiatric hospital comprising a total of seventy-six (76) beds, forty (40) of which will provide services for adult patients plus thirty-six (36) of which will provide services for geriatric patients. If this project is approved and licensed, Saint Thomas West will close its twenty-four (24) bed psychiatric unit and those beds will be voluntarily surrendered, resulting in a net increase of only fifty-two (52) new hospital beds. The proposed beds in this application will be licensed by the Tennessee Department of Mental Health and Substance Abuse Services as hospital beds. There is no major medical equipment involved with this project. No other health services will be initiated or discontinued. The estimated project cost is anticipated to be approximately $32,216,800.00, which includes a $95,000.00 filing fee. The anticipated date of filing the application is: June 01, 2018.

The contact person for this project is E. Graham Baker, Jr., Attorney, who may be reached at Anderson & Baker, 2021 Richard Jones Road, Suite 120, Nashville, TN 37215, 615/370-3380.

The Applicant has no outstanding Certificate of Need applications that are approved but not yet in service.

Acadia Healthcare, LLC ("Acadia"), the owner of Acadia Nashville JV Holdings, LLC, owns TrustPoint Hospital in Murfreesboro, which has two outstanding CON applications: CN1502-006AE and CN1606-024A, both of which are on schedule and on budget. Also, Acadia has an ownership interest in (1) Erlanger Behavioral Health, an approved 88 bed psychiatric hospital in Hamilton County, Tennessee (CN1603-012A), and (2) Crestwyn Behavioral Health located in Memphis, TN, which has filed a 14-bed CON application (CN1803-018).

In addition, Saint Thomas Health has an ownership interest in several outstanding projects:

(1) Saint Thomas Highlands Senior Care – CN1706-020A – approved 10/25/17. Construction is ongoing and on budget. The project is expected to be complete by June 30, 2018;

(2) Saint Thomas Rutherford Hospital – CN1707-021A – approved 10/25/17. The project remains in design phases with construction scheduled to start in August. The project is on budget, and construction is expected to begin in October, 2018;

(3) CN1701-003, Premier Radiology – Construction for the MRI & CT rooms is complete. The initial building survey was conducted March 16, 2018. Health and Life Safety surveys are pending;

(4) CN1706-070, Saint Thomas Highlands Hospital – Architectural plans have been reviewed and approved by the State Department of Health. Construction contracts have been bid and work on the project is expected to start in April, 2018; and

(5) CN1707-022, Saint Thomas Surgery Center, New Salem – Final land acquisition was completed March 19, 2018, clearing the way for further development.

2) Ownership structure;

Response: Cumberland Behavioral Health, LLC ("Applicant"), 300 Great Circle Road, Nashville TN 37228, is a limited liability company which is owned by the Saint Thomas Health and Acadia Nashville JV Holdings, LLC Saint Thomas Health will own 50.1% of the Applicant, and Acadia Nashville JV Holdings, LLC will own the remaining 49.9% of the Applicant.

3) Service area;

Response: The primary service area will be Davidson, Cheatham and Robertson Counties, but patients will be accepted from a wider geographic area if referred and if those referrals are appropriate for our facility.

4) Existing similar service providers;

Response: There are now five (5) psychiatric bed providers in the primary service area, all of which are in Nashville, including:

300 beds at Middle Tennessee Mental Health Institute;
24 beds at Saint Thomas West;
105 beds at TriStar Madison;
109 beds at TriStar Parthenon; and
88 beds at Vanderbilt University Medical Center.

The 24 beds at Saint Thomas West will be voluntarily surrendered if this CON application is approved and licensed.

5) Project cost;

Response: The estimated project cost is anticipated to be approximately $32,216,800.00, which includes the $95,000.00 filing fee.

6) Funding;

Response: Acadia, through its wholly owned subsidiary, Acadia Nashville JV Holdings, LLC, will contribute 49.9% of the total capital needed to construct, equip and operate the Applicant. Saint Thomas Health will contribute the remaining 50.1% of the total capital needed.

7) Financial Feasibility including when the proposal will realize a positive financial margin; and

Response: All programs and services will accept and care for patients with commercial, managed care, Medicare, Tri-Care and TennCare forms of payment. All service lines will accept charity and unfunded patients as a function of our mission to serve the broader community.

Conservative utilization projections indicate that the facility will operate with a positive cash flow in its second year of operation and thereafter.

8) Staffing.

Response: Acadia and Saint Thomas Health have a strong network of academic affiliations for the recruitment, training, and hiring of clinical and non-clinical personnel. Partnering with local universities, colleges, trade schools, and traditional non-academic recruitment strategies will support the human resources needed to fully staff the hospital. All clinical staff will be recruited consistent with the Hospital's Human Resource practices, which include: advertisement in local and regional newspapers, recruitment web sites, work fairs, universities, colleges, and direct applications from prospective employees.

See staffing matrices included in Section B.H of this application.

B. **Rationale for Approval**

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in Section B. of this application. Please summarize in one page or less each of the criteria:

1) Need;

Response: It is proposed to construct/establish a new psychiatric inpatient hospital for the care of adult and geriatric patients. The total inpatient psychiatry hospital beds requested in this application is 76, comprised as follows:

Adult Psychiatry Unit 1	20 beds
Adult Psychiatry Unit 2	20 beds
Geriatric Psychiatry Unit 1	18 beds
Geriatric Psychiatry Unit 2	18 beds
Total Inpatient	76 beds

Proposed Adult Psychiatry Service: The adult psychiatry program will comprise two treatment units with a combined 40 beds providing inpatient mental health and substance abuse services for adults age 18 to 64. The first treatment unit will be 20 beds, specializing in the care of adult psychiatric patients with *serious* mental illness as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (e.g., mood disorders, co-occurring disorders) (American Psychiatric Association, 2013). The second treatment unit will be 20 beds, specializing in the care of adult psychiatric patients with *severe* mental illness as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (e.g., psychosis, thought disorders, developmental disabilities, and imminent risk of danger to self or others). *Id.*

Proposed Geriatric Psychiatry Service: The geriatric psychiatry program will comprise two treatment units with a combined 36 beds providing inpatient mental health and substance abuse services for adult patients age 65 and over with a primary acute psychiatric diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (American Psychiatric Association, 2013). The first treatment unit will be 18 beds, specializing in the care of geriatric patients with serious psychiatric, neuro-cognitive, and behavioral disturbances. The second treatment unit will be 18 beds, specializing in the care of geriatric patients with severe mental illness associated with disturbance of mood, co-occurring disorders, and adjustment. It is intended that the existing patients occupying the 24 geriatric inpatient psychiatry beds located at Saint Thomas West Hospital will move to this new hospital. Saint Thomas West Hospital has not specified their intended use for those vacated beds at this time.

All four units will accept voluntary and involuntary admissions pursuant to Tennessee Code Annotated §33-6-404.

By separating the adult and geriatric patient populations by major diagnostic classifications and severity of illness, the Applicant will be better able to provide care that is tailored to the individual needs of patients in an environment that is safe, efficient, and highly reliable.

Researchers Hankin, Bronstone, and Koran (2011) found that psychiatric patients with psychosis and other forms of thought disorder present a high risk for acts of violence against themselves and others. The nature of the patient's illness, together with the potential triggers resulting in risk for harm, support the need for distinct treatment units specific to the needs of varied populations (Hankin et al., 2011). Further, this hospital will support the long-term population growth in Davidson, Cheatham, and Robertson Counties, and the needs of other surrounding counties that may rely on the Applicant for inpatient psychiatric.

All treatment units are designed with semi-private rooms, which still allows for single occupancy as needed for the individualized care requirement of patients.

This project will involve new construction with a cost estimated at just under $24 million.

This project will significantly improve much needed access to state of the art facilities and treatment of psychiatric patients, reduce the overwhelming burden on an already taxed care delivery system, and reduce the enormous pressure faced by emergency departments holding psychiatric patients in need of inpatient care.

In addition,

1. The current system for access to inpatient psychiatric care continues to be in crisis with patients boarding for extensive periods of time in emergency departments (hours, days, and weeks);

2. Patients have a right of choice in their care provider, and should have access to state of the art facilities and treatment to meet their complex mental health care needs;

3. Existing services are inadequate to meet the immediate and future needs of the community: not enough beds, geographic reach, diversity of care options and providers, rapidly growing population; and

4. TDMHSAS statistics show more than 27,000 patients waiting in emergency departments for more than 24 hours with mental health as primary diagnosis due to lack of beds and capacity to serve – an increase of 9% over prior year (THA and TDMHSAS, 2015 most recent data). This phenomenon is not getting better, only worse, with no substantive change in access to care opportunities for many years.

Finally, according to "The State of Mental Health in America 2018," an in-depth report by Mental Health America (formerly the National Mental Health Association), several disturbing facts were uncovered regarding the mental health ranking of the State of Tennessee, as follows:

1. Tennessee's overall ranking (indicating both a higher prevalence of mental illness and lower rates of access to care) is 46th out of all states plus the District of Columbia;
2. 39th in prevalence of mental illness;
3. 44th in adult psychiatric care;
4. 44th in mental health workforce availability;
5. 44th in incidents of depression;
6. 50th in adults with any mental illness who are uninsured;
7. 5th in adult alcohol dependence; and
8. 11th in adult use of marijuana.

While this application focuses on geriatric and adult populations, Tennessee also ranks poorly in psychiatric care for youth, as follows:

1. The 7th highest rate of prevalence of mental illness;
2. 2nd in alcohol dependence;
3. last (51st) in access to care youth;
4. 49th in youth Major Depressive Episodes ("MDE"); and
5. 51st in care for youth that did not receive treatment for MDE.

The licensure of this new seventy-six (76) bed hospital will result in a net increase of only fifty-two (52) beds, since Saint Thomas West will at that point voluntarily surrender the twenty-four (24) beds currently providing geriatric psychiatric care.

2) Economic Feasibility;

Response: The implementation costs of this project are reasonable, and it is projected that the project will operate with a positive cash flow following the first year of operation and thereafter. Further, the partnership between Acadia and Saint Thomas Health supports the economic feasibility of this project. Both organizations have deep ties to the community with significant investments in hospitals, treatment facilities, and related business interests. All programs and services will accept and care for patients with commercial, managed care, Medicare, Tri-Care and TennCare forms of payment. All service lines will accept charity and unfunded patients as a function of our mission to serve the broader community.

3) Appropriate Quality Standards; and

Response: This hospital will be fully accredited by the Joint Commission, certified by the Centers for Medicare and Medicaid Services, and licensed by the Tennessee Department of Mental Health and Substance Abuse Services. The hospital will provide its clinical services following established, evidence-based best practices. The hospital will meet the same high standards for quality, safety, and reliability as found in both Acadia and Saint Thomas Health facilities.

4) Orderly Development to adequate and effective health care.

Response: There has not been an increase in inpatient psychiatric beds in Davidson County for several years. As the population continues to explode, the need for new services is critical. The location of the proposed hospital is intended to provide improve access to psychiatric care. Further, Saint Thomas West will voluntarily surrender 24 Geriatric Psychiatric beds if this CON project is approved and licensed. This will result in a new increase of only fifty-two (52) new hospital beds in the service area.

B. Consent Calendar Justification

If Consent Calendar is requested, please provide the rationale for an expedited review.

A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

Response: Not applicable.

4. SECTION A: PROJECT DETAILS

A. Owner of the Facility, Agency or Institution

Cumberland Behavioral Health, LLC — 615-861-6000
Name — Phone Number

300 Great Circle Road — Davidson
Street or Route — County

Nashville — TN — 37228
City — State — Zip Code

B. Type of Ownership of Control (Check One)

A.	Sole Proprietorship	_____	F.	Government (State of TN or Political Subdivision)	_____
B.	Partnership	_____	G.	Joint Venture	_____
C.	Limited Partnership	_____	H.	Limited Liability Company	X
D.	Corporation (For Profit)	_____	I.	Other (Specify)_____	_____
E.	Corporation (Not-for-Profit)	_____			(see below)

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's web-site at https://tnbear.tn.gov/ECommerce/FilingSearch.aspx. See **Attachment A.4.A.**

Describe *the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.* **Applicant is a limited liability company owned by the Saint Thomas Health (50.1%) and Acadia Nashville JV Holdings, LLC (49.9%), as explained in the application.**

5. Name of Management/Operating Entity (If Applicable)

Acadia Management Company, LLC
Name

6100 Tower Circle, #1000 — Williamson
Street or Route — County

Franklin — TN — 37067
City — State — Zip Code

Website address: https://acadiahealthcare.com

For new facilities or existing facilities *without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.* See **Attachment A.5**.

6A. Legal Interest in the Site of the Institution (Check One)

A.	Ownership	____	D.	Option to Lease	____
B.	Option to Purchase	__x__	E.	Other (Specify) _____	____
C.	Lease of ___Years	____		_____	

Check appropriate line above: *For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application. **See Attachments A.6.A.1, 2, 3, and 4.**

6B. Attach **a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site** on an 8 1/2" x 11" sheet of white paper, single or double-sided. ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

1) Plot Plan **must include**:

   a. Size of site (***in acres***); (approximately 4.86 Acres)

   b. Location of structure on the site; (see shaded outline on attachment)

   c. Location of the proposed construction/renovation; on plans; and (see shaded outline)

   d. Names of streets, roads or highway that cross or border the site. (noted)

2) Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8 ½ by 11 sheet of paper or as many as necessary to illustrate the floor plan.

3) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response: The facility will be constructed on a 4.86 Acre site on Great Circle Road in Nashville (**Attachment A.6.B.1**). There will be two 18 bed geriatric units on the 1st floor, and two 20 bed adult units on the 2nd floor (**Attachment A.6.B.2**, which is 8 pages. **Patient Beds are numbered**). The site is on Great Circle Road, which is in the Rhodes Park Area of Metro Center North. Public transportation is available. As such, the site is readily accessible to patients, family members, and other health care providers.

7. **Type of Institution** **(Check as appropriate--more than one response may apply)**

A.	Hospital (Specify) psychiatric	x	H.	Nursing Home	
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		I.	Outpatient Diagnostic Center	
C.	ASTC, Single Specialty		J.	Rehabilitation Facility	
D.	Home Health Agency		K.	Residential Hospice	
E.	Hospice		L.	Nonresidential Substitution-Based Treatment Center for Opiate Addiction	
F.	Mental Health Hospital	x			
G.	Intellectual Disability Institutional Habilitation Facility ICF/IID		M.	Other (Specify)_____	

Check appropriate lines(s).

8. **Purpose of Review** **(Check appropriate lines(s) – more than one response may apply)**

A.	New Institution	x	F.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response:* **Increase**, *Decrease, Designation, Distribution, Conversion, Relocation]*	
B.	Modifying an ASTC with limitation still required per CON				
C.	Addition of MRI Unit				
D.	Pediatric MRI				
E.	Initiation of Health Care Service as defined in T.C.A. §68-11-1607(4) (Specify)_____		G.	Satellite Emergency Dept.	
			H.	Change of Location	
			I.	Other (Specify)_____	

9. **Medicaid/TennCare, Medicare Participation**

MCO Contracts [Check all that apply]

_x_ AmeriGroup _x_ United Healthcare Community Plan _x_ BlueCare _x_ TennCare Select

Medicare Provider Number _*will apply*_

Medicaid Provider Number _*will apply*_

Certification Type _*Hospital*_

If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare?

Medicare __X__Yes ____No ____N/A Medicaid/TennCare __X__Yes ____No ____N/A

All MCO boxes were checked above, as we will apply for all. All programs and services will accept and care for patients with commercial, managed care, Medicare, Tri-Care and TennCare forms of payment. All service lines will accept charity and unfunded patients as a function of our mission to serve the broader community.

10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds.

	Current Licensed	*Beds Staffed*	*Beds Proposed*	**Beds Approved*	***Beds Exempted*	*TOTAL Beds at Completion*
1) Medical						
2) Surgical						
3) ICU/CCU						
4) Obstetrical						
5) NICU						
6) Pediatric						
7) Adult Psychiatric			40			40
8) Geriatric Psychiatric			36			36
9) Child/Adolescent Psychiatric						
10) Rehabilitation						
11) Adult Chemical Dependency						
12) Child/Adolescent Chemical Dependency						
13) Long-Term Care Hospital						
14) Swing Beds						
15) Nursing Home – SNF (Medicare only)						
16) Nursing Home – NF (Medicaid only)						
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home – Licensed (non-certified)						
19) ICF/IID						
20) Residential Hospice						
TOTAL			76			76

**Beds approved but not yet in service* ***Beds exempted under 10% per 3 year provision*

B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services. **Response:** not applicable, as there are no existing services.

C. Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.

CON Number(s)	CON Expiration Date	Total Licensed Beds Approved
n/a		

NOTE: The Applicant has no outstanding Certificate of Need applications that are approved but not yet in service.

Acadia Healthcare, LLC ("Acadia"), the owner of Acadia Nashville JV Holdings, LLC, owns TrustPoint Hospital in Murfreesboro, which has two outstanding CON applications: CN1502-006AE and CN1606-024A, both of which are on schedule and on budget. Also, Acadia has an ownership interest in (1) Erlanger Behavioral Health, an approved 88 bed psychiatric hospital in Hamilton County, Tennessee (CN1603-012A), and (2) Crestwyn Behavioral Health located in Memphis, TN, which has filed a 14-bed CON application (CN1803-018).

In addition, Saint Thomas Health has an ownership interest in several outstanding projects:

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(4) CN1706-070, Saint Thomas Highlands Hospital – Architectural plans have been reviewed and approved by the State Department of Health. Construction contracts have been bid and work on the project is expected to start in April, 2018; and

(5) CN1707-022, Saint Thomas Surgery Center, New Salem – Final land acquisition was completed March 19, 2018, clearing the way for further development.

11. Home Health Care Organizations – Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply: **(Not Applicable)**

	Existing Licensed County	Parent Office County	Proposed Licensed County		Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson				Lauderdale			
Bedford				Lawrence			
Benton				Lewis			
Bledsoe				Lincoln			
Blount				Loudon			
Bradley				McMinn			
Campbell				McNairy			
Cannon				Macon			
Carroll				Madison			
Carter				Marion			
Cheatham				Marshall			
Chester				Maury			
Claiborne				Meigs			
Clay				Monroe			
Cocke				Montgomery			
Coffee				Moore			
Crockett				Morgan			
Cumberland				Obion			
Davidson				Overton			
Decatur				Perry			
DeKalb				Pickett			
Dickson				Polk			
Dyer				Putnam			
Fayette				Rhea			
Fentress				Roane			
Franklin				Robertson			
Gibson				Rutherford			
Giles				Scott			
Grainger				Sequatchie			
Greene				Sevier			
Grundy				Shelby			
Hamblen				Smith			
Hamilton				Stewart			
Hancock				Sullivan			
Hardeman				Sumner			
Hardin				Tipton			
Hawkins				Trousdale			
Haywood				Unicoi			
Henderson				Union			
Henry				Van Buren			
Hickman				Warren			
Houston				Washington			
Humphreys				Wayne			
Jackson				Weakley			
Jefferson				White			
Johnson				Williamson			
Knox				Wilson			
Lake							

12. Square Footage and Cost Per Square Footage Chart (Not Applicable – no construction/renovation)

Unit/Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage		
					Renovated	New	Total
Administration						3,850	3,850
Bldg. Support						1,770	1,770
Dietary						4,510	4,510
Education/Activity						5,360	5,360
I/P Nursing Units						27,180	27,180
O/P Therapy						2,775	2,775
Pharmacy						300	300
Public Spaces						880	880
Unit/Department GSF Sub-Total						46,625	46,625
Other GSF Total						25,975	25,975
Total GSF						72,600	72,600
*Total Cost						23,667,000	23,667,000
**Cost Per Square Foot						325.99	325.99
Cost per Square Foot Is Within Which Range *(For quartile ranges, please refer to the Applicant's Toolbox on www.in.gov/hsda)*					☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☒ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☒ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile

* The Total Construction Cost should equal the Construction Cost reported on line A5 of the Project Cost Chart.

** Cost per Square Foot is the construction cost divided by the square feet. Please do not include contingency costs.

NOTE: Other GSF includes Mechanical, Electrical, Circulation, and Structural GSF. Also, Construction Cost Chart from HSDA indicates new hospital construction at $289.85 Median, and $395.94 3rd Quartile.

13. MRI, PET, and/or Linear Accelerator (Not Applicable)

1. Describe the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding a MRI scanner in counties with population less than 250,000 or initiation of pediatric MRI in counties with population greater than 250,000 and/or
2. Describe the acquisition of any Positron Emission Tomographer (PET) or Linear Accelerator if initiating the service by responding to the following:

A. Complete the chart below for acquired equipment.

☐ Linear Accelerator	Mev _____ Types:	☐ SRS ☐ IMRT ☐ IGRT ☐ Other _____ ☐ By Purchase Total Cost*: _____ ☐ By Lease Expected Useful Life (yrs) ___ ☐ New ☐ Refurbished ☐ If not new, how old? (yrs) _____
☐ MRI	Tesla: ____ Magnet:	☐ Breast ☐ Extremity ☐ Open ☐ Short Bore ☐ Other _____ ☐ By Purchase Total Cost*: _____ ☐ By Lease Expected Useful Life (yrs) ___ ☐ New ☐ Refurbished ☐ If not new, how old? (yrs) _____
☐ PET	☐ PET only ☐ PET/CT ☐ PET/MRI	☐ By Purchase Total Cost*: _____ ☐ By Lease Expected Useful Life (yrs) ___ ☐ New ☐ Refurbished ☐ If not new, how old? (yrs) _____

* As defined by Agency Rule 0720-9-.01(13)

B. In the case of equipment purchase, include a quote and/or proposal from an equipment vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

C. Compare lease cost of the equipment to its fair market value. Note: Per Agency Rule, the higher cost must be identified in the project cost chart.

D. Schedule of Operations:

Location	Days of Operation (*Sunday through Saturday*)	Hours of Operation (*example: 8 am – 3 pm*)
Fixed Site *(Applicant)*	_____	_____
Mobile Locations *(Applicant)*	_____	_____
(Name of Other Location)	_____	_____
(Name of Other Location)		

E. Identify the clinical applications to be provided that apply to the project.

F. If the equipment has been approved by the FDA within the last five years provide documentation of the same.

SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of health care." Further standards for guidance are provided in the State Health Plan developed pursuant to T.C.A. § 68-11-1625.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper, single-sided or double sided*. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. ***If a question does not apply to your project, indicate "Not Applicable (NA)."***

QUESTIONS

SECTION B: NEED

A. Provide a response to each criterion and standard in Certificate of Need Categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained from the Tennessee Health Services and Development Agency or found on the Agency's website at http://www.tn.gov/hsda/article/hsda-criteria-and-standards.

Response: See **Attachment B.Need.A**.

B. Describe the relationship of this project to the applicant facility's long-range development plans, if any, and how it relates to related previously approved projects of the applicant.

Response: The Applicant will constantly monitor patient needs and healthcare delivery systems at our facility. At present, this application, as filed, represents the long-range development plan of the Applicant.

C. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the Border States, if applicable.

Response: Please complete the following tables, if applicable:

Service Area Counties	**Historical Utilization-County Residents**	**# and % of total patients**
County #1	Not applicable	
Total		

Service Area Counties	**Projected Utilization-County Residents**	**# and % of total patients**
County #1	Davidson	20.7 and 72.4%
	Cheatham	1.3 and 4.5%
	Robertson	2.3 and 8.1%
	Other Middle Tennessee Counties	4.3 and 15.0%
Total		28.6 and 100%

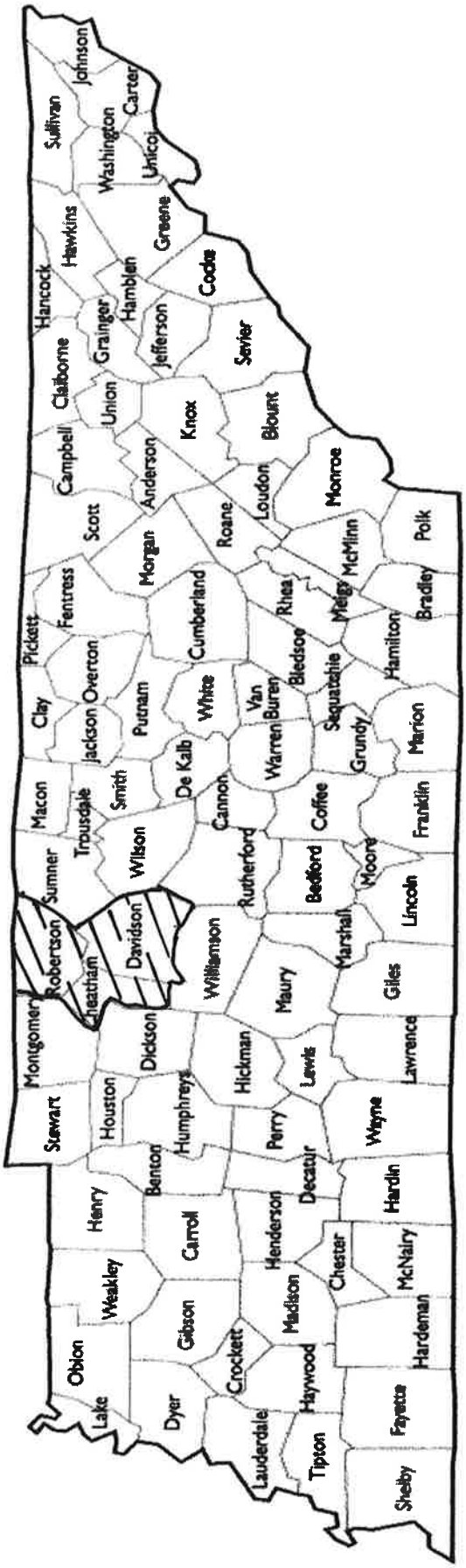
Note: The facility's projected primary service area is Davidson, Cheatham, and Robertson Counties, Tennessee.

The Applicant projects that approximately 85% of the patients will probably originate from the primary service area, with the remaining 15% originating from other counties in Middle Tennessee. The assumption was also made that of the three counties in the primary service area, patient origination would reflect the same percentage as did the target population of each county to the whole. For example, 85.1% of the total primary service area target population resided in Davidson County, and the assumption was made that 85.1% of the total patients from the three counties of the primary service area would originate from Davidson County, 5.5% from Cheatham County and 9.4% from Robertson County. With those assumptions in mind, the Projected Utilization (2nd chart above) for Year 1 was completed using the following projections:

28.6 patients x 85% x 85.1% = 20.7 patients from Davidson County,
28.6 patients x 85% x 5.5% = 1.3 patients from Cheatham County,
28.6 patients x 85% x 9.4% = 2.3 patients from Robertson County, and
the resulting 4.3 patients from surrounding counties.

The requested map follows this page.

County Level Map



D. 1). a) Describe the demographics of the population to be served by the proposal.

Response:

Please see **Attachment B.Need.D.1.a** (9 pages) for more Quick Facts about the primary service area.

b) Using current and projected population data from the Department of Mental Health and Substance Abuse Services, the most recent enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data: http://www.tn.gov/health/article/statistics-population

TennCare Enrollment Data: http://www.tn.gov/tenncare/topic/enrollment-data

Census Bureau Fact Finder: http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Response: See the following chart:

Demographic Variable/ Geographic Area	Department of Health/Health Statistics							Bureau of the Census				TennCare	
	Total Population- Current Year	Total Population- Projected Year	Total Population-% Change	*Target Population- Current Year	*Target Population- Project Year	*Target Population- % Change	Target Population Projected Year as %	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of	TennCare Enrollees	TennCare Enrollees as % of Total
Davidson Co	698061	730414	+4.6	532997	553478	+3.8	75.8	34.2	$50,484	110923	17.7	139472	21.8
Cheatham Co	41269	42699	+3.5	32442	34844	+7.4	81.6	40.2	$53,179	5045	12.9	7064	17.2
Robertson Co	76231	81065	+6.3	57949	62071	+7.1	76.6	38.5	$56,331	6960	10.5	11359	15.1
Service Area Total	815561	854178	+4.7	623388	650393	+4.3	76.1			122928		249268	25.8
State of TN Total	6960524	7263893	+4.4	5414988	5672576	+4.8	78.1	38.5	$46,574	1188730	17.7	1412063	20.5

** Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2018, then default Projected Year is 2022.*

NOTES on chart above: Bureau of the Census data is from 2016 (latest data). TennCare Enrollees, latest data, is from June, 2017, as are TennCare population figures.

Psychiatric problems affect all ages. However, for purposes of this question, the "Target Population" will include those aged 18 and over. The chart above reflects that assumption.

2) Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response: All of Cheatham and Robertson Counties are medically underserved areas, according to Health Resources and Services Administration, as are many census tracts in Davidson County. The addition of more psychiatric beds in the service area will add more health care services and staff. See **Attachment B.Need.D.2** for a list of the MUA tracts in the three counties.

E. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. This doesn't apply to projects that are solely relocating a service.

Response: Selected JAR utilization/statistics for the psychiatric facilities located in our primary service area are listed in the charts on the following page. These charts reflect data provided by the various facilities on their respective Joint Annual Reports (JARs) for 2014, 2015, and 2016.

The Applicant does not vouch for the correctness of any data contained on the JARs, and some numbers may be not total exactly due to rounding errors.

2016

Facility	C&A beds	C&A %	Adult beds	Adult %	Geri beds	Geri %	Total beds	Total %
Mid TN MHI	*	<0.1	*	52.6	*	5.5	300	58.1
Saint Thomas West**	0	0	0	5.9	24	38.2	24	44.1
TriStar Madison	21	60.0	70	67.9	14	37.6	105	62.4
TriStar Parthenon	0	0	53	78.5	56	44.8	109	61.2
Vanderbilt	26	71.3	54	98.4	8	46.7	88	85.7
Total	47	-	177	-	102	-	626	75.0

Note: * Middle Tennessee Mental Health Institute does not break down type of bed, but does provide utilization. Occupancy Rate is given as percentage of total bed capacity.
** The beds at Saint Thomas West will be surrendered if the instant CON application is approved. The Saint Thomas beds are all licensed as Geriatric, but the JARs report both Adult and Geriatric services.

2015

Facility	C&A beds	C&A %	Adult beds	Adult %	Geri beds	Geri %	Total beds	Total %
Mid TN MHI	*	<0.1	*	53.6	*	6.9	300	60.5
Saint Thomas West**	0	0	0	7.1	24	38.9	24	50.0
TriStar Madison	21	64.7	70	71.6	14	8.6	105	61.8
TriStar Parthenon	0	0	53	91.8	56	41.7	109	66.1
Vanderbilt	26	83.0	54	87.9	8	72.4	88	85.1
Total	47	-	177	-	102	-	626	64.8

Note: Same as above.

2014

Facility	C&A beds	C&A %	Adult beds	Adult %	Geri beds	Geri %	Total beds	Total %
Mid TN MHI	*	<0.1	*	50.6	*	8.5	300	59.1
Saint Thomas West**	0	0	0	12.3	24	44.8	24	57.1
TriStar Madison	21	58.4	70	68.9	14	77.3	105	73.1
TriStar Parthenon	0	0	53	110.0	56	57.1	109	82.7
Vanderbilt	26	83.3	54	91.1	8	81.8	88	88.0
Total	47	-	177	-	102	-	626	69.6

Note: Same as above, with this addition: Saint Thomas' JAR does not indicate its beds are specifically licensed as geriatric, and both adult and geriatric services were reported. Occupancy rate is given as percentage of total bed capacity.

F. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

Response: As a new facility, there is no historic utilization.

The Applicant anticipates the occupancy rates for the first two years following completion of the project as follows: 37.7% in Year 1, and 70.4% in Year 2. These estimates are based on actual utilization experience of the management company (and one of the owners of the Applicant) when opening similarly-sized facilities in the past. The only assumption being made is that all of the similar additions that the management company have experienced in the past will replicate on this project. There is nothing known that indicates the facility, the locale, or the population to be served is statistically different from past experience. Further, the voluntary surrender of 24 existing psychiatric beds to our project should result in a more rapid increase in bed utilization than by increasing the number of psychiatric beds in Davidson County by seventy-six (76).

SECTION B: ECONOMIC FEASIBILITY

A. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

1) All projects should have a project cost of at least $15,000 (the minimum CON Filing Fee). (See Application Instructions for Filing Fee).

Response: The filing fee amounts to $95,000.00.

2) The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

Response: The Project Costs Chart lists the actual purchase price of the land for this project, plus the actual estimated construction and other costs.

3) The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

Response: There is no equipment as suggested by this question.

4) Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total Construction Cost reported on the Square Footage Chart.

Response: The chart is completed.

5) For projects that include new construction, modification, and/or renovation—**documentation must be** provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:

a) A general description of the project;

b) An estimate of the cost to construct the project;

c) A description of the status of the site's suitability for the proposed project; and

d) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

Response: Please see **Attachment B.EconomicFeasibility.A.5**.

PROJECT COST CHART

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	1,459,800
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	225,000
3.	Acquisition of Site	4,000,000
4.	Preparation of Site	
5.	Total Construction Costs	23,667,000
6.	Contingency Fund	1,000,000
7.	Fixed Equipment (Not included in Construction Contract)	340,000
8.	Moveable Equipment (List all equipment over $50,000 as separate attachments)	1,430,000
9.	Other (Specify) _____	
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land) (FMV of leased space)	
2.	Building only	
3.	Land only	
4.	Equipment (Specify)_ _____ (by lease)	
5.	Other (Specify) _____	
C.	Financing Costs and Fees:	
1.	Interim Financing	
2.	Underwriting Costs	
3.	Reserve for One Year's Debt Service	
4.	Other (Specify) _____	
D.	Estimated Project Cost (A+B+C)	**32,121,800**
E.	CON Filing Fee	95,000
F.	Total Estimated Project Cost (D+E) **TOTAL**	**32,216,800**

B. Identify the funding sources for this project.

Check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment Section B-Economic Feasibility-B.)***

__ 1) Commercial loan – Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

__ 2) Tax-exempt bonds – Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

__ 3) General obligation bonds – Copy of resolution from issuing authority or minutes from the appropriate meeting;

__ 4) Grants – Notification of intent form for grant application or notice of grant award;

__ 5) Cash Reserves – Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or

_x_ 6) Other – Identify and document funding from all other sources.

Response: The two owners of the Applicant will provide necessary capital for this project in the same percentage as is their respective ownership interests. Please see **Attachment B.EconomicFeasibility.B** (2 letters).

C. Complete Historical Data Charts on the following two pages—***Do not modify the Charts provided or submit Chart substitutions!***

Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being presented in the proposed project, if applicable. **Only complete one chart if it suffices.**

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

x **Total Facility**
□ Project Only

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).

NOT APPLICABLE ____ ____ ____

A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) Patient Days

B. Revenue from Services to Patients
   1. Inpatient Services
   2. Outpatient Services
   3. Emergency Services
   4. Other Operating Revenue (Specify)_prior year adjustments

Gross Operating Revenue

C. Deductions from Gross Operating Revenue
   1. Contractual Adjustments
   2. Provision for Charity Care
   3. Provisions for Bad Debt

Total Deductions

NET OPERATING REVENUE

D. Operating Expenses
   1. Salaries and Wages
      a. Direct Patient Care
      b. Non-Patient Care
   2. Physician's Salaries and Wages
   3. Supplies
   4. Rent
      a. Paid to Affiliates
      b. Paid to Non-Affiliates
   5. Management Fees:
      a. Paid to Affiliates
      b. Paid to Non-Affiliates
   6. Other Operating Expenses

Total Operating Expenses

E. **Earnings Before Interest, Taxes and Depreciation**

F. Non-Operating Expenses
   1. Taxes
   2. Depreciation
   3. Interest
   4. Other Non-Operating Expenses

Total Non-Operating Expenses

NET INCOME (LOSS)

Chart Continues Onto Next Page

NET INCOME (LOSS)

G. Other Deductions

1. Annual Principal Debt Repayment
2. Annual Capital Expenditure

Total Other Deductions

NET BALANCE

DEPRECIATION

FREE CASH FLOW (Net Balance + Depreciation)

□ **Total Facility**
□ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES

1. Professional Services
2. Contract Labor
3. Utilities and Insurance
4. Benefits
5. Other

Total Other Expenses

D. Complete Projected Data Charts on the following two pages – ***Do not modify the Charts provided or submit Chart substitutions!***

The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility. **Only complete one chart if it suffices.**

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

Response: The chart is completed. Please note that the relatively small amount of "rent" paid to non-affiliates refers to small equipment rental (wheelchairs, walkers, copiers, bariatric beds, etc.). As the Applicant will have fee simple title to the land, there is no "rent" for the real property.

PROJECTED DATA CHART

☒ **Total Facility**
☐ Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in July (Month).

	Year 1 (2020)	Year 2 (2021)
A. Utilization Data (Specify unit of measure: **Average Daily Census**)	28.6	53.5
B. Revenue from Services to Patients		
1. Inpatient Services	$17,562,710	$33,671,867
2. Outpatient Services	384,000	928,000
3. Emergency Services		
4. Other Operating Revenue (Specify) **food services**	10,000	30,000
Gross Operating Revenue	**$17,956,710**	**$34,629,867**
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$9,332,936	$17,990,929
2. Provision for Charity Care	386,317	742,547
3. Provisions for Bad Debt	879,223	793,320
Total Deductions	$10,598,476	$19,526,795
NET OPERATING REVENUE	$7,358,234	$15,103,072
D. Operating Expenses		
1. Salaries and Wages		
a. Direct Patient Care	1,621,841	2,990,396
b. Non-Patient Care	2,109,370	3,262,392
2. Physician's Salaries and Wages	633,420	1,047,398
3. Supplies	355,803	529,772
4. Rent		
a. Paid to Affiliates		
b. Paid to Non-Affiliates	24,000	24,720
5. Management Fees:		
a. Paid to Affiliates	294,329	604,123
b. Paid to Non-Affiliates		
6. Other Operating Expenses	3,072,506	4,451,411
Total Operating Expenses	$8,111,269	$12,910,212
E. **Earnings Before Interest, Taxes and Depreciation**	$(753,035)	$2,192,860
F. Non-Operating Expenses		
1. Taxes	$(478,172)	$284,277
2. Depreciation	1,086,089	1,099,840
3. Interest		
4. Other Non-Operating Expenses		
Total Non-Operating Expenses	$607,917	$1,383,764
NET INCOME (LOSS)	$(1,360,952)	$809,095

Chart Continues Onto Next Page

NET INCOME (LOSS)	$(1,360,952)	$809,095
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment		
2. Annual Capital Expenditure	$82,375	$158,964
Total Other Deductions	$82,375	$158,964
NET BALANCE	$(1,443,327)	$650,132
DEPRECIATION	$1,086,089	$1,099,488
FREE CASH FLOW (Net Balance + Depreciation)	$(357,238)	$1,749,619

☒ **Total Facility**
☐ Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year2020	Year 2021
1. Professional Services	$148,228	$196,810
2. Contract Labor	1,197,280	1,659,100
3. Utilities and Insurance	384,000	395,520
4. Benefits	856,967	1,443,759
5. Other	486,031	756,222
Total Other Expenses	**$3,072,506**	**$4,451,411**

□ Total Facility
□ **Project Only**

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in July (Month).
NOT APPLICABLE

	Year 1	Year 2
A. Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) Patient Days.		
B. Revenue from Services to Patients		
1. Inpatient Services		
2. Outpatient Services		
3. Emergency Services		
4. Other Operating Revenue (Specify)Vending, Food, Rebates		
Gross Operating Revenue		
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments		
2. Provision for Charity Care		
3. Provisions for Bad Debt		
Total Deductions		
NET OPERATING REVENUE		
D. Operating Expenses		
1. Salaries and Wages		
a. Direct Patient Care		
b. Non-Patient Care		
2. Physician's Salaries and Wages		
3. Supplies		
4. Rent		
a. Paid to Affiliates		
b. Paid to Non-Affiliates		
5. Management Fees:		
a. Paid to Affiliates		
b. Paid to Non-Affiliates		
6. Other Operating Expenses		
Total Operating Expenses		
E. **Earnings Before Interest, Taxes and Depreciation**		
F. Non-Operating Expenses		
1. Taxes		
2. Depreciation		
3. Interest		
4. Other Non-Operating Expenses		
Total Non-Operating Expenses		
NET INCOME (LOSS)		

Chart Continues Onto Next Page

NET INCOME (LOSS)

G. Other Deductions

1. Estimated Annual Principal Debt Repayment
2. Annual Capital Expenditure

Total Other Deductions

NET BALANCE

DEPRECIATION

FREE CASH FLOW (Net Balance + Depreciation)

□ Total Facility
□ **Project Only**

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	**Year**	**Year**
1. Professional Services Contract		
2. Contract Labor		
3. Imaging Interpretation Fees		
4. Benefits		
5. General and Administrative		
6. Other		
Total Other Expenses		

E. 1) Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Previous Year	Current Year	Year One	Year Two	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	n/a	n/a	1,719	1,768	n/a
Deduction from Revenue *(Total Deductions/Utilization Data)*	n/a	n/a	1,015	997	n/a
Average Net Charge *(Net Operating Revenue/Utilization Data)*	n/a	n/a	704	771	n/a

NOTE: As a new facility, there are no previous or current year figures. Year One and Year Two figures are rounded to the nearest dollar. The % Change from Year One to Year Two, while not requested, would be: 2.9%, -1.7%, and 9.5%, respectively.

2) Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

Response: The proposed charges for the total project are reflected in the table above: Year 1, $1,719 in gross operating revenue per patient day, $1,015 in revenue deductions per patient day; and $704 in net operating revenue per patient day. The implementation of this project, coupled with normal increases in costs, will increase the average gross charge per patient day by approximately 2.9% in Year Two. This increase is to be expected due to the higher acuity of patients being seen, plus inflation estimates.

3) Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: Our projected service area is primarily Davidson, Cheatham, and Robertson Counties, Tennessee. Below is a chart showing charges of the existing psychiatric facilities in our primary service area for 2016.

Select Financial Information

Psychiatric Facilities in Davidson County, 2016

Facility	Gross	Adj.	Net
Mid TN MHI	755	594	161
Saint Thomas West**	2587	1961	626
TriStar Madison	4969	4013	956
TriStar Parthenon	5057	4025	1032
Vanderbilt	2907	1919	988

NOTE: Gross = Gross Operating Revenue per Patient Day, Rounded Nearest Dollar
Adj. = Contractual Adjustments per Patient Day, Rounded Nearest Dollar
Net = Net Operating Revenue per Patient Day, Rounded Nearest Dollar

The Applicant anticipates comparable figures to be $1,719, $1,015, and $704 in Year 1.

F. 1) Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as **Attachment B.Economic Feasibility.F.1**. NOTE: Publicly held entities only need to reference their SEC filings.

Response: Based on conservative budget and utilization projections, the hospital is anticipated to realize a positive cash flow in the first year following licensing, and all years thereafter.

Financials are included as **Attachment B.EconomicFeasibility.F.1.** Please note that there are sets of financial data from both owners of the Applicant.

2) Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Response: Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

Year	2nd Year previous to Current Year	1st Year previous to Current Year	Current Year	Projected Year 1	Projected Year 2
Net Operating Margin Ratio	n/a	n/a	n/a	-10.2%	14.5%

3) Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: [Long-term debt/(Long-term debt + Total Equity (Net assets)] x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

Response: The only long-term debt anticipated by the Applicant will be a $5M revolving line of credit from Acadia Healthcare Company, Inc., as lender, that will not be drawn upon until closer to opening as the entity begins incurring payroll and other operating expenses.

The Acadia party to the JV, Acadia Nashville JV Holdings, LLC, will have no debt.

Acadia Healthcare Company, Inc. has a Capitalization Ratio of 0.55% as of December 31, 2017.

Saint Thomas Health reports a Capitalization Ratio of 27.9%.

G. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Response: Historical: Not Applicable.

Payor Source	Projected Gross Operating Revenue ($)	As a % of Total
Medicare/Medicare Managed Care		
TennCare/Medicaid		
Commercial/Other Managed Care		
Self-Pay		
Charity Care		
Other (Specify) Worker's Compensation		
Total		

Project Only Projected Yr1: Not Applicable.

Payor Source	Projected Gross Operating Revenue ($)	As a % of Total
Medicare/Medicare Managed Care		
TennCare/Medicaid		
Commercial/Other Managed Care		
Self-Pay		
Charity Care		
Other (Specify) Worker's Compensation		
Total		

Total Facility Projected Yr 1:

Payor Source	Projected Gross Operating Revenue ($)	As a % of Total
Medicare/Medicare Managed Care	6,450,575	35.2
TennCare/Medicaid	5,045,559	27.5
Commercial/Other Managed Care	5,396,813	29.4
Self-Pay	526,881	2.9
Charity Care (See Note below)	386,317	2.1
Other (Specify) Worker's Compensation	536,881	2.9
Total	18,343,026	100.0

NOTE: Charity Care is normally recorded after contractual and administrative adjustments, but is included above to comply with the requested chart.

H. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

Response: Acadia and Saint Thomas Health have a strong network of academic affiliations for the recruitment, training, and hiring of clinical and non-clinical personnel. Partnering with local universities, colleges, trade schools, and traditional non-academic recruitment strategies will support the human resources needed to fully staff the hospital. All clinical staff will be recruited consistent with the Hospital's Human Resource practices, which include: advertisement in local and regional newspapers, recruitment web sites, work fairs, universities, colleges, and direct applications from prospective employees.

Proposed staffing and salary/wage data are an average of cost by category of employee. The following staffing matrices reflect proposed staffing based on bed allocations requested in this Certificate of Need proposal.

Adult Psychiatry:

ADULT PSYCHIATRY: 2 UNITS at 20 BEDS EACH					Salary/Wage
	CENSUS	1-10	11-15	16-20	
	DIRECTOR	0.5	0.5	0.5	$96,000/YR
	NRS MGR	1	1	1	$70,000/YR
DAYS/EVENINGS	RN/LPN	1	2	2	Avg $25-32/hr
	MHA	1	1	2	Avg $14-16/hr
	CLERICAL	1	1	1	Avg $14-16/hr
	SOCIAL WORK	1	1.5	2	Avg $22-30/hr
NIGHTS	RN/LPN	1	2	2	Avg $25-32/hr
	MHA	1	1	1.5	Avg $14-16/hr
HOUSE SUPERVISOR (RN)					$75,000/YR

At least one RN must be scheduled each shift.
NRS MGR = Nurse Manager

MHA = Mental Health Associate

Geriatric Psychiatry:

GERIATRIC PSYCHIATRY: 2 UNITS at 18 BEDS EACH					Salary/Wage
	CENSUS	1-6	7-12	13-18	
	DIRECTOR	0.5	0.5	0.5	$96,000/YR
	NRS MGR	1	1	1	$70,000/YR
DAYS/EVENINGS	RN/LPN	1	2	3	Avg $25-32/hr
	MHA	2	2	3	Avg $14-16/hr
	CLERICAL	1	1	1	Avg $14-16/hr
	Social Work	1	1.5	2	Avg $22-30/hr
NIGHTS	RN/LPN	2	2	2	Avg $25-32/hr
	MHA	1	1	2	Avg $14-16/hr
HOUSE SUPERVISOR (RN)					$75,000/YR

At least one RN must be scheduled each shift.
NRS MGR = Nurse Manager
MHA = Mental Health Associate

I. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

1) Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

Response: First, doing nothing is always an alternative, but was discarded since indicators are that more beds are needed in the service area. Second, the addition of beds to an existing facility was discarded as being cost-inefficient. The only facility in the service area that belonged to one of the owners did not have the space available for such an addition.

2) Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

Response: First, doing nothing is always an alternative, but was discarded since indicators are that more beds are needed in the service area. Second, the addition of beds to an existing facility was discarded as being cost-inefficient. The only facility in the service area that belonged to one of the owners did not have the space available for such an addition.

SECTION B: CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

A. List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as, transfer agreements, contractual agreements for health services.

Response: We will have a transfer agreement with Saint Thomas West and Saint Thomas Midtown. We hope to have either transfer agreements or working arrangements with all other acute facilities in our service area.

B. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition and/or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

1) Positive Effects

Response: The provision of healthcare services to patients in need normally has a positive impact on those patients, and this project is no exception. Once these beds are approved and licensed, the Applicant will be in a better position to provide needed services to adult and geriatric patients requiring psychiatric care. Further, twenty-four (24) psychiatric inpatient hospital beds at Saint Thomas West will be surrendered once the beds requested in this application are approved and licensed. Therefore, there will be a net increase of only fifty-two (52) hospital beds. Please see **Attachment B.Orderly.Development.B.1**.

2) Negative Effects

Response: The Applicant is unaware of any negative impact that this project might have on the health care system, as the need appears to outweigh any possible negative impact on existing providers brought on by competitive forces.

C. 1) Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements and/or requirements of accrediting agencies, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.

Response: Acadia and Saint Thomas Health have a strong network of academic affiliations for the recruitment, training, and hiring of clinical and non-clinical personnel. Partnering with local universities, colleges, trade schools, and traditional non-academic recruitment strategies will support the human resources needed to fully staff the hospital. All clinical staff will be recruited consistent with the Hospital's Human Resource practices, which include: advertisement in local and regional newspapers, recruitment web sites, work fairs, universities, colleges, and direct applications from prospective employees.

2) Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

Response: The Applicant understands these standards.

3) Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Response: Acadia and Saint Thomas Health have a strong network of academic affiliations for the recruitment, training, and hiring of clinical and non-clinical personnel. The applicant anticipates replicating relationships as currently exist with TrustPoint Hospital, owned by Acadia, as previously reported to the HSDA, as follows:

> "TrustPoint Hospital is dedicated to delivering high quality care to patients that is safe, efficient and reliable. As an organization committed to these qualities in health care delivery, TrustPoint Hospital embraces its duty to develop and train future clinical staff to care for the sick, poor and vulnerable in our community. To accomplish this mission, TrustPoint Hospital affiliates with the following colleges, universities and programs for on-site clinical training and practicum to train aspiring health care professionals.
>
> - Belmont University
> - Nursing
> - Occupational Therapy
> - Pharmacy
> - Physical Therapy
> - Eastern Tennessee State University
> - Nursing
> - Middle Tennessee State University
> - Nursing
> - Speech Therapy
> - Motlow College
> - Nursing
> - Tennessee State University
> - Occupational Therapy
> - Physical Therapy
> - Volunteer State Community College
> - Physical Therapy"

D. Identify the type of licensure and certification requirements applicable and verify the applicant has reviewed and understands them. Discuss any additional requirements, if applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Response: Please see below:

Licensure: Tennessee Department of Mental Health and Substance Abuse Services

Certification Type (e.g. Medicare SNF, Medicare LTAC, etc.): Hospital, certified in Medicare, Medicaid/TennCare, patients served through various MCO contracts.

Accreditation (i.e., Joint Commission, CARF, etc.): Joint Commission

1) If an existing institution, describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility and accreditation designation.

Response: Not applicable.

2) For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected by providing a letter from the appropriate agency.

Response: Not applicable.

3) Document and explain inspections within the last three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.

   a) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

Response: Not applicable.

E. Respond to all of the following and for such occurrences, identify, explain and provide documentation:

1) Has any of the following:

a) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);

Response: No.

b) Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or

Response: No.

c) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.

Response: No.

2) Been subjected to any of the following:

a) Final Order or Judgment in a state licensure action;

Response: No.

b) Criminal fines in cases involving a Federal or State health care offense;

Response: No.

c) Civil monetary penalties in cases involving a Federal or State health care offense;

Response: No.

d) Administrative monetary penalties in cases involving a Federal or State health care offense;

Response: No.

e) Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services; and/or

Response: No.

f) Suspension or termination of participation in Medicare or Medicaid/TennCare programs.

Response: No.

g) Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware.

Response: No.

h) Is presently subject to a corporate integrity agreement.

Response: No.

F. Outstanding Projects:

1) Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and

Outstanding Projects					
CON Number	Project Name	Date Approved	*Annual Progress Report(s)		Expiration Date
			Due Date	Date Filed	

* Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

2) Provide a brief description of the current progress, and status of each applicable outstanding CON.

Response: The Applicant has no outstanding Certificate of Need applications that are approved but not yet in service.

Acadia Healthcare, LLC ("Acadia"), the owner of Acadia Nashville JV Holdings, LLC, owns TrustPoint Hospital in Murfreesboro, which has two outstanding CON applications: CN1502-006AE and CN1606-024A, both of which are on schedule and on budget. Also, Acadia has an ownership interest in (1) Erlanger Behavioral Health, an approved 88 bed psychiatric hospital in Hamilton County, Tennessee (CN1603-012A), and (2) Crestwyn Behavioral Health located in Memphis, TN, which has filed a 14-bed CON application (CN1803-018).

In addition, Saint Thomas Health has an ownership interest in several outstanding projects:

(1) Saint Thomas Highlands Senior Care – CN1706-020A – approved 10/25/17. Construction is ongoing and on budget. The project is expected to be complete by June 30, 2018;

(2) Saint Thomas Rutherford Hospital – CN1707-021A – approved 10/25/17. The project remains in design phases with construction scheduled to start in August. The project is on budget, and construction is expected to begin in October, 2018;

(3) CN1701-003, Premier Radiology – Construction for the MRI & CT rooms is complete. The initial building survey was conducted March 16, 2018. Health and Life Safety surveys are pending;

(4) CN1706-070, Saint Thomas Highlands Hospital – Architectural plans have been reviewed and approved by the State Department of Health. Construction contracts have been bid and work on the project is expected to start in April, 2018; and

(5) CN1707-022, Saint Thomas Surgery Center, New Salem – Final land acquisition was completed March 19, 2018, clearing the way for further development.

G. Equipment Registry – For the applicant and all entities in common ownership with the applicant.

1) Do you own, lease, operate, and/or contract with a mobile vendor for a Computed Tomography scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)? _____

2) If yes, have you submitted their registration to HSDA? If you have, what was the date of submission?_____

3) If yes, have you submitted your utilization to Health Services and Development Agency? If you have, what was the date of submission? _____

Response: Not Applicable.

SECTION B: QUALITY MEASURES

Please verify that the applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

Response: The Applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

Further, the Applicant offers the following responses to Quality Measures:

Please discuss the applicant's commitment to the proposal in meeting appropriate quality standards by addressing each of the following factors:

(a) Whether the applicant commits to maintaining an actual payor mix that is comparable to the payor mix projected in its CON application, particularly as it relates to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent;

Response: The Applicant so commits.

(b) Whether the applicant commits to maintaining staffing comparable to the staffing chart presented in its CON application;

Response: The Applicant so commits.

(c) Whether the applicant will obtain and maintain all applicable state licenses in good standing;

Response: The Applicant so commits.

(d) Whether the applicant will obtain and maintain TennCare and Medicare certification(s), if participation in such programs was indicated in the application;

Response: The Applicant so commits.

(e) Whether an existing healthcare institution applying for a CON has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action shall be considered;

Response: The Applicant so commits.

(f) Whether an existing health care institution applying for a CON has been decertified within the prior three years. This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility;

Response: The Applicant is applying for a new facility, but has never been decertified.

(g) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

Response: The Applicant so commits.

(h) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

Response: The Applicant so commits.

(i) 1. This may include accreditation by any organization approved by Centers for Medicare and Medicaid Services (CMS) and other nationally recognized programs. The Joint Commission or its successor, for example, would be acceptable if applicable.

Response: The Applicant so commits to pursue accreditation by CMS for Medicare and Medicaid, and for accreditation by the Joint Commission.

SECTION C: STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at http://www.tn.gov/health/topic/health-planning). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan.

A. The purpose of the State Health Plan is to improve the health of the people of Tennessee.

Response: The Applicant will provide inpatient psychiatric care to adult and geriatric patients in a service area in need of such services. Due to the increasing need for inpatient psychiatric care (previously reported in this application), there continues to be a need for psychiatric hospital beds. The Applicant's goal of providing these appropriate and needed services is consistent with the State Health Plan, and this project will improve the health of Tennesseans.

B. People in Tennessee should have access to health care and the conditions to achieve optimal health.

Response: The Applicant will provide psychiatric services currently needed by all adult and geriatric citizens in the service area, thereby increasing the availability of such services.

C. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.

Response: The development of services by the Applicant's owners has always been the result of attempts to meet the needs of the patients they serve. There is an unmet need for adult and geriatric care in the service area. Therefore, the approval of this application will enhance the development of more psychiatric services for residents in the proposed service area.

D. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.

Response: Tennessee is fortunate to have an excellent licensing division of the Department of Mental Health and Substance Abuse Services (the "Department"). The Department also provides standards for and monitoring of licensed health care providers. This Applicant will be licensed by the Department of Mental Health and Substance Abuse Services, will be certified by Medicare and Medicaid (TennCare), and will be accredited by the JCAHO.

E. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

Response: The Applicant is committed to providing its staff both safe working conditions and continuing education.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.

Response: Proof of Publication is attached or will be submitted as received.

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Note that T.C.A. §68-11-1607(c)(9)(A) states that "...Within ten (10) days of the filing of an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the state representative and senator representing the house district and senate district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution-based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.
Response: Not Applicable.

DEVELOPMENT SCHEDULE

T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

Response: The Project Completion Forecast Chart is completed.

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1 below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

Phase	Days Required	Anticipated Date [Month/Year]
1. Initial HSDA decision date		08/2018
2. Architectural and engineering contract signed	30	09/2018
3. Construction documents approved by the Tennessee Department of Mental Health and Substance Abuse Services	240	05/2019
4. Construction contract signed	60	07/2019
5. Building permit secured	60	09/2019
6. Site preparation completed	90	12/2019
7. Building construction commenced	1	12/2019
8. Construction 40% complete	210	07/2020
9. Construction 80% complete	210	02/2021
10. Construction 100% complete (approved for occupancy	130	06/2021
11. *Issuance of License	30	07/2021
12. *Issuance of Service	1	07/2021
13. Final Architectural Certification of Payment	1	07/2021
14. Final Project Report Form submitted (Form HR0055)	1	07/2021

***For projects that *DO NOT* involve construction or renovation, complete Items 11 & 12 only.**

NOTE: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

E. Graham Baker, Jr., being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. §68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of his knowledge, information and belief.

E Graham Baker, Jr

SIGNATURE/TITLE

Sworn to and subscribed before me this 1ST day of June, 2018.
(Month) (Year)

a Notary Public in and for the County/State of Davidson/Tennessee.

K. Kathleen Baker

NOTARY PUBLIC

State of Tennessee Notary Public Davidson County

My commission expires JULY 05, 2021.
Month/Day) (Year)

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF FORMATION OF "CUMBERLAND BEHAVIORAL HEALTH, LLC", FILED IN THIS OFFICE ON THE TWENTY-FIFTH DAY OF APRIL, A.D. 2017, AT 5:12 O`CLOCK P.M.

Jeffrey W. Bullock, Secretary of State

6391738 8100
SR# 20172795317

Authentication: 202435329
Date: 04-25-17

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

State of Delaware
Secretary of State
Division of Corporations
Delivered 05:12 PM 04/25/2017
FILED 05:12 PM 04/25/2017
SR 20172795317 - File Number 6391738

CERTIFICATE OF FORMATION
OF
CUMBERLAND BEHAVIORAL HEALTH, LLC

Pursuant to Section 18-201 of the Delaware Limited Liability Company Act (the "Act"), the undersigned, desiring to form a limited liability company, does hereby certify as follows:

1. The name of the limited liability company is Cumberland Behavioral Health, LLC (the "Company").

2. The address of the Company's registered office in the State of Delaware is Corporation Trust Center, 1209 Orange Street, Wilmington, DE 19801. The name of the registered agent is The Corporation Trust Company.

3. This Certificate of Formation shall be effective upon filing with the Delaware Secretary of State.

IN WITNESS WHEREOF, the undersigned has executed this Certificate of Formation on this 25th day of April, 2017.

Christopher L. Howard, Authorized Person

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "CUMBERLAND BEHAVIORAL HEALTH, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE SECOND DAY OF MAY, A.D. 2018.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "CUMBERLAND BEHAVIORAL HEALTH, LLC" WAS FORMED ON THE TWENTY-FIFTH DAY OF APRIL, A.D. 2017.

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

Jeffrey W. Bullock, Secretary of State

6391738 8300

SR# 20183286789

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

Authentication: 202624542

Date: 05-02-18

05537-2445 05/03/2018 3:40 PM Received by Tennessee Secretary of State Fire Marshal

Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Cumberland Behavioral Health, LLC
STE 1000
6100 TOWER CIR
FRANKLIN, TN 37067-1509

May 3, 2018

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

SOS Control # :	**000961937**	Formation Locale:	DELAWARE
Filing Type:	Limited Liability Company - Foreign	Date Formed:	04/25/2017
Filing Date:	05/03/2018 3:48 PM	Fiscal Year Close:	12
Status:	Active	Annual Report Due:	04/01/2019
Duration Term:	Perpetual	Image # :	B0537-2443
Managed By:	Member Managed		

Document Receipt

Receipt # : 004068747	Filing Fee:	$300.00
Payment-Check/MO - WALLER LANSDEN DORTCH & DAVIS LLP, NASHVILLE, TN		$300.00

Registered Agent Address:
C T CORPORATION SYSTEM
300 MONTVUE RD
KNOXVILLE, TN 37919-5546

Principal Address:
STE 1000
6100 TOWER CIR
FRANKLIN, TN 37067-1509

Congratulations on the successful filing of your **Application for Certificate of Authority** for **Cumberland Behavioral Health, LLC** in the State of Tennessee which is effective on the date shown above. Please visit the Tennessee Department of Revenue website (apps.tn.gov/bizreg) to determine your online tax registration requirements. If you need to obtain a Certificate of Existence for this entity, you can request, pay for, and receive it from our website.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Tre Hargett
Secretary of State

Processed By: Tammy Morris

APPLICATION FOR CERTIFICATE OF AUTHORITY
LIMITED LIABILITY COMPANY (ss-4233)

Business Services Division
Tre Hargett, Secretary of State
State of Tennessee
312 Rosa L. Parks AVE, 6th Fl.
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50.00 per member
(minimum fee = $300, maximum fee = $3,000)

For Office Use Only

FILED

To The Secretary of the State of Tennessee:
Pursuant to the provisions of T.C.A. §48-249-904 of the Tennessee Revised Limited Liability Company Act, the undersigned hereby applies for a certificate of authority to transact business in the State of Tennessee, and for that purpose sets forth:

1. The name of the Limited Liability Company is: Cumberland Behavioral Health, LLC

   If different, the name under which the certificate of authority is to be obtained is: _____

NOTE: The Secretary of State of the State of Tennessee may not issue a certificate of authority to a foreign Limited Liability Company if its name does not comply with the requirements of T.C.A. §48-249-106 of the Tennessee Revised Limited Liability Company Act. If obtaining a certificate of authority under an assumed Limited Liability Company name, an application must be filed pursuant to T.C.A. §48-249-106(d).

2. The state or country under whose law it is formed is: Delaware

   and the date of its formation is: 04 / 25 / 2017 (Month / Day / Year) and the date it commenced doing business in Tennessee is: 05 / 01 / 2018 (Month / Day / Year)

   NOTE: Additional filing fees and proof of tax clearance confirming good standing may apply if the Limited Liability Company commenced doing business in Tennessee prior to the approval of this application. See T.C.A. §48-249-913(d) and T.C.A. §48-249-905(c)

3. This company has the additional designation of:

4. The name and complete address of its registered agent and office located in the state of Tennessee is:

   Name: C T Corporation System

   Address: 300 Montvue Road

   City: Knoxville State: TN Zip Code: 37919-5546 County: Knox

5. Fiscal Year Close Month: December

6. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is: (Not to exceed 90 days)

   Effective Date: ____ / ____ / ____ (Month / Day / Year) Time: _____

7. The LLC will be: ☒ Member Managed ☐ Manager Managed ☐ Director Managed ☐ Board Managed ☐ Other

8. Number of Members at the date of filing: 1

9. Period of Duration: ☒ Perpetual ☐ Other ____ / ____ / ____ (Month / Day / Year)

10. The complete address of its principal executive office is:

    Address: 6100 Tower Circle, Suite 1000

    City: Franklin State: TN Zip Code: 37067

TN063 - 7/15/2014 Wolters Kluwer Online

05537-2443 05/03/2018 3:40 PM Received by Tennessee Secretary of State Tre Hargett

APPLICATION FOR CERTIFICATE OF AUTHORITY
LIMITED LIABILITY COMPANY (ss-4233)

Business Services Division
Tre Hargett, Secretary of State
State of Tennessee
312 Rosa L. Parks AVE, 6th Fl.
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50.00 per member
(minimum fee = $300, maximum fee = $3,000)

For Office Use Only

The name of the Limited Liability Company is: Cumberland Behavioral Health, LLC

11. The complete mailing address of the entity (if different from the principal office) is:

Address: _____

City: _____ State: _____ Zip Code: _____

12. Non-Profit LLC (required only if the Additional Designation of "Non-Profit LLC" is entered in section 3.)

☐ I certify that this entity is a Non-Profit LLC whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in T.C.A. §67-4-2004. The business is disregarded as an entity for federal income tax purposes.

13. Professional LLC (required only if the Additional Designation of "Professional LLC" is entered in section 3.)

☐ I certify that this PLLC has one or more qualified persons as members and no disqualified persons as members or holders.

☐ I certify that this entity meets the requirement of T.C.A. §48-249-1123(b)(3)

Licensed Profession: _____

14. Series LLC (required only if the Additional Designation of "Series LLC" is entered in section 3.)

☐ I certify that this entity meets the requirements of T.C.A. §48-249-309(i)

If the provisions of T.C.A. §48-249-309(i) (relating to foreign series LLCs) apply, then the information required by that section should be attached as part of this document.

15. Obligated Member Entity (list of obligated members and signatures must be attached)

☐ This entity will be registered as an Obligated Member Entity (OME) Effective Date: ____/____/____ (Month / Day / Year)

☐ I understand that by statute: THE EXECUTION AND FILING OF THIS DOCUMENT WILL CAUSE THE MEMBER(S) TO BE PERSONALLY LIABLE FOR THE DEBTS, OBLIGATIONS AND LIABILITIES FOR THE LIMITED LIABILITY COMPANY TO THE SAME EXTENT AS A GENERAL PARTNER OF A GENERAL PARTNERSHIP. CONSULT AN ATTORNEY.

16. Other Provisions: _____

May 3, 2018
Signature Date

Signature

Vice President and Secretary
Signer's Capacity (if other than individual capacity)

Christopher L. Howard
Name (printed or typed)

Rev. 10/12

RDA 2458

TN063 - 7/15/2014 Wolters Kluwer Online

B0537-2444 05/03/2018 3:48 PM Received by Tennessee Secretary of State Tre Hargett

MANAGEMENT SERVICES AGREEMENT

This Management Services Agreement ("Agreement") is entered into this 7th day of May, 2018 (the "Effective Date"), by and between Cumberland Behavioral Health, LLC, a Delaware limited liability company ("Hospital"), and Acadia Management Company, LLC, a Delaware limited liability company ("Company"). Hospital and Company are each referred to as a "Party" and collectively as the "Parties."

WHEREAS, Company desires to provide to Hospital the services described in this Agreement and Hospital wishes for Company to provide such services in connection with Hospital's ownership and operation of a psychiatric hospital located in the Nashville, Tennessee area.

NOW, THEREFORE, in consideration of the premises and mutual covenants and conditions set forth hereinafter, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties, intending to be legally bound, agree as follows:

I. PROFESSIONAL SERVICES AND COMPENSATION

1.1 Services. Company will provide to Hospital the services described in Schedule 1.1 to this Agreement (the "Services"). In providing the Services, Company shall act in good faith and with reasonable diligence, and shall provide the Services in compliance with all Applicable Laws (as defined below) and in substantially the same manner and with the same standard of care as such Services are provided by Company at other facilities owned or operated by Company and/or its Affiliates.

1.2 Additional Services. In the event that Hospital wishes to obtain services from Company in addition to the Services described in Section 1.1, Company shall discuss with Hospital the options available to Hospital for obtaining such services, and the related cost thereof if Company were to perform and provide, or arrange for the performance and provision of, those items or services. If the Parties agree on terms (including cost) with respect to any additional services ("Additional Services"), the Parties shall set forth, in a written addendum to this Agreement signed by the Parties (an "Additional Services Addendum"), the specific Additional Services to be provided by Company and the additional fees (the "Additional Services Fee") payable by Hospital to Company for the provision of such Additional Services. The term "Services," as used in this Agreement, shall include any Additional Services agreed upon by the Parties after the Effective Date in accordance with the terms of this Section 1.2.

1.3 Service Fee and Expense Reimbursement. Company shall charge Hospital a fee for the Services equal to four percent (4%) of the Hospital's net operating revenue (the "Services Fee"). In addition to the Services Fee, Hospital will reimburse Company for the reasonable out-of-pocket expenses described in Schedule 1.3 to this Agreement (the "Expenses").

1.4 Invoices. Company will submit a monthly invoice to Hospital on or before the fifteenth (15) day of each month for the previous month's Services Fee and Expenses. Hospital will pay such invoices within thirty (30) days of receipt thereof.

1.5 Compensation Not Related to Volume or Value of Referrals. The Parties acknowledge that state and federal laws regulate compensation arrangements between healthcare providers. Nothing in the compensation provisions of this Agreement should be construed by the Parties to (a) provide payments in return for restricting, limiting, or otherwise reducing the provision of medically necessary services to patients, (b) act as an inducement or incentive to induce or reward referrals or

admissions of patients for services or to generate business of any kind whatsoever, or (c) act as an inducement or incentive to make a false determination. The amounts to be paid hereunder represent the fair market value of the services to be provided as established by arms' length negotiations by the Parties and have not been determined in any manner that takes into account the volume or value of any potential referrals between the Parties. In addition, the amounts charged hereunder do not include any discount, rebate, kickback or other reduction in charges, and the amount charged is not intended to be, nor shall it be construed to be, an inducement or payment for referral of patients by any Party to any other Party. Further, it is agreed that none of the Parties shall refer or attempt to influence the referrals of any patients to any particular program.

1.6 Independent Contractor Relationship. Hospital engages Company as an independent contractor. Neither Company nor its employees are employees of Hospital and nothing in this Agreement or the Services establishes an employer-employee relationship between Hospital and Company.

1.7 Limitations on Authority. Notwithstanding any other provision of this Agreement to the contrary, each of Company and Hospital expressly acknowledge and agree that pursuant to the LLC Agreement (as hereafter defined), Hospital's Management Board will have the authority to control and direct the operations of the Hospital, and all management services provided by Company under this Agreement are subject to the oversight of the Management Board. Company shall operate within any reasonable parameters, policies and procedures communicated to it by the Management Board, so long as such parameters, policies and procedures do not, in Company's reasonable judgment, require Company or Hospital to engage in any illegal or unethical acts, or require Company to provide services not contemplated by this Agreement. Hospital does not delegate, and Company does not assume, any of the powers, duties, or responsibilities which Company is required to maintain under applicable law. Company shall not be a "manager" of Hospital under the terms of the Delaware Limited Liability Company Act. Without limiting the generality of the foregoing, and notwithstanding anything to the contrary contained in this Agreement, Company shall not (a) take any actions inconsistent with the express decisions of the Board; make expenditures or incur reimbursable expenses not authorized by the applicable budget approved by the Management Board in accordance with the terms of the LLC Agreement (the "Budget"); provided, however, that no approval shall be required for variations in expenditure levels from that set forth in the Budget if such variations either (i) result from the ordinary course of business (e.g., unexpected increases in patient census) and are not in excess of $50,000, or (ii) are required for the Hospital to maintain its licensure or accreditation or to comply with a legal requirement, and approval of the Company in accordance with the terms of the LLC Agreement cannot be obtained within the time reasonably necessary to maintain such licensure or accreditation or comply with such legal requirement; provided the Company shall promptly report to the Management Board any such expenditure, or (b) take any other actions inconsistent with the terms of the LLC Agreement.

1.8 Charitable and Religious Purposes. Company acknowledges and agrees that so long as Hospital Member (as hereafter defined) or any of its Affiliates is a direct or indirect owner of Hospital, the Hospital is required to be managed and operated in a manner that furthers and is consistent with the charitable and religious healthcare purposes of the Hospital Member and its Affiliates as required by the Operating Agreement, and that the members of the Management Board appointed by the Hospital Member have the unilateral right to make decisions with respect to such charitable and religious purposes as set forth in the LLC Agreement. Notwithstanding anything to the contrary contained in this Agreement, Company shall cause the Hospital to be operated at all times in accordance with the

Company's Charity Policy. the ERDs, in a manner consistent with the requirements of the LLC Agreement, and pursuant to the direction of the Management Board or members of the Management Board appointed by the Hospital Member, as applicable.

II. TERM AND TERMINATION

2.1 Term. The initial term of this Agreement is five (5) years beginning on the Effective Date. At the end of the initial term, this Agreement will automatically renew for successive terms of twelve (12) months each unless terminated by either Party in writing at least ninety (90) days prior to the end of the then current term.

2.2 Termination. This Agreement may be terminated:

(a) by either Party if the other Party breaches any material term of this Agreement and fails to cure such breach to the reasonable satisfaction of the non-breaching party within thirty (30) days after its receipt of notice from the non-breaching Party specifying the nature of such breach;

(b) by either Party immediately upon notice to the other Party, in the event of:

i. the exclusion of such other Party or its Affiliate from participating in any Federal Health Care Program pursuant to 42 U.S.C. §1320a-7;

ii. any act or failure to act by Company that in Hospital's sole discretion adversely affects, or could adversely affect the care, safety, health or welfare of a Hospital patient; or

iii. the commission or conviction (including by a plea of guilty or nolo contendere) by a Party or its Affiliate of a felony or a crime of moral turpitude;

(c) by either Party immediately at any time at which an Affiliate of Company is no longer a Member of Hospital.

(d) by mutual written consent of the Parties.

2.3 Effect of Termination.

(a) Upon termination or expiration of this Agreement, Company will fully cooperate with Hospital in order to effectuate a smooth transition of services. Other than in the event of a termination in the event of a Hospital breach pursuant to Section 2.2(a), Company shall, upon Hospital's request, for a period not to exceed one (1) year following the effective date of expiration without renewal or termination of this Agreement (the "Transition Period"), continue to provide such Services as requested by Hospital from time to time (the "Transition Services"), upon the terms and subject to the conditions set forth in this Agreement.

(b) Company shall immediately return to Hospital any and all assets or property of Hospital then in possession of Company ("Hospital Assets"); provided, however, that in the event that Company provides Transition Services, Company shall not be required to return to Hospital any Hospital Assets that are necessary for the provision of Transition Services until the end of the Transition Period,

at which time Company shall immediately return to Hospital any and all remaining Hospital Assets then held or retained by Company.

III. REPRESENTATIONS AND WARRANTIES

3.1 Representations and Warranties of Both Parties. Each Party represents and warrants that:

(a) Neither such Party, nor, to such Party's knowledge, any of its Affiliates or its or their members, employees, officers, directors, managers, contractors or owners, has ever been (i) excluded from participation in any Federal Health Care Program pursuant to 42 U.S.C. §1320a-7 or (ii) convicted of any offense related to healthcare or related to the provision of services paid for by Medicare, Medicaid or another Federal Health Care Program;

(b) Such Party is legally authorized to do business in the relevant jurisdiction;

(c) Such Party is authorized to enter into this Agreement and perform its obligations hereunder; and

(d) This Agreement has been duly executed and delivered by such Party and is a legal, valid and binding obligation of such Party enforceable against it in accordance with its terms, except as enforceability may be limited by bankruptcy, insolvency, reorganization, moratorium, fraudulent transfer or conveyance or similar law relating to or limiting creditors' rights generally or by equitable principles relating to enforceability (whether or not the issue of enforceability is decided by a court of law or in equity).

IV. ADDITIONAL AGREEMENTS

4.1 Medical Records, Lists, and Histories. All business and patient records, patient case histories, patient lists, employee files and other files and related materials concerning the business and patients of Hospital shall belong to and remain the property of Hospital.

4.2 Government Access to Records. Until the expiration of four (4) years after the termination of this Agreement, the Parties will make available, upon written request by the Secretary of the Department of Health and Human Services, or upon request by the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the Services. In the event that Company carries out any of its duties under this Agreement through an approved subcontract with a related organization with a value or cost of $10,000 or more over a twelve (12)-month period, such subcontract will contain a provision requiring the related organization to make available until the expiration of four (4) years after the furnishing of such services pursuant to such subcontract upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of such subcontract and such books, documents and records of such organization as are necessary to verify the nature and extent of such costs.

4.3 Insurance Coverage. Company shall, and shall require any applicable subcontractors to, procure and maintain throughout the term of this Agreement insurance with types of coverage and limits no less than the following:

Professional Liability:	$1,000,000 per Occurrence; $3,000,000 Aggregate
Workers' Compensation:	limits as required by state law.
General Liability:	$1,000,000 per Occurrence; $3,000,000 Aggregate
Automobile Liability:	$1,000,000 Combined Single Limit
Umbrella Liability:	$5,000,000

4.4 Compliance with Laws. Company agrees that it will, and will cause its employees to, comply with all applicable state and federal laws and regulations, including (a) the disclosure requirements and self-referral prohibitions of the Stark Law, codified at 42 C.F.R. Part 411, Subpart J, and any applicable state self-referral laws, (b) the anti-fraud and abuse statute, 42 U.S.C. §1320a-7b(b) and any applicable state anti-kickback laws, and (c) the privacy and security requirements set forth in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), codified at 45 C.F.R. Parts 160 and 164, and any applicable state patient privacy laws (collectively, "Applicable Laws").

4.5 HIPAA Business Associate Relationship. Because the Services involve the use or disclosure of individually identifiable health information relating to Hospital's patients, Company, Company's employees, and Hospital are deemed to be a business associates under HIPAA and the federal privacy regulations set forth at 45 CFR Part 160 and Part 164. Company and Hospital have entered into the Business Associate Agreement attached hereto as Exhibit A.

V. GENERAL PROVISIONS

5.1 Notices. Any and all notices, designations, consents, offers, acceptances, or other communications provided for herein will be given in writing to Company and Hospital at the addresses set forth under the signature lines below, with a copy to:

If to Company:

Acadia Management Company, LLC
c/o Acadia Healthcare Company, Inc.
6100 Tower Circle
Suite 1000
Franklin, TN 37067
Attn: General Counsel

with a copy to:
Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, TN 37219
Attn: E. Brent Hill, Esq.

If to Hospital:

Cumberland Behavioral Health, LLC
c/o Saint Thomas Health
102 Woodmont Blvd., Ste. 800
Nashville, TN 37205
Attn: Chief Executive Officer

with a copy to:
Saint Thomas Health
102 Woodmont Boulevard, Ste. 800
Nashville, TN 37205
Attn: General Counsel

Notices shall be deemed received and properly given when actually received, if delivered in person, or when mailed, if sent by registered or certified United States mail, postage prepaid, or when sent by email transmission, return receipt requested.

5.2 Amendment. This Agreement may be amended only in writing signed by both Parties.

5.3 Counterparts. This Agreement may be executed in several counterparts, each of which will be deemed an original and all of which together will constitute one and the same Agreement.

5.4 Assignment. Neither Party may assign or transfer this Agreement by operation of law or otherwise without the prior written consent of the other Party; provided, that, either Party may assign this Agreement to an Affiliate of such Party without prior written consent of the other Party. Any assignment (or attempted assignment) of this Agreement in violation of this Section 5.4 is void. All the terms and provisions of this Agreement will be binding upon and inure to the benefit of the Parties, their successors, assigns and legal representatives.

5.5 Choice of Law. This Agreement will be construed pursuant to the laws of the State of Delaware without regard to principles of conflicts of laws.

5.6 Entire Agreement. This Agreement, including the Schedules and Exhibits hereto, constitutes the entire understanding of the parties hereto, and no deviation from the Agreement or failure to enforce rights or obligations hereunder will be construed as a waiver of the rights and obligations of the parties hereto, whether any such deviation or waiver is continuing or otherwise.

5.7 Confidential Information. Unless specifically authorized in writing by Hospital, Company shall, and shall cause its agents and Affiliates to, keep confidential and not disclose or make any use of any Hospital Confidential Information, except as and to the extent required to enable Company to perform its obligations under this Agreement, or as may otherwise be required by Applicable Laws. At the termination of this Agreement, Company shall return to Hospital all Hospital Confidential Information in the possession of Company or any of Company's agents or Affiliates, including any and all copies, summaries and compilations thereof, and whether in electronic or hard copy form. If requested by Hospital, an executive officer or legal counsel of Company must also certify in writing to Hospital that Company has returned (or if permitted by Hospital with respect to all or any part of such Hospital Confidential Information, destroyed) all Hospital Confidential Information in its possession or in the possession of any of its Agents or Affiliates. "Hospital Confidential Information" means any and all information relating to Hospital, whether or not such information is designated as being confidential or proprietary, but shall exclude any information that Company is able to demonstrate (a) was independently developed by Company without the use of any Hospital Confidential Information; (b) is available in the public domain; and (c) was ordered to be released by requirement of a governmental agency or court of law.

5.8 Equitable Relief. The Parties acknowledge and agree that the remedies at law for a breach of this Agreement would be inadequate and that in addition to any remedy at law which it may have, a Party may be granted temporary, preliminary and permanent injunctive relief in any proceeding which may be brought to enforce such provisions, without the necessity of posting a bond as security or proof of actual damage. Each Party further acknowledges and agrees that any proceeding brought pursuant to this Section 5.8 may be adjudicated in a court of competent jurisdiction located in Davidson

County, Tennessee, and that such court shall have all of the necessary authority to issue the injunctive relief described in this Agreement.

5.9 Dispute Resolution. Except as expressly set forth in Section 5.8, the Parties agree that any dispute under this Agreement shall be submitted to the dispute resolution proceedings described in Section 10.3 of the LLC Agreement (as hereinafter defined).

5.10 Definitions. Capitalized terms used but not otherwise defined herein shall have the meanings ascribed to such terms in the Amended and Restated Limited Liability Company Agreement, dated as of even date herewith, by and among Hospital, Acadia Nashville JV Holdings, LLC ("Acadia Member") and Saint Thomas Health (the "Hospital Member") (the "LLC Agreement").

5.11 Interpretation and Headings and Exhibits. The section, subsection and any paragraph headings contained in this Agreement are for the purpose of convenience only and are not intended to define or limit or affect, and shall not be considered in connection with the interpretation or application of, any of the terms or provisions of this Agreement. Unless otherwise indicated elsewhere in this Agreement, (a) the term "including" shall mean "including, without limitation," and (b) the terms "hereof," "herein" and "hereunder" and terms of similar import shall refer to this Agreement as a whole and not to any particular Section or paragraph where such term may be used. The recitals to and all Schedules and Exhibits to this Agreement are fully incorporated into and are an integral part of this Agreement as if set forth in this Agreement.

[Remainder of Page Intentionally Left Blank]

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement effective as of the Effective Date.

Company:

Acadia Management Company, LLC

By: _____

Name: Christopher Howard

Title: VP & Secretary

Hospital:

Cumberland Behavioral Health, LLC

By: _____

Name: Christopher Howard

Title: VP & Secretary

4828-5057-8526.3

[Signature page to the Management Services Agreement]

4832-0350-6019.5

Schedule 1.1

SERVICES

Company will provide corporate office management services to Hospital, including support in the following areas:

Senior Personnel	Company will employ individuals selected by the Hospital in accordance with the LLC Agreement to serve as the CEO and CFO of the Hospital on a full-time basis. All other personnel will be employed by Hospital.
Business Office Support	Company will provide training, ongoing advice and guidance, reporting and trend tracking, and templates, policies and procedures relating to Hospital's revenue cycle and supply chain.
Clinical Quality and Compliance	Company will (a) provide ongoing advice and guidance, policies, procedures and programs to Hospital to assist it in complying with Hospital's Compliance Program; state licensure regulations; Medicare, Medicaid, and other payors' conditions of participation and reimbursement standards; and state and federal regulations governing Hospital's operations, patient rights, and patient privacy; (b) assist Hospital in maintaining compliance with all licensure and accreditation requirements, including preparing for licensure and accreditation surveys; (c) assist Hospital in tracking and reporting clinical quality indicators; and (d) provide and administer a compliance hotline available by phone and internet, for Hospital's employees, patients and the public to raise concerns about Hospital's compliance with the laws, rules and regulations that apply to it.
Costs and Expenses	Company will pay all operating costs and expenses associated with the ownership of the assets of Hospital including without limitation, insurance, ad valorem taxes, maintenance costs, advisory, consulting, accounting and legal fees, and principal and interest due on any indebtedness encumbering the assets of Hospital.

Finance and Accounting	Subject to Section 10.15 of the LLC Agreement, Company will take such actions as are necessary for the Hospital Member to be able to consolidate the financial results of operations and financial condition of Hospital with the financial results of operations and financial condition of the Hospital Member and its Affiliates in accordance with the accounting principles of Hospital determined in accordance with GAAP by the Hospital Member and its Affiliates, and applied on a consistent basis, as such may change from time to time; provided that any such action does not have any financial consequence for Hospital or the Acadia Member; and shall comply with policies and procedures of the Hospital Member related to GAAP accounting and capital management.
Human Resources and Payroll	Company will (a) employ or have an Affiliate employ, retain or otherwise secure or enter into contracts with or for employees for Hospital, consultants, accountants, agents or firms to assist in the business of Hospital, all on such terms and for such consideration as Company deems advisable, such consideration to be a normal operating expense; (b) subject to Section 6.10 of the LLC Agreement, determine all human resource and employment related decisions with respect to the employees and staff working at Hospital, including, without limitation, all staffing level decisions, hiring and firing decisions and compensation and benefit decisions with respect to such employees and staff; (c) provide HRIS and payroll systems licensing, training and support; (d) assist Hospital in establishing staffing schedules and wage structures; (e) provide ongoing employee relations advice and counsel; (f) provide draft templates, policies and procedures; (g) provide employee benefit plan enrollment, management, and administration; and (h) investigate and make recommendations in response to employee concerns.
Insurance	Company will purchase insurance coverage for Hospital in the following lines, in such coverage amounts and upon such other terms as approved by Hospital's Management Board: (a) property damage and casualty; (b) workers' compensation; general and professional liability; directors' and officers' liability; (c) automobile damage and liability or (d) any other contract of insurance as approved by Hospital's Management Board. Company will work with the insurance brokers and carriers in the adjustment and administration of insurance claims by and against Hospital, and will oversee insured litigation against Hospital or its affiliated insureds. All insurance premium costs will be paid by the Hospital.
Information Technology	Company will (a) provide and administer software licenses and service and maintenance contracts for Hospital's information systems; (b) assist with installs and upgrades to those systems, and will provide help desk support 24/7/365 and (c) provide for appropriate security, backup and disaster recovery for Hospital's

	information systems.
Internal audit	Company will (a) audit Hospital's financial and operational information to ensure that it is complete and accurate; (b) conduct internal control testing and analysis, and will train and provide ongoing advice and guidance to Hospital personnel regarding financial internal controls; and (c) provide appropriate templates, policies and procedures, and will conduct a full scope audit at least every three years and a desk audit at least every two years. In carrying out its internal audit responsibilities set forth herein, Company shall comply with all policies and procedures of the Hospital Member and its Affiliates applicable to the Hospital and as otherwise necessary in connection with the consolidation of the financial results of Hospital with the Hospital Member and its Affiliates, including, without limitation the policies and procedures of Ascension Health with respect to joint venture financial integrity, including but not limited to its requirements for quarterly review of financial statements and footnotes, control checklists, management representation letters, and financial code of ethics.
Legal	Company will provide training, advice, policies and procedures to Hospital on a broad range of legal issues, including: business growth and expansion; employee relations; litigation and investigation management; payor, vendor, and professional service contracting; and real estate matters. Company will provide legal review and tracking of all of Hospital's significant contracts. The Company's legal department will also work with the compliance, human resources and risk management departments of Hospital and the Company, in their support of Hospital.
Marketing	Company will assist Hospital in developing, executing and reviewing marketing, advertising and PR strategies and campaigns. Direct marketing and advertising expenses will be reimbursed in accordance with Schedule 1.3.
Budgets	Company will, subject to the approval of the Management Board in accordance with the LLC Agreement, including, without limitation, Section 6.2(a)(ii) thereof, (a) establish the annual operating and capital budgets of Hospital; (b) set pricing for goods and services provided by Hospital; and (c) execute, acknowledge and deliver any and all instruments, documents, certifications, guaranties, accommodation endorsements or agreements necessary or convenient in connection with the conduct and operation of the business and purpose of Hospital and/or in furtherance of any of the foregoing, including without limitation, executing contracts for the purchase or sale of goods or services.

Operations Management	Company will provide training, ongoing advice and guidance, policies and procedures to Hospital on: (a) managing and growing its service line and margin; (b) managing its labor costs and other expenses; and (c) improving its service and payor mix.
Recruiting	Company will assist Hospital in recruiting key personnel, as requested by Hospital, including but not limited to adequate physician staffing.
Reimbursement	Subject to the powers of the Tax Matter Member (as defined in the LLC Agreement) set forth in Article 9 of the LLC Agreement, Company will (a) assist Hospital in determining and setting patient charges and will review and as necessary revise Hospital's cost reports, which will be prepared by a third party vendor; (b) assist Hospital with governmental and commercial payor negotiations, credentialing and contracting to the extent permitted by applicable law and (c) provide oversight and ongoing advice on Hospital's reimbursement, bad debt and denial rates.
Risk Management	As requested by Hospital, Company will (a) provide training and advice, as well as proposed policies, procedures and programs designed to promote patient and employee safety and the timely and accurate reporting, investigation, and mitigation of incidents and risks; (b)provide and administer an online incident reporting and tracking system, capturing critical data about patient and employee safety incidents, identifying and remedying root causes, and identifying and curbing negative trends; and (c) give advice and counsel to Hospital in potentially adverse situations involving patients/family members, regulatory bodies, accrediting organizations, law enforcement, and news media
Tax	Company will (a) prepare and file Hospital's state and federal tax filings and returns; (b) implement appropriate internal controls related to taxes; and (c) provide tax planning and advice to Hospital.
Treasury and Cash Management	Company will (a) provide centralized treasury, cash management and bank account management services to Hospital; (b) open and maintain bank accounts for the deposit of the funds of Hospital, with withdrawals to be made upon such signature or signatures as Company may designate; and (c) invest in short-term government obligations, certificates of deposit, tax-exempt obligations, interest-bearing deposits, money market accounts, or other cash equivalents, using such funds of Hospital as are temporarily not required in Company's opinion in conducting the business of Hospital or in paying distributions to Members.

Schedule 1.3

EXPENSES

Hospital will reimburse Company for the following out-of-pocket expenses:

(a) the actual reasonable and documented out-of-pocket costs of outside service providers and consultants, legal counsel, tax advisors and outside auditors incurred by Company, solely to the extent related to its provision of the Services;

(b) Hospital's proportional amount (based on Hospital's relative number of beds compared to the number of beds of Company and its other Affiliates) of the costs of Company and its Affiliates for software licenses, insurance and employee benefits;

(c) the actual reasonable and documented out-of-pocket marketing and advertising costs incurred by Company, solely to the extent related to its provision of the Services; and

(d) the actual reasonable and documented out-of-pocket travel expenses incurred by Company, which shall generally include coach class airfare not to exceed $700, car rental expenses not to exceed $50 per day, lodging not to exceed $150 per day, and meals (which shall not include any alcohol) not to exceed $50 per person per day, and which shall not include pay for travel time.

Exhibit A

Business Associate Agreement

See attached.

Execution Version

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the "Agreement"), is made as of the 7th day of May, 2018 (the "Effective Date"), by and between Cumberland Behavioral Health, LLC ("Covered Entity") and Acadia Management Company, LLC ("Business Associate") (collectively the "Parties") to comply with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191) (the "Act"), codified at 42 U.S.C. Section 1320d et. seq., as amended by the Health Information Technology for Economic and Clinical Health Act (Pub. L. No. 111-5) ("HITECH") and the regulations promulgated by the U.S. Department of Health and Human Services thereunder, including, 45 C.F.R. parts 160 and 164, subparts A and E ("the Privacy Rule"), 45 C.F.R. parts 160, 162 and 164, subpart C ("the Security Rule"), and 45 C.F.R. Subpart D ("Breach Notification Rule"), as amended from time to time (the Act, HITECH, the Privacy Rule, the Security Rule, and the Breach Notification Rule are collectively referred to herein as "HIPAA") and other applicable federal and state confidentiality and security laws.

RECITALS

WHEREAS, Covered Entity and Business Associate have entered into an arrangement (the "Underlying Agreement"), pursuant to which Business Associate provides certain services for or on behalf of Covered Entity, which may require access to, or the use or disclosure of, Protected Health Information that is subject to protection under HIPAA; and

WHEREAS, HIPAA requires that Covered Entity receive adequate assurances that Business Associate will comply with certain obligations with respect to the PHI received in the course of providing services to or on behalf of Covered Entity.

NOW THEREFORE, in consideration of the mutual promises and covenants herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

A. Definitions. Terms used herein, but not otherwise defined, shall have meaning ascribed by HIPAA.

1. Breach. "Breach" shall mean the acquisition, access, use or disclosure of PHI in a manner not permitted under the Privacy Rule which "compromises the security or privacy of the PHI" as set forth in 45 C.F.R. § 164.402; provided however, that a breach shall not include (i) any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of Covered Entity or Business Associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in a further use or disclosure in a manner not permitted under the Privacy Rule; (ii) any inadvertent disclosure by a person authorized to access PHI at Covered Entity or Business Associate to another person authorized to access PHI at Covered Entity or Business Associate, or an organized health care arrangement in which Covered Entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the Privacy Rule; or (iii) a disclosure of PHI where Covered Entity or Business Associate has a good faith belief that the

unauthorized person to whom the disclosure was made would not have reasonably been able to retain the disclosed information.

2. Designated Record Set. "Designated Record Set" shall mean a group of records maintained by or for a Covered Entity that is: (i) the medical records and billing records about Individuals maintained by or for a covered health care provider; (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (iii) used, in whole or in part, by or for the covered entity to make decisions about Individuals. For purposes of this definition, the term "record" means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

3. Electronic Protected Health Information ("EPHI"). "Electronic Protected Health Information" or EPHI shall have the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

4. Individual. "Individual" shall mean the person who is the subject of the protected health information.

5. Protected Health Information ("PHI"). "Protected Health Information" or PHI shall have the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity. As used in this Agreement, Protected Health Information shall also include Electronic Protected Health Information.

6. Required by Law. "Required by Law" shall mean a mandate contained in law that compels a use or disclosure of PHI and that is enforceable in a court of law.

7. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his or her designee.

8. Security Incident. "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI maintained or interference with system operations in an information system maintained by Business Associate that contains PHI received from Covered Entity.

9. Unsecured PHI. "Unsecured PHI" shall have the same meaning as "unsecured protected health information" in 45 C.F.R. § 164.402, which shall mean PHI that is not rendered unusable, unreadable, or indecipherable through the use of a technology or methodology specified by the Secretary in the guidance issued under Section 13402(h)(2) of Public Law 111-5.

B. Obligations of Business Associate. Business Associate agrees to comply with applicable federal and state confidentiality and security laws, specifically the provisions of the

Privacy Rule applicable to business associates (as defined by the Privacy Rule), including:

1. Use and Disclosure of PHI. Except as otherwise limited in the Underlying Agreement or this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in this Agreement, provided that such use or disclosure would not violate HIPAA if done by Covered Entity. Business Associate may use and disclose PHI as necessary for the proper management and administration of Business Associate, or to carry out its legal responsibilities. Business Associate shall in such cases:

   (a) provide information to members of its workforce using or disclosing PHI regarding the confidentiality requirements of the Privacy Rule and this Agreement;

   (b) obtain reasonable assurances from the person or entity to whom the PHI is disclosed that: (a) the PHI will be held confidential and further used and disclosed only as Required by Law or for the purpose for which it was disclosed to the person or entity; and (b) the person or entity will notify Business Associate of any instances of which it is aware in which confidentiality of the PHI has been breached; and

   (c) agree to notify the designated Privacy Officer of Covered Entity of any instances of which it is aware in which the PHI is used or disclosed for a purpose that is not otherwise provided for in this Agreement or for a purpose not expressly permitted by HIPAA.

2. Data Aggregation. To the extent permitted by the Underlying Agreement, or as otherwise expressly agreed to in writing by Covered Entity, Business Associate may use and disclose PHI for data aggregation purposes, however, only in order to analyze data for permitted health care operations, and only to the extent that such use is permitted under the Privacy Rule.

3. De-identified Information. Business Associate may use and disclose de-identified health information if (i) the use is disclosed to Covered Entity and permitted by Covered Entity in its sole discretion and (ii) the de-identification is in compliance with 45 C.F.R. §164.502(d), and the de-identified health information meets the standard and implementation specifications for de-identification under 45 C.F.R. §164.514(a) and (b).

4. Safeguards. Business Associate shall maintain appropriate safeguards to ensure that PHI is not used or disclosed other than as provided by this Agreement or as Required by Law. Business Associate shall comply with the Security Rule and implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any

Electronic PHI it creates, receives, maintains, or transmits on behalf of Covered Entity.

5. Minimum Necessary. Business Associate shall use reasonable efforts to limit uses, disclosures and requests for PHI, to the extent practicable, to a Limited Data Set (as defined in 45 C.F.R. § 164.514(e)(2)), or, if needed by Business Associate, to the minimum necessary to accomplish the intended purposes of such use, disclosure, or request, in accordance with the minimum necessary standards at 45 C.F.R. § 164.502(b), Section 13405(b) of HITECH, and any guidance issued by the Secretary.

6. Accounting of Disclosures. Business Associate agrees to maintain documentation of the information required to provide an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528, and to make this information available to Covered Entity upon Covered Entity's request, in order to allow Covered Entity to respond to an Individual's request for accounting of disclosures. Under the Privacy Rule, Covered Entity is required to take action on such requests as soon as possible but not later than sixty (60) days following receipt of the request. Business Associate agrees to use its best efforts to assist Covered Entity in meeting this deadline. Such accounting must be provided without cost to the individual or Covered Entity if it is the first accounting requested by an individual within any twelve (12) month period; however, a reasonable, cost-based fee may be charged for subsequent accountings if Business Associate informs the individual in advance of the fee and is afforded an opportunity to withdraw or modify the request. Such accounting is limited to disclosures that were made in the six (6) years prior to the request (not including disclosures prior to the compliance date of the Privacy Rule) and shall be provided for as long as Business Associate maintains the PHI. This Section shall survive termination of the Agreement.

7. Disclosure to Agents and Subcontractors. If Business Associate discloses PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, to agents, including a subcontractor, Business Associate shall require the agent or subcontractor to agree, in a writing that complies with the requirements of 45 C.F.R. § 164.504(e)(2) through (e)(4), to the same restrictions and conditions as apply to Business Associate under this Agreement. Business Associate shall ensure that any agent, including a subcontractor, agrees to comply with the applicable requirements of the Security Rule with respect to any Electronic PHI it creates, receives, maintains, or transmits on behalf of Covered Entity, including implementing reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of such electronic PHI. Business Associate shall be liable to Covered Entity for any acts, failures or omissions of the agent or subcontractor in providing the services as if they were Business Associate's own acts, failures or omissions, to the extent permitted by law. Business Associate further expressly warrants that its agents or subcontractors will be specifically advised of, and will comply in all respects with, the terms of this Agreement.

8. Individual Rights Regarding Designated Record Sets. If Business Associate maintains a Designated Record Set on behalf of Covered Entity Business Associate agrees as follows:

(a) Individual Right to Copy or Inspection. Business Associate agrees that if it maintains a Designated Record Set for Covered Entity that is not maintained by Covered Entity, it will permit an Individual to inspect or copy PHI about the Individual in that set in accordance with the requirements of 45 C.F.R. § 164.524. Under the Privacy Rule, Covered Entity is required to take action on such requests as soon as possible, but not later than thirty (30) days following receipt of the request. Business Associate agrees to make reasonable efforts to assist Covered Entity in meeting this deadline. The information shall be provided in the form or format requested if it is readily producible in such form or format, including an electronic copy of PHI maintained electronically in a Designated Record Set; or in summary, if the Individual has agreed in advance to accept the information in summary form. A reasonable, cost-based fee for copying health information may be charged.

(b) Individual Right to Amendment. Business Associate agrees, if it maintains PHI in a Designated Record Set, to make amendments to PHI at the request and direction of Covered Entity pursuant to 45 C.F.R. 164.526. If Business Associate maintains a record in a Designated Record Set that is not also maintained by Covered Entity, Business Associate agrees that it will accommodate an Individual's request to amend PHI only in conjunction with a determination by Covered Entity that the amendment is appropriate according to 45 C.F.R. § 164.526.

9. Restrictions on Uses and Disclosures. Business Associate shall comply with any communicated restrictions in the use or disclosure of PHI to which Covered Entity has agreed pursuant to 45 C.F.R. § 164.522, and shall further comply with any Individual's request for restrictions on PHI disclosures that Covered Entity or Business Associate is Required by Law to honor, including, without limitation, requests for restrictions on disclosures to a health plan if the disclosure is for payment or health care operations and pertains solely to a health care item or service for which the Individual (or someone other than the health plan on behalf of the individual) has paid Covered Entity in full, unless disclosure is otherwise Required by Law. Business Associate shall forward any request for restrictions by an Individual to Covered Entity within five (5) business days of such request. Covered Entity shall determine whether to grant or deny an Individual's request for restrictions.

10. Internal Practices, Policies and Procedures. Except as otherwise specified herein, Business Associate shall make available its internal practices, policies and procedures relating to the use and disclosure of PHI, received from or on behalf of Covered Entity to the Secretary or his or her agents for the purpose of determining Covered Entity's compliance with HIPAA, or any other health oversight agency,

or to Covered Entity. Records requested that are not protected by an applicable legal privilege will be made available in the time and manner specified by Covered Entity or the Secretary.

11. Notice of Privacy Practices. Business Associate shall abide by the limitations of Covered Entity's Notice of which it has knowledge. Any use or disclosure permitted by this Agreement may be amended by changes to Covered Entity's Notice; provided, however, that the amended Notice shall not affect permitted uses and disclosures on which Business Associate relied prior to receiving notice of such amended Notice.

12. Withdrawal of Authorization. If the use or disclosure of PHI in this Agreement is based upon an Individual's specific authorization for the use or disclosure of his or her PHI, and the Individual revokes such authorization, the effective date of such authorization has expired, or such authorization is found to be defective in any manner that renders it invalid, Business Associate shall, if it has notice of such revocation, expiration, or invalidity, cease the use and disclosure of the Individual's PHI except to the extent it has relied on such use or disclosure, or if an exception under the Privacy Rule expressly applies.

13. Knowledge of HIPAA. Business Associate agrees to review and understand HIPAA as it applies to Business Associate, and to comply with the applicable requirements of HIPAA and HITECH (including without limitation 45 C.F.R. §§ 164.306, .308, .310, .312, .314 and .316), as well as any applicable amendments.

14. Security Incident. Business Associate agrees immediately to report to the Covered Entity any security incident of which Business Associate becomes aware.

15. Securing PHI. Business Associate shall secure any and all Electronic PHI covered by this Agreement in accordance with the guidance issued by the Secretary entitled "Guidance Specifying the Technologies and Methodologies that Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals," as amended and updated from time to time. In addition, with respect to PHI covered by this Agreement, Business Associate shall comply with any guidance issued by the Secretary under the authority of HITECH Section 13401(c). Business Associate shall use best efforts to avoid the creation or storage of paper PHI.

16. Breach Notification.

    (a) Breach of Unsecured PHI. Business Associate shall implement a reasonable system for discovery of Breaches of Unsecured PHI. Business Associate shall notify Covered Entity of any and all Breaches of Unsecured PHI. A Breach shall be treated as discovered by Business Associate on the first day on which such Breach is known to Business Associate or, by exercising reasonable diligence, would have been known

to Business Associate. Business Associate is deemed to have knowledge of a Breach if the Breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach), who is an employee, officer or other agent of the Business Associate.

(b) Notification of Breach. Following the discovery of a Breach of Unsecured PHI, Business Entity shall initially notify Covered Entity without unreasonable delay and in no case later than three (3) calendar days after discovery of a breach.

(c) Content of Notice. Business Associate's initial notice to Covered Entity shall include (i) the identification of each Individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, used, or disclosed during the Breach; and (ii) any other available information that Covered Entity is required to include in the notification to the Individual under 45 C.F.R. § 164.404(c). To the extent Business Associate is not able to provide (i) and (ii) at the time of initial notification, Business Associate shall provide (i) and (ii) as soon as the information becomes available.

(d) Notice to Individuals and Media. In the event Business Associate discovers a Breach of Unsecured PHI, Covered Entity shall decide how and when the notification to Individuals and media shall be provided and shall approve the content of such notifications. At the request of Covered Entity and in Covered Entity's sole discretion, Business Associate shall provide the notification to Individuals and/or the media as directed by Covered Entity, and/or reimburse Covered Entity for the cost of notifying Individuals and/or the media.

(e) Reimbursement of Costs. To the extent any Breach of Unsecured Protected Health Information or security breach under applicable State privacy or information security laws is attributable to either: (i) a breach of the obligations under this Agreement by Business Associate or (ii) a violation of HIPAA or a State's privacy or information security laws, Business Associate shall bear (a) the costs incurred by Covered Entity in complying with its legal obligations relating to such breach or violation, and (b) in addition to other damages for which Business Associate may be liable for under this Agreement, the following expenses incurred by Covered Entity in responding to such breach: (1) the cost of preparing and distributing notifications to affected Individuals, (2) the cost of providing notice to government agencies, credit bureaus, and/or other required entities, (3) the cost of providing affected Individuals with credit monitoring services for a specific period not to exceed twenty-four (24) months, or longer if Required by Law, to the extent the incident could lead to a compromise of the data subject's credit or credit standing, (4) call center support for such affected Individuals for a specific period not to

exceed thirty (30) days from the date the breach notification is sent to such affected Individuals and (5) the cost of any other measures required under applicable law.

17. Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Breach of Unsecured PHI, Security Incident, or use or disclosure of PHI in violation of this Agreement or applicable state and federal law.

18. Performance of Covered Entity Obligations. To the extent this Agreement or the Underlying Agreement requires Business Associate to carry out any obligation of Covered Entity under the Privacy Rule, Business Associate agrees to comply with the same Privacy Rule requirements that would apply to Covered Entity in the performance of such obligation.

19. Privacy Provisions of HITECH. Business Associate acknowledges and agrees that under the express statutory language of HITECH, the privacy provisions of HITECH are directly applicable to Business Associate; accordingly, such provisions are herein incorporated into this Agreement. Business Associate represents and warrants that it is compliance with such provisions now in effect and will come into compliance with the rest of such provisions as they take effect.

C. Term and Termination.

1. Term. This Agreement shall be effective as of the Effective Date and shall be terminated when all PHI provided to Business Associate by Covered Entity, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, the terms of this Agreement are extended to cover such information in accordance with the termination provisions in this Section C.

2. Termination for Breach. If Business Associate breaches any provision in this Agreement, Covered Entity may, at its option, access and audit the records of Business Associate related to its use and disclosure of PHI, require Business Associate to submit to monitoring and reporting, and such other conditions as Covered Entity may determine is necessary to ensure compliance with this Agreement, or Covered Entity may terminate this Agreement on a date specified by Covered Entity.

3. Effect of Termination. Upon termination of this Agreement for any reason, Business Associate agrees to return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, maintained by Business Associate in any form. If Business Associate determines that the return or destruction of PHI is not feasible, Business Associate shall inform Covered Entity in writing of the reason thereof, and shall agree to extend the protections of this Agreement to such PHI and limit further uses and

disclosures of the PHI to those purposes that make the return or destruction of the PHI not feasible for so long as Business Associate retains the PHI.

D. Miscellaneous.

1. Indemnification. To the extent permitted by law, Business Associate agrees to indemnify and hold harmless Covered Entity from and against all claims, demands, liabilities, judgments or causes of action of any nature for any relief, elements of recovery or damages recognized by law (including, without limitation, attorney's fees, defense costs, and equitable relief), for any damage or loss incurred by Covered Entity arising out of, resulting from, or attributable to any acts or omissions or other conduct of Business Associate or its agents or subcontractors in connection with the performance of Business Associate's or its agents' or subcontractors' duties under this Agreement. This indemnity shall apply even if Covered Entity is alleged to be solely or jointly negligent or otherwise solely or jointly at fault; provided, however, that a trier of fact finds Covered Entity not to be solely or jointly negligent or otherwise solely or jointly at fault. This indemnity shall not be construed to limit Covered Entity's rights, if any, to common law indemnity.

   Covered Entity shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of Business Associate. Covered Entity shall provide Business Associate with timely notice of the existence of such proceedings and such information, documents and other cooperation as reasonably necessary to assist Business Associate in establishing a defense to such action.

   These indemnities shall survive termination of this Agreement, and Covered Entity reserves the right, at its option and expense, to participate in the defense of any suit or proceeding through counsel of its own choosing.

2. Mitigation. If Business Associate violates this Agreement or HIPAA, Business Associate agrees to mitigate any damage caused by such violation.

3. Rights of Proprietary Information. Covered Entity retains any and all rights to the proprietary information, confidential information, and PHI it releases to Business Associate.

4. Disclaimer. PHI IS PROVIDED TO BUSINESS ASSOCIATE SOLELY ON AN "AS IS" BASIS. COVERED ENTITY DISCLAIMS ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, IMPLIED WARRANTIES OF MERCHANTABILITY, NON-INFRINGEMENT AND FITNESS FOR A PARTICULAR PURPOSE.

5. Survival. The respective rights and obligations of Business Associate under Section C.3 of this Agreement shall survive the termination of this Agreement.

6. Notices. Any notices pertaining to this Agreement shall be given in writing and shall be deemed duly given when personally delivered to a Party or a Party's authorized representative as listed below or sent by means of a reputable overnight carrier, or sent by means of certified mail, return receipt requested, postage prepaid. A notice sent by certified mail shall be deemed given on the date of receipt or refusal of receipt. All notices shall be addressed to the appropriate Party as follows:

If to Covered Entity:
Cumberland Behavioral Health, LLC
c/o Saint Thomas Health
102 Woodmont Blvd., Ste. 800
Nashville, TN 37205
Attn: General Counsel

If to Business Associate:
Acadia Management Company, LLC
c/o Acadia Healthcare Company, Inc.
6100 Tower Circle
Suite 1000
Franklin, TN 37067
Attn: General Counsel

7. Amendments. This Agreement may not be changed or modified in any manner except by an instrument in writing signed by a duly authorized officer of each of the Parties hereto; provided however, that Covered Entity may amend this Agreement from time to time as necessary, to comply with changes in applicable laws or regulations, including without limitation HIPAA, by providing thirty (30) days' written notice to Business Associate.

8. Choice of Law. This Agreement and the rights and the obligations of the Parties hereunder shall be governed by and construed under the laws of the State of Delaware, without regard to applicable conflict of laws principles.

9. Assignment of Rights and Delegation of Duties. This Agreement is binding upon and inures to the benefit of the Parties hereto and their respective successors and permitted assigns. However, neither Party may assign any of its rights or delegate any of its obligations under this Agreement without the prior written consent of the other Party, which consent shall not be unreasonably withheld or delayed. Notwithstanding any provisions to the contrary, however, Covered Entity retains the right to assign or delegate any of its rights or obligations hereunder to any of its wholly owned subsidiaries, affiliates or successor companies. Assignments made in violation of this provision are null and void.

10. Relationship of Parties. Unless otherwise set forth in a separate agreement between Covered Entity and Business Associate, Business Associate's relationship with Covered Entity will be that of an independent contractor and

Business Associate is not the agent of Covered Entity and is not authorized to make any representation, contract, or commitment on behalf of Covered Entity unless specifically requested to do so, by Covered Entity, in writing. Nothing in this Agreement should be construed to create a partnership, joint venture, or employer-employee relationship between the parties.

11. No Waiver. Failure or delay on the part of either Party to exercise any right, power, privilege or remedy hereunder shall not constitute a waiver thereof. No provision of this Agreement may be waived by either Party except by a writing signed by an authorized representative of the Party making the waiver.

12. Equitable Relief. Any disclosure or misappropriation of PHI by Business Associate in violation of this Agreement will cause Covered Entity irreparable harm, the amount of which may be difficult to ascertain. Business Associate therefore agrees that Covered Entity shall have the right to apply to a court of competent jurisdiction for specific performance and/or an order restraining and enjoining Business Associate from any such further disclosure or breach, and for such other relief as Covered Entity shall deem appropriate. Such rights are in addition to any other remedies available to Covered Entity at law or in equity. Business Associate expressly waives the defense that a remedy in damages will be adequate, and further waives any requirement in an action for specific performance or injunction for the posting of a bond by Covered Entity.

13. Severability. The provisions of this Agreement shall be severable, and if any provision of this Agreement shall be held or declared to be illegal, invalid or unenforceable, the remainder of this Agreement shall continue in full force and effect as though such illegal, invalid or unenforceable provision had not been contained herein.

14. No Third Party Beneficiaries. Nothing in this Agreement shall be considered or construed as conferring any right or benefit on a person not party to this Agreement nor imposing any obligations on either Party hereto to persons not a party to this Agreement.

15. Headings. The descriptive headings of the articles, sections, subsections, exhibits and schedules of this Agreement are inserted for convenience only, do not constitute a part of this Agreement and shall not affect in any way the meaning or interpretation of this Agreement.

16. Entire Agreement. This Agreement, together with all Exhibits, Riders and amendments, if applicable, which are fully completed and signed by authorized persons on behalf of both Parties from time to time while this Agreement is in effect, constitutes the entire Agreement between the Parties hereto with respect to the subject matter hereof and supersedes all previous written or oral understandings, agreements, negotiations, commitments, and any other writing and communication by or between the Parties with respect to the subject matter hereof. In the event of any inconsistencies between any provisions of this

Agreement in any provisions of the Exhibits, Riders, or amendments, the provisions of this Agreement shall control.

17. Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with HIPAA and any applicable federal or state confidentiality or security laws. The provisions of this Agreement shall prevail over the provisions of any other agreement that exists between the Parties that may conflict with, or appear inconsistent with, any provision of this Agreement or HIPAA.

18. Regulatory References. A citation in this Agreement to the Code of Federal Regulations (C.F.R.) shall mean the cited section as that section may be amended from time to time.

[Signature page follows]

IN WITNESS WHEREOF, the Parties enter into this Agreement as of the Effective Date.

BUSINESS ASSOCIATE:

ACADIA MANAGEMENT COMPANY, LLC

By: _____
(Authorized Signature)

Name: Christopher Howard
(Type or Print)

Title: VP & Secretary

COVERED ENTITY:

CUMBERLAND BEHAVIORAL HEALTH, LLC

By: _____
(Authorized Signature)

Name: Christopher Howard
(Type or Print)

Title: VP & Secretary

[Signature page to the Business Associate Agreement]

PURCHASE AND SALE AGREEMENT

THIS PURCHASE AND SALE AGREEMENT (this "Agreement") is entered into as of this ___ day of March, 2017 (the "Effective Date"), by and between SEV METROCENTER IV, LLC, a Tennessee limited liability company ("Seller"), and ACADIA HEALTHCARE COMPANY, INC., a Delaware corporation, its successors and permitted assigns ("Buyer").

RECITALS

WHEREAS, the parties desire to enter into this Agreement pursuant to which Buyer will purchase the Property (as hereinafter defined) on the terms and conditions contained in this Agreement.

NOW, THEREFORE, in consideration of the promises and mutual agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto do hereby agree as follows:

ARTICLE 1
PURCHASE AND SALE OF PROPERTY

1.1 Purchase and Sale. Subject to the terms and provisions hereof, Seller agrees to sell to Buyer, and Buyer agrees to purchase from Seller, upon the terms and conditions of this Agreement:

1.1.1 Fee simple title in and to the land identified and described on **Exhibit A**, together with all rights and appurtenances pertaining to such land, including Seller's respective right, title and interest, if any, in and to the following: (i) all minerals, water, oil, gas and other hydrocarbon substances thereon; (ii) all adjacent strips, streets, roads, alleys and rights-of-way, public or private, open or proposed; (iii) all easements, privileges, development rights and hereditaments, whether or not of record; and (iv) all access, air, water, riparian, solar and utility rights and wastewater, fresh water, storm sewer or other utilities capacity or service commitments and allocations, and all other rights and benefits running with such land and any and all other real property rights owned by the owner of such land (the "Land"); and;

1.1.2 All right, title and interest of Seller in and to all use, occupancy, utility connections, permits, approvals, and development rights relating to the Land (collectively, the "Permits");

1.1.3 The Land, Permits, and all other property described in this Section 1.1 are hereinafter sometimes referred to collectively as the "Property."

1.2 Purchase and Sale. Buyer agrees to purchase from Seller, and Seller agrees to sell to Buyer, all of Seller's interest in and to the Property, on the terms and conditions set forth in this Agreement.

1.3 Purchase Price. The purchase price to be paid by Buyer to Seller for the Property (the "Purchase Price") at Closing is Three Million Nine Hundred Ninety Seven Thousand Sixty Five and 60/100 Dollars ($3,997,065.60), subject to the prorations and adjustments set forth herein.

1.4 Deposit And Escrow.

1.4.1 Within three (3) Business Days (as defined below) after the Effective Date, Buyer shall deliver to Old Republic Title Insurance Company (the "Title Company"), Attn: Kirk Moser, 201 Forth Avenue North, Suite 150, Nashville, TN 37219 ("Escrow Agent"), a deposit in the amount of Seventy-Five Thousand and No/100 Dollars ($75,000.00) (the "Initial Deposit"). At Buyer's option, the

Deposit (as defined below) shall be held in an insured, interest-bearing account with interest accruing for the benefit of Buyer. For purposes of this Agreement the term "Deposit" shall include the Initial Deposit and any Extension Deposit (as defined below), together with any and all interest earned thereon.

1.4.2 The Deposit shall be applied to the Purchase Price if the Closing (as defined below) occurs. Except as hereinafter set forth, (a) the Initial Deposit shall become non-refundable at the expiration of the Due Diligence Period and (b) each Extension Deposit shall be non-refundable at the time it is delivered to the Escrow Agent pursuant to Section 3.4. The Initial Deposit shall not be returned to Buyer unless Closing fails to occur due to (i) Buyer's termination of this Agreement during the Due Diligence Period as permitted in this Agreement; (ii) Seller's breach or default under this Agreement, (iii) a failure of a representation or warranty by Seller to be true and correct in all material respects as of the Closing, or (iv) a failure of a condition precedent set forth in Section 5.2. No Extension Deposit shall be returned to Buyer unless Closing fails to occur due to (i) Seller's breach or default under this Agreement, (ii) a failure of a representation or warranty by Seller to be true and correct in all material respects as of the Closing, or (iii) a failure of a condition precedent set forth in Section 5.2. In the event Buyer shall elect to terminate this Agreement during the Due Diligence Period, the Approvals Period (as extended from time to time) or as otherwise provided in this Agreement, the Initial Deposit and each Extension Deposit, as applicable, shall be returned to Buyer or paid to Seller as provided in Section 3.5 below.

1.5 Closing Date. The closing ("Closing") means the date on which Seller transfers its interest in the Property to Buyer pursuant to the Deed (as defined below) and shall take place in a location and on a day which is mutually agreeable to Buyer and Seller on the later to occur of (i) the date that is thirty (30) days following the expiration of the Approvals Period (as defined below, and as it may be extended from time to time), and (ii) the date of satisfaction or waiver of the conditions precedent in Sections 5.2 and 5.3 below (the later to occur of (i) and (ii) being known herein as the "Closing Date").

ARTICLE 2
TITLE AND SURVEY

2.1 Title and Survey. Buyer shall obtain a preliminary title report or commitment from the Title Company (the "Preliminary Report") for the Land, together with legible copies of all recorded encumbrances and exceptions to title (the "Exception Documents"). Buyer may, at its option and expense, order an ALTA survey of the Land prepared by a licensed surveyor or registered professional engineer (the "Survey"). Buyer shall promptly deliver to the Seller without charge to the Seller copies of the Preliminary Report, the Exception Documents and the Survey.

2.2 Required Title Condition. Title to the Property shall be conveyed to Buyer subject only to the following matters: (i) current, non-delinquent real estate taxes and assessments, (ii) the matters set forth in the Preliminary Report and permitted by Buyer, in Buyer's sole and absolute discretion, as part of the Title Policy (as defined below), and (iii) any other matters approved in writing by Buyer in Buyer's sole and absolute discretion (collectively, the "Required Title Condition"). Buyer shall have the option to object to matters shown on the Preliminary Report and/or the Survey by providing written notice to Seller of any such objections ("Buyer's Objection Notice") prior to the expiration of the Due Diligence Period. Any exception to which Buyer does not timely give notice of objection within the time period set forth above (excluding the monetary encumbrances described above which must be paid and discharged at Closing) shall be deemed a title exception permitted by Buyer and shall become a part of the Required Title Condition. Seller shall respond to any such notice within ten (10) days of receipt thereof ("Seller Response Period") to indicate whether Seller elects to cure or remove any such objections, and, if so, to identify any such proposed curative measures. If Seller either (a) does not respond within the Seller Response Period, or (b) does not cure (or cause to be cured) or agree to cure at or prior to Closing Buyer's

objections to Buyer's reasonable satisfaction, within fifteen (15) days after Seller's receipt of the Buyer's Objection Notice (the "Objection Cure Period"), Buyer may at any time thereafter terminate this Agreement and receive a refund of the Deposit. If Seller elects to cure or remove any such objections, it shall become a condition to Closing hereunder that Seller cure or remove any applicable objections in the manner specified in Seller's response, the failure of which shall entitle Buyer to terminate this Agreement and receive a refund of the Deposit. Notwithstanding anything contained in this Section 2.2 to the contrary, Seller shall be obligated, at its sole cost and expense, to satisfy at or prior to Closing all monetary encumbrances affecting the Property not occasioned by Buyer's acts or omissions evidenced by deeds of trust, tax liens, judgments, mechanics' liens, or other liens or charges in a fixed sum, and Seller authorizes the use of the Purchase Price or a portion thereof to pay and discharge the same at Closing.

2.3 Restrictions and Project Review Committee. Buyer hereby acknowledges that the Property is subject to certain declarations, covenants and restrictions of record in the Register's Office for Davidson County, Tennessee (collectively, the "Restrictions"). Buyer acknowledges that the Restrictions provide for a Project Review Committee which regulates and administers construction and development in MetroCenter, and Buyer covenants and agrees to comply with all of the terms and provisions of all rules, regulations and requirements of the Project Review Committee with respect to all improvements undertaken by or on behalf of the Buyer. It is expressly understood and agreed that the approval of plans by the Project Review Committee shall not entitle the Buyer to rely thereon with respect to conformity of laws, regulations, codes, or ordinances or with respect to the physical condition of the Property, and Buyer hereby waives any claims, demands or causes of action growing out of any plan approvals by the Project Review Committee. Prior to the commencement of construction on the Property, Buyer agrees to furnish to the Project Review Committee pursuant to the Restrictions, for review and approval, duplicate copies of the following: (i) final exterior building and landscape plans, including but not limited to all working drawings for landscaping, architectural, signage and trash collection (Seller and Buyer hereby expressly agree, acknowledge and understand that the phrase "final exterior building plans" includes any plans, interior, exterior or otherwise which affect, or may have an effect on the exterior of any buildings constructed on the Property, and the Project Review Committee, in reviewing and approving such final exterior building plans in no way is limited in its ability to review and approve such other plans, drawings or specifications); (ii) storm water drainage plans showing that drainage is under control and including the location of sediment ponds; (iii) a grading plan if not included in the storm water drainage plan or if different therefrom; and (iv) water and sanitary sewer plans. The Project Review Committee shall have the right to enter upon the Property in accordance with the provisions of the Restrictions for the purpose of determining Buyer's compliance with the provisions of this Section. After thirty (30) days prior written notice of noncompliance, provided such noncompliance has not been fully remedied to the Project Review Committee's reasonable satisfaction within said thirty (30) day period, the Project Review Committee may enter upon the Property and perform such work or other duties as may be reasonably necessary to remedy the condition in question and the cost of such work shall be paid by Buyer to the Project Review Committee together with interest at the highest legal rate of interest permitted under Tennessee law. The terms and provisions of this Section shall survive the Closing and shall not merge therein and may, at Seller's option, be included in the Deed.

ARTICLE 3
INSPECTION, DUE DILIGENCE PERIOD, AND APPROVALS PERIOD

3.1 Inspection. From and after the Effective Date through the Closing, Buyer and its authorized agents or representatives shall be entitled to make such investigations, including appraisals, interviews of government officials, engineering studies, soil tests, environmental studies and underwriting analyses, as Buyer deems necessary or advisable; provided, however, Buyer shall not conduct any so-called "Phase II" environmental assessment of the Property or other invasive or intrusive environmental inspection or

testing of the Property without Seller's written consent, which consent may be withheld in Seller's sole discretion. Buyer shall provide Seller with reasonable advance notice of all inspection activities, and Seller shall ensure that Buyer has access to the Property. Prior to any inspection by Buyer or its agents or representatives, Buyer shall provide Seller with a certificate of general liability insurance sufficient to insure matters that may arise from Buyer's inspection of the Property and listing Seller as an additional insured party. Buyer shall remove or bond any lien which attaches to the Property or any part thereof by virtue of Buyer's inspection. Buyer hereby agrees to indemnify and hold Seller (and Seller's agents, advisors, partners, members, owners, officers and directors, as the case may be) harmless from any physical damage arising out of all inspections and investigations by Buyer or its agents or independent contractors, but in no event shall the indemnity of this Section 3.1 include the discovery of pre-existing conditions disclosed by Buyer's investigations. Notwithstanding any other provision in this Agreement to the contrary, this indemnification shall survive the termination of or Closing under this Agreement. In the event Buyer terminates this Agreement for any reason other than a Seller default, Buyer shall promptly deliver to the Seller without charge to the Seller copies of any third-party tests, investigations and studies commissioned by the Buyer in respect of the Property.

3.2 Due Diligence Period. Buyer shall have from the Effective Date until the later of (a) the date occurring not less than ninety (90) days from the Effective Date that Seller satisfies its obligations set forth in Section 4.5.6 and Section 4.5.7 or (b) one hundred twenty (120) days from the Effective Date of this Agreement (such period being the "Due Diligence Period") to physically inspect the Property, review the economic data, conduct appraisals, examine the Property for the presence of Hazardous Materials (as defined below), and to otherwise conduct such due diligence review of the Property and all of the items to be furnished by Seller to Buyer pursuant to Section 3.3 below, and all records and other materials related thereto as Buyer deems appropriate.

3.3 Items to be Provided by Seller. To the extent not previously provided, then no later than ten (10) days after the Effective Date, Seller and its agents shall deliver to Buyer accurate and complete copies of all of the information set forth on Exhibit B to the extent such information is in Seller's possession or control (collectively, the "Property Information"), or alternatively, Seller or its agents shall affirmatively state that the Seller or its agents are not in possession of such Property Information.

3.4 Approvals Period. Provided that Buyer has not terminated this Agreement during the Due Diligence Period, Buyer shall have until the date that is Two Hundred Forty (240) days following the expiration of the Due Diligence Period (the "Approvals Period") to obtain a certificate of need required for Buyer to construct and operate certain improvements on the Property for Buyer's intended use (the "CON"). The CON shall not be deemed obtained until it is issued in "final" form and not subject to appeal by any third party. Buyer may elect to extend the Approvals Period for Three (3) successive periods of Thirty (30) days each (each, an "Approvals Extension") by notifying Seller of such election prior to the expiration of the Approvals Period, or the then-current Approvals Extension, as applicable, and delivering to Escrow Agent an additional escrow deposit equal to Fifteen Thousand and No/100 Dollars ($15,000.00) (each an "Extension Deposit") at or prior to notifying Seller of such election.

3.5 Buyer's Possible Termination.

(a) At any time before expiration of the Due Diligence Period, Buyer may provide a "Termination Notice" to Seller if Buyer elects to terminate the Agreement for any reason or no reason at all. If Buyer timely provides a Termination Notice to Seller, this Agreement shall immediately terminate, and the parties shall be released from all further obligations under this Agreement (except with respect to any provisions that by their terms survive a termination of this Agreement). Subject to the terms of this Agreement, upon termination pursuant to a Termination Notice, the Escrow Agent shall pay the entire

Initial Deposit to Buyer not later than one (1) Business Day following termination of this Agreement. No notice to Escrow Agent from Seller shall be required for the release of the Initial Deposit by Escrow Agent under this Section 3.5(a), and the Initial Deposit shall be released and delivered to Buyer upon Escrow Agent's receipt of Buyer's confirmation of termination of the Agreement pursuant to this Section 3.5(a).

(b) At any time before expiration of the Approvals Period (as such period may be extended), Buyer may provide a "CON Termination Notice" to Seller if Buyer, in its sole discretion, determines that Buyer is unable to obtain the CON. If Buyer timely provides a CON Termination Notice to Seller, this Agreement shall immediately terminate, and the parties shall be released from all further obligations under this Agreement (except with respect to any provisions that by their terms survive a termination of this Agreement). Subject to the terms of this Agreement, upon termination pursuant to a CON Termination Notice, the Escrow Agent shall pay the entire Deposit to Seller not later than one (1) Business Day following termination of this Agreement. The Deposit shall be released and delivered to Seller upon Escrow Agent's receipt of Buyer's confirmation of termination of the Agreement pursuant to this Section 3.5(b).

ARTICLE 4
REPRESENTATIONS, WARRANTIES AND COVENANTS

4.1 Seller's Representations. Except as otherwise disclosed in writing to Buyer, Seller represents and warrants to Buyer as follows:

4.1.1 Seller is duly formed and validly existing in good standing under the laws of the state of its organization. Seller has full power and authority to enter into this Agreement, to perform its obligations under this Agreement and to consummate the transactions contemplated hereby. The execution, delivery and performance of this Agreement and all documents contemplated hereby by Seller has been duly and validly authorized by all necessary action on the part of Seller and all required consents and approvals have been duly obtained and will not result in a breach of any of the terms or provisions of, or constitute a default under any indenture, agreement or instrument to which Seller is a party. This Agreement is a legal, valid and binding obligation of Seller, enforceable against Seller in accordance with its terms, subject to the effect of applicable bankruptcy, insolvency, reorganization, arrangement, moratorium or other similar laws affecting the rights of creditors generally.

4.1.2 Seller has good and marketable title to the Property, subject only to the conditions of title set forth in the Preliminary Report. There are no outstanding rights of first refusal, rights of reverter or options to purchase relating to the Property or any interest therein. There are no unrecorded or undisclosed documents or other matters which affect title to the Property.

4.1.3 Seller is not a "foreign person" within the meaning of Section 1445(f) of the Internal Revenue Code of 1986, as amended (the "Code").

4.1.4 Neither Seller nor any of its members is, nor will they become, a person or entity with whom United States persons or entities are restricted from doing business under regulations of the Office of Foreign Asset Control ("OFAC") of the Department of the Treasury (including those named on OFAC's Specially Designated and Blocked Persons List) or under any statute, executive order (including, without limitation, the September 24, 2001, Executive Order Blocking Property and Prohibiting Transactions with Persons Who Commit, Threaten to Commit, or Support Terrorism), or other governmental action, and is not and will not engage in any dealings or transactions or be otherwise associated with such persons or entities.

4.1.5 Except as expressly provided in Section 4.5.6 and Section 4.5.7, no authorization, consent, or approval of any governmental authority (including courts) is required for the execution and delivery by Seller of this Agreement or the performance of its obligations hereunder.

4.1.6 There are no actions, suits or proceedings pending, or, to Seller's Knowledge, threatened against (i) any portion of the Property, or (ii) affecting Seller. There is no pending, or, to Seller's Knowledge, threatened or contemplated, condemnation proceeding relating to the Property, and Seller has received no notice from any governmental agency or official to the effect that any such proceeding is contemplated.

4.1.7 Seller has not (i) made a general assignment for the benefit of creditors, (ii) filed any voluntary petition in bankruptcy or suffered the filing of an involuntary petition by Seller's creditors, (iii) suffered the appointment of a receiver to take possession of all or substantially all of Seller's assets, (iv) suffered the attachment or other judicial seizure of all, or substantially all, of Seller's assets, (v) admitted in writing its inability to pay its debts as they come due, or (vi) made an offer of settlement, extension or composition to its creditors generally.

4.1.8 Neither the execution, delivery or performance of this Agreement by Seller nor compliance herewith (i) conflicts or will conflict with or results or will result in a breach of or constitutes or will constitute a default under any law or any order, writ, injunction or decree of any court or governmental authority, or (ii) results in the creation or imposition of any lien, charge or encumbrance upon its property pursuant to any such agreement or instrument.

4.1.9 Seller has not entered into any material commitments or agreements with any governmental authorities or agencies affecting the Property except as provided in the Property Information or the Exception Documents.

4.1.10 There are no service, supply, and similar contracts or leases to which Seller is a party related to the ownership, operation, maintenance, repair or management of the Property ("Service Contracts").

4.1.11 Seller has not received any written notice from, and to Seller's Knowledge there are no grounds for, any governmental agency requiring the correction of any condition with respect to the Property, or any part thereof, by reason of a violation of any applicable federal, state, county or municipal law, code, rule or regulation (including those respecting the Americans With Disabilities Act), which has not been cured or waived. Seller has not received any written notice of an intention to revoke any certificate of occupancy, license, or permit issued in connection with the Property.

4.1.12 To Seller's Knowledge, there are no Hazardous Materials stored on, incorporated into, located on, present in or used at the Property in violation of, and requiring remediation under, any laws, ordinances, statutes, codes, rules or regulations as of the date of this Agreement or, upon the date of Closing. For purposes of this Agreement, the term "Hazardous Materials" shall mean any substance which is or contains: (i) any "hazardous substance" as now or hereafter defined in Section 101(14) of the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended (42 U.S.C. Section 9601 et seq.) ("CERCLA") or any regulations promulgated under CERCLA; (ii) any "hazardous waste" as now or hereafter defined in the Recourse Conservation and Recovery Act (42 U.S.C. Section 6901 et seq.) ("RCRA") or regulations promulgated under RCRA; (iii) any substance regulated by the Toxic Substances Control Act (15 U.S.C. Section 2601 et. seq.); (iv) gasoline, diesel fuel or other petroleum hydrocarbons; (v) asbestos and asbestos containing materials, in any form, whether friable or non-friable; (vi) polychlorinated biphenyls; (vii) radon gas; and (viii) any

additional substances or materials which are now or hereafter classified or considered to be hazardous or toxic under any laws, ordinances, statutes, codes, rules, regulations, agreements, judgments, orders and decrees now or hereafter enacted, promulgated, or amended, of the United States, the state, the county, the city or any other political subdivision in which the Property is located and any other political subdivision, agency or instrumentality exercising jurisdiction over the owner of the Property, or the use of the Property relating to pollution, the protection or regulation of human health, natural resources or the environment, or the emission, discharge, release or threatened release of pollutants, contaminants, chemicals or industrial, toxic or hazardous substances or waste into the environment (including, without limitation, ambient air, surface water, ground water or land or soil).

4.1.13 To Seller's Knowledge, there are no claims pending or unpaid bills which would result in the creation of any lien on the Property for any improvements completed or in progress, including, but not limited to, water, sewage, street paving, electrical or power improvements.

4.1.14 All information given by Seller to Buyer in this Agreement or in connection with the transactions contemplated hereunder shall be true and correct in all material respects as of the date hereof and at the time of Closing. Seller has not failed to disclose any fact to Buyer necessary to make the statements herein or otherwise provided in connection with the transactions contemplated hereunder not misleading in any material respect. To Seller's Knowledge, there are no facts, circumstances, or conditions that are inconsistent with the representations and warranties contained herein. Seller shall promptly inform Buyer in writing if there occurs any (i) material adverse change in the condition, financial or otherwise, of the Property, or the operation thereof, at any time prior to Closing or (ii) if any information, document, agreement or other material delivered to Buyer is amended, superseded, modified or supplemented.

As used herein, "Seller's Knowledge" shall mean, and be limited to, the actual knowledge of the members, as of the Effective Date, of Southeast Venture, LLC, the managing member of the Seller.

4.2 Buyer's Representations. Buyer represents and warrants to Seller as follows:

4.2.1 Buyer is a duly formed and validly existing corporation in good standing under the laws of the state of its organization.

4.2.2 Buyer has full power and authority to enter into this Agreement, to perform its obligations under this Agreement and to consummate the transactions contemplated hereby. The execution, delivery and performance of this Agreement and all documents contemplated hereby by Buyer has or will be duly and validly authorized by all necessary action on the part of Buyer and all required consents and approvals have or will be duly obtained and will not result in a breach of any of the terms or provisions of, or constitute a default under any indenture, agreement or instrument to which Buyer is a party. This Agreement is a legal, valid and binding obligation of Buyer, enforceable against Buyer in accordance with its terms, subject to the effect of applicable bankruptcy, insolvency, reorganization, arrangement, moratorium or other similar laws affecting the rights of creditors generally.

4.3 Survivability of Representations and Warranties. The representations and warranties of Seller and Buyer set forth in this Agreement are remade as of the Closing Date, shall not be deemed to be merged into or waived by the instruments of Closing and shall survive the Closing for a period of twelve (12) months.

4.4 Property Conveyed "As Is". Except as may be expressly represented herein, in the exhibits attached hereto and in the documents to be executed and delivered by Seller to Buyer at Closing, Buyer

agrees that the Property shall be sold, and Buyer shall accept possession of the Property at Closing on an "as-is-where-is" basis.

4.5 Leasing & Other Activities Prior to Closing.

4.5.1 Leasing Activities. Seller shall not, after the Effective Date, enter into any lease affecting the Property, without the prior written consent of Buyer, which may be given or withheld in Buyer's sole discretion.

4.5.2 Service Contracts. Seller shall not, after the Effective Date, enter into any new contracts for the Property, including without limitation any Service Contracts, without the written consent of Buyer, which consent may be given or withheld in Buyer's sole discretion.

4.5.3 Conducting Business. At all times prior to Closing, Seller shall continue to (i) conduct business with respect to the Property in the same manner in which said business has been heretofore conducted and (ii) insure the Property substantially as it is currently insured and in any event in commercially reasonable amounts and in accordance with the requirements of any mortgage or deed of trust affecting the Property.

4.5.4 Encumbrances. At all times prior to Closing, Seller shall not sell, mortgage, pledge, encumber, hypothecate or otherwise transfer or dispose of all or any part of the Property or any interest therein without the prior written consent of Buyer, which may be given or withheld in Buyer's sole discretion; and, except as expressly provided for in this Agreement, Seller shall not consent to, approve or otherwise take any action with respect to zoning or any other governmental rules or regulations presently applicable to all or any part of the Property without the prior written consent of Buyer, which may be given or withheld in Buyer's sole discretion.

4.5.5 Compliance with Laws and Regulations. At all times prior to Closing, Seller shall not knowingly take any action that would result in a failure to comply in all material respects with all applicable statutes, rules, regulations and requirements of all federal, state and local commissions, boards, bureaus and agencies applicable to the Property, it being understood and agreed that prior to Closing, Seller will have the right to contest any of the same.

4.5.6 Zoning. During the Due Diligence Period, Seller shall obtain all necessary government approvals in order to change the current zoning on the Property from "IWD - Industrial Warehousing/Distribution" to "MUG - Mixed-Use General", as defined in the Code of the Metropolitan Government of Nashville and Davidson County, Tennessee.

4.5.7 Hydrological Determination. During the Due Diligence Period, Seller shall obtain at its cost and provide to Buyer a Hydrologic Determination from The Division of Water Resources of the Tennessee Department of Environment and Conservation which permits the relocation of the current drainage feature located on the Property.

4.6 Indemnifications.

4.6.1 Seller Indemnity. In addition to any other applicable rights under this Agreement, Seller agrees to indemnify, defend and hold Buyer and its officers, directors, partners, members, agents, employees, affiliates, attorneys, heirs, successors and assigns (collectively, "Buyer's Indemnified Parties") harmless from and against any and all liabilities, liens, claims, damages, costs, expenses, suits or judgments paid or incurred by any of Buyer's Indemnified Parties and all expenses related thereto,

including, without limitation, court costs and reasonable attorneys' fees arising out of or in any way connected or related to (i) Seller's ownership, maintenance, or operation of the Property and accruing prior to Closing, (ii) any breach or nonperformance by Seller of any provision or covenant contained in this Agreement or in any certificate or other instrument or document furnished (or to be furnished) by Seller with respect to the transactions contemplated hereunder, (iii) any liability arising because of a breach of lease, breach of contract or other matter related to the Property which occurred or arose or is alleged to have occurred or arisen prior to Closing and which is not due to actions taken by Buyer, or (iv) the breach of any representation or warranty of Seller contained in this Agreement. The indemnities set forth in this Section shall survive Closing for a period of twelve (12) months after Closing or the earlier termination of this Agreement.

4.6.2 Buyer Indemnity. In addition to any other applicable rights under this Agreement, Buyer agrees to indemnify, defend and hold Seller and its officers, directors, partners, members, agents, employees, affiliates, attorneys, heirs, successors and assigns (collectively, "Seller's Indemnified Parties") harmless from and against any and all liabilities, liens, claims, damages, costs, expenses, suits or judgments paid or incurred by any of Seller's Indemnified Parties and all expenses related thereto, including, without limitation, court costs and reasonable attorneys' fees arising out of or in any way connected or related to (i) the ownership, maintenance, or operation of the Property and arising from events or conditions that occur entirely after the Closing, (ii) any breach or nonperformance by Buyer of any provision or covenant contained in this Agreement or in any certificate or other instrument or document furnished (or to be furnished) by Buyer with respect to the transactions contemplated hereunder, (iii) any liability arising because of a breach of lease, breach of contract or other matter related to the Property which occurred or is alleged to have occurred after Closing and which is not due to actions taken by Seller, or (iv) the breach of any representation, warranty or covenant of Buyer contained in this Agreement. The indemnities set forth in this Section shall survive Closing for a period of twelve (12) months after Closing or the earlier termination of this Agreement.

ARTICLE 5
CLOSING

5.1 Closing. The Closing shall take place in a location mutually agreeable to Buyer and Seller on the Closing Date set forth in Section 1.5, as the same may be adjusted, provided all conditions to the Closing have been satisfied or duly waived.

5.2 Conditions Precedent Favoring Buyer. In addition to any other conditions precedent in favor of Buyer as may be expressly set forth elsewhere in this Agreement, Buyer's obligations under this Agreement are subject to the timely fulfillment of the conditions set forth in this Section 5.2 on or before the Closing Date, or such earlier date as is set forth below. Each condition may be waived in whole or in part only, by written notice of such waiver from Buyer to Seller.

5.2.1 Seller shall have performed and complied in all material respects with all of the terms of this Agreement to be performed and complied with by Seller prior to or at the Closing, including, without limitation Seller's obligations in Section 4.5.6 and Section 4.5.7 above.

5.2.2 On the Closing Date, all of the representations and warranties of Seller set forth in Section 4 hereof shall be true and correct in all material respects.

5.2.3 At Closing, the Title Company shall issue, or be prepared to issue, to Buyer a current ALTA form extended coverage Owner's Policy of Title Insurance ("Title Policy") insuring Buyer's fee simple interest in the Land for the sum equal to the Purchase Price conforming to the

Required Title Condition set forth in Section 2.2 above and containing such endorsements as Buyer shall have reasonably required.

5.2.4 There shall have been no material adverse change in the physical condition of the Property from the end of the Due Diligence Period through the Closing Date.

The conditions set forth in this Section 5.2 are solely for the benefit of Buyer and may be waived only by Buyer. At all times Buyer has the right to waive any condition by giving written notice of such waiver to Seller. Such waiver or waivers must be in writing to Seller. If Buyer notifies Seller of a failure of a condition precedent set forth in this Section 5.2 on or before the Closing Date, this Agreement shall be automatically terminated, the Deposit shall immediately be returned to Buyer without any further action required from either party and neither party shall have any continuing obligations hereunder; provided, however, if such failure constitutes a breach or default of its covenants, representations or warranties, Seller shall remain liable for such breach or default as otherwise set forth in this Agreement.

5.3 Conditions Precedent Favoring Seller. In addition to any other condition precedent in favor of Seller as may be expressly set forth elsewhere in this Agreement, Seller's obligations under this Agreement are expressly subject to the timely fulfillment of the conditions set forth in this Section 5.3 on or before the Closing Date, or such earlier date as is set forth below. Each condition may be waived in whole or part only by written notice of such waiver from Seller to Buyer.

5.3.1 Buyer shall have performed and complied in all material respects with all of the terms of this Agreement to be performed and complied with by Buyer prior to or at the Closing.

5.3.2 On the Closing Date, all of the representations of Buyer set forth in this Agreement shall be true and correct in all material respects.

The conditions set forth in this Section 5.3 are solely for the benefit of Seller and may be waived only by Seller. At all times Seller has the right to waive any condition by giving written notice of such waiver to Buyer. Such waiver or waivers must be in writing to Buyer.

5.4 Seller Deliveries. At the Closing or on the date otherwise specified below, Seller shall deliver or cause to be delivered to Buyer, at Seller's sole expense, each of the following items:

5.4.1 A duly executed, acknowledged and delivered Special Warranty Deed for recordation on a form approved by Buyer and Title Company, whereby Seller will convey its fee simple interest in the Property to Buyer, in the Required Title Condition (the "Deed").

5.4.2 A blanket bill of sale, duly and originally executed and acknowledged by Seller, on a form that is reasonably satisfactory to Buyer, which shall transfer, convey, sell, assign and set over to Buyer all of Seller's right, title and interest in and to the Permits (the "Bill of Sale and Assignment").

5.4.3 A non-foreign person affidavit sworn to by Seller as required by Section 1445 of the Internal Revenue Code.

5.4.4 Such evidence, documents, affidavits and indemnifications as may be reasonably required by the Title Company as a precondition to the issuance of the Title Policy relating to: (i) mechanics' or materialmen's liens; (ii) parties in possession; (iii) the status and capacity of Seller and the authority of the person or persons who are executing the various documents on behalf of Seller in

connection with the sale of the Property; or (iv) any other matter reasonably required to enable the Title Company to issue the Title Policy and endorsements thereto.

5.4.5 [Reserved].

5.4.6 A duly executed Closing Statement (as defined below).

5.4.7 Such evidence or documents as may reasonably be required by Buyer evidencing the power and authority of the Seller and its respective partners and the due authority of, and execution and delivery by, any person or persons who are executing any of the documents required in connection with the sale of the Property.

5.4.8 Such other instruments as may be reasonably required to consummate the transactions contemplated by this Agreement.

5.5 Buyer's Deliveries. At the Closing, Buyer shall deliver to Seller the following items:

5.5.1 Immediately available federal funds sufficient to pay the Purchase Price (less the Deposit and any prorations required by this Agreement) and Buyer's share of all escrow costs and closing expenses.

5.5.2 A duly executed Bill of Sale and Assignment.

5.5.3 A duly executed Closing Statement (as defined below).

5.5.4 Such evidence, documents, affidavits and indemnifications as may be reasonably required by the Title Company as a precondition to the issuance of the Title Policy relating to: (i) the status and capacity of Buyer and the authority of the person or persons who are executing the various documents on behalf of Buyer in connection with the purchase of the Property; or (ii) any other matter reasonably required to enable the Title Company to issue the Title Policy and endorsements thereto.

5.5.5 Such other instruments as may be reasonably required to consummate the transactions contemplated by this Agreement.

5.6 Costs, Prorations and Credits.

5.6.1 Closing Costs. Buyer and Seller shall each pay their own legal fees related to the preparation of this Agreement and all documents required to settle the transaction contemplated hereby. Seller shall pay for (i) transfer taxes (including any roll back taxes, if applicable), and (ii) one-half of any escrow charges. Buyer shall pay (i) the Preliminary Report, (ii) the title insurance premiums for the Title Policy (including the cost of any endorsements), (iii) all costs associated with its investigation of the Property, including the cost of appraisals, Survey, architectural, engineering, credit and environmental reports, (iv) any title insurance endorsements, (v) recording fees, and (vi) one-half of any escrow charges.

5.6.2 Prorations. The following shall be prorated, credited, debited and adjusted between Seller and Buyer as of 11:59 p.m. on the day prior to the Closing (except as otherwise provided) in accordance with this section:

(a) Property Taxes. Real property taxes shall be prorated at Closing.

(b) Items Not Prorated. Seller and Buyer agree that (i) on the Closing Date, the Property will not be subject to any financing arranged by Seller; (ii) none of the insurance policies relating to the Property will be assigned to Buyer and Buyer shall be responsible for arranging for its own insurance as of the Closing Date; and (iii) Buyer shall be responsible for all the necessary actions needed to arrange for utilities, if any, to be transferred to the hame of Buyer on the Closing Date, including the posting of any required deposits. Accordingly, there will be no prorations for debt service or insurance or utilities.

(c) Other Items. All other items customarily prorated or required by any other provision of this Agreement to be prorated or adjusted.

For purposes of calculating prorations, Buyer shall be deemed to be in title to the Property for the entire day upon which the Closing occurs. Except as hereinafter expressly provided, all prorations shall be done on the basis of a three hundred sixty-five (365) day year and the actual number of days elapsed to the Closing Date or the actual number of days in the month in which the Closing occurs and the actual number of days elapsed in such month to the Closing Date, as applicable.

5.6.3 Calculation / Re-prorations. Any item which cannot be finally prorated because of the unavailability of information shall be tentatively prorated on the basis of the best data then available and adjusted when the information is available in accordance with this subsection. The estimated closing statement as adjusted as aforesaid and approved in writing by the parties shall be referred to therein as the "Closing Statement".

5.6.4 Survival. The provisions of this Section 5.6 shall survive the Closing.

5.7 Possession. Exclusive possession of the Property shall be delivered to Buyer by Seller at the Closing, subject only to the rights arising under the matters set forth in the Preliminary Report and permitted as part of the Required Title Condition.

ARTICLE 6
TERMINATION AND DEFAULT

6.1 Buyer Default. If the sale contemplated hereby is not consummated because of a default by Buyer in its obligation to purchase the Property in accordance with the terms of this Agreement after Seller has performed or tendered performance of all of its material obligations in accordance with this Agreement, then: (i) this Agreement shall terminate; (ii) the Deposit shall be paid to and retained by Seller as liquidated damages; and (iii) neither Seller nor Buyer shall have any further obligations to each other except those which survive the termination of this Agreement. Buyer and Seller acknowledge that the damages to Seller in the event of a breach of this Agreement by Buyer would be difficult or impossible to determine, that the amount of the Deposit plus interest represents the parties' best and most accurate estimate of the damages that would be suffered by Seller if the transaction should fail to close and that such estimate is reasonable under the circumstances existing as of the date of this Agreement and under the circumstances that Seller and Buyer reasonably anticipate would exist at the time of such breach. Buyer and Seller agree that Seller's right to retain the Deposit together with any interest and earnings earned thereon shall be Seller's sole remedy, at law and in equity, for Buyer's failure to purchase the Property in accordance with the terms of this Agreement. Seller hereby waives any right to an action for specific performance of any provisions of this Agreement and the defense of mutuality of remedies.

6.2 Seller's Default. If, prior to Closing, a Seller fails to perform any of its material obligations or is otherwise in default hereunder or willfully causes the failure of a condition precedent pursuant to Section 5.2 hereof, Buyer shall have the right to exercise any or all of the following remedies:

6.2.1 Waive such failure and proceed to the Closing with no reduction in the Purchase Price; provided, however, that this provision will not limit Buyer's right to receive reimbursement for attorney's fees pursuant to Section 9.8 below in connection with any legal proceedings instituted by Buyer with respect to the enforcement of this Agreement, nor waive or affect Seller's indemnity obligations under this Agreement or Buyer's rights to enforce those indemnity obligations, nor waive or affect any of Seller's other obligations under this Agreement to be performed after the Closing or Buyer's rights to enforce those obligations.

6.2.2 Seek and obtain specific performance by Seller of its covenants, agreements and obligations to convey the Property to Buyer as set forth in this Agreement; provided, however, Buyer shall be entitled to sue Seller for money damages if the remedy of specific performance is not available to Buyer.

6.2.3 Terminate this Agreement by notice to Seller to that effect, to recover the full amount of the Deposit and all earnings thereon, in addition to reimbursement of Buyer's documented and actually incurred out-of-pocket costs in conjunction with the Agreement, not to exceed $50,000.00; provided, however, Buyer shall have no right to reimbursement of its out-of-pocket costs as set forth in the foregoing clause in the event that Seller uses commercially reasonable efforts to satisfy the obligations set forth in Section 4.5.6 and Section 4.5.7 but is unable to do so through no fault of its own.

Notwithstanding anything to the contrary, Buyer shall not be required to fund the balance of the Purchase Price in order to enforce its remedies under this Agreement.

ARTICLE 7
CONDEMNATION

7.1 Intentionally Deleted.

7.2 Condemnation. In the event that any portion of the Property should be condemned prior to the Closing, at Buyer's sole option, elect either to:

(a) terminate this Agreement and receive back the Deposit; or

(b) close the transaction contemplated by this Agreement.

In all other cases, or if Buyer elects to proceed under Section 7.2(b), Buyer shall purchase the Property in accordance with the terms hereof (without reduction in the Purchase Price) and the Seller shall assign to Buyer at Closing all condemnation proceeds payable as a result of such condemnation. Buyer shall be deemed to have elected to proceed under Section 7.2(b) unless, within ninety (90) days from written notice of the condemnation, Buyer provides Seller with written notice that Buyer elects to terminate this Agreement pursuant to Section 7.2(a).

ARTICLE 8
REAL ESTATE COMMISSION

Buyer represents and warrants to Seller that only Baker Storey McDonald Properties ("Buyer's Broker") has served as Buyer's Broker in this transaction and that no other real estate broker or agent has been authorized to act on Buyer's behalf. Buyer hereby indemnifies and agrees to hold Seller harmless from any actual, out-of-pocket loss, liability, damage, cost or expense (including reasonable attorneys' fees) paid or incurred by Buyer's breach of the representation and warranty made in this Article 8. Seller represents and warrants to Buyer that only Southeast Venture, LLC ("Seller's Broker") has served as Seller's Broker in this transaction and that no other real estate broker or agent has been authorized to act on Seller's behalf. Seller hereby indemnifies and agrees to hold Buyer harmless from any actual, out-of-pocket loss, liability, damage, cost or expense (including reasonable attorneys' fees) paid or incurred by Seller's breach of the representation and warranty made in this Article 8. The indemnities set forth in this Article 8 shall survive Closing Seller shall pay a commission to Seller's Broker in connection with this Agreement pursuant to a separate written agreement between Seller and Seller's Broker. Seller's Broker will pay a commission to Buyer's Broker in connection with this Agreement pursuant to a separate written agreement between Seller's Broker and Buyer's Broker.

ARTICLE 9
MISCELLANEOUS

9.1 Entire Agreement. This Agreement constitutes the entire agreement between the parties hereto with respect to the transactions contemplated herein, and it supersedes all prior discussions, understandings or agreements between the parties. All Exhibits and Schedules attached hereto are a part of this Agreement and are incorporated herein by reference.

9.2 Binding On Successors and Assigns. Subject to Section 9.3, this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns.

9.3 Assignments. Buyer and Seller may not assign, delegate or otherwise transfer any of their rights or obligations under this Agreement without the consent of the other party hereto; provided, however, that Buyer may, upon written notice to Seller, assign this Agreement and its rights or obligations hereunder to any entity controlled by Acadia Healthcare Company, Inc. Buyer shall remain jointly and severally liable for its obligations and the obligations of its permitted assignee. Upon such permitted assignment, the references in this Agreement to Buyer shall also apply to any such assignee unless the context requires otherwise.

9.4 Waiver. The excuse or waiver of the performance by a party of any obligation of the other party under this Agreement shall only be effective if evidenced by a written statement signed by the party so excusing or waiving. No delay in exercising any right or remedy shall constitute a waiver thereof, and no waiver by Seller or Buyer of the breach of any covenant of this Agreement shall be construed as a waiver of any preceding or succeeding breach of the same or any other covenant or condition of this Agreement.

9.5 Governing Law. This Agreement shall be governed by and construed under the internal laws of the state of Tennessee without regard to the principles of conflicts of law.

9.6 Counterparts. This Agreement may be executed in any number of counterparts and it shall be sufficient that the signature of each party appear on one or more such counterparts. All counterparts shall collectively constitute a single agreement. Originals transmitted by facsimile or electronic mail shall be considered original in all respects.

9.7 Notices. All notices, demands and other communications of any type given by any party hereunder, whether required by this Agreement or in any way related to the transaction contracted for herein, shall be void and of no effect unless given in accordance with the provisions of this Section. All notices shall be in writing and shall be delivered (i) by courier; (ii) by Federal Express or other nationally recognized overnight delivery service, or (iii) electronic mail. Notices shall be deemed received (1) if by courier, upon delivery or refusal of same; or (2) if by Federal Express or other nationally recognized overnight delivery service, the Business Day following deposit; or (3) if by electronic mail, upon delivery. Any notice received on a non-Business Day or after 6:00 p.m. Central Time on a Business Day shall be deemed received on the next Business Day. Notices shall be given to the following addresses:

To Buyer:	Acadia Healthcare Company, Inc. 6100 Tower Circle, Suite 1000 Franklin, TN 37067 Attention: Keith Thompson, Esq. Email: keith.thompson@acadiahealthcare.com
With a copy to:	Waller Lansden Dortch & Davis, LLP 511 Union Street, Suite 2700 Nashville, TN 37219 Attention: J. Steven Kirkham, Esq. Email: steve.kirkham@wallerlaw.com
To Seller:	SEV Metrocenter IV, LLC 4011 Armory Oaks Drive Nashville, TN 37204 Attention: Cam Sorenson Email: csorenson@southeastventure.com
With a copy to:	Bass, Berry & Sims PLC 150 Third Avenue South, Suite 2800 Nashville, TN 37201 Attention: John Seehorn Email: jseehorn@bassberry.com

Any address or name specified above may be changed by notice given to the addressee by the other party in accordance with this Section 9.7. The inability to deliver notice because of a changed address of which no notice was given as provided above, or because of rejection or other refusal to accept any notice, shall be deemed to be the receipt of the notice as of the date of such inability to deliver or rejection or refusal to accept. Any notice to be given by any party hereto may be given by the counsel for such party.

9.8 Attorneys' Fees. In the event of a judicial or administrative proceeding or action by one party against the other party with respect to the interpretation or enforcement of this Agreement, the prevailing party shall be entitled to recover reasonable costs and expenses including, without limitation, reasonable attorneys' fees and expenses, whether at the investigative, pretrial, trial or appellate level. The prevailing party shall be determined by the court based upon an assessment of which party's major arguments or position prevailed.

9.9 Time Periods. If the time for performance of any obligation hereunder expires on a day that is not a Business Day, the time for performance shall be extended to the next Business Day.

9.10 Modification of Agreement. No modification of this Agreement shall be deemed effective unless in writing and signed by the party against whom enforcement is sought.

9.11 Survival of Provisions After Closing. Any provisions of this Agreement that require observance or performance after the Closing Date shall continue in force and effect following the Closing Date.

9.12 Further Instruments. Each party, promptly upon the request of the other, shall execute and have acknowledged and delivered to the other or to the Escrow Agent, as may be appropriate, any and all further instruments reasonably requested or appropriate to evidence or give effect to the provisions of this Agreement and which are consistent with the provisions of this Agreement.

9.13 Descriptive Headings; Word Meaning. The descriptive headings of the paragraphs of this Agreement are inserted for convenience only and shall not control or affect the meaning or construction of any provisions of this Agreement. Words such as "herein," "hereinafter," "hereof" and "hereunder" when used in reference to this Agreement, refer to this Agreement as a whole and not merely to a subdivision in which such words appear, unless the context otherwise requires. The singular shall include the plural and the masculine sender shall include the feminine and neuter, and vice versa, unless the context otherwise requires. The word "including" shall not be restrictive and shall be interpreted as if followed by the words "without limitation."

9.14 Business Day. As used herein, the term "Business Day" means any day other than Saturday, Sunday and any day which is a legal holiday in the State of Tennessee.

9.15 Construction of Agreement. This Agreement shall not be construed more strictly against one party than against the other merely by virtue of the fact that it may have been prepared primarily by counsel for one of the parties, it being recognized that both Buyer and Seller have contributed substantially and materially to the preparation of this Agreement.

9.16 Severability. The parties hereto intend and believe that each provision in this Agreement comports with all applicable local, state and federal laws and judicial decisions. However, if any provision in this Agreement is found by a court of law to be in violation of any applicable local, state or federal law, statute, ordinance, administrative or judicial decision, or public policy, or if in any other respect such a court declares any such provision to be illegal, invalid, unlawful, void or unenforceable as written, then it is the intent of all parties hereto that, consistent with and with a view towards preserving the economic and legal arrangements among the parties hereto as expressed in this Agreement, such provision shall be given force and effect to the fullest possible extent, and that the remainder of this Agreement shall be construed as if such illegal, invalid, unlawful, void or unenforceable provision were not contained herein, and that the rights, obligations and interests of the parties under the remainder of this Agreement shall continue in full force and effect.

9.17 Exclusivity. After the Effective Date, Seller and its respective agents, representatives and employees shall immediately cease all marketing of the Property until such time as this Agreement is terminated and Seller shall not directly or indirectly make, accept, negotiate, entertain or otherwise pursue any offers for the sale of the Property.

9.18 Confidentiality. The terms of the transaction contemplated in this Agreement shall remain confidential and shall not be disclosed by any party hereto without the written consent of the other parties, except (a) to such party's affiliates, successors, assigns, directors, officers, partners, members, employees, legal counsel, accountants, engineers, architects, financial advisors and similar professionals and consultants and to their respective lenders, investors and other entities providing financing to such party,

to the extent such party deems it necessary or appropriate in connection with the transactions contemplated hereunder (and such party shall inform each of the foregoing parties of such party's obligations under this Section and shall secure the agreement of such parties to be bound by the terms hereof and such party will be responsible for any breach of this Section by any of the each of the foregoing parties to whom it provides such information); (b) to governmental officials or other third parties (including the public, respecting information contained in public reports), any such data and information as may be required to comply with such party's reporting requirements under law; (c) publicly available information (other than information which was made publicly available as a result of a violation of this provision); or (d) as otherwise required by law or regulation or to enforce the terms of this Agreement.

9.19 Waiver of Jury Trial. TO THE FULLEST EXTENT PERMITTED BY LAW, EACH PARTY HEREBY WAIVES TRIAL BY JURY IN ANY ACTION, PROCEEDING, CLAIM OR COUNTERCLAIM BROUGHT BY ANY PARTY IN CONNECTION WITH ANY MATTER ARISING OUT OF OR IN ANY WAY CONNECTED WITH THIS AGREEMENT, THE RELATIONSHIP OF SELLER AND BUYER HEREUNDER, BUYER'S OWNERSHIP OR USE OF ANY PROPERTY OR ANY CLAIMS OF INJURY OR DAMAGE.

(Signature Page to Follow)

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first written above.

Seller:

SEV METROCENTER IV, LLC

By: Southeast Venture LLC, Manager

By: _____

Name: Cameron W. Sorenson

Title: Manager

Buyer:

ACADIA HEALTHCARE COMPANY, INC.,
a Delaware corporation

By: _____

Name: Christopher Howard

Title: EVP & General Counsel

4820-5370-2973.9

EXHIBIT A

LAND

Parcel: 07012001000

Address: 300 Great Circle Road, Nashville, TN

EXHIBIT B

PROPERTY INFORMATION

(a) Tax Statements. Copies of all ad valorem tax statements relating to the Land for the 2014, 2015 and 2016 tax years;

(b) Title and Survey Matters. Any existing title insurance policies and surveys relating to the Property;

(c) Environmental Information. All existing Phase I reports relating to the Property in Seller's possession; and

(d) Geotechnical Reports. All existing geotechnical reports relating to the Property in Seller's possession.

FIRST AMENDMENT TO PURCHASE AND SALE AGREEMENT

THIS FIRST AMENDMENT TO PURCHASE AND SALE AGREEMENT (this "Amendment") is made and entered into effective as of the 27th day of July, 2017 (the "Effective Date"), by and between **SEV METROCENTER IV, LLC**, a Tennessee limited liability company ("Seller"), and **ACADIA HEALTHCARE COMPANY, INC.**, a Delaware corporation ("Buyer").

RECITALS:

WHEREAS, Seller and Buyer entered into that certain Purchase and Sale Agreement dated March 29, 2017 (the "Purchase Agreement") for the purchase and sale of certain real property as more specifically described in the Purchase Agreement, pursuant to the terms and conditions as further described therein; and

WHEREAS, Seller and Buyer now wish to amend certain provisions of the Purchase Agreement as more fully set forth herein.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. Amendment of Section 3.2. Section 3.2 of the Purchase Agreement is deleted in its entirety, with the following substituted in lieu thereof:

"Buyer will have through the close of business on July 27, 2017 to satisfy itself as to all matters relating to the development and use of the Property (the "Due Diligence Period"), with the exception of such matters as described by Section 3.4 (CON) and Section 4.5.6 (Zoning) in which such case Buyer has until the dates described therein."

2. Amendment to Add Section 3.5(c). The Purchase Agreement is hereby amended by the addition of the following new Section 3.5(c):

"(c) Buyer shall have the right to terminate this Agreement and be returned the Initial Deposit at any time prior to the Seller's satisfaction of the rezoning as contemplated by Section 4.5.6. Such rezoning shall not be deemed satisfied if it is rezoned with any condition(s) that, in Buyer's discretion, would materially impair Buyer's ability to develop the Property for Buyer's intended use."

3. No Further Amendment. Except as specifically set forth herein, there are no further changes or amendments to the Purchase Agreement, and the parties hereby adopt and ratify the balance of the Purchase Agreement.

4. Counterparts. This Amendment may be executed in one or more counterparts, each of which shall constitute a separate document but all of which together shall constitute one and the same agreement. Electronic signatures will be deemed the equivalent of original, "wet ink" signatures.

[Signatures on following page]

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the Effective Date.

SELLER:

SEV METROCENTER IV, LLC

By: Southeast Venture LLC, Manager

By: _____

Name: Cameron W. Sorenson

Title: Member

PURCHASER:

ACADIA HEALTHCARE COMPANY, INC.

By: _____

Name: Christopher L. Howard

Title: EVP, General Counsel & Secretary

23314245.3

SECOND AMENDMENT TO PURCHASE AND SALE AGREEMENT

THIS SECOND AMENDMENT TO PURCHASE AND SALE AGREEMENT (this "Amendment") is made and entered into effective as of the 5th day of December, 2017 (the "Effective Date"), by and between **SEV METROCENTER IV, LLC**, a Tennessee limited liability company ("Seller"), and **ACADIA HEALTHCARE COMPANY, INC.**, a Delaware corporation ("Buyer").

RECITALS:

WHEREAS, Seller and Buyer entered into that certain Purchase and Sale Agreement dated March 29, 2017, as amended by that certain First Amendment to Purchase and Sale Agreement dated July 27, 2017 (as amended, the "Purchase Agreement"), for the purchase and sale of certain real property as more specifically described in the Purchase Agreement, pursuant to the terms and conditions as further described therein; and

WHEREAS, Seller and Buyer now wish to amend certain provisions of the Purchase Agreement as more fully set forth herein.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. Amendment of Section 3.4. Section 3.4 of the Purchase Agreement is hereby amended to delete the words "expiration of the Due Diligence Period" in the third line, and substituting in their place "satisfaction of Seller's obligation pursuant to Section 4.5.6 to have the Property rezoned." The revised, complete Section 3.4 now reads as follows:

"Provided that Buyer has not terminated this Agreement during the Due Diligence Period, Buyer shall have until the date that is Two Hundred Forty (240) days following the satisfaction of Seller's obligation pursuant to Section 4.5.6 to have the Property rezoned (the "Approvals Period") to obtain a certificate of need required for Buyer to construct and operate certain improvements on the Property for Buyer's intended use (the "CON"). The CON shall not be deemed obtained until it is issued in "final" form and not subject to appeal by any third party. Buyer may elect to extend the Approvals Period for Three (3) successive periods of Thirty (30) days each (each, an "Approvals Extension") by notifying Seller of such election prior to the expiration of the Approvals Period, or the then-current Approvals Extension, as applicable, and delivering to Escrow Agent an additional escrow deposit equal to Fifteen Thousand and No/100 Dollars ($15,000.00) (each an "Extension Deposit") at or prior to notifying Seller of such election."

3. No Further Amendment. Except as specifically set forth herein, there are no further changes or amendments to the Purchase Agreement, and the parties hereby adopt and ratify the balance of the Purchase Agreement.

4. Counterparts. This Amendment may be executed in one or more counterparts, each of which shall constitute a separate document but all of which together shall constitute one and the same agreement. Electronic signatures will be deemed the equivalent of original, "wet ink" signatures.

[Signatures on following page]

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the Effective Date.

SELLER:

SEV METROCENTER IV, LLC

By: Southeast Venture LLC, Manager

By: _____
Name: Cameron W. Sorenson
Title: Member

PURCHASER:

ACADIA HEALTHCARE COMPANY, INC.

By: _____
Name: Christopher Howard
Title: EVP & General Counsel

ASSIGNMENT AND ASSUMPTION OF PURCHASE AND SALE AGREEMENT

THIS ASSIGNMENT AND ASSUMPTION OF PURCHASE AND SALE AGREEMENT (this "Assignment") is made and entered into as of April 30, 2018 (the "Assignment Date") by and among **ACADIA HEALTHCARE COMPANY, INC.,** a Delaware corporation (hereinafter referred to as "Assignor"), **ACADIA JV HOLDINGS, LLC**, a Delaware limited liability company (hereinafter referred to as "JV Holdings"), **ACADIA NASHVILLE JV HOLDINGS, LLC**, a Delaware limited liability company (hereinafter referred to as "Acadia Nashville") and **CUMBERLAND BEHAVIORAL HEALTH, LLC,** a Delaware limited liability company ("Assignee"). The entities named above are sometimes collectively referred to herein as the "Parties", and each of the Parties is sometimes singularly referred to herein as a "Party."

WHEREAS, Assignor entered into that certain Purchase and Sale Agreement dated March 2017, as amended by that certain First Amendment dated July 27, 2017, and as further amended by that certain Second Amendment dated December 5, 2017 (the "Agreement") with SEV Metrocenter IV, LLC, a Tennessee limited liability company ("SEV"), pursuant to which Assignor agreed to purchase, and SEV agreed to sell, the Property (as defined in the Agreement);

WHEREAS, a fully executed copy of the Agreement is attached hereto and incorporated herein as **Exhibit "A"**;

WHEREAS, Assignor desires to assign its right, title and interest in the Agreement to JV Holdings and JV Holdings desires to accept the assignment of the Agreement in accordance with the terms and provisions of this Assignment (the "First Assignment and Assumption");

WHEREAS, immediately after the First Assignment and Assumption, JV Holdings desires to assign its right, title and interest in the Agreement to Acadia Nashville and Acadia Nashville desires to accept the assignment of the Agreement in accordance with the terms and provisions of this Assignment (the "Second Assignment and Assumption");

WHEREAS, immediately after the Second Assignment and Assumption, Acadia Nashville desires to assign its right, title and interest in the Agreement to Assignee and Assignee desires to accept the assignment of the Agreement in accordance with the terms and provisions of this Assignment (the "Final Assignment and Assumption"); and

NOW, THEREFORE, in consideration of the promises and mutual agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

ARTICLE I

1.1 Assignment. Assignor hereby assigns, conveys, transfers and delivers to JV Holdings all of Assignor's right, title and interest in, under and to the Agreement, subject to the terms and provisions hereof.

1.2 Assumption. JV Holdings hereby accepts the assignment of Assignor's right, title and interest in, under and to the Agreement and hereby assumes, undertakes and agrees to perform and discharge all of Assignor's duties and obligations under the Agreement, subject to the terms and conditions of this Assignment.

ARTICLE II

2.1 Assignment. JV Holdings hereby assigns, conveys, transfers and delivers to Acadia Nashville all of JV Holdings's right, title and interest in, under and to the Agreement, subject to the terms and provisions hereof.

2.2 Assumption. Acadia Nashville hereby accepts the assignment of JV Holdings's right, title and interest in, under and to the Agreement and hereby assumes, undertakes and agrees to perform and discharge all of JV Holdings's duties and obligations under the Agreement, subject to the terms and conditions of this Assignment.

ARTICLE III

3.1 Assignment. Acadia Nashville hereby assigns, conveys, transfers and delivers to Assignee all of Acadia Nashville's right, title and interest in, under and to the Agreement, subject to the terms and provisions hereof.

3.2 Assumption. Assignee hereby accepts the assignment of Acadia Nashville's right, title and interest in, under and to the Agreement and hereby assumes, undertakes and agrees to perform and discharge all of Acadia Nashville's duties and obligations under the Agreement, subject to the terms and conditions of this Assignment.

3.3 Assignor's Obligations. Notwithstanding any term in this Assignment to the contrary, Acadia Nashville acknowledges and agrees that it shall not be released or discharged from any liability under the Agreement and shall remain liable for the performance of all obligations of purchaser under the Agreement.

[Signature page follows]

EXECUTED to be effective as of the Assignment Date.

Assignor:

ACADIA HEALTHCARE COMPANY, INC.,
a Delaware corporation

By: _____
Name: Christopher L. Howard
Title: Executive Vice President and Secretary

JV Holdings:

ACADIA JV HOLDINGS, LLC,
a Delaware limited liability company

By: _____
Name: Christopher L. Howard
Title: Vice President and Secretary

Acadia Nashville:

ACADIA NASHVILLE JV HOLDINGS, LLC,
a Delaware limited liability company

By: _____
Name: Christopher L. Howard
Title: Vice President and Secretary

Assignee:

CUMBERLAND BEHAVIORAL HEALTH, LLC,
a Delaware limited liability company

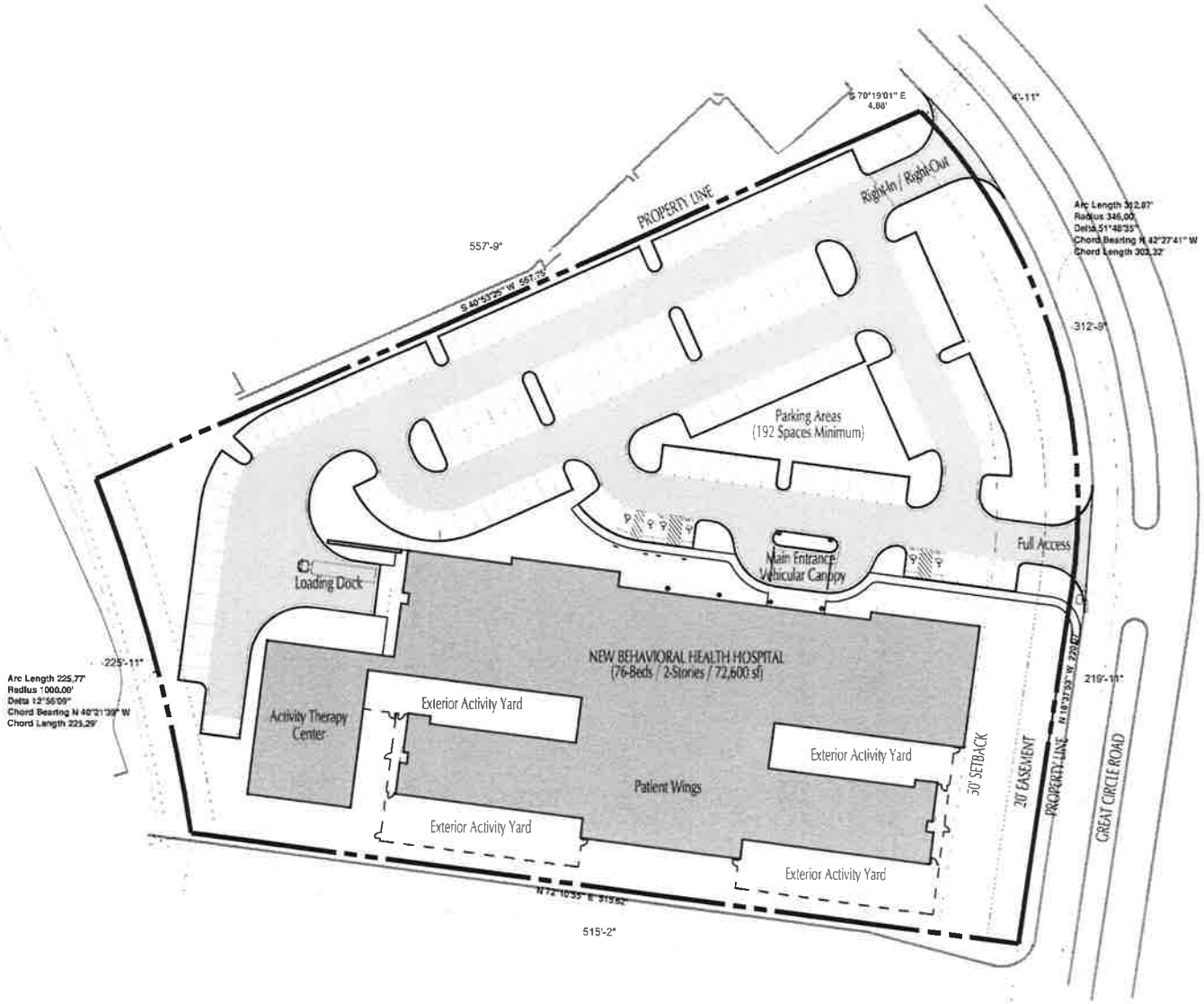
By: _____
Name: Christopher L. Howard
Title: Vice President and Secretary

[Signature page to the Assignment and Assumption of the PSA]

EXHIBIT "A"

COPY OF AGREEMENT

(see attached)



EXISTING SITE AREA = 4.86 ACRES

SITE PLAN
CO01-00

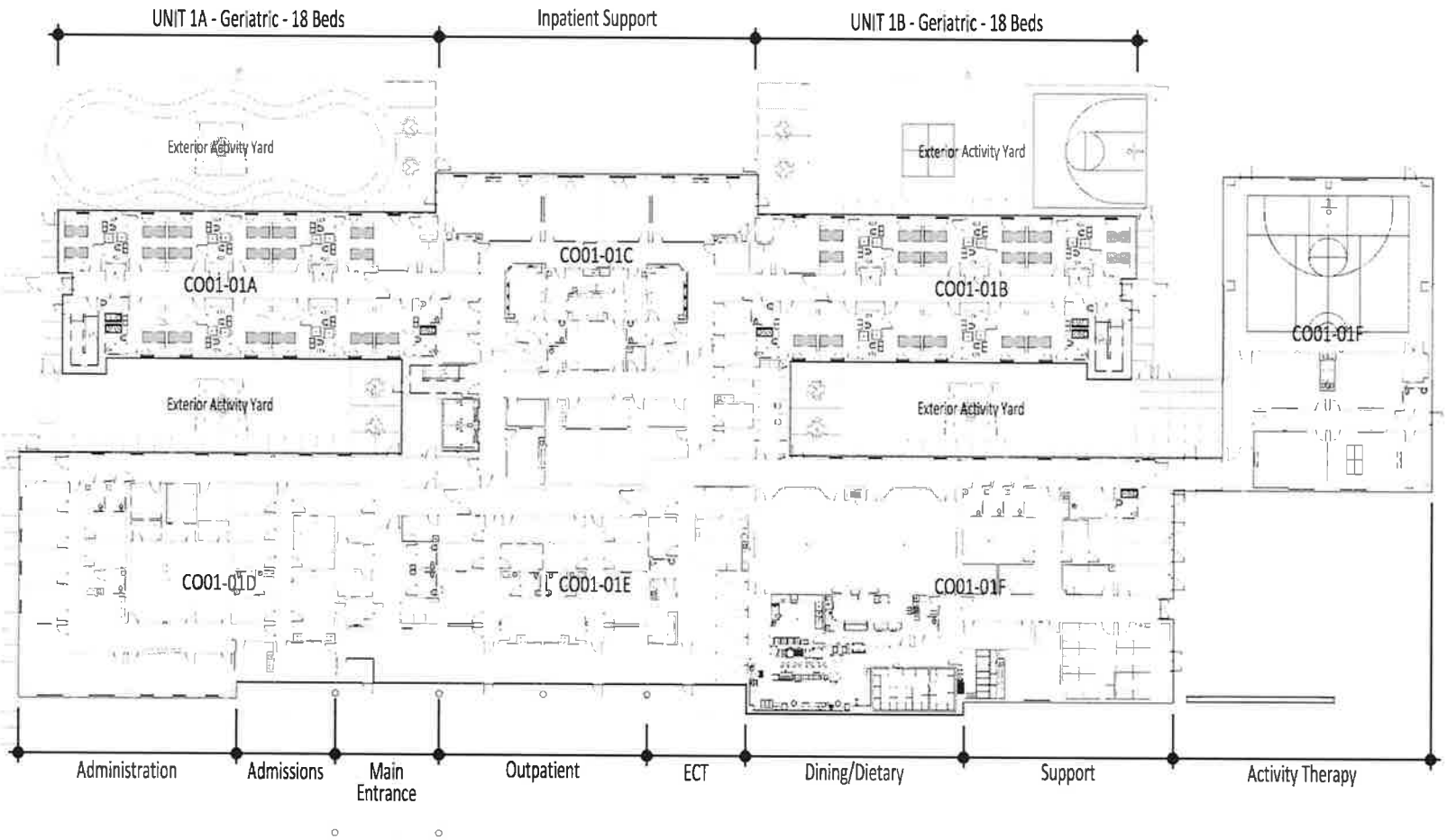
NORTH

GRAPHIC SCALE

0' 50' 100' 200'

NEW BEHAVIORAL HEALTH HOSPITAL
Acadia Healthcare Company - Nashville, Tennessee
September 13, 2017

ATTACHMENT A.6.B.1



FIRST FLOOR BUILDING AREA = 52,600 SF

COMPOSITE FIRST FLOOR PLAN CO01-01

NORTH

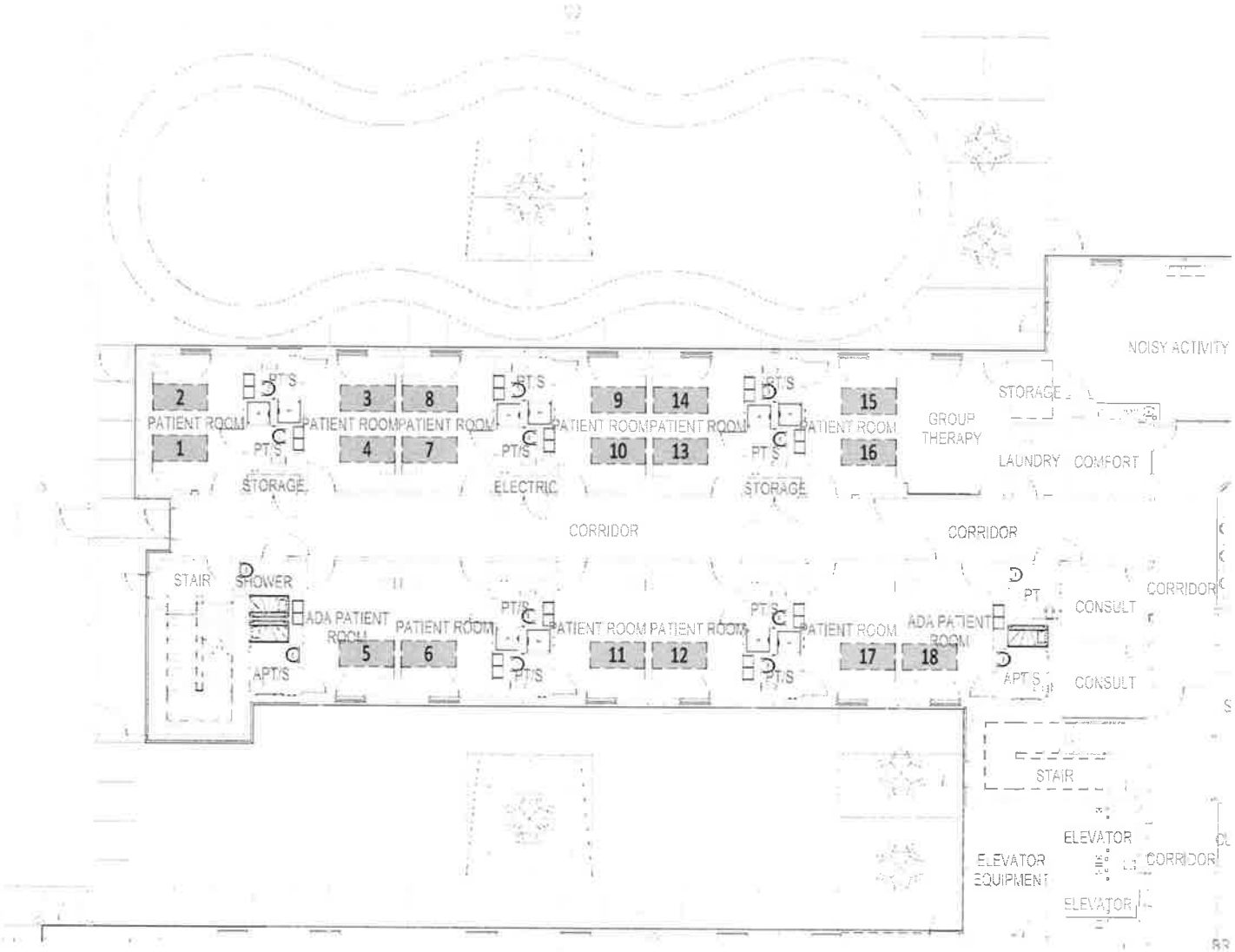
GRAPHIC SCALE

0' 25' 50' 100'

NEW BEHAVIORAL HEALTH HOSPITAL
Acadia Healthcare Company - Nashville, Tennessee
September 13, 2017

ATTACHMENT A.6.B.2

LEGEND
Proposed New Licensed Beds



PARTIAL
FIRST FLOOR PLAN
CO01-01A

NORTH

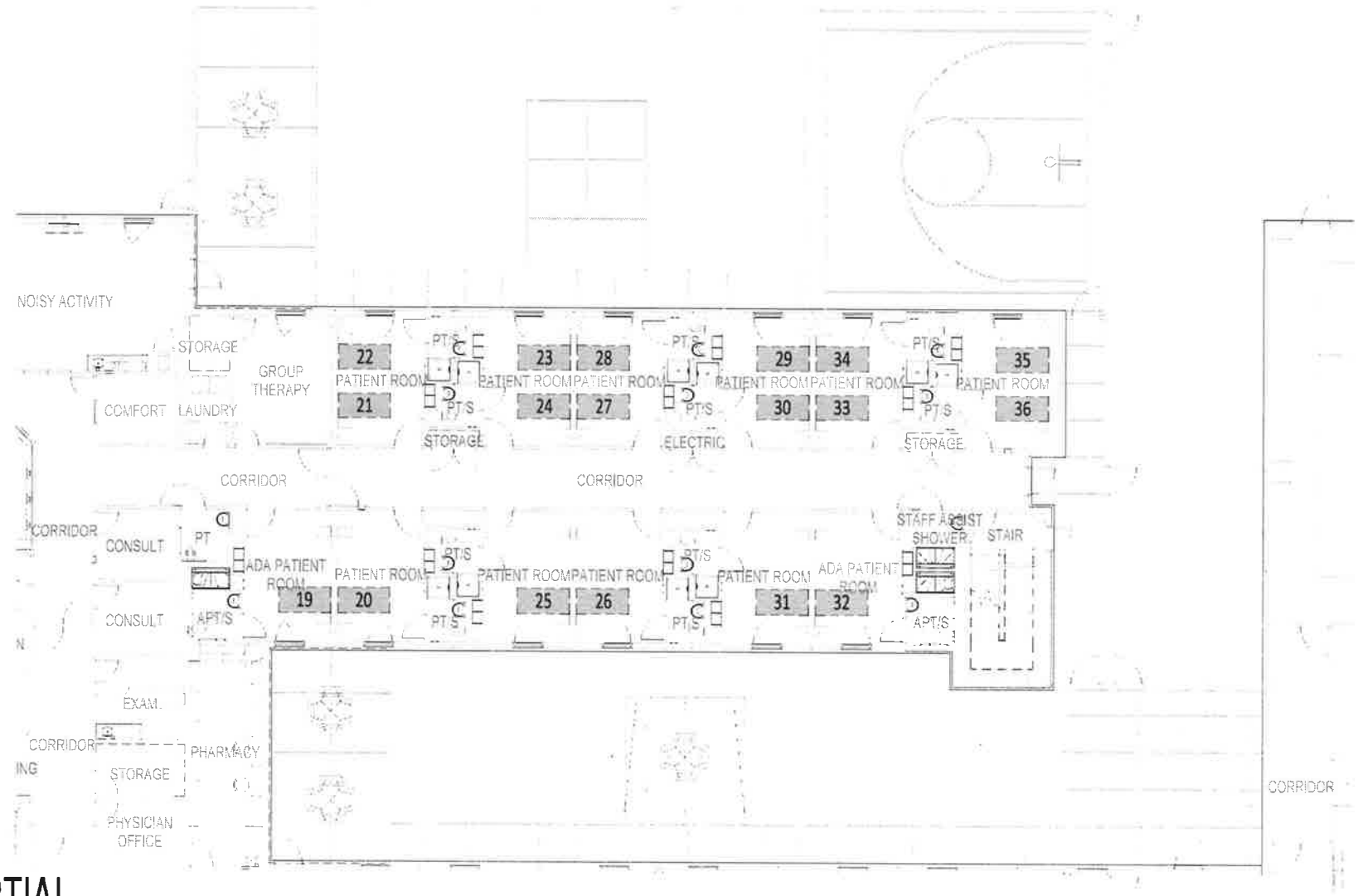
GRAPHIC SCALE

0' 10' 20' 40'

NEW BEHAVIORAL HEALTH HOSPITAL
Acadia Healthcare Company - Nashville, Tennessee
September 13, 2017

LEGEND

Proposed New Licensed Beds



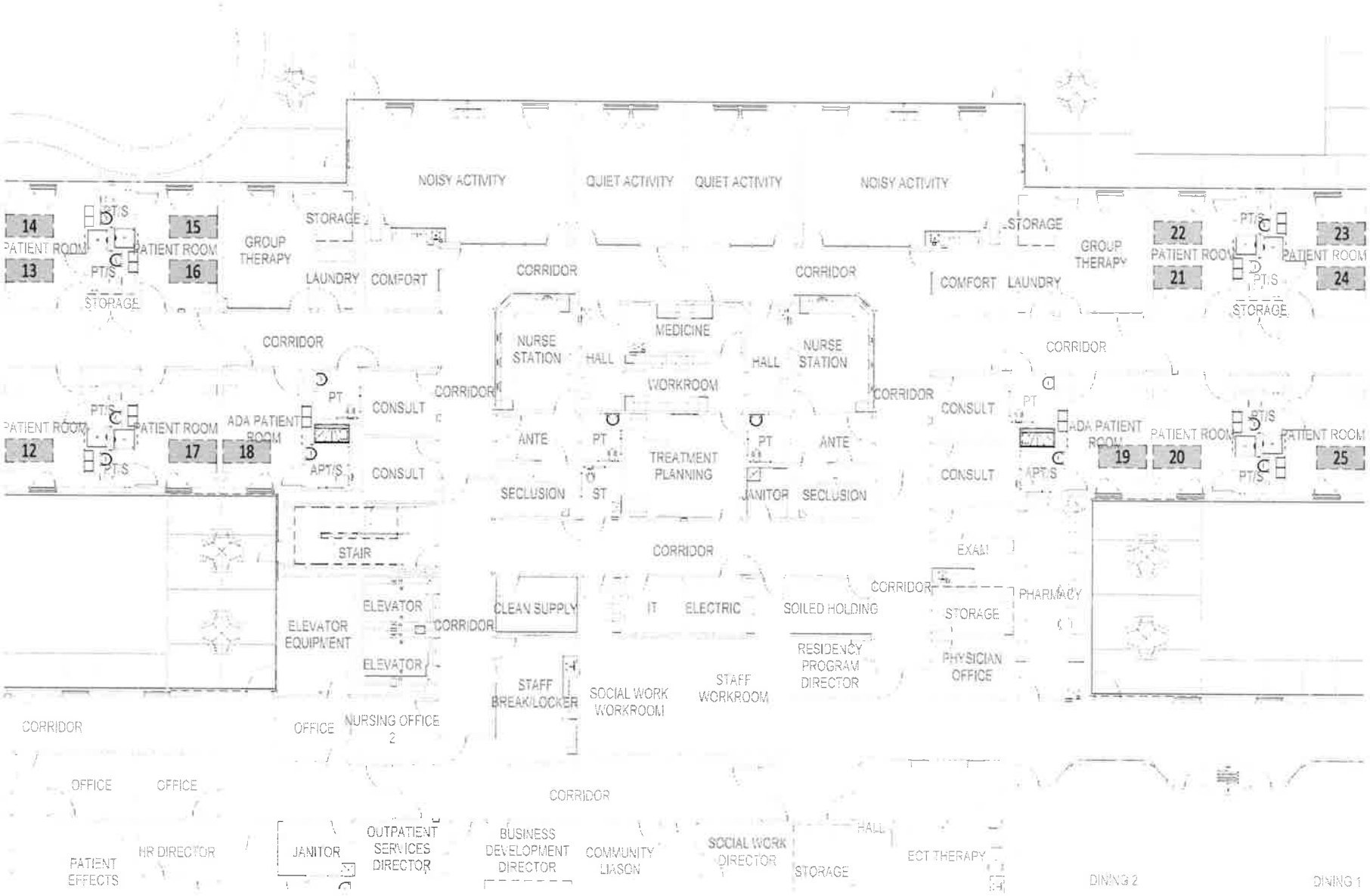
PARTIAL FIRST FLOOR PLAN C001-01B

NORTH

GRAPHIC SCALE

0' 10' 20' 40'

NEW BEHAVIORAL HEALTH HOSPITAL
Acadia Healthcare Company - Nashville, Tennessee
September 13, 2017



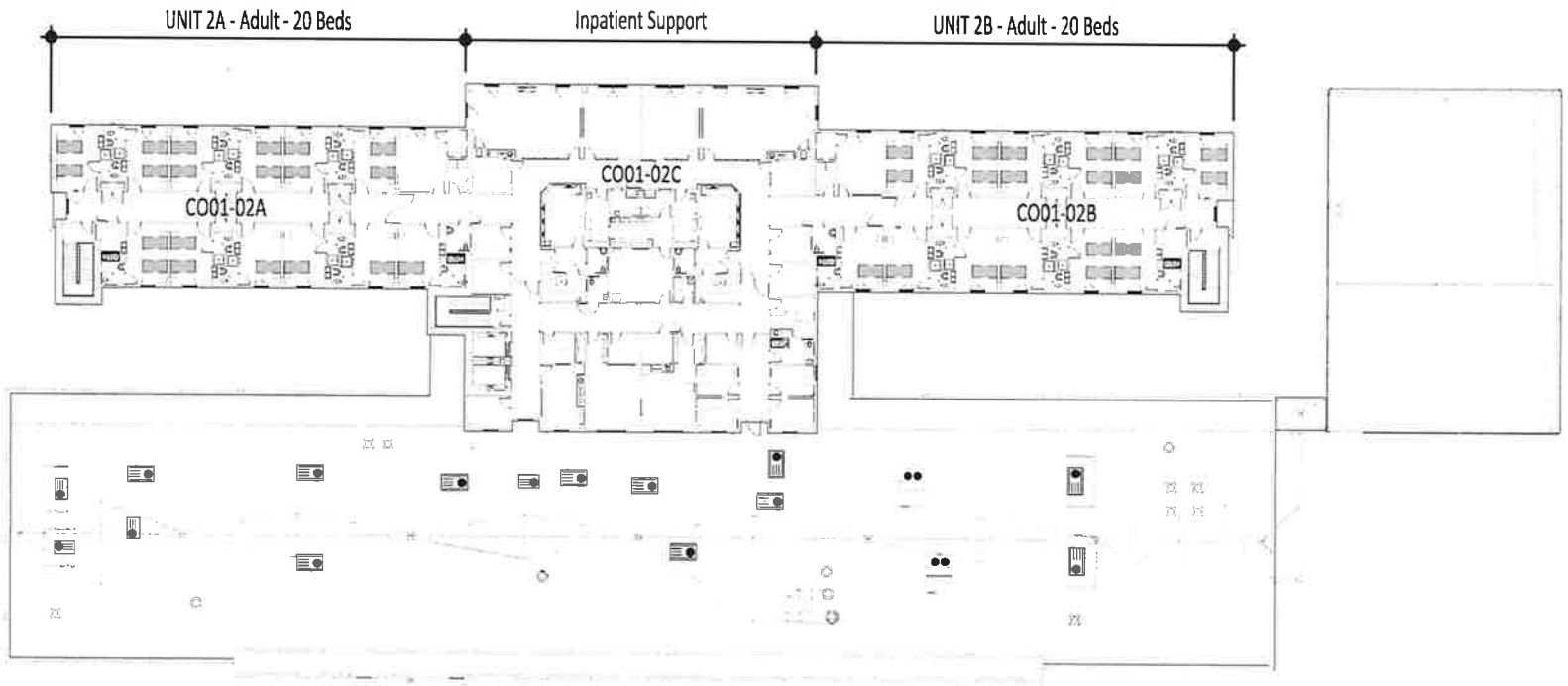
PARTIAL
FIRST FLOOR PLAN
CO01-01C

NORTH

GRAPHIC SCALE

0' 10' 20' 40'

NEW BEHAVIORAL HEALTH HOSPITAL
Acadia Healthcare Company - Nashville, Tennessee
September 13, 2017



SECOND FLOOR BUILDING AREA = 20,000 SF

COMPOSITE SECOND FLOOR PLAN CO01-02

NORTH

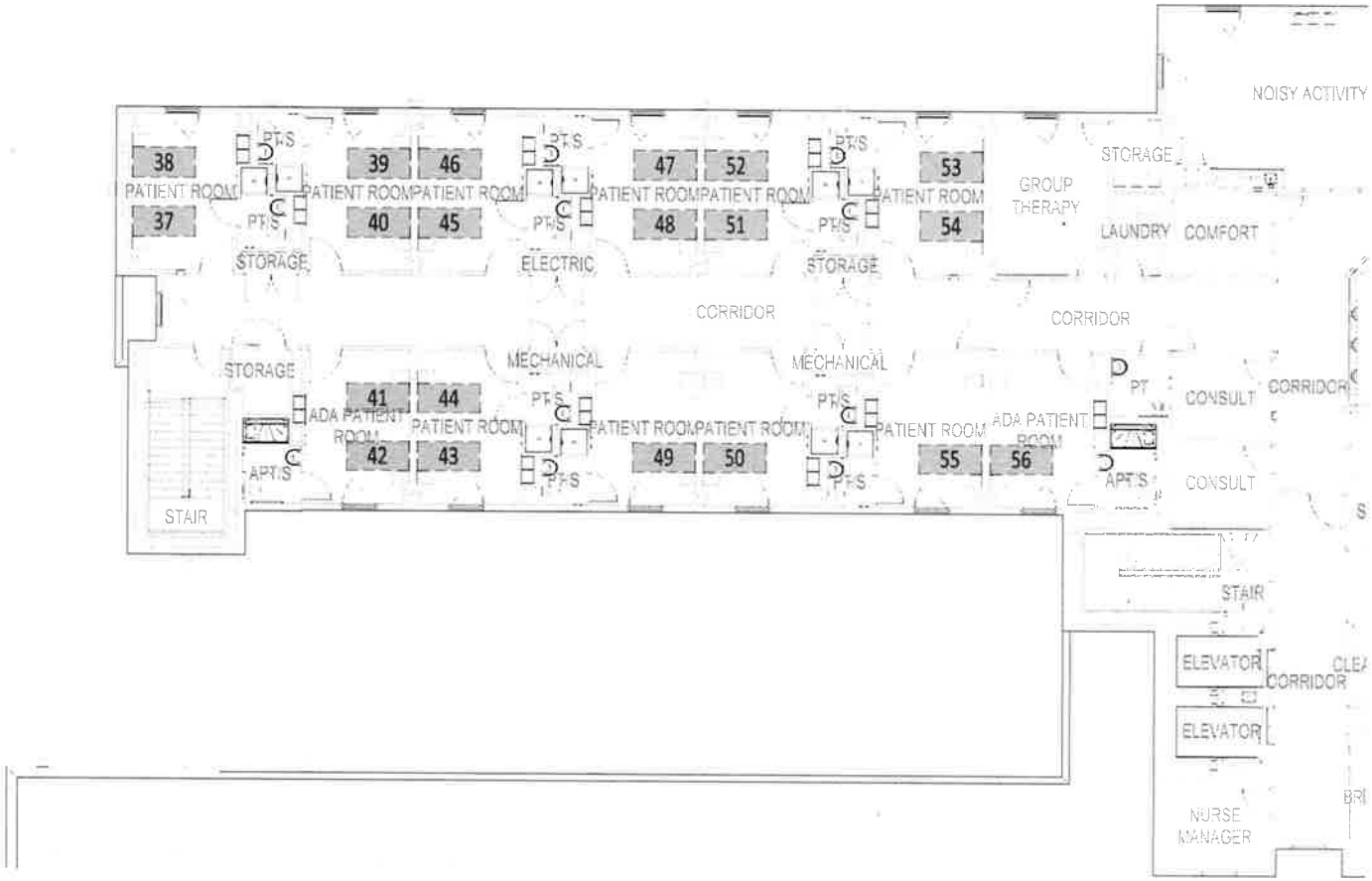
GRAPHIC SCALE

0' 25' 50' 100'

NEW BEHAVIORAL HEALTH HOSPITAL
Acadia Healthcare Company - Nashville, Tennessee
September 13, 2017

LEGEND

Proposed New Licensed Beds



PARTIAL SECOND FLOOR PLAN CO01-02A

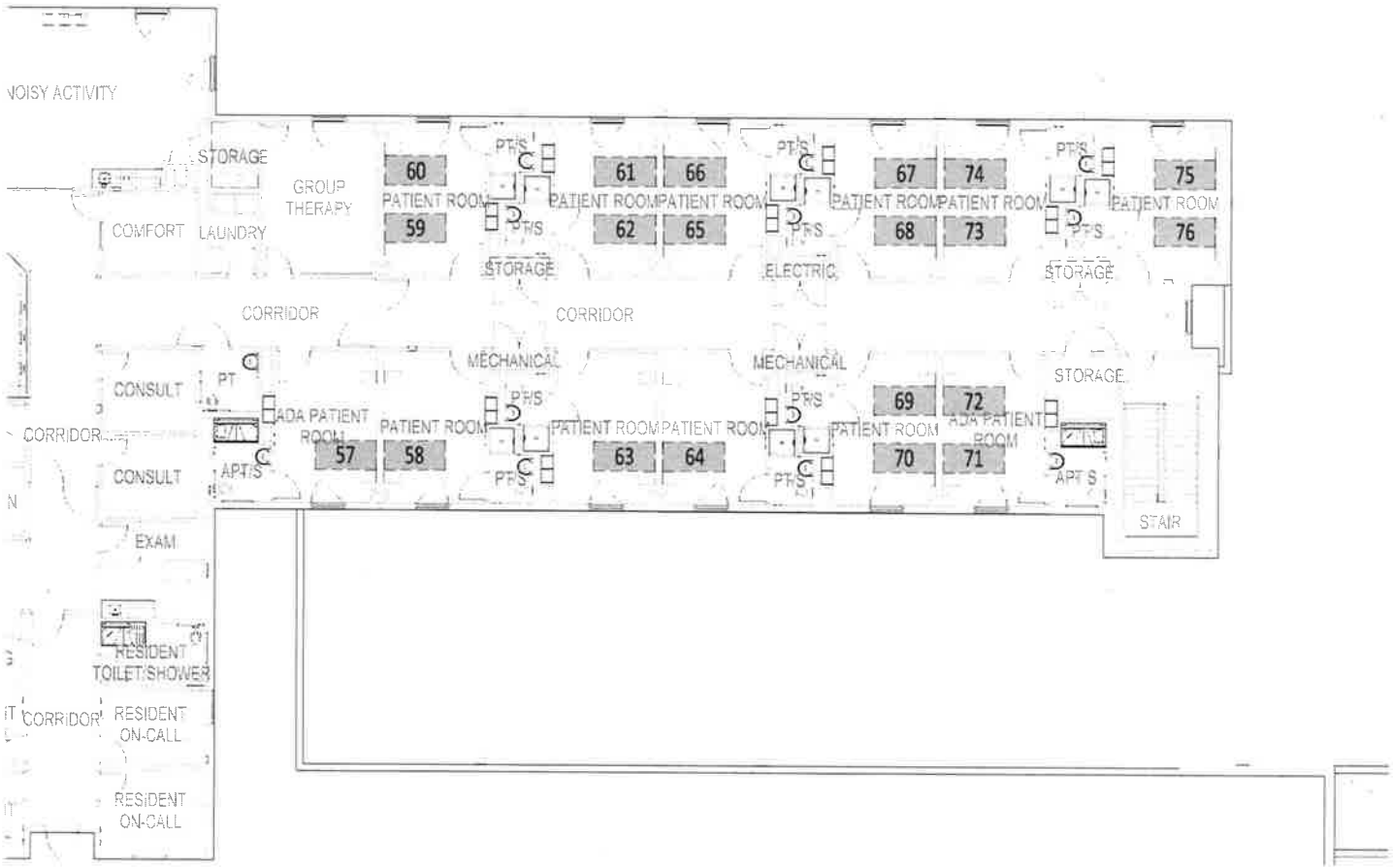
NORTH

GRAPHIC SCALE

0' 10' 20' 40'

NEW BEHAVIORAL HEALTH HOSPITAL
Acadia Healthcare Company - Nashville, Tennessee
September 13, 2017

LEGEND
Proposed New Licensed Beds



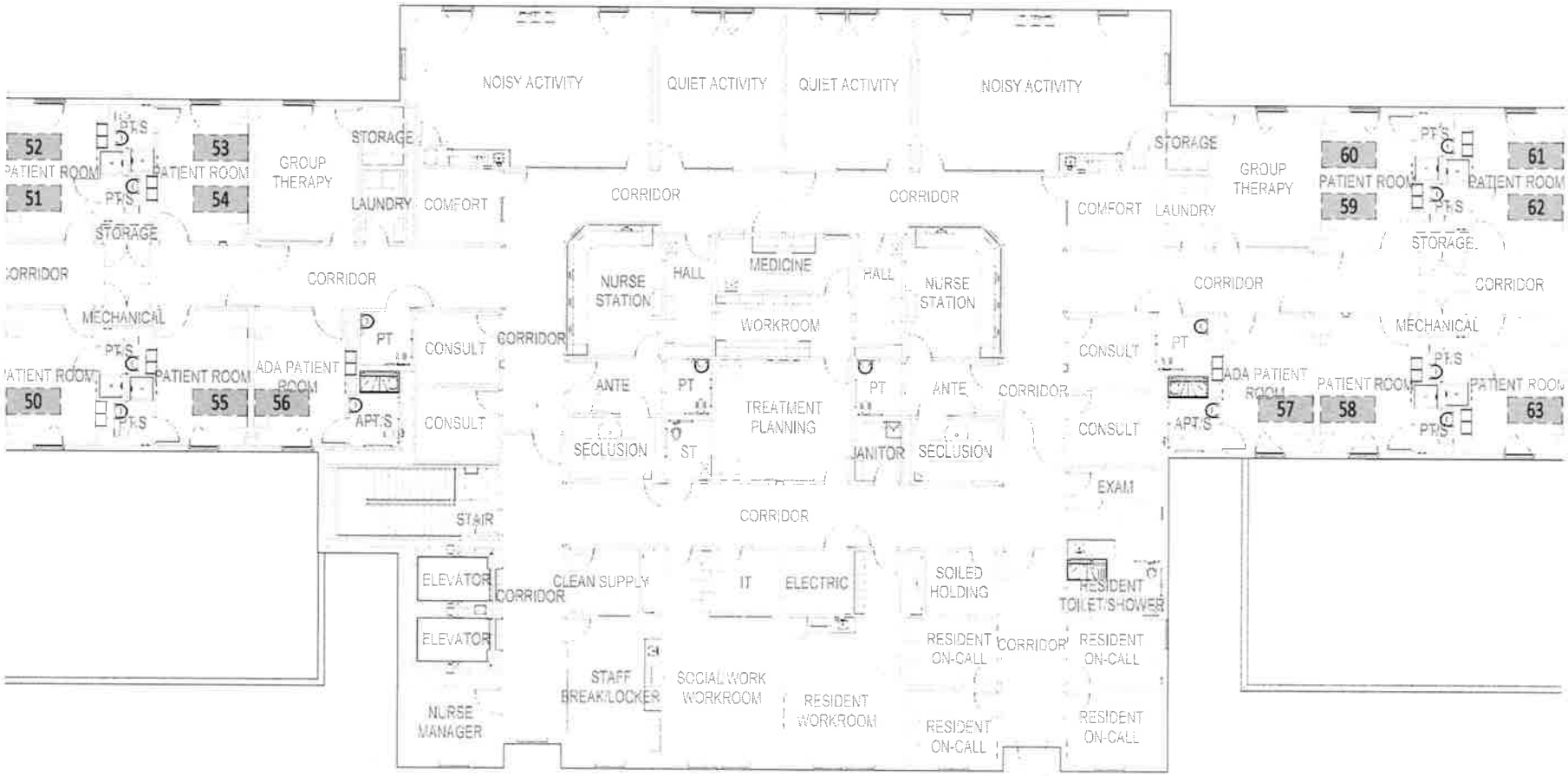
PARTIAL SECOND FLOOR PLAN CO01-02B

NORTH

GRAPHIC SCALE

0' 10' 20' 40'

NEW BEHAVIORAL HEALTH HOSPITAL
Acadia Healthcare Company - Nashville, Tennessee
September 13, 2017



PARTIAL
SECOND FLOOR PLAN
CO01-02C

NORTH

GRAPHIC SCALE

0' 10' 20' 40'

NEW BEHAVIORAL HEALTH HOSPITAL
Acadia Healthcare Company - Nashville, Tennessee
September 13, 2017

PSYCHIATRIC INPATIENT SERVICES

A. Need

1. **The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of Health and applying the data in Joint Annual Reports).**

Response: The Standard and Criteria of 30 beds per 100,000 formula was utilized. The Applicant believes the current formula understates the need for inpatient psychiatric services, as explained in the application and replicated here.

It is proposed to construct/establish a new psychiatric inpatient hospital for the care of adult and geriatric patients. The total inpatient psychiatry hospital beds requested in this application is 76, comprised as follows:

Adult Psychiatry Unit 1	20 beds
Adult Psychiatry Unit 2	20 beds
Geriatric Psychiatry Unit 1	18 beds
Geriatric Psychiatry Unit 2	18 beds
Total Inpatient	76 beds.

Proposed Adult Psychiatry Service: The adult psychiatry program will comprise two treatment units with a combined 40 beds providing inpatient mental health and substance abuse services for adults age 18 to 64. The first treatment unit will be 20 beds, specializing in the care of adult psychiatric patients with *serious* mental illness as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (e.g., mood disorders, co-occurring disorders) (American Psychiatric Association, 2013). The second treatment unit will be 20 beds, specializing in the care of adult psychiatric patients with *severe* mental illness as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (e.g., psychosis, thought disorders, developmental disabilities, and imminent risk of danger to self or others). *Id.*

Proposed Geriatric Psychiatry Service: The geriatric psychiatry program will comprise two treatment units with a combined 36 beds providing inpatient mental health and substance abuse services for adult patients age 65 and over with a primary acute psychiatric diagnosis as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (American Psychiatric Association, 2013). The first treatment unit will be 18 beds, specializing in the care of geriatric patients with serious psychiatric, neuro-cognitive, and behavioral disturbances. The second treatment unit will be 18 beds, specializing in the care of geriatric patients with severe mental illness associated with disturbance of mood, co-occurring disorders, and adjustment. It is intended that the existing patients occupying the 24 geriatric inpatient psychiatry beds located at Saint Thomas West Hospital will move to this new hospital. Saint Thomas West Hospital has not specified their intended use for those vacated beds at this time.

All four units will accept voluntary and involuntary admissions pursuant to Tennessee Code Annotated §33-6-404.

By separating the adult and geriatric patient populations by major diagnostic classifications and severity of illness, the Applicant will be better able to provide care that is tailored to the individual needs of patients in an environment that is safe, efficient, and highly reliable.

Researchers Hankin, Bronstone, and Koran (2011) found that psychiatric patients with psychosis and other forms of thought disorder present a high risk for acts of violence against themselves and others. The nature of the patient's illness, together with the potential triggers resulting in risk for harm, support the need for distinct treatment units specific to the needs of varied populations (Hankin et al., 2011). Further, this hospital will support the long-term population growth in Davidson, Cheatham, and Robertson Counties, and the needs of other surrounding counties that may rely on the Applicant for inpatient psychiatric.

All treatment units are designed with semi-private rooms, which still allows for single occupancy as needed for the individualized care requirement of patients.

This project will involve new construction with a cost estimated at just under $24 million.

This project will significantly improve much needed access to state of the art facilities and treatment of psychiatric patients, reduce the overwhelming burden on an already taxed care delivery system, and reduce the enormous pressure faced by emergency departments holding psychiatric patients in need of inpatient care.

In addition,

1. The current system for access to inpatient psychiatric care continues to be in crisis with patients boarding for extensive periods of time in emergency departments (hours, days, and weeks);

2. Patients have a right of choice in their care provider, and should have access to state of the art facilities and treatment to meet their complex mental health care needs;

3. Existing services are inadequate to meet the immediate and future needs of the community: not enough beds, geographic reach, diversity of care options and providers, rapidly growing population; and

4. TDMHSAS statistics show more than 27,000 patients waiting in emergency departments for more than 24 hours with mental health as primary diagnosis due to lack of beds and capacity to serve – an increase of 9% over prior year (THA and TDMHSAS, 2015 most recent data). This phenomenon is not getting better, only worse, with no substantive change in access to care opportunities for many years.

Finally, according to "The State of Mental Health in America 2018," an in-depth report by Mental Health America (formerly the National Mental Health Association), several disturbing facts were uncovered regarding the mental health ranking of the State of Tennessee, as follows:

1. Tennessee's overall ranking (indicating both a higher prevalence of mental illness and lower rates of access to care) is 46th out of all states plus the District of Columbia;
2. 39th in prevalence of mental illness;
3. 44th in adult psychiatric care;
4. 44th in mental health workforce availability;
5. 44th in incidents of depression;
6. 50th in adults with any mental illness who are uninsured;
7. 5th in adult alcohol dependence; and
8. 11th in adult use of marijuana.

While this application focuses on geriatric and adult populations, Tennessee also ranks poorly in psychiatric care for youth, as follows:

1. The 7th highest rate of prevalence of mental illness;
2. 2nd in alcohol dependence;
3. last (51st) in access to care youth;
4. 49th in youth Major Depressive Episodes ("MDE"); and
5. 51st in care for youth that did not receive treatment for MDE.

The licensure of this new seventy-six (76) bed hospital will result in a net increase of only fifty-two (52) beds, since Saint Thomas West will at that point voluntarily surrender the twenty-four (24) beds currently providing geriatric psychiatric care.

2. **For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.**

Response: The age group of 18 years and older was utilized in calculating the estimated total number of beds needed. The target population (18 and older) of 2020 is 650,393, which results in a statistical bed need of 196 beds. See target population figures on the following chart:

Demographic Variable/ Geographic Area	Department of Health/Health Statistics							Bureau of the Census				TennCare	
	Total Population- Current Year	Total Population- Projected Year	Total Population-% Change	*Target Population- Current Year	*Target Population- Project Year	*Target Population- % Change	Target Population Projected Year as %	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as %	TennCare Enrollees	TennCare Enrollees as % of Total
Davidson Co	698061	730414	+4.6	532997	553478	+3.8	75.8	34.2	$50,484	110923	17.7	139472	21.8
Cheatham Co	41269	42699	+3.5	32442	34844	+7.4	81.6	40.2	$53,179	5045	12.9	7064	17.2
Robertson Co	76231	81065	+6.3	57949	62071	+7.1	76.6	38.5	$56,331	6960	10.5	11359	15.1
Service Area Total	815561	854178	+4.7	623388	650393	+4.3	76.1			122928		249268	25.8
State of TN Total	6960524	7263893	+4.4	5414988	5672576	+4.8	78.1	38.5	$46,574	1188730	17.7	1412063	20.5

** Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2018, then default Projected Year is 2022.*

NOTES on previous chart: Bureau of the Census data is from 2016 (latest data). TennCare Enrollees, latest data, is from June, 2017, as are TennCare population figures.

3. **For child inpatient under age 13, and if adolescent program the age group of 13-17 should be used.**

Response: Not applicable.

4. **These estimates for total need should be adjusted by the existent staffed beds operating in the area as counted by the Department of Health in the Joint Annual Reports.**

Response: There are five existing facilities in Davidson County that provide inpatient psychiatric care. One of these facilities, at Saint Thomas West, will voluntarily surrender its beds once the beds requested in this application are approved and licensed. Due to the need for inpatient psychiatric care, there should be minimal impact on existing providers.

B. Service Area

1. **The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.**

Response: The requested beds will be located in Davidson County. The site is on Great Circle Road, which is in the Rhodes Park Area of Metro Center North. Public transportation is available. As such, the site is readily accessible to patients, family members, and other health care providers.

2. **The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.**

Response: All of Cheatham and Robertson Counties are medically underserved areas, according to Health Resources and Services Administration, as are many census tracts in Davidson County. The addition of more psychiatric beds in the service area will add more health care services and staff. See **Attachment B.Need.D.2** for a list of the MUA tracts in the three counties.

Please see **Attachment B.Need.D.1.a** (9 pages) for more Quick Facts about the primary service area.

Selected JAR utilization/statistics for the psychiatric facilities located in our primary service area are listed in the charts on the following page. These charts reflect data provided by the various facilities on their respective Joint Annual Reports (JARs) for 2014, 2015, and 2016.

The Applicant does not vouch for the correctness of any data contained on the JARs, and some numbers may be not total exactly due to rounding errors.

2016

Facility	C&A beds	C&A %	Adult beds	Adult %	Geri beds	Geri %	Total beds	Total %
Mid TN MHI	*	<0.1	*	52.6	*	5.5	300	58.1
Saint Thomas West**	0	0	0	5.9	24	38.2	24	44.1
TriStar Madison	21	60.0	70	67.9	14	37.6	105	62.4
TriStar Parthenon	0	0	53	78.5	56	44.8	109	61.2
Vanderbilt	26	71.3	54	98.4	8	46.7	88	85.7
Total	47	-	177	-	102	-	626	75.0

Note: * Middle Tennessee Mental Health Institute does not break down type of bed, but does provide utilization. Occupancy Rate is given as percentage of total bed capacity.
** The beds at Saint Thomas West will be surrendered if the instant CON application is approved. The Saint Thomas beds are all licensed as Geriatric, but the JARs report both Adult and Geriatric services.

2015

Facility	C&A beds	C&A %	Adult beds	Adult %	Geri beds	Geri %	Total beds	Total %
Mid TN MHI	*	<0.1	*	53.6	*	6.9	300	60.5
Saint Thomas West**	0	0	0	7.1	24	38.9	24	50.0
TriStar Madison	21	64.7	70	71.6	14	8.6	105	61.8
TriStar Parthenon	0	0	53	91.8	56	41.7	109	66.1
Vanderbilt	26	83.0	54	87.9	8	72.4	88	85.1
Total	47	-	177	-	102	-	626	64.8

Note: Same as above.

2014

Facility	C&A beds	C&A %	Adult beds	Adult %	Geri beds	Geri %	Total beds	Total %
Mid TN MHI	*	<0.1	*	50.6	*	8.5	300	59.1
Saint Thomas West**	0	0	0	12.3	24	44.8	24	57.1
TriStar Madison	21	58.4	70	68.9	14	77.3	105	73.1
TriStar Parthenon	0	0	53	110.0	56	57.1	109	82.7
Vanderbilt	26	83.3	54	91.1	8	81.8	88	88.0
Total	47	-	177	-	102	-	626	69.6

Note: Same as above, with this addition: Saint Thomas' JAR does not indicate its beds are specifically licensed as geriatric, and both adult and geriatric services were reported. Occupancy rate is given as percentage of total bed capacity.

Patients coming to our hospital will represent the full cultural, social, economic, and racial cross-section of citizens in our primary service area and surrounding counties. The United States Department of Health and Human Services (USDHHS) identifies disparity in access to care, care that is safe, efficient, and reliable and stigma associated with mental illness as primary obstacles to improved mental health and general health outcomes nationally (USDHHS, 2014). According to USDHHS (2014), one in seventeen adults suffer a serious and debilitating mental illness that substantial compromises health, wellness, ability to engage in productive living, increased risk of morbidity and premature mortality. For the targeted population in our primary service area, these statistics inform that by 2022, 38,259 adult residents will be suffering a serious and debilitating mental illness. Yet, the 2016 JARs of existing adult psychiatric providers report only 11,677 admissions. As a highly vulnerable segment of our community, the ability to reach these individuals and provide access to care is essential to their well-being and the well-being of our community now and in the future. The USDHHS (2014) addresses the impact of serious mental illness on communities. Among other things, twenty-five percent of all lost time from work due to disability and premature death are directly tied to serious mental illness (USDHHS, 2014). The impact on the individual, their families, businesses and communities is staggering and resonates as a *call-to-action* to ensure high quality mental health services are available to meet the needs of this at-risk population.

Please see page 20 of the application for a map of the service area.

C. Relationship to Existing Applicable Plans

1. The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.

Response: The State of Tennessee Health Services and Development Agency philosophy states: It "strongly favors those institutions that provide services to the elderly." Almost half (36 of 76 beds) of our beds will be dedicated to geriatric care.

The elderly have the highest need for mental health services of any segment of the population. The National Institute of Health reported that depressed older adults have the highest risk of suicide (18.5 per 100,000) of any age group. As many as 40% of nursing home residents have co-morbidity and co-existing psychiatric illnesses. The addition of our proposed hospital will provide improved accessibility and cost effectiveness by offering needed inpatient psychiatric services in the proposed service area.

2. The proposal's relationship to underserved geographic areas and underserved population groups as identified in state, city, county and/or regional plans and other documents should be a significant consideration.

Response: All of Cheatham and Robertson Counties are medically underserved areas, according to Health Resources and Services Administration, as are many census tracts in Davidson County. The addition of more psychiatric beds in the service area will add more health care services and staff. See **Attachment B.Need.D.2** for a list of the MUA tracts in the three counties.

Please see **Attachment B.Need.D.1.a** (9 pages) for more Quick Facts about the primary service area.

The Applicant will care for all persons who are in need of inpatient psychiatric care, without regard to race, gender, or the patient's ability to pay. In fact, this application targets the elderly, as about half of the beds will be for geriatric patients if this application is approved.

3. **The impact of the proposal on similar services supported by state appropriations should be assessed and considered.**

Response: There are five existing facilities in Davidson County that provide inpatient psychiatric care. One of these facilities, at Saint Thomas West, will voluntarily surrender its beds once the beds requested in this application are approved and licensed. Due to the need for inpatient psychiatric care, there should be minimal impact on existing providers.

4. **The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.**

Response: The Applicant's hospital will admit all patients requiring inpatient psychiatric care, whether the admission is voluntary or involuntary. The involuntary admissions are important in the service area, given those individuals are usually more acutely ill than other patients, and they need acute psychiatric care closer to their home and attending physician(s).

Although the Applicant's psychiatry service is designed for acute psychiatric care, with average lengths of stay of 10 to 12 days for adults aged 18 through 64, and 12 to 14 days for elderly patients, the Applicant anticipates occasionally admitting a patient who needs longer term care. The Applicant's hospital will stabilize those patients and will work with other providers to find the most clinically appropriate long-term setting for those individuals.

5. **The degree of projected financial participation in the Medicare and TennCare programs should be considered.**

Response: The following chart indicates the Applicant's projected financial participation in the Medicare and TennCare programs:

Payor Source	Projected Gross Operating Revenue ($)	As a % of Total
Medicare/Medicare Managed Care	6,450,575	35.2
TennCare/Medicaid	5,045,559	27.5
Commercial/Other Managed Care	5,396,813	29.4
Self-Pay	526,881	2.9
Charity Care (See Note below)	386,317	2.1
Other (Specify) Worker's Compensation	536,881	2.9
Total	18,343,026	100.0

NOTE: Charity Care is normally recorded after contractual and administrative adjustments, but is included above to comply with the requested chart.

All programs and services will accept and care for patients with commercial, managed care, Medicare, Tri-Care and TennCare forms of payment. All service lines will accept charity and unfunded patients as a function of our mission to serve the broader community.

D. Relationship to Existing Similar Services in the Area.

1. **The area's trends in occupancy and utilization of similar services should be considered.**

Response: Overall occupancy of the five existing inpatient psychiatric facilities has increased 7.8% from 2014 to 2016, according to the JARs.

2. **Accessibility to specific special need groups should be an important factor.**

Response: All of Cheatham and Robertson Counties are medically underserved areas, according to Health Resources and Services Administration, as are many census tracts in Davidson County. The addition of more psychiatric beds in the service area will add more health care services and staff. See **Attachment B.Need.D.2** for a list of the MUA tracts in the three counties.

Due to the proximity to major highways and local providers of inpatient medical care, the Applicant's hospital will be accessible with reasonable travel time to all residents of the service area.

E. Feasibility

The ability of the applicant to meet Tennessee Department of Mental Health licensure requirements (related to personnel and staffing for psychiatric inpatient facilities) should be considered.

Response: The Applicant's owners are familiar with licensure requirements and will have no problem in meeting those standards.

United States Census Bureau

ATTACHMENT B.NEED.D.1.a

QuickFacts
Davidson County, Tennessee

QuickFacts provides statistics for all states and counties, and for cities and towns with a ***population of 5,000 or more.***

Table

All Topics	Davidson County, Tennessee
Population estimates, July 1, 2016, (V2016)	**684,410**
PEOPLE	
Population	
Population estimates, July 1, 2017, (V2017)	691,243
Population estimates, July 1, 2016, (V2016)	**684,410**
Population estimates base, April 1, 2010, (V2017)	626,580
Population estimates base, April 1, 2010, (V2016)	626,580
Population, percent change - April 1, 2010 (estimates base) to July 1, 2017, (V2017)	10.3%
Population, percent change - April 1, 2010 (estimates base) to July 1, 2016, (V2016)	9.2%
Population, Census, April 1, 2010	626,681
Age and Sex	
Persons under 5 years, percent	▲ 6.9%
Persons under 18 years, percent	▲ 21.3%
Persons 65 years and over, percent	▲ 11.5%
Female persons, percent	▲ 51.8%
Race and Hispanic Origin	
White alone, percent (a)	▲ 65.2%
Black or African American alone, percent (a)	▲ 28.1%
American Indian and Alaska Native alone, percent (a)	▲ 0.5%
Asian alone, percent (a)	▲ 3.7%
Native Hawaiian and Other Pacific Islander alone, percent (a)	▲ 0.1%
Two or More Races, percent	▲ 2.4%
Hispanic or Latino, percent (b)	▲ 10.1%
White alone, not Hispanic or Latino, percent	▲ 56.4%
Population Characteristics	
Veterans, 2012-2016	33,728
Foreign born persons, percent, 2012-2016	12.2%
Housing	
Housing units, July 1, 2016, (V2016)	306,393
Owner-occupied housing unit rate, 2012-2016	54.0%
Median value of owner-occupied housing units, 2012-2016	$177,700
Median selected monthly owner costs -with a mortgage, 2012-2016	$1,332
Median selected monthly owner costs -without a mortgage, 2012-2016	$461
Median gross rent, 2012-2016	$904
Building permits, 2016	9,566
Families & Living Arrangements	
Households, 2012-2016	269,078
Persons per household, 2012-2016	2.40
Living in same house 1 year ago, percent of persons age 1 year+, 2012-2016	80.9%
Language other than English spoken at home, percent of persons age 5 years+, 2012-2016	16.4%
Education	
High school graduate or higher, percent of persons age 25 years+, 2012-2016	87.5%
Bachelor's degree or higher, percent of persons age 25 years+, 2012-2016	38.2%
Health	
With a disability, under age 65 years, percent, 2012-2016	8.8%
Persons without health insurance, under age 65 years, percent	▲ 12.6%
Economy	
In civilian labor force, total, percent of population age 16 years+, 2012-2016	69.9%
In civilian labor force, female, percent of population age 16 years+, 2012-2016	65.5%
Total accommodation and food services sales, 2012 ($1,000) (c)	2,573,787

Total health care and social assistance receipts/revenue, 2012 ($1,000) (c)	8,547,681
Total manufacturers shipments, 2012 ($1,000) (c)	7,319,390
Total merchant wholesaler sales, 2012 ($1,000) (c)	17,607,006
Total retail sales, 2012 ($1,000) (c)	10,138,326
Total retail sales per capita, 2012 (c)	$15,638
Transportation	
Mean travel time to work (minutes), workers age 16 years+, 2012-2016	24.2
Income & Poverty	
Median household income (in 2016 dollars), 2012-2016	$50,484
Per capita income in past 12 months (in 2016 dollars), 2012-2016	$30,595
Persons in poverty, percent	

Is this page helpful? X
Yes No

BUSINESSES

Businesses	
Total employer establishments, 2016	19,470
Total employment, 2016	439,335
Total annual payroll, 2016 ($1,000)	23,468,411
Total employment, percent change, 2015-2016	3.0%
Total nonemployer establishments, 2015	68,869
All firms, 2012	72,042
Men-owned firms, 2012	40,315
Women-owned firms, 2012	25,144
Minority-owned firms, 2012	16,598
Nonminority-owned firms, 2012	52,727
Veteran-owned firms, 2012	6,412
Nonveteran-owned firms, 2012	62,305

GEOGRAPHY

Geography	
Population per square mile, 2010	1,243.3
Land area in square miles, 2010	504.03
FIPS Code	47037

Value Notes

▲ Estimates are not comparable to other geographic levels due to methodology differences that may exist between different data sources.

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable. Click the Quick Info ⓘ icon to the le TABLE view to learn about sampling error.

The vintage year (e.g., V2017) refers to the final year of the series (2010 thru 2017). *Different vintage years of estimates are not comparable.*

Fact Notes

- **(a)** Includes persons reporting only one race
- **(b)** Hispanics may be of any race, so also are included in applicable race categories
- **(c)** Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

Value Flags

- **-** Either no or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest or upper inter distribution.
- **D** Suppressed to avoid disclosure of confidential information
- **F** Fewer than 25 firms
- **FN** Footnote on this item in place of data
- **NA** Not available
- **S** Suppressed; does not meet publication standards
- **X** Not applicable
- **Z** Value greater than zero but less than half unit of measure shown

QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance Estimates, Small Area Income and Po State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.

United States Census Bureau

QuickFacts

Cheatham County, Tennessee; Davidson County, Tennessee

QuickFacts provides statistics for all states and counties, and for cities and towns with a ***population of 5,000 or more***.

Table

All Topics	Cheatham County, Tennessee	Davidson County, Tennessee
Population estimates, July 1, 2016, (V2016)	**39,880**	**684,410**
PEOPLE		
Population		
Population estimates, July 1, 2017, (V2017)	40,330	691,243
Population estimates, July 1, 2016, (V2016)	**39,880**	**684,410**
Population estimates base, April 1, 2010, (V2017)	39,103	626,580
Population estimates base, April 1, 2010, (V2016)	39,103	626,580
Population, percent change - April 1, 2010 (estimates base) to July 1, 2017, (V2017)	3.1%	10.3%
Population, percent change - April 1, 2010 (estimates base) to July 1, 2016, (V2016)	2.0%	9.2%
Population, Census, April 1, 2010	39,105	626,681
Age and Sex		
Persons under 5 years, percent	▲ 5.7%	▲ 6.9%
Persons under 18 years, percent	▲ 22.7%	▲ 21.3%
Persons 65 years and over, percent	▲ 14.5%	▲ 11.5%
Female persons, percent	▲ 50.4%	▲ 51.8%
Race and Hispanic Origin		
White alone, percent (a)	▲ 95.5%	▲ 65.2%
Black or African American alone, percent (a)	▲ 1.8%	▲ 28.1%
American Indian and Alaska Native alone, percent (a)	▲ 0.5%	▲ 0.5%
Asian alone, percent (a)	▲ 0.5%	▲ 3.7%
Native Hawaiian and Other Pacific Islander alone, percent (a)	▲ 0.1%	▲ 0.1%
Two or More Races, percent	▲ 1.7%	▲ 2.4%
Hispanic or Latino, percent (b)	▲ 2.8%	▲ 10.1%
White alone, not Hispanic or Latino, percent	▲ 93.1%	▲ 56.4%
Population Characteristics		
Veterans, 2012-2016	2,887	33,728
Foreign born persons, percent, 2012-2016	1.9%	12.2%
Housing		
Housing units, July 1, 2016, (V2016)	15,960	306,393
Owner-occupied housing unit rate, 2012-2016	79.1%	54.0%
Median value of owner-occupied housing units, 2012-2016	$163,700	$177,700
Median selected monthly owner costs -with a mortgage, 2012-2016	$1,230	$1,332
Median selected monthly owner costs -without a mortgage, 2012-2016	$377	$461
Median gross rent, 2012-2016	$912	$904
Building permits, 2016	173	9,566
Families & Living Arrangements		
Households, 2012-2016	14,543	269,078
Persons per household, 2012-2016	2.70	2.40
Living in same house 1 year ago, percent of persons age 1 year+, 2012-2016	86.4%	80.9%
Language other than English spoken at home, percent of persons age 5 years+, 2012-2016	2.8%	16.4%
Education		
High school graduate or higher, percent of persons age 25 years+, 2012-2016	85.6%	87.5%
Bachelor's degree or higher, percent of persons age 25 years+, 2012-2016	19.4%	38.2%
Health		
With a disability, under age 65 years, percent, 2012-2016	11.2%	8.8%
Persons without health insurance, under age 65 years, percent	▲ 9.4%	▲ 12.6%
Economy		
In civilian labor force, total, percent of population age 16 years+, 2012-2016	64.7%	69.9%
In civilian labor force, female, percent of population age 16 years+, 2012-2016	59.7%	65.5%
Total accommodation and food services sales, 2012 ($1,000) (c)	26,011	2,573,787

Is this page helpful? Yes No

Total health care and social assistance receipts/revenue, 2012 ($1,000) (c)	44,473	8,547,681
Total manufacturers shipments, 2012 ($1,000) (c)	820,245	7,319,390
Total merchant wholesaler sales, 2012 ($1,000) (c)	D	17,607,006
Total retail sales, 2012 ($1,000) (c)	225,775	10,138,326
Total retail sales per capita, 2012 (c)	$5,749	$15,638
Transportation		
Mean travel time to work (minutes), workers age 16 years+, 2012-2016	31.6	24.2
Income & Poverty		
Median household income (in 2016 dollars), 2012-2016	$53,179	$50,484
Per capita income in past 12 months (in 2016 dollars), 2012-2016	$24,279	$30,595
Persons in poverty, percent	▲ 11.1%	▲ 15.1%

BUSINESSES

Businesses		
Total employer establishments, 2016	608	19,470
Total employment, 2016	6,377	439,335
Total annual payroll, 2016 ($1,000)	243,917	23,468,411
Total employment, percent change, 2015-2016	5.9%	3.0%
Total nonemployer establishments, 2015	3,444	68,869
All firms, 2012	3,536	72,042
Men-owned firms, 2012	2,160	40,315
Women-owned firms, 2012	1,007	25,144
Minority-owned firms, 2012	213	16,598
Nonminority-owned firms, 2012	3,263	52,727
Veteran-owned firms, 2012	446	6,412
Nonveteran-owned firms, 2012	2,939	62,305

GEOGRAPHY

Geography		
Population per square mile, 2010	129.3	1,243.3
Land area in square miles, 2010	302.44	504.03
FIPS Code	47021	47037

Value Notes

▲ Estimates are not comparable to other geographic levels due to methodology differences that may exist between different data sources.

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable. Click the Quick Info ⓘ icon to the le TABLE view to learn about sampling error.

The vintage year (e.g., V2017) refers to the final year of the series (2010 thru 2017). *Different vintage years of estimates are not comparable.*

Fact Notes

- **(a)** Includes persons reporting only one race
- **(b)** Hispanics may be of any race, so also are included in applicable race categories
- **(c)** Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

Value Flags

- **-** Either no or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest or upper inte distribution.
- **D** Suppressed to avoid disclosure of confidential information
- **F** Fewer than 25 firms
- **FN** Footnote on this item in place of data
- **NA** Not available
- **S** Suppressed; does not meet publication standards
- **X** Not applicable
- **Z** Value greater than zero but less than half unit of measure shown

QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance Estimates, Small Area Income and Po State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.

United States Census Bureau

QuickFacts

Robertson County, Tennessee; Cheatham County, Tennessee; Davidson County, Tennessee

QuickFacts provides statistics for all states and counties, and for cities and towns with a ***population of 5,000 or more.***

Table

All Topics	Robertson County, Tennessee	Cheatham County, Tennessee	Davidson County, Tennessee
Population estimates, July 1, 2016, (V2016)	**69,165**	**39,880**	**684,410**
PEOPLE			
Population			
Population estimates, July 1, 2017, (V2017)	70,177	40,330	691,243
Population estimates, July 1, 2016, (V2016)	**69,165**	**39,880**	**684,410**
Population estimates base, April 1, 2010, (V2017)	66,349	39,103	626,580
Population estimates base, April 1, 2010, (V2016)	66,349	39,103	626,580
Population, percent change - April 1, 2010 (estimates base) to July 1, 2017, (V2017)	5.8%	3.1%	10.3%
Population, percent change - April 1, 2010 (estimates base) to July 1, 2016, (V2016)	4.2%	2.0%	9.2%
Population, Census, April 1, 2010	66,283	39,105	626,681
Age and Sex			
Persons under 5 years, percent	▲ 6.4%	▲ 5.7%	▲ 6.9%
Persons under 18 years, percent	▲ 24.5%	▲ 22.7%	▲ 21.3%
Persons 65 years and over, percent	▲ 14.2%	▲ 14.5%	▲ 11.5%
Female persons, percent	▲ 50.8%	▲ 50.4%	▲ 51.8%
Race and Hispanic Origin			
White alone, percent (a)	▲ 89.6%	▲ 95.5%	▲ 65.2%
Black or African American alone, percent (a)	▲ 7.6%	▲ 1.8%	▲ 28.1%
American Indian and Alaska Native alone, percent (a)	▲ 0.5%	▲ 0.5%	▲ 0.5%
Asian alone, percent (a)	▲ 0.6%	▲ 0.5%	▲ 3.7%
Native Hawaiian and Other Pacific Islander alone, percent (a)	▲ 0.1%	▲ 0.1%	▲ 0.1%
Two or More Races, percent	▲ 1.5%	▲ 1.7%	▲ 2.4%
Hispanic or Latino, percent (b)	▲ 6.5%	▲ 2.8%	▲ 10.1%
White alone, not Hispanic or Latino, percent	▲ 84.0%	▲ 93.1%	▲ 56.4%
Population Characteristics			
Veterans, 2012-2016	4,142	2,887	33,728
Foreign born persons, percent, 2012-2016	3.5%	1.9%	12.2%
Housing			
Housing units, July 1, 2016, (V2016)	26,842	15,960	306,393
Owner-occupied housing unit rate, 2012-2016	75.2%	79.1%	54.0%
Median value of owner-occupied housing units, 2012-2016	$158,800	$163,700	$177,700
Median selected monthly owner costs -with a mortgage, 2012-2016	$1,232	$1,230	$1,332
Median selected monthly owner costs -without a mortgage, 2012-2016	$420	$377	$461
Median gross rent, 2012-2016	$831	$912	$904
Building permits, 2016	370	173	9,566
Families & Living Arrangements			
Households, 2012-2016	24,730	14,543	269,078
Persons per household, 2012-2016	2.71	2.70	2.40
Living in same house 1 year ago, percent of persons age 1 year+, 2012-2016	87.4%	86.4%	80.9%
Language other than English spoken at home, percent of persons age 5 years+, 2012-2016	5.7%	2.8%	16.4%
Education			
High school graduate or higher, percent of persons age 25 years+, 2012-2016	86.5%	85.6%	87.5%
Bachelor's degree or higher, percent of persons age 25 years+, 2012-2016	18.1%	19.4%	38.2%
Health			
With a disability, under age 65 years, percent, 2012-2016	10.9%	11.2%	8.8%
Persons without health insurance, under age 65 years, percent	▲ 10.5%	▲ 9.4%	▲ [illegible]
Economy			

Is this page helpful? X
Yes No

In civilian labor force, total, percent of population age 16 years+, 2012-2016	65.9%	64.7%	69.9%
In civilian labor force, female, percent of population age 16 years+, 2012-2016	60.4%	59.7%	65.5%
Total accommodation and food services sales, 2012 ($1,000) (c)	65,614	26,011	2,573,787
Total health care and social assistance receipts/revenue, 2012 ($1,000) (c)	176,334	44,473	8,547,681
Total manufacturers shipments, 2012 ($1,000) (c)	1,792,963	820,245	7,319,390
Total merchant wholesaler sales, 2012 ($1,000) (c)	724,095	D	17,607,006
Total retail sales, 2012 ($1,000) (c)	675,221	225,775	10,138,326
Total retail sales per capita, 2012 (c)	$10,088	$5,749	$15,638
Transportation			
Mean travel time to work (minutes), workers age 16 years+, 2012-2016	29.2	31.6	24.2
Income & Poverty			
Median household income (in 2016 dollars), 2012-2016	$56,331	$53,179	$50,484
Per capita income in past 12 months (in 2016 dollars), 2012-2016	$25,534	$24,279	$30,595
Persons in poverty, percent	▲ 10.3%	▲ 11.1%	▲ 15.1%

BUSINESSES

Businesses			
Total employer establishments, 2016	1,155	608	19,470
Total employment, 2016	18,705	6,377	439,335
Total annual payroll, 2016 ($1,000)	715,971	243,917	23,468,411
Total employment, percent change, 2015-2016	0.4%	5.9%	3.0%
Total nonemployer establishments, 2015	5,048	3,444	68,869
All firms, 2012	5,533	3,536	72,042
Men-owned firms, 2012	3,240	2,160	40,315
Women-owned firms, 2012	1,793	1,007	25,144
Minority-owned firms, 2012	410	213	16,598
Nonminority-owned firms, 2012	4,981	3,263	52,727
Veteran-owned firms, 2012	574	446	6,412
Nonveteran-owned firms, 2012	4,788	2,939	62,305

GEOGRAPHY

Geography			
Population per square mile, 2010	139.2	129.3	1,243.3
Land area in square miles, 2010	476.29	302.44	504.03
FIPS Code	47147	47021	47037

Value Notes

▲ Estimates are not comparable to other geographic levels due to methodology differences that may exist between different data sources.

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable. Click the Quick Info ⓘ icon to the le TABLE view to learn about sampling error.

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Fact Notes

- **(a)** Includes persons reporting only one race
- **(b)** Hispanics may be of any race, so also are included in applicable race categories
- **(c)** Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

Value Flags

- **-** Either no or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest or upper inte distribution.
- **D** Suppressed to avoid disclosure of confidential information
- **F** Fewer than 25 firms
- **FN** Footnote on this item in place of data
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- **S** Suppressed; does not meet publication standards
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QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance Estimates, Small Area Income and Po State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.

U.S. Department of Health & Human Services

ATTACHMENT B.NEED.D.2

HRSA Health Resources & Services Administration Data Warehouse

Topic Areas | Tools | Data | FAQs & Resources | About HDW | HRSA.gov

Home > Tools > Analyzers > MUA Find > MUA Find Results

MUA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 4/30/2018

State: Tennessee
County: Davidson County
MUA ID: All

Collapse All

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County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Population Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Da
Davidson County	037	Bordeaux/Inglewood	03242	Medically Underserved Area	Medically Underserved Area	61.00	05/04/1994	03/27/2008
CT 0117.00 CT 0118.00 CT 0119.00 CT 0192.00 CT 0193.00								
Davidson County	037	Davidson Service Area	03243	Medically Underserved Area	Medically Underserved Area	48.27	05/10/1982	05/04/1994
CT 0161.00 CT 0162.00 CT 0163.00 CT 0164.00 CT 0168.00 CT 0169.00 CT 0170.00 CT 0171.00								
Davidson County	037	Davidson Service Area	03248	Medically Underserved Area	Medically Underserved Area	57.06	07/12/1994	07/12/1994
CT 0136.01 CT 0136.02 CT 0137.00 CT 0139.00 CT 0142.00 CT 0143.00 CT 0144.00 CT 0148.00 CT 0194.00 CT 0195.00								

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U. S. Department of Health & Human Services

HRSA Health Resources & Services Administration Data Warehouse

Topic Areas | Tools | Data | FAQs & Resources | About HDW | HRSA.gov

Home > Tools > Analyzers > MUA Find > MUA Find Results

MUA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 4/30/2018

State: Tennessee
County: Cheatham County
MUA ID: All

Collapse All

1 Page Size: 20 01 items in 01 pa

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Population Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Da
Cheatham County	021	CHEATHAM SERVICE AREA	03180	Medically Underserved Area	Medically Underserved Area	60.70	11/01/1978	11/01/1978

1 Page Size: 20 01 items in 01 pa

U. S. Department of Health & Human Services

HRSA Health Resources & Services Administration Data Warehouse

Topic Areas | Tools | Data | FAQs & Resources | About HDW | HRSA.gov

Home > Tools > Analyzers > MUA Find > MUA Find Results

MUA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 4/30/2018

State: Tennessee
County: Robertson County
MUA ID: All

Collapse All

1 Page Size: 20 01 items in 01 pa

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Population Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Da
Robertson County	147	ROBERTSON SERVICE AREA	03228	Medically Underserved Area	Medically Underserved Area	60.90	11/01/1978	11/01/1978

1 Page Size: 20 01 items in 01 pa

STENGEL-HILL ARCHITECTURE

Dr. Jeffrey D. Woods, DNP, RN-BC
Group Chief Executive Officer
Acadia Healthcare - Tennessee

Re: Attestation of Construction Cost
New Behavioral Health Hospital
Cumberland Behavioral Health, LLC
Nashville, Tennessee

23 March 2018

SHA.AHC1508

Dr. Woods,

Per recent conversations with you regarding a Certificate of Need Submission for a New Behavioral Health Hospital for Cumberland Behavioral Health, LLC in Nashville, Tennessee, I have prepared the following supporting documentation for your review.

I have reviewed the construction cost estimate in the CON Submission for this Project. Based on my experience and knowledge of the current health care market, it is my opinion that the projected construction cost of $23,667,000 appears to be reasonable for a project of this type and size.

Additionally, please note that the Project will be designed in compliance with all applicable State and Federal Regulations, including the following:

- → Guidelines for the Design and Construction of Health Care Facilities
- → Rules of the Tennessee Department of Mental Health
- → International Building Code
- → National Electrical Code
- → National Fire Protection Association (NFPA) Codes
- → Americans with Disabilities Act (ADA)

If you have any questions or comments regarding this information, please do not hesitate to contact me at your convenience.

Thank you.

Bradford P. Stengel, AIA
Senior Principal
Stengel Hill Architecture Incorporated
Tennessee Registered Architect No. #000102 523

BRADFORD P. STENGEL
REGISTERED ARCHITECT
AGRICULTURE
COMMERCE
No. 000102 523
STATE OF TENNESSEE

copy: Steve Davidson AHC

CAH/tww

613 WEST MAIN STREET LOUISVILLE, KENTUCKY 40202
tel: 502.893.1875 fax: 502.893.1876 www.stengelhill.com

ACADIA
HEALTHCARE

April 20, 2018

Melanie Hill, Executive Director
Health Services and Development Agency
State of Tennessee
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Dear Mrs. Hill:

This letter will confirm that Acadia Healthcare Company, Inc. ("Acadia"), through its wholly owned subsidiary, Acadia Nashville JV Holdings, LLC, will contribute 49.9% of the total capital needed for Cumberland Behavioral Health, LLC to construct, equip and operate a 76-bed acute psychiatric hospital in Davidson County, Tennessee.

Acadia is a publicly held company, with stock traded on the NASDAQ Stock Market. As such, the company is required to file an Annual Report on Form 10-K with the Securities and Exchange Commission annually. I have attached the most recent 10-K for the year ending December 31, 2017, which includes the company's audited financial statements for the year ended December 31, 2017.

Thank you for your consideration and I urge approval of this project.

Sincerely,

David Duckworth
Chief Financial Officer

6100 Tower Circle, Suite 1000 • Franklin, TN 37067 • Office: 615.861.6000

ASCENSION

May 11, 2018

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Certificate of Need Application – Cumberland Behavioral Health, LLC

Dear Ms. Hill:

Ascension has a centralized cash management program for managing and investing operational funds for Ascension hospitals and clinics, including Saint Thomas Health.

This letter is to confirm Ascension has available more than sufficient resources to fund its share of the projected CON cost of $16,140,617 required to implement Cumberland Behavioral Health, LLC's 76 inpatient bed project.

Ascension will be funding the $16,140,617 from cash reserves. As evidence of Ascension's ability to provide necessary capital, the following information is offered.

1. Ascension, the parent company of Saint Thomas Health, had $673,301,000 in cash and cash equivalents as of April 30, 2018. Ascension had $15,910,518,000 in short and long-term investments as of April 30, 2018.

2. Ascension has a current rating of Aa2, Aa2/VMIG 1, and Aa2/P-1, subordinated debt ratings of Aa3 and Aa3/VMIG 1, and commercial paper rating of P-1 by Moody's Investor Service.

Thank you for attention to this matter.

Sincerely,

ASCENSION

Elizabeth C Foshage

Elizabeth C. Foshage
Senior Vice-President, Finance

APR 23 '18 AM 10:08

ACADIA
HEALTHCARE

April 19, 2018

Melanie Hill, Executive Director
Health Services and Development Agency
State of Tennessee
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Dear Mrs. Hill:

This letter will confirm that Acadia Healthcare Company, Inc. ("Acadia"), through its wholly owned subsidiary, Acadia Nashville JV Holdings, LLC, will contribute 49.9% of the total capital needed for Cumberland Behavioral Health, LLC to construct, equip and operate a 76-bed acute psychiatric hospital in Davidson County, Tennessee.

Acadia is a publicly held company, with stock traded on the NASDAQ Stock Market. As such, the company is required to file an Annual Report on Form 10-K with the Securities and Exchange Commission annually. I have attached the most recent 10-K for the year ending December 31, 2017, which includes the company's audited financial statements for the year ended December 31, 2017.

Thank you for your consideration and I urge approval of this project.

Sincerely,

David Duckworth
Chief Financial Officer

6100 Tower Circle, Suite 1000 • Franklin, TN 37067 • Office: 615.861.6000

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2017

or

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

For the transition period from _____ to _____

Commission File Number: 001-35331

ACADIA HEALTHCARE COMPANY, INC.
(Exact Name of Registrant as Specified in Its Charter)

Delaware (State or other jurisdiction of incorporation or organization)	**45-2492228** (I.R.S. Employer Identification No.)

6100 Tower Circle, Suite 1000
Franklin, Tennessee 37067
(Address, including zip code, of registrant's principal executive offices)

(615) 861-6000
(Registrant's telephone number, including area code)

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

Title of each Class	Name of exchange on which registered
Common Stock, $.01 par value	NASDAQ Global Select Market

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

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

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

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

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

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

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

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

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

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

As of June 30, 2017, the aggregate market value of the shares of common stock of the registrant held by non-affiliates was approximately $3.9 billion, based on the closing price of the registrant's common stock reported on the NASDAQ Global Select Market of $49.38 per share.

As of February 27, 2018, there were 87,950,965 shares of the registrant's common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive proxy statement for its 2018 annual meeting of stockholders to be held on May 3, 2018 are incorporated by reference into Part III of this Form 10-K.

ACADIA HEALTHCARE COMPANY, INC.
ANNUAL REPORT ON FORM 10-K
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PART I

Unless the context otherwise requires, all references in this Annual Report on Form 10-K to "Acadia," "the Company," "we," "us" or "our" mean Acadia Healthcare Company, Inc. and its consolidated subsidiaries.

Item 1. Business.

Overview

Our business strategy is to acquire and develop behavioral healthcare facilities and improve our operating results within our facilities and our other behavioral healthcare operations. We strive to improve the operating results of our facilities by providing quality patient care, expanding referral networks and marketing initiatives while meeting the increased demand for behavioral healthcare services through expansion of our current locations as well as developing new services within existing locations. At December 31, 2017, we operated 582 behavioral healthcare facilities with approximately 17,800 beds in 39 states, the United Kingdom ("U.K.") and Puerto Rico. During the year ended December 31, 2017, we acquired one facility and added 750 new beds (exclusive of the acquisition), including 588 added to existing facilities and 162 added through the opening of two de novo facilities. For the year ending December 31, 2018, we expect to add more than 800 total beds exclusive of acquisitions.

We are the leading publicly traded pure-play provider of behavioral healthcare services, with operations in the United States ("U.S.") and the U.K. Management believes that we are positioned as a leading platform in a highly fragmented industry under the direction of an experienced management team that has significant industry expertise. Management expects to take advantage of several strategies that are more accessible as a result of our increased size and geographic scale, including continuing a national marketing strategy to attract new patients and referral sources, increasing our volume of out-of-state referrals, providing a broader range of services to new and existing patients and clients and selectively pursuing opportunities to expand our facility and bed count in the U.S. and U.K.

Acadia was formed as a limited liability company in the State of Delaware in 2005, and converted to a corporation on May 13, 2011. Our common stock is listed for trading on The NASDAQ Global Select Market under the symbol "ACHC." Our principal executive offices are located at 6100 Tower Circle, Suite 1000, Franklin, Tennessee 37067, and our telephone number is (615) 861-6000.

Acquisitions

2017 Acquisition

On November 13, 2017, we completed the acquisition of Aspire Scotland ("Aspire"), an education facility with 36 beds located in Scotland, for cash consideration of approximately $21.3 million.

2016 U.S. Acquisitions

On June 1, 2016, we completed the acquisition of Pocono Mountain Recovery Center ("Pocono Mountain"), an inpatient psychiatric facility with 108 beds located in Henryville, Pennsylvania, for cash consideration of approximately $25.4 million.

On May 1, 2016, we completed the acquisition of TrustPoint Hospital ("TrustPoint"), an inpatient psychiatric facility with 100 beds located in Murfreesboro, Tennessee, for cash consideration of approximately $62.7 million.

On April 1, 2016, we completed the acquisition of Serenity Knolls ("Serenity Knolls"), an inpatient psychiatric facility with 30 beds located in Forest Knolls, California, for cash consideration of approximately $10.0 million.

Priory

On February 16, 2016, we completed the acquisition of Priory Group No. 1 Limited ("Priory") for a total purchase price of approximately $2.2 billion, including cash consideration of approximately $1.9 billion and the issuance of 4,033,561 shares of our common stock to shareholders of Priory. Priory was the leading independent provider of behavioral healthcare services in the U.K., operating 324 facilities with approximately 7,100 beds at the acquisition date.

The Competition and Markets Authority (the "CMA") in the U.K. reviewed our acquisition of Priory. On July 14, 2016, the CMA announced that our acquisition of Priory was referred for a phase 2 investigation unless we offered acceptable undertakings to address the CMA's competition concerns relating to the provision of behavioral healthcare services in certain markets. On July 28, 2016, the CMA announced that we had offered undertakings to address the CMA's concerns and that, in lieu of a phase 2 investigation, the CMA would consider our undertakings.

On October 18, 2016, we signed a definitive agreement with BC Partners ("BC Partners") for the sale of 21 existing U.K. behavioral health facilities and one de novo behavioral health facility with an aggregate of approximately 1,000 beds (collectively, the "U.K. Disposal Group"). On November 10, 2016, the CMA accepted our undertakings to sell the U.K. Disposal Group to BC Partners and confirmed that the divestiture satisfied the CMA's concern about the impact of our acquisition of Priory on competition for the provision of behavioral healthcare services in certain markets in the U.K. As a result of the CMA's acceptance of our undertakings, our acquisition of Priory was not referred for a phase 2 investigation. On November 30, 2016, we completed the sale of the U.K. Disposal Group to BC Partners for £320 million cash (the "U.K. Divestiture").

Our completed acquisitions of Priory, Serenity Knolls, TrustPoint, and Pocono Mountain are referred to collectively in this report as the "2016 Acquisitions".

2015 Acquisitions

During 2015, we completed the acquisition of CRC Health Group, Inc. ("CRC"), Quality Addition Management Inc., Choice Lifestyles, Pastoral Care Group, Mildmay Oaks f/k/a Vista Independent Hospital, Care UK Limited, The Manor Clinic, Belmont Behavioral Health, Southcoast Behavioral, The Danshell Group, Health and Social Care Partnerships, Manor Hall, Meadow View, Cleveland House, Duffy's Napa Valley Rehab, Discovery House-Group Inc and MMO Behavioral Health Systems (collectively with the 2016 Acquisitions , the "2015 and 2016 Acquisitions").

Financing Transactions

On May 10, 2017, we entered into a Third Repricing Amendment (the "Third Repricing Amendment") to the Amended and Restated Credit Agreement, dated as of December 31, 2012 (the "Amended and Restated Credit Agreement"). The Third Repricing Amendment reduced the Applicable Rate with respect to the Tranche B-1 Term Loan facility (the "Tranche B-1 Facility") and the Tranche B-2 Term Loan facility (the "Tranche B-2 Facility") from 3.0% to 2.75% in the case of Eurodollar Rate loans and from 2.0% to 1.75% in the case of Base Rate Loans. In connection with the Third Repricing Amendment, the Company recorded a debt extinguishment charge of $0.8 million, including the discount and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of operations.

On November 30, 2016, we entered into a Refinancing Facilities Amendment (the "Refinancing Amendment") to the Amended and Restated Credit Agreement. The Refinancing Amendment increased our line of credit on our revolving credit facility to $500.0 million from $300.0 million and reduced our Term Loan A facility (the "TLA Facility") to $400.0 million from $600.6 million (together, the "Refinancing Facilities"). In addition, the Refinancing Amendment extended the maturity date for the Refinancing Facilities to November 30, 2021 from February 13, 2019, and lowered the effective interest rate on our line of credit on our revolving credit facility and TLA Facility by 50 basis points. In connection with the Refinancing Amendment, we recorded a debt extinguishment charge of $0.8 million, including the write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of income.

On November 22, 2016, we entered into a Tenth Amendment (the "Tenth Amendment") to the Amended and Restated Credit Agreement. The Tenth Amendment, among other things, (i) amended the negative covenant regarding dispositions, (ii) modified the collateral package to release any real property with a fair market value of less than $5.0 million and (iii) changed certain investment, indebtedness and lien baskets.

On September 21, 2016, we entered into a Tranche B-2 Repricing Amendment to the Amended and Restated Credit Agreement. The Tranche B-2 Repricing Amendment reduced the Applicable Rate with respect to our Tranche B-2 Facility from 3.75% to 3.00% in the case of Eurodollar Rate loans and 2.75% to 2.00% in the case of Base Rate Loans. In connection with the Tranche B-2 Repricing Amendment, we recorded a debt extinguishment charge of $3.4 million, including the discount and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of income.

On May 26, 2016, we entered into a Tranche B-1 Repricing Amendment to the Amended and Restated Credit Agreement. The Tranche B-1 Repricing Amendment reduced the Applicable Rate with respect to our Tranche B-1 Facility from 3.5% to 3.0% in the case of Eurodollar Rate loans and 2.5% to 2.0% in the case of Base Rate Loans.

On February 16, 2016, we issued $390.0 million of 6.500% Senior Notes due 2024 (the "6.500% Senior Notes"). The 6.500% Senior Notes mature on March 1, 2024 and bear interest at a rate of 6.500% per annum, payable semi-annually in arrears on March 1 and September 1 of each year, beginning on September 1, 2016. We used the net proceeds to fund a portion of the purchase price for the acquisition of Priory and the fees and expenses for such acquisition and the related financing transactions.

On February 16, 2016, we entered into a Second Incremental Facility Amendment (the "Second Incremental Amendment") to our Amended and Restated Credit Agreement. The Second Incremental Amendment activated our Tranche B-2 Facility and added $135.0 million to the TLA Facility to our Amended and Restated Senior Secured Credit Facility (the "Amended and Restated Senior Credit Facility"), subject to limited conditionality provisions. Borrowings under the Tranche B-2 Facility were used to fund a portion of the purchase price for the acquisition of Priory and the fees and expenses for such acquisition and the related financing transactions. Borrowings under the TLA Facility were used to pay down the majority of our $300.0 million revolving credit facility.

On January 25, 2016, we entered into the Ninth Amendment (the "Ninth Amendment") to the Amended and Restated Credit Agreement. The Ninth Amendment modified certain definitions and provided increased flexibility to us in terms of our financial covenants. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources—Amended and Restated Senior Credit Facility" for additional information.

On January 12, 2016, we completed the offering of 11,500,000 shares of common stock (including shares sold pursuant to the exercise of the over-allotment option that we granted to the underwriters as part of the offering) at a public offering price of $61.00 per share. The net proceeds to us from the sale of the shares, after deducting the underwriting discount of $15.8 million and additional offering related costs of $0.7 million, were approximately $685.0 million. We used the net offering proceeds to fund a portion of the purchase price for the acquisition of Priory.

On September 21, 2015, we issued $275.0 million of additional 5.625% Senior Notes due 2033 (the "5.625% Senior Notes"). The 5.625% Senior Notes mature on February 15, 2023 and bear interest at a rate of 5.625% per annum, payable semi-annually in arrears on February 15 and August 15 of each year, beginning on August 15, 2015. The additional notes formed a single class of debt securities with the 5.625% Senior Notes issued in February 2015. Giving effect to this issuance, we have outstanding an aggregate of $650.0 million of 5.625% Senior Notes.

On September 21, 2015, we purchased approximately $88.3 million aggregate principal amount of 12.875% Senior Notes due 2018 (the "12.875% Senior Notes") in connection with a tender offer for any and all of the 12.875% Senior Notes. The notes purchased represented 90.6% of the outstanding $97.5 million principal amount of 12.875% Senior Notes. The 12.875% Senior Notes were purchased at a price of 107.875% of the principal amount thereof plus accrued and unpaid interest to, but not including, September 21, 2015. On September 18, 2015, we delivered a notice to redeem all $9.2 million in principal amount of the 12.875% Senior Notes remaining outstanding following the consummation of the tender offer. On November 1, 2015, we redeemed all of the outstanding $9.2 million principal amount of the 12.875% Senior Notes. As a result of this redemption, both the 12.875% Senior Notes and the indenture governing the 12.875% Senior Notes were satisfied and discharged in accordance with their terms. In connection with the purchase of notes, the Company recorded a debt extinguishment charge of approximately $10.8 million for the year ended December 31, 2015, including the premium and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of income.

On May 11, 2015, we completed the offering of 5,175,000 shares of common stock (including shares sold pursuant to the exercise of the over-allotment option that we granted to the underwriters as part of the offering) at a price of $66.50 per share. The net proceeds to us from the sale of the shares, after deducting the underwriting discount of $12.0 million and additional offering-related costs of $0.8 million, were $331.3 million. We used the net offering proceeds to repay outstanding indebtedness and fund acquisitions.

On April 22, 2015, we entered into an Eighth Amendment (the "Eighth Amendment") to our Amended and Restated Credit Agreement. The Eighth Amendment changed the definition of "Change of Control" in part to remove a provision whose purpose was, when calculating whether a majority of incumbent directors have approved new directors, that any incumbent director that became a director as a result of a threatened or actual proxy contest was not counted in such calculation.

On February 11, 2015, we issued $375.0 million of 5.625% Senior Notes. We used the net proceeds to fund a portion of the consideration for the acquisition of CRC.

On February 11, 2015, we entered into a First Incremental Facility Amendment (the "First Incremental Amendment") to the Amended and Restated Credit Agreement. The First Incremental Amendment activated our Tranche B-1 Facility that was added to the Amended and Restated Senior Secured Credit Facility, subject to limited conditionality provisions. Borrowings under the Tranche B-1 Facility were used to fund a portion of the consideration for the acquisition of CRC.

On February 6, 2015, we entered into a Seventh Amendment (the "Seventh Amendment") to our Amended and Restated Credit Agreement. The Seventh Amendment added Citibank, N.A. as an "L/C Issuer" under the Amended and Restated Credit Agreement in order to permit the rollover of CRC's existing letters of credit into the Amended and Restated Credit Agreement and increased both the Company's Letter of Credit Sublimit and Swing Line Sublimit to $20.0 million.

Competitive Strengths

Management believes the following strengths differentiate us from other providers of behavioral healthcare services:

Premier operational management team with track record of success. Our management team has approximately 160 combined years of experience in acquiring, integrating and operating a variety of behavioral health facilities. Following the sale of Psychiatric Solutions, Inc. ("PSI") to Universal Health Services, Inc. ("UHS") in November 2010, certain of PSI's key former executive officers joined Acadia in February 2011. The extensive national experience and operational expertise of our management team give us what management believes to be the premier leadership team in the behavioral healthcare industry. Our management team strives to use its years of experience operating behavioral healthcare facilities to generate strong cash flow and grow a profitable business.

Favorable industry and legislative trends. According to a 2014 survey by the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services ("SAMHSA"), 18.1% of adults in the U.S. aged 18 years or older suffered from a mental illness in the prior year and 4.1% suffered from a serious mental illness. Further, approximately 8.1% of people aged 12 or older in 2014 were classified with a substance abuse disorder in the past year. According to the National Institute of Mental Health, over 20% of children, either currently or at some point in their life, have had a seriously debilitating mental disorder. Management believes the market for behavioral services will continue to grow due to increased awareness of mental health and substance abuse conditions and treatment options. According to a 2014 SAMHSA report, national expenditures at substance abuse treatment facilities are expected to reach $42.1 billion in 2020, up from $24.3 billion in 2009.

While the growing awareness of mental health and substance abuse conditions is expected to accelerate demand for services, recent healthcare reform in the U.S. is expected to increase access to industry services as more people obtain insurance coverage. A key aspect of reform legislation is the extension of mental health parity protections established into law by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "MHPAEA"). The MHPAEA requires employers who provide behavioral health and addiction benefits to provide such coverage to the same extent as other medical conditions. On December 13, 2016, President Obama signed the 21st Century Cures Act. The 21st Century Cures Act appropriates substantial resources for the treatment of behavioral health and substance abuse disorders and contains measures intended to strengthen the MHPAEA.

The mental health hospitals market in the U.K. was estimated at £15.9 billion for 2014/2015. As a result of government budget constraints and an increased focus on quality, the independent mental health hospitals market has witnessed significant expansion in the last decade, making it one of the fastest growing sectors in the U.K. healthcare industry. Demand for independent sector beds has grown significantly as a result of the National Health Service (the "NHS") reducing its bed capacity and increasing hospitalization rates. Independent sector demand is expected to further increase in light of additional bed closures and reduction in community capacity by the NHS.

Leading platform in attractive healthcare niche. We are a leading behavioral healthcare platform in an industry that is undergoing consolidation in an effort to reduce costs and expand programs to better serve the growing need for inpatient behavioral healthcare services. Management expects to take advantage of several strategies that are more accessible as a result of our increased size and geographic scale, including continuing a national marketing strategy to attract new patients and referral sources, increasing our volume of out-of-state referrals, providing a broader range of services to new and existing patients and clients and selectively pursuing opportunities to expand our facility and bed count in the U.S. and U.K.

Diversified revenue and payor bases. As of December 31, 2017, we operated 582 facilities in 39 states, the U.K. and Puerto Rico. Our payor, patient and geographic diversity mitigates the potential risk associated with any single facility. For the year ended December 31, 2017, we received 32% of our revenue from public funded sources in the U.K. (including the NHS, Clinical Commissioning Groups ("CCGs") and Local Authorities), 28% from Medicaid, 20% from commercial payors, 10% from Medicare and 10% from other payors. As we receive Medicaid payments from 45 states, the District of Columbia and Puerto Rico, management does not believe that we are significantly affected by changes in reimbursement policies in any one state or territory. No facility accounted for more than 3% of revenue for the year ended December 31, 2017, and no state or U.S. territory accounted for more than 8% of revenue for the year ended December 31, 2017. Our U.K. operations accounted for approximately 36% of our revenue for the year ended December 31, 2017. We believe that our increased geographic diversity will mitigate the impact of any financial or budgetary pressure that may arise in a particular state or market where we operate.

Strong cash flow generation and low capital requirements. We generate strong free cash flow by profitably operating our business and by actively managing our working capital. Moreover, as the behavioral healthcare business does not typically require the procurement and replacement of expensive medical equipment, our maintenance capital expenditure requirements are generally less than that of other facility-based healthcare providers. For the year ended December 31, 2017, our maintenance capital expenditures amounted to approximately 3% of our revenue. In addition, our accounts receivable management is less complex than medical/surgical hospital providers because behavioral healthcare facilities have fewer billing codes and generally are paid on a per diem basis.

Business Strategy

We are committed to providing the communities we serve with high-quality, cost-effective behavioral healthcare services, while growing our business, increasing profitability and creating long-term value for our stockholders. To achieve these objectives, we have aligned our activities around the following growth strategies:

Increase margins by enhancing programs and improving performance at existing facilities. Management believes we can improve efficiencies and increase operating margins by utilizing our management's expertise and experience within existing programs and their expertise in improving performance at underperforming facilities. Management believes the efficiencies can be realized by investing in growth in strong markets, addressing capital-constrained facilities that have underperformed and improving management systems. Furthermore, our recent acquisitions of additional facilities give us an opportunity to develop a marketing strategy in many markets which should help us increase the geographic footprint from which our existing facilities attract patients and referrals.

Opportunistically pursue acquisitions and partnerships. We have positioned our company as a leading provider of mental health services in the U.S. and the U.K. The behavioral healthcare industry in the U.S. and the independent behavioral healthcare industry in the U.K. are highly fragmented, and we selectively seek opportunities to expand and diversify our base of operations by acquiring additional facilities and entering into partnerships with healthcare providers to acquire and develop additional facilities. Acadia management believes there are a number of acquisition candidates available at attractive valuations, and we have a number of potential joint ventures and acquisitions in various stages of development and consideration in the U.S.

Management believes our focus on behavioral healthcare and history of completing acquisitions provides us with a strategic advantage in sourcing, evaluating and closing acquisitions. We leverage our management team's expertise to identify and integrate acquisitions based on a disciplined acquisition strategy that focuses on quality of service, return on investment and strategic benefits. We also have a comprehensive post-acquisition strategic plan to facilitate the integration of acquired facilities that includes improving facility operations, retaining and recruiting psychiatrists and other healthcare professionals and expanding the breadth of services offered by the facilities.

Drive organic growth of existing facilities. We seek to increase revenue at our facilities by providing a broader range of services to new and existing patients and clients. In addition, management intends to increase bed counts in our existing facilities. During the year ended December 31, 2017, we added 750 new beds (exclusive of the acquisition), including 588 added to existing facilities and 162 added through the opening of two de novo facilities. For the year ending December 31, 2018, we expect to add more than 800 total beds exclusive of acquisitions. Furthermore, management believes that opportunities exist to leverage out-of-state referrals to increase volume and minimize payor concentration in the U.S., especially with respect to our youth and adolescent focused services and our substance abuse services.

U.S. Operations

Our U.S. facilities and services can generally be classified into the following categories: acute inpatient psychiatric facilities; specialty treatment facilities; residential treatment centers; and outpatient community-based services. The table below presents the percentage of our total U.S. revenue attributed to each category for the year ended December 31, 2017:

Facility/Service	U.S. Revenue for the Year Ended December 31, 2017
Acute inpatient psychiatric facilities	43%
Specialty treatment facilities	40%
Residential treatment centers	15%
Outpatient community-based services	2%

We receive payments from the following sources for services rendered in our U.S. facilities: (i) state governments under their respective Medicaid and other programs; (ii) commercial insurers; (iii) the federal government under the Medicare program administered by the Centers for Medicare and Medicaid Services ("CMS"); and (iv) individual patients and clients. For the year ended December 31, 2017 in our U.S. facilities, we received 43% of our revenue from Medicaid, 31% from commercial payors, 15% from Medicare and 11% from other payors.

At December 31, 2017, our U.S. facilities included 209 behavioral healthcare facilities with approximately 8,900 beds in 39 states and Puerto Rico. Of our U.S. facilities, approximately 40% are acute inpatient psychiatric facilities, approximately 41% are specialty treatment facilities, approximately 14% are residential treatment centers and approximately 5% are outpatient community-based service facilities at December 31, 2017. Of the 209 behavioral healthcare facilities, 112 are comprehensive treatment centers ("CTCs") which is a subset of specialty treatment facilities. Of our CTCs, 14 are owned properties and 98 are leased properties. Of the 97 facilities that are not CTCs, 77 are owned properties and 20 are leased properties. For the years ended December 31, 2017 and 2016, our U.S. operations generated revenue of $1.8 billion and $1.7 billion, respectively.

Acute Inpatient Psychiatric Facilities

Acute inpatient psychiatric facilities provide a high level of care in order to stabilize patients that are either a threat to themselves or to others. The acute setting provides 24-hour observation, daily intervention and monitoring by psychiatrists. Generally, due to shorter lengths of stay, the related higher patient turnover, and the special security and health precautions required, acute inpatient psychiatric facilities have lower average occupancy than residential treatment centers. Our facilities that offer acute care services provide evaluation and crisis stabilization of patients with severe psychiatric diagnoses through a medical delivery model that incorporates structured and intensive medical and behavioral therapies with 24-hour monitoring by a psychiatrist, psychiatric trained nurses, therapists and other direct care staff. Lengths of stay for crisis stabilization and acute care range from three to five days and from five to twelve days, respectively.

Specialty Treatment Facilities

Our specialty treatment facilities include residential recovery facilities, eating disorder facilities and CTCs. We provide a comprehensive continuum of care for adults with addictive disorders and co-occurring mental disorders. Our detoxification, inpatient, partial hospitalization and outpatient treatment programs are cost-effective and give patients access to the least restrictive level of care. All programs offer individualized treatment in a supportive and nurturing environment.

The majority of our specialty treatment services are provided to patients who abuse addictive substances such as alcohol, illicit drugs or opiates, including prescription drugs. Some of our facilities also treat other addictions and behavioral disorders such as chronic pain, sexual compulsivity, compulsive gambling, mood disorders, emotional trauma and abuse. The goal of our treatment facilities is to provide the appropriate level of treatment to an individual no matter where they are in the lifecycle of their disease in order to restore the individual to a healthier, more productive life, free from dependence on illicit substances and destructive behaviors. Our treatment facilities provide a number of different treatment services such as assessment, detoxification, medication-assisted treatment, counseling, education, lectures and group therapy. We assess and evaluate the medical, psychological and emotional needs of the patient and address these needs in the treatment process. Following this assessment, an individualized treatment program is designed to provide a foundation for a lifelong recovery process. Many modalities are used in our treatment programs to support the individual, including the twelve step philosophy, cognitive/behavioral therapies, supportive therapies and continuing care.

Residential Recovery Facilities. Our inpatient facilities house and care for patients over an extended period and typically treat patients from a broadly defined regional market. We provide three basic levels of residential treatment depending on the severity of the patient's addiction and/or behavioral disorder. Patients with the most severe dependencies are typically placed into inpatient treatment, in which the patient resides at a treatment facility. If a patient's condition is less severe, he or she will be offered day treatment, which allows the patient to return home in the evening. The least intensive service is where the patient visits the facility for just a few hours a week to attend counseling/group sessions.

Following primary treatment, our extended care programs typically offer residential care, which allows patients to develop healthy and appropriate living skills while remaining in a safe and nurturing setting. Patients are supported in their recovery by a semi-structured living environment that allows them to begin the process of employment or to pursue educational goals and to take personal responsibility for their recovery. The structure of this treatment phase is monitored by a primary therapist who works with each patient to integrate recovery skills and build a foundation of sobriety with a strong support system. Length of stay will vary depending on the patient's needs with a minimum stay of 30 days and could be multiple months if needed.

Our outpatient clinics serve patients that do not require inpatient treatment or are transitioning from a residential treatment program; have employment, family or school commitments; and have stabilized in their substance addiction recovery practices and are seeking ongoing continuing care.

Eating Disorder Facilities. Our eating disorder facilities provide treatment services for eating disorders and weight management, each of which may be effectively treated through a combination of medical, psychological and social treatment programs.

Comprehensive Treatment Centers. Our CTCs specialize in providing medication-assisted and abstinent-based treatment. Medication-assisted treatment combines behavioral therapy and medication to treat substance use disorders. CTCs utilize medication-assisted treatment to individuals addicted to opiates such as opioid analgesics (prescription pain medications) and heroin. Medication is used to normalize brain chemistry to block the euphoric effects of alcohol and opioids allowing our professional staff to provide behavioral therapy. Patients begin their treatment attending the clinic almost daily. Then, through successfully progressing in treatment, patients attend less frequently depending on individual treatment plans. The length of treatment differs from patient to patient, but typically ranges from one to three years.

Each of our CTCs provide a range of comprehensive substance abuse treatment support services that include medical, counseling, vocational, educational, and other treatment services. Our behavioral therapies are delivered in array of treatment models that may include individual and group therapy, intensive outpatient, outpatient, partial hospitalization/day treatment, road to recovery, and other programs that can be either abstinent or medication assisted based.

Residential Treatment Centers

Residential treatment centers treat patients with behavioral disorders in a non-hospital setting, including outdoor programs. The facilities balance therapy activities with social, academic and other activities. Because the setting is less intensive, demands on staffing, security and oversight are generally lower than inpatient psychiatric facilities. In contrast to acute care psychiatric facilities, occupancy in residential treatment centers can be managed more easily given a longer length of stay. Over time, however, residential treatment centers have continued to serve increasingly severe patients who would have been treated in acute care facilities in earlier years.

We provide residential treatment care through a medical model residential treatment facility, which offers intensive, medically-driven interventions and individualized treatment regimens designed to deal with moderate to high level patient acuity. Children and adolescents admitted to these facilities typically have had multiple prior failed treatment plans, severe physical, sexual and emotional abuse, termination of parental custody, substance abuse, marked deficiencies in social, interpersonal and academic skills and a wide range of psychiatric disorders. Treatment typically is provided by an interdisciplinary team coordinating psychopharmacological, individual, group and family therapy, along with specialized accredited educational programs in both secure and unlocked environments. Lengths of stay range from three months to several years.

Certain of our residential treatment centers provide group home, therapeutic group home and therapeutic foster care programs. Our group home programs provide family-style living for youths in a single house or apartment within residential communities where supervision and support are provided by 24-hour staff. The goal of a group home program is to teach family living and social skills through individual and group counseling sessions within a real life environment. The residents are encouraged to take responsibility for the home and their health as well as actively take part in community functions. Most attend an accredited and licensed on-premises school or a local public school. We also operate therapeutic group homes that provide comprehensive treatment services for seriously, emotionally disturbed adolescents. The ultimate goal is to reunite or place these children with their families or prepare them, when appropriate, for permanent placement with a relative or an adoptive family. We also manage therapeutic foster care programs, which are considered the least restrictive form of therapeutic placement for children and adolescents with emotional disorders. Children and adolescents in our therapeutic foster care programs often are part of the child welfare or juvenile justice system. Care is delivered in private homes with experienced foster parents who are trained to work with children and adolescents with special needs.

Outpatient Community-Based Services

Our community-based services can be divided into two age groups: children and adolescents (seven to 18 years of age) and young children (three months to six years of age). Community-based programs are designed to provide therapeutic treatment to children and adolescents who have a clinically-defined emotional, psychiatric or chemical dependency disorder while enabling the youth to remain at home and within their community. Many patients who participate in community-based programs have transitioned out of a residential facility or have a disorder that does not require placement in a facility that provides 24-hour care.

Community-based programs developed for these age groups provide a unique array of therapeutic services to a very high-risk population of children. These children suffer from severe congenital, neurobiological, speech/motor and early onset psychiatric disorders. These services are provided in clinics and employ a treatment model that is consistent with our interdisciplinary medical treatment approach. Depending on their individual needs and treatment plan, children receive speech, physical, occupational and psychiatric interventions that are coordinated with services provided by their referring primary care physician. The children generally receive treatment during regular business hours.

U.K. Operations

Overview

With the Priory and Partnerships in Care acquisitions, we are the leading independent provider of mental health services in the U.K. operating 373 inpatient behavioral health facilities with approximately 8,900 beds as of December 31, 2017. The facilities are located in England, Wales, Scotland and Northern Ireland. For the years ended December 31, 2017 and 2016, our U.K. operations generated revenue of $1.0 billion and $1.1 billion, respectively, primarily through the operation and management of inpatient behavioral health facilities. The year ended December 31, 2016 was impacted by the acquisition of Priory on February 16, 2016 and the U.K. Divestiture on November 30, 2016.

United Kingdom Healthcare and Adult Social Care Sectors

In the U.K., central government spending on health for fiscal year 2017-2018 is budgeted at approximately £149 billion, according to the U.K. government budget. This spending is primarily delivered by the NHS, which operates as three separate national public sector bodies in England, Scotland and Wales as well as the Northern Ireland Health and Social Care Board. Local Government gross spending on adult social care for the fiscal year 2017-2018 is budgeted at approximately £25 billion and is commissioned by local authorities in England, Scotland and Wales, which we refer to as Local Authorities and by the Northern Ireland Health and Social Care Board. The NHS, Local Authorities and Northern Ireland Health and Social Care Board commissioners dominate the U.K. health and social care markets in terms of the funding of care. With the exception of the elderly residential and nursing care market, private health insurance and self-payment play a minor role in these sectors.

The mental health market in the U.K. was estimated at £15.9 billion for 2014/2015. The independent mental health market accounted for roughly £1.4 billion of that amount, or approximately 9% market share. As a result of government budget constraints and an increased focus on quality, the independent mental health market has witnessed significant expansion in the last decade, making it one of the fastest growing sectors in the U.K. healthcare industry.

Publicly-funded healthcare services in England are commissioned at two levels as follows: (i) nationally by NHS England which, via its Local Area Teams commissions specialized healthcare services, including specialized Mental Health Secure, Eating Disorder and Children and Adolescent (CAMHS) services, and (ii) locally by over 200 local CCGs, which commission all acute, rehabilitation and community-based healthcare services. In Scotland and Wales, all healthcare services are commissioned by Local/Regional Health Boards.

The principal distinction between healthcare and social care relates to an individual's assessed care needs. If there is a primary health need, services are commissioned by the NHS under the general NHS principle that the services are free at the point of delivery. In the case of adult social care, individuals' healthcare-related needs have been assessed as being of secondary importance with services being means-tested. Local Authority commissioners of adult social care provided in care homes and other community settings are responsible for undertaking financial assessments to determine the level of contributions that individuals must pay towards the cost of their care. Individuals with income or capital above set statutory thresholds must fund the full cost of their care.

In recent years, the U.K. Government has placed increasing emphasis on implementing integrated care pathways across health and social care services. Integrated care pathways provide patients with highly coordinated and personalized care overseen by relevant commissioners working together to plan, arrange and monitor patient progression through each stage of the care pathway.

Additionally, mental health commissioning trends toward moving patients more quickly down care pathways, out of higher acuity, more intensive care settings towards community focused care services have increased the demand for community and rehabilitation services in the independent mental health market. The Department of Health in England recently identified priorities for essential change in mental health that include, among other things, funding providers based on the quality of their service rather than volume of patients, allocating funds to support specialized housing for people with mental health problems and adopting a new rating system and inspection process to improve the quality of care. Increasing political focus on the provision of mental health services in the U.K. and increasing support for the rights of mental health patients are expected to lead to further increases in the size of the mental health market in the U.K. In addition, rising demand for mental health services in the U.K. coupled with a constrained mental healthcare funding environment are increasing pressure to improve operational efficiency and refer patients to single provider programs with care pathways that more appropriately reflect each patient's specific mental health needs. As a result of these pressures and an increased focus on quality, the independent mental health market has witnessed significant expansion in the last decade, making it one of the fastest growing sectors in the U.K. healthcare industry.

Description of U.K. Facilities

In the U.K., we provide inpatient services through a variety of facilities, including mental health hospitals, clinics, care homes, schools, colleges and children's homes. In addition to these services, we also operate a U.K. division that leverages on our clinical knowledge to provide Employee Assistance Programs ("EAP") to organizations.

Our U.K. facilities and services can generally be classified into the following categories: healthcare facilities, education and children's services, adult care facilities and elderly care facilities. The table below presents the percentage of our total U.K. revenue attributed to each category for the year ended December 31, 2017:

Facility/Service	U. K. Revenue for the Year Ended December 31, 2017
Healthcare facilities	55%
Education and Children's Services	17%
Adult Care facilities	18%
Elderly Care facilities	10%

We receive payments from approximately 500 public funded sources in the U.K. (including the NHS, CCGs and Local Authorities) and individual patients and clients. For the year ended December 31, 2017 in our U.K. facilities, we received 91% of our revenue from public funded sources in the U.K. (including the NHS, CCGs and Local Authorities) and 9% from other payors.

At December 31, 2017, our U.K. facilities included 373 behavioral healthcare facilities with approximately 8,900 beds, including approximately 1,000 non-residential education places, in the U.K. Of our U.K. facilities, approximately 22% are healthcare facilities, approximately 20% are education and children's services facilities, approximately 47% are adult care facilities and approximately 11% are elderly care facilities at December 31, 2017. At December 31, 2017, 291 of our U.K. facilities are owned properties and 82 are leased properties.

Healthcare

In the U.K., mental health hospitals provide psychiatric treatment and nursing for sufferers of mental disorders, including for patients detained under a section of the U.K.'s Mental Health Act of 1983, and whose risk of harm to others and risk of escape from hospitals cannot be managed safely within other mental health settings. In order to manage the risks involved with treating patients, the facility is managed through the application of a range of security measures depending on the level of dependency and risk exhibited by the patient. The levels of dependency and risk stemming from the wide range of disorders treated at these hospitals determine the level of care provided, which are comprised of:

- *Secure Services.* Medium and Low secure facilities treat patients who may present a serious danger to others and themselves but do not need the physical security arrangements of a high security hospital. The purpose of medium secure services is to provide effective care and treatment to reduce risk, promote recovery and support patients moving through the care pathway to lower levels of security or to reestablishing themselves successfully in the community. Low secure facilities provide treatment for patients whom, because of the level of risk or challenge they present, cannot be treated in open mental health settings. Low secure services deliver intensive, comprehensive and multidisciplinary treatment to patients demonstrating disturbed behavior in the context of a serious mental disorder and require the provision of security but pose a lesser risk of harm to themselves and to others.

- *Specialty Treatment Services.* Specialty treatment services provide treatment relating to specific conditions including eating disorders and addiction. Our eating disorder facilities provide treatment services for eating disorders and weight management for both adults and adolescents. Our addiction services provide treatment for abuse of addictive substances such as alcohol and illicit drugs as well as facilities for other addictions and behavioral disorders such as compulsive gambling.

- *Child and Adolescent Mental Health Services.* Child and adolescent mental health services provide treatment to young people in need of expert care and support for behavioral, emotional or mental health difficulties. These services are designed to enable the children and young people within our care to improve their long-term wellbeing and effectively reintegrate into the community when they are ready.

- *Rehabilitation Services.* Both locked and open mental health rehabilitation services provide a bridge between secure hospital facilities and community living by providing relapse prevention and social integration services as well as vocational opportunities.

- *Acute Services.* Acute services provide treatment relating to emergency admissions for patients at risk to themselves or others, as well as crisis intervention and treatment of behavioral emergencies.

- *Care Homes.* Care homes provide long-term, non-acute care for adults suffering from a mental illness or addiction, or who have a learning disability or brain injury and are unable to cope unsupported in the community.

Other Services

- *Education and Children's Services.* Education and children's services provide specialist education for children and young people with special educational needs, including autism, Asperger's Syndrome, social, emotional and mental health, and specific learning difficulties, such as dyslexia. The division also offers standalone children's homes for children that require 52-week residential care to support complex and challenging behavior and fostering services.
- *Adult Care.* Adult Care focuses on care of service users with a variety of learning difficulties, mental health illnesses and adult autism spectrum disorders. Care is provided in a number of settings, including in residential care homes and through supported living.
- *Elderly Care.* Elderly care provides long-term, short-term and respite nursing care to high-dependency elderly individuals who are physically frail or suffering from dementia.
- *Care First.* Care First leverages our clinical knowledge to provide EAP to organizations. These support services are designed to help employees manage difficult issues in their professional or personal lives with services that include:
  - A call center for telephone counseling available 24-hours a day, seven days a week;
  - A national network of counselors available for live, face-to-face support;
  - Interactive health and wellness programs;
  - Debt management advice services; and
  - Management training.

Sources of Revenue

We receive payments from the following sources for services rendered in our facilities: (i) state governments under their respective Medicaid and other programs; (ii) commercial insurers; (iii) the federal government under the Medicare program administered by CMS; (iv) public funded sources in the U.K. (including the NHS, CCGs and Local Authorities); and (v) individual patients and clients. Revenue is recorded in the period in which services are provided at established billing rates less contractual adjustments based on amounts reimbursable by Medicare or Medicaid under provisions of cost or prospective reimbursement formulas or amounts due from other third-party payors at contractually determined rates. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Revenue" for additional disclosure. Other information related to our revenue, income and other operating information is provided in our Consolidated Financial Statements.

Regulation

U.S. Overview

The healthcare industry is subject to numerous laws, regulations and rules including, among others, those related to government healthcare program participation requirements, various licensure and accreditation standards, reimbursement for patient services, health information privacy and security rules, and government healthcare program fraud and abuse provisions. Providers that are found to have violated any of these laws and regulations may be excluded from participating in government healthcare programs, subjected to loss or limitation of licenses to operate, subjected to significant fines or penalties and/or required to repay amounts received from the government for previously billed patient services. Management believes that we are in substantial compliance with all applicable laws and regulations and is not aware of any material pending or threatened investigations involving allegations of wrongdoing.

Licensing, Certification and Accreditation

All of our facilities must comply with various federal, state and local licensing and certification regulations and undergo periodic inspection by licensing agencies to certify compliance with such regulations. The initial and continued licensure of our facilities and certification to participate in government healthcare programs depends upon many factors including various state licensure regulations relating to quality of care, environment of care, equipment, services, staff training, personnel and the existence of adequate policies, procedures and controls. Federal, state and local agencies survey our facilities on a regular basis to determine whether the facilities are in compliance with regulatory operating and health standards and conditions for participating in government healthcare programs.

Most of our inpatient and residential facilities maintain accreditation from private entities, such as The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities ("CARF"). The Joint Commission and CARF are private organizations that have accreditation programs for a broad spectrum of healthcare facilities. The Joint Commission accredits a broad variety of healthcare organizations, including hospitals and behavioral health organizations. CARF accredits behavioral health organizations providing mental health and alcohol and drug use and addiction services, as well as opiate treatment programs, and many other types of healthcare programs. These accreditation programs are intended generally to improve the quality, safety, outcomes and value of healthcare services provided by accredited facilities. Certain federal and state licensing agencies as well as many in government and private healthcare payment programs require that providers be accredited as a condition of licensure, certification or participation. Accreditation is typically granted for a specified period, ranging from one to three years, and renewals of accreditation generally require completion of a renewal application and an on-site renewal survey.

Certificates of Need

Many of the states in which we operate facilities have enacted certificate of need ("CON") laws that regulate the construction or expansion of certain healthcare facilities, certain capital expenditures or changes in services or bed capacity. Failure to obtain CON approval of certain activities can result in: our inability to complete an acquisition, expansion or replacement; the imposition of civil penalties; the inability to receive Medicare or Medicaid reimbursement; or the revocation of a facility's license, any of which could harm our business.

Quality Improvement

Services provided to Medicare beneficiaries are subject to review by Quality Improvement Organizations ("QIOs"), which aim to improve the effectiveness, efficiency, economy and quality of services furnished within the Medicare program. QIOs are independent organizations that contract with CMS to perform several functions, including reviewing the appropriateness of patient admissions and discharges, the quality of care provided, the validity of diagnosis related group classifications, and the appropriateness of length of stay, as well as investigating beneficiary complaints. QIOs may recommend the imposition of sanctions against a Medicare provider found to have, among other things, provided services deemed medically unnecessary or not of a quality that meets professionally recognized standards of care. Such sanctions may include monetary assessments and exclusion from participation in government healthcare programs.

Audits

Our healthcare facilities are also subject to federal, state and commercial payor audits to validate the accuracy of claims submitted to the government healthcare programs and commercial payors. If these audits identify overpayments, we could be required to make substantial repayments, subject to various appeal rights. Several of our facilities have undergone claims audits related to their receipt of payments during the last several years with no material overpayments identified. However, potential liability from future audits could ultimately exceed established reserves, and any excess could potentially be substantial. Further, Medicare and Medicaid regulations, as well as commercial payor contracts, also provide for withholding or suspending payments in certain circumstances, which could adversely affect our cash flow.

The Anti-Kickback Statute and Stark Law

The Anti-Kickback Statute prohibits healthcare providers and others from directly or indirectly soliciting, receiving, offering or paying any remuneration, in cash or in kind, as an inducement or reward for using, referring, ordering, recommending or arranging for such referrals or orders of services or other items paid for by a government healthcare program. The Anti-Kickback Statute may be found to have been violated if at least one purpose of the remuneration is to induce or reward referrals. A provider is not required to have actual knowledge or specific intent to commit a violation of the Anti-Kickback Statute to be found guilty of violating the law.

The Office of Inspector General of the Department of Health and Human Services has issued safe harbor regulations that protect certain types of common arrangements from prosecution or sanction under the Anti-Kickback Statute and there are also several statutory exceptions toward that end. The fact that conduct or a business arrangement does not fall within a safe harbor or exception does not automatically render the conduct or business arrangement illegal under the Anti-Kickback Statute. However, conduct and business arrangements falling outside the safe harbors may lead to increased scrutiny by government enforcement authorities.

Although management believes that our arrangements with physicians and other referral sources comply with current law and available interpretative guidance, as a practical matter it is not always possible to structure our arrangements so as to fall squarely within an available safe harbor. Where that is the case, we cannot guarantee that applicable regulatory authorities will determine these financial arrangements do not violate the Anti-Kickback Statute or other applicable laws, including state anti-kickback laws.

In addition to the Anti-Kickback Statute, the federal Physician Self-Referral Law, also known as the Stark Law, prohibits physicians from refering Medicare patients to healthcare entities with which they or any of their immediate family members have a financial relationship for the furnishing of any "designated health services" unless certain exceptions apply. A violation of the Stark Law may result in a denial of payment; required refunds to the Medicare program; imposition of civil monetary penalties of up to $24,253 for each prohibited claim, up to $161,692 for circumvention schemes, and up to $19,246 for each day the entity fails to report required information; exclusion from government healthcare programs; and liability under the False Claims Act. There are ownership and compensation arrangement exceptions for many customary financial arrangements between physicians and facilities, including the employment exception, personal services exception, lease exception and certain recruitment exceptions. Management believes that our financial arrangements with physicians are structured to comply with the regulatory exceptions to the Stark Law. However, the Stark Law is a strict liability statute, meaning that no intent is required to violate the law, and even a technical violation may lead to significant penalties.

These laws and regulations are extremely complex and, in many cases, we do not have the benefit of regulatory or judicial interpretation. It is possible that different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our arrangements relating to facilities, equipment, personnel, services, capital expenditure programs and operating expenses. A determination that we have violated one or more of these laws, or the public announcement that we are being investigated for possible violations of one or more of these laws, could have a material adverse effect on our business, financial condition or results of operations. In addition, we cannot predict whether other federal or state legislation or regulations will be adopted, what form such legislation or regulations may take or what their impact on us may be.

If we are deemed to have failed to comply with the Anti-Kickback Statute, the Stark Law or other applicable laws and regulations, we could be subjected to liabilities, including criminal penalties, civil penalties, and exclusion of one or more facilities from participation in the government healthcare programs. The imposition of such penalties could have a material adverse effect on our business, financial condition or results of operations.

Federal False Claims Act and Other Fraud and Abuse Provisions

The federal False Claims Act provides the government a tool to pursue healthcare providers for submitting false claims or requests for payment for healthcare items or services. Under the False Claims Act, the government may fine any person or entity that, among other things, knowingly submits, or causes the submission of, false or fraudulent claims for payment to the federal government or knowingly and improperly avoids or decreases an obligation to pay money to the federal government. The federal government has widely used the False Claims Act to prosecute Medicare and other federal healthcare program fraud such as coding errors, billing for services not provided, submitting false cost reports, and providing care that is not medically necessary or that is substandard in quality. Claims for services or items rendered in violation of the Anti-Kickback Statute or the Stark Law can provide a basis for liability under the False Claims Act as well. The False Claims Act is also implicated by the knowing failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later.

Violations of the False Claims Act are punishable by significant penalties totaling $10,957 to $21,916 for each fraudulent claim plus three times the amount of damages sustained by the government. In addition, under the qui tam, or whistleblower, provisions of the False Claims Act, private parties may bring actions under the False Claims Act on behalf of the federal government. These private parties, often referred to as relators, are entitled to share in any amounts recovered by the government, and, as a result, whistleblower lawsuits have increased significantly in recent years. Many states have similar false claims statutes that impose liability for the types of acts prohibited by the False Claims Act or that otherwise prohibit the submission of false or fraudulent claims to the state government or Medicaid program.

In addition to the False Claims Act, the federal government may use several criminal laws, such as the federal mail fraud, wire fraud, or health care fraud statutes, to prosecute the submission of false or fraudulent claims for payment to the federal government. Most states have also adopted generally applicable insurance fraud statutes and regulations that prohibit healthcare providers from submitting inaccurate, incorrect, or misleading claims to private insurance companies. Management believes our healthcare facilities have implemented appropriate safeguards and procedures to complete claim forms and requests for payment in an accurate manner and to operate in compliance with applicable laws. However, the possibility of billing or other errors can never be completely eliminated, and we cannot guarantee that the government or a qui tam plaintiff, upon audit or review, would not take the position that billing or other errors, should they occur, are violations of the False Claims Act.

HIPAA Administrative Simplification and Privacy and Security Requirements

The administrative simplification provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. HIPAA also established federal rules protecting the privacy and security of individually identifiable protected health information ("PHI"). The privacy and security regulations control the use and disclosure of PHI and the rights of patients to be informed about and control how such PHI is used and disclosed. Violations of HIPAA can result in both criminal and civil fines and penalties.

The HIPAA security regulations require healthcare providers to implement administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of PHI. HITECH has strengthened certain HIPAA rules regarding the use and disclosure of PHI, extended certain HIPAA provisions to business associates, and created security breach notification requirements including notifications to the individuals affected by the breach, the Department of Health and Human Services, and in certain cases, the media. HITECH has also increased maximum penalties for violations of HIPAA privacy rules. Management believes that we have been in material compliance with the HIPAA regulations and have developed our policies and procedures to ensure ongoing compliance, although we cannot guarantee that our facilities will not be subject to security incidents or breaches which could have a material adverse effect on our business, financial condition, or results of operations.

The Emergency Medical Treatment & Labor Act

The Emergency Medical Treatment & Labor Act ("EMTALA") is intended to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with emergency medical conditions. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer must be implemented. EMTALA imposes additional obligations on hospitals with specialized capabilities, such as ours, to accept the transfer of patients in need of such specialized capabilities if those patients present in the emergency room of a hospital that does not possess the specialized capabilities.

Mental Health Parity Legislation

The MHPAEA was signed into law in October 2008 and requires health insurance plans that offer mental health and addiction coverage to provide that coverage on par with financial and treatment coverage offered for other illnesses. The MHPAEA has some limitations because health plans that do not already cover mental health treatments are not required to do so, and health plans are not required to provide coverage for every mental health condition published in the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association. The MHPAEA also contains a cost exemption which operates to exempt a group health plan from the MHPAEA's requirements if compliance with the MHPAEA becomes too costly.

On December 13, 2016, then President Obama signed the 21st Century Cures Act. The 21st Century Cures Act appropriated substantial resources for the treatment of behavioral health and substance abuse disorders and contained measures intended to strengthen the MHPAEA.

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, "PPACA") dramatically altered the U.S. health care system. PPACA sought to provide coverage and access to substantially all Americans, to increase the quality of care provided, and to reduce the rate of growth in health care expenditures. PPACA attempted to achieve these goals by, among other things, requiring most Americans to obtain health insurance, expanding the Medicare program's use of value-based purchasing programs, bundling payments to hospitals and other providers, reducing Medicare and Medicaid payments to providers, expanding Medicaid eligibility, and tying reimbursement to the satisfaction of certain quality criteria.

On January 20, 2017, Donald Trump became President of the United States. During the 2016 election cycle, Republicans also assumed control of both the United States Senate and House of Representatives. Shortly after his inauguration, President Trump issued an executive order that, among other things, stated that it was the intent of his administration to repeal PPACA and, pending that repeal, instructed the executive branch of the federal government to defer or delay the implementation of any provision or requirement of PPACA that would impose a fiscal burden on any state or a cost, fee, tax, or penalty on any individual, family, health care provider, or health insurer. Several bills have been introduced and voted upon in the House of Representatives and United States Senate that would either repeal and replace or simply repeal PPACA, although none have been enacted to-date.

On October 12, 2017, President Trump signed an executive order intending to expand the availability of so-called association health plans and short-term plans outside PPACA's requirements. President Trump also announced that the administration would cease making cost-sharing reduction payments to health insurance companies that help cover out-of-pocket costs for low-income individuals. Finally, the Tax Act (as defined and described below) effectively eliminates PPACA's individual health insurance mandate as of 2018 by reducing to zero the tax penalty associated with failure to maintain health insurance coverage.

It is difficult to predict whether PPACA will be repealed, replaced, or modified; what the effect will be of the health care-related provisions in the Tax Act; or the impact that the President's executive actions will have on the implementation and enforcement of the provisions of PPACA or the regulations adopted or to be adopted to implement the law or the President's executive orders. In addition, if PPACA is replaced or modified, it remains unclear what the replacement plan or modifications would be, when the changes would become effective, or whether any of the existing provisions of PPACA would remain in place. Even if the current administration is not successful in its efforts to repeal and replace PPACA, there have been and likely will continue to be a number of legal challenges to various provisions of the law and President Trump's recent executive actions. Limitations on the availability of adequate insurance coverage for patients seeking services at our facilities; any reductions in government healthcare spending; and the possible repeal, replacement or modification of PPACA could have a material adverse effect on our business, financial condition, or results of operations.

U.S. Tax Reform

On December 22, 2017, Public Law 115-97, informally referred to as the Tax Cuts and Jobs Act (the "Tax Act") was enacted into law. The Tax Act provides for significant changes to the U.S. tax code that impact businesses. Effective January 1, 2018, the Tax Act reduces the U.S. federal tax rate for corporations from 35% to 21% for U.S. taxable income. The Tax Act requires a one-time remeasurement of deferred taxes to reflect their value at a lower tax rate of 21%. The Tax Act includes other changes, including, but not limited to, requiring a one-time transition tax on certain unrepatriated earnings of foreign subsidiaries that is payable over eight years, a general elimination of U.S. federal income taxes on dividends from foreign subsidiaries, a new provision designed to tax global intangible low-taxed income, a limitation of the deduction for net operating losses, elimination of net operating loss carrybacks, immediate deductions for certain new investments instead of deductions for depreciation expense for certain qualified property, additional limitations on the deductibility of executive compensation and limitations on the deductibility of interest. The effects of the Tax Act on the Company are still being evaluated.

U.K. Overview

The regulatory environment applicable to facilities in the U.K. is complex and multifaceted. The regulatory regime is made up of multiple statutes, regulations and minimum standards that are subject to continuous change. The laws and regulations applicable to the U.K. facilities include, without limitation, the Mental Capacity Act of 2005, Safeguarding Vulnerable Groups Act of 2006, Mental Health Act of 2007, Health and Social Care Act of 2008 and Corporate Manslaughter and Corporate Homicide Act of 2008. These laws and regulations are predominantly protective in nature and share the same general underlying purpose to protect vulnerable persons from exploitation or harm. The regulatory requirements relevant to our facilities in the U.K. cover our operations from the initial establishments of new facilities, which are subject to registration and licensing requirements, to the recruitment and appointment of staff, occupational health and safety, duty of care to service users, clinical and educational standards, conduct of our professional and support staff and other areas.

Mental Capacity Act of 2005. The Mental Capacity Act of 2005 establishes the process for determining whether a person lacks mental capacity at a particular time and also sets out who can make decisions in those circumstances and how they should go about this. The Act sets out when liability may arise for actions in connection with the care or treatment of persons who lack capacity to consent to such actions.

Safeguarding Vulnerable Groups Act of 2006. The Safeguarding Vulnerable Groups Act of 2006 created the Independent Safeguarding Authority ("ISA"). In December 2012, the ISA merged with the Criminal Records Bureau to form the Discharge and Barring Service ("DBS") and is required to establish and maintain lists of persons barred from working with children and adults. It is a criminal offense for a barred person to seek to work, or work in, activities from which they are barred. It is also generally a criminal offense for an employer to allow a barred person, or person who is not appropriately registered, to work in any regulated activity. The Children Act 1989 also allocates duties to Local Authorities, courts, parents, and other agencies in the U.K. to ensure children are safeguarded and their welfare is promoted.

The Mental Health Act of 2007. The Mental Health Act of 2007 regulates the manner in which an individual can be committed or detained against his or her will. The main purpose of the legislation is to ensure that people with serious mental disorders which threaten their health or safety or the safety of the public can be treated irrespective of their consent where it is necessary to prevent them from harming themselves or others. The Act places the burden on the entity detaining a person to prove that the entity has the right to hold the detainee. This places a substantial regulatory burden on service providers to ensure compliance with the law. There is similar legislation in Scotland, Wales and Northern Ireland.

The Health and Social Care Act of 2008. The Health and Social Care Act of 2008 ("HSCA"), as amended by the Care Act 2014, established the Care Quality Commission ("CQC") as the registration and regulatory body for health and adult social care in England. Under the HSCA, service providers carrying out "regulated activities" must be registered with the CQC for each separate regulated activity provided. Where the service provider is a company, each regulated activity/location must also have an individual registered as the registered manager. Registration depends both on an assessment of the fitness of the registered provider and also the individual registered manager. Regulated activities include the provision of residential accommodation together with nursing or personal care and the provision of treatment for a disease, disorder or injury by or under the supervision of a social worker or a multidisciplinary team which includes a social worker where the treatment is for a mental disorder.

The Care Act 2014. The Care Act 2014 came into force on April 1, 2015 along with a range of supporting regulations and a single set of statutory guidance. The Care Act 2014 requires Local Authorities to set personal budgets for individuals that are appropriate to meeting those individuals' assessed eligible care and support needs. The Care Act 2014 also imposes new statutory duties upon Local Authorities to ensure the supply of diverse, good quality, local services, including a duty to plan for future demand and to ensure that services are high quality and sustainable.

The regulated activities regulations and the registration regulations issued pursuant to the HSCA place legally binding obligations on health and social care providers. Breach of certain provisions of the HSCA or the regulations is a criminal offense. In addition, a breach may lead to the CQC taking action to suspend, cancel or vary the conditions of registration of a service provider or impose a substantial fine.

Inspections by regulators in the U.K. can be carried out on both an announced and an unannounced basis depending on the specific regulatory provisions relating to the different services provided and also depending upon whether the inspection is routine or as a result of specific information regarding the service that has been provided to the regulator. Generally, however, a majority of inspections tend to be unannounced. A failure to comply with laws and regulations, the receipt of a poor inspection report rating or a lower rating, or the receipt of a negative report that leads to a determination of regulatory non-compliance or a failure to cure any defect noted in an inspection report may result in reputational damage, fines, the revocation or suspension of the registration of any facility or a decrease in, or cessation of, the services provided at any given location.

Corporate Manslaughter and Corporate Homicide Act of 2007. The Corporate Manslaughter and Corporate Homicide Act of 2007 provides liability if the way in which a provider's activities are managed or organized causes a person's death and amounts to a gross breach of a relevant duty of care owed to the deceased person.

Regulatory and Enforcement Bodies in the U.K.

The primary healthcare regulatory enforcement bodies in the U.K. are NHS Improvement, the CQC, Healthcare Inspectorate Wales ("HIW"), Care Inspectorate Wales ("CIW"), Healthcare Improvement Scotland ("HIS"), Social Care and Social Work Improvement Scotland ("SCSWIS") and Regulation and Quality Improvement Authority ("RQIA"). In addition, the Office for Standards in Education, Children's Services and Skills ("OFSTED"), Estyn, Education Scotland and other regulatory bodies regulate and inspect education services in England, Wales and Scotland, as applicable. These enforcement bodies control and administer the registration, inspection and complaints procedures set out under the applicable laws and regulations. The enforcement bodies have the power to terminate a facility's registration, refuse to register a facility, impose admissions holds, or impose significant fines if a service provider fails to meet the key minimum standards and requirements prescribed under the various laws and regulations. See "Risk Factors— If we fail to comply with extensive laws and government regulations, we could suffer penalties or be required to make significant changes to our operations."

Our primary regulators continually review their regulatory regimes and may extend their enforcement powers with the intention of holding parent companies and senior executives accountable for material breaches of regulations depending on the circumstances. Additionally, there are other regulators in the U.K. who may take enforcement action against us, including (i) the Health and Safety Executive ("HSE") for violations of the Health and Safety at Work Act in connection with patient incidents at our facilities; (ii) the Information Commissioners Office ("ICO") for breaches of data protection legislation (and following the introduction of the General Data Protection Regulations (the "GDPR") which come into force in May 2018, fines for material breaches may be as high as 4% of global turnover); and (iii) Her Majesty's Revenue and Customs ("HMRC") who in November 2017 established the Social Care Compliance Scheme (the "SCCS") for social care providers in the U.K. with the aim of addressing the issue of potential underpayments of the National Minimum Wage ("NMW") to workers who are paid a fixed allowance to undertake "sleep-in shifts" at care homes and other facilities at night. See "—Our operating costs are subject to increases, including due to statutorily mandated increases in the wages and salaries of our staff" for further details on U.K. staffing risks to which we are subject.

NHS Improvement. NHS Improvement now incorporates Monitor, the former economic regulator for the NHS in England. NHS Improvement is responsible for regulating the market for NHS funded services in England. It fulfills this role through licensing NHS Foundation Trusts and certain other healthcare providers and, together with the NHS England, sets the Tariff Rules for national and local pricing of NHS services. NHS Improvement's role is to oversee the NHS healthcare market, at all times protecting and promoting patients' interests, tackling abuses by commissioners and/or providers and dealing with unjustifiable restrictions on competition.

The CQC. The CQC is the independent regulator for health and adult social care in England. The CQC is distinct from NHS Improvement in that it focuses on quality and ensuring the maintenance of standards in health and social care practices. The CQC licenses NHS and adult social care service providers to enable it to keep a check on safety and quality standards. The CQC also carries out facility inspections. Care homes for young adults (including specialist college accommodation) are registered and inspected by the CQC. In addition, the CQC is responsible for monitoring the financial viability of corporate providers of social care.

HIW. HIW is the independent inspectorate and regulator of all health care in Wales. Certain independent healthcare services are required to register with HIW. HIW also inspects NHS and independent healthcare organizations in Wales to ensure compliance with its and the NHS's standards, policies, guidance and regulations. The HIW Review Service for Mental Health monitors the use of the Mental Health Act 1983 to ensure that it is being used properly on behalf of Welsh Ministers.

CIW. Social care and social services in Wales are regulated by the CIW. CIW carries out unannounced inspections and measure against regulations. Children's homes in Wales are inspected by CIW.

HIS. HIS is the independent regulator for healthcare services in Scotland. HIS inspects healthcare providers in Scotland to ensure compliance with its standards, policies, guidance and regulations.

SCSWIS. Care services in Scotland are regulated by the Care Inspectorate Scotland (also known as SCSWIS) and all care services in Scotland must be registered with them. As well as registration, SCSWIS inspects services against the National Care Standards and they can take action to force services to improve and can close services if necessary. Independent schools with boarding facilities must register their boarding provision with SCSWIS for the regulation of care as a school care accommodation service.

RQIA. In Northern Ireland, RQIA is Northern Ireland's independent health and social care regulator. RQIA is responsible for registering, inspecting and encouraging improvement in a range of health and social care services in accordance with the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and its supporting regulations. RQIA inspections are based on certain minimum care standards.

OFSTED. OFSTED was established under the Education (Schools) Act of 1992 and regulates and inspects services in England that care for children and young people, and services providing education and skills for learners of all ages. OFSTED carries out routine day school and further education college inspections to ensure compliance with inspection frameworks.

Estyn. In Wales, Estyn is led by Her Majesty's Chief Inspector of Education and Training and inspects quality standards in all education provisions in Wales including children's homes, independent and residential schools and colleges.

Education Scotland. In Scotland, the education provision for independent schools with boarding facilities is regulated by Education Scotland.

Risk Management and Insurance

The healthcare industry in general continues to experience an increase in the frequency and severity of litigation and claims. As is typical in the healthcare industry, we could be subject to claims that our services have resulted in injury to our patients or clients or other adverse effects. In addition, resident, visitor and employee injuries could also subject us to the risk of litigation. While management believes that quality care is provided to patients and clients in our facilities and that we materially comply with all applicable regulatory requirements, an adverse determination in a legal proceeding or government investigation could have a material adverse effect on our business, financial condition or results of operations.

Our statutory workers' compensation program is fully insured with a $0.5 million deductible per accident. A portion of our professional liability risk is insured through a wholly-owned insurance subsidiary. Our wholly-owned insurance subsidiary insures us for professional liability losses up to $78.0 million in the aggregate. The insurance subsidiary has obtained reinsurance with unrelated commercial insurers for professional liability risks of $75.0 million in excess of a retention level of $3.0 million.

Environmental Matters

We are subject to various federal, state and local environmental laws that: (i) regulate certain activities and operations that may have environmental or health and safety effects, such as the handling, storage, transportation, treatment and disposal of medical waste products generated at our facilities, the identification and warning of the presence of asbestos-containing materials in buildings, as well as the removal of such materials, the presence of other hazardous substances in the indoor environment, and protection of the environment and natural resources in connection with the development or construction of our facilities; (ii) impose liability for costs of cleaning up, and damages to natural resources from, past spills, waste disposals on and off-site, or other releases of hazardous materials or regulated substances; and (iii) regulate workplace safety. Some of our facilities generate infectious or other hazardous medical waste due to the illness or physical condition of our patients. The management of infectious medical waste is subject to regulation under various federal, state and local environmental laws, which establish management requirements for such waste. These requirements include record-keeping, notice and reporting obligations. Each of our facilities has an agreement with a waste management company for the disposal of medical waste. The use of such companies, however, does not completely protect us from violations of medical waste laws or from related third-party claims for clean-up costs.

From time to time, our operations have resulted in, or may result in, non-compliance with, or liability pursuant to, environmental or health and safety laws or regulations. Management believes that our operations are generally in compliance with environmental and health and safety regulatory requirements or that any non-compliance will not result in a material liability or cost to achieve compliance. Historically, the costs of achieving and maintaining compliance with environmental laws and regulations at our facilities have not been material. However, we cannot assure you that future costs and expenses required for us to comply with any new or changes in existing environmental and health and safety laws and regulations or new or discovered environmental conditions will not have a material adverse effect on our business, financial condition or results of operations.

We have not been notified of and management is otherwise currently not aware of any contamination at our currently or formerly operated facilities that could result in material liability or cost to us under environmental laws or regulations for the investigation and remediation of such contamination, and we currently are not undertaking any remediation or investigation activities in connection with any such contamination conditions. There may, however, be environmental conditions currently unknown to us relating to our prior, existing or future sites or operations or those of predecessor companies whose liabilities we may have assumed or acquired which could have a material adverse effect on our business.

New laws, regulations or policies or changes in existing laws, regulations or policies or their enforcement, future spills or accidents or the discovery of currently unknown conditions or non-compliances may give rise to investigation and remediation liabilities, compliance costs, fines and penalties, or liability and claims for alleged personal injury or property damage due to substances or materials used in our operations, any of which may have a material adverse effect on our business, financial condition or results of operations.

Competition

The healthcare industry is highly competitive. Our principal competitors include other behavioral healthcare service companies, including UHS, private equity firms, and the NHS in the U.K. We also compete against hospitals and general healthcare facilities that provide mental health services. An important part of our business strategy is to continue making targeted acquisitions of other behavioral health facilities. However, reduced capacity, the passage of mental health parity legislation and increased demand for mental health services are likely to attract other potential buyers, including diversified healthcare companies and possibly other pure-play behavioral healthcare companies.

The mental health services sector in the U.K. comprises hospitals or establishments that provide psychiatric treatment for illness or mental disorder at all security and treatment levels. We operate in several highly competitive markets in the U.K. with a variety of for-profit, the NHS and other not-for-profit groups in each of our markets. Most competition is regional or local, based on relevant catchment areas and procurement initiatives. The NHS is often the dominant provider, although the trend has been towards increased outsourcing, whereby the NHS is both a provider and customer of mental healthcare services. NHS in-house beds accounts for approximately 71% of the total mental health hospital beds providing care in the U.K., with independent providers accounting for the remaining approximately 29% of beds.

In addition to the competition we face for acquisitions, we must also compete for patients. Patients are referred to our behavioral healthcare facilities through a number of different sources, including healthcare practitioners, public programs, other treatment facilities, managed care organizations, unions, emergency departments, judicial officials, social workers, police departments and word of mouth from previously treated patients and their families, among others. These referral sources may instead refer patients to hospitals that are able to provide a full suite of medical services or to other behavioral healthcare centers.

Employees

As of December 31, 2017, we had approximately 40,600 employees (approximately 20,000 in the U.S. and approximately 20,600 in the U.K), of which 27,500 were employed full-time. As of December 31, 2017, labor unions represented approximately 460 of our U.S. employees at five of our U.S. facilities through eight collective bargaining agreements. Organizing activities by labor unions and certain potential changes in federal labor laws and regulations could increase the likelihood of employee unionization in the future. The Royal College of Nursing is the trade union for full and part-time nurses, nursing cadets and healthcare assistants in the U.K.

Typically, our inpatient facilities are staffed by a chief executive officer, medical director, director of nursing, chief financial officer, clinical director and director of performance improvement. Psychiatrists and other physicians working in our facilities are licensed medical professionals who are generally not employed by us and work in our facilities as independent contractors or medical staff members.

Seasonality of Demand for Services

Our residential recovery and other inpatient facilities typically experience lower patient volumes and revenue during the holidays, and our child and adolescent facilities typically experience lower patient volumes and revenue during the summer months, holidays and other periods when school is out of session.

Available Information

Our Internet website address is www.acadiahealthcare.com. We make available our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and all amendments to those reports free of charge on our website on the Investors webpage under the caption "SEC Filings" as soon as reasonably practicable after such material is electronically filed with, or furnished to, the Securities and Exchange Commission (the "SEC"). The public may read and copy materials filed with the SEC at the Public Reference Room of the SEC at 100 F Street, NE, Washington, D. C. 20549. The public may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-732-0330. The SEC maintains a website that contains reports, proxy and information statements, and other information regarding issuers that file or furnish information electronically with the SEC at www.sec.gov. Our website and the information contained therein or linked thereto are not intended to be incorporated into this Annual Report on Form 10-K.

Item 1A. Risk Factors

Any of the following risks could materially and adversely affect our business, financial condition or results of operations. These risks should be carefully considered before making an investment decision regarding us. The risks and uncertainties described below are not the only ones we face and there may be additional risks that we are not presently aware of or that we currently consider not likely to have a significant impact. If any of the following risks actually occurred, our business, financial condition and operating results could suffer, and the trading price of our common stock could decline.

Fluctuations in our operating results, quarter to quarter earnings and other factors, including factors outside our control, may result in significant decreases in the price of our common stock.

The stock markets experience volatility, in some cases unrelated to operating performance. These broad market fluctuations may adversely affect the trading price of our common stock and, as a result, there may be significant volatility in the market price of our common stock. If we are unable to operate our facilities as profitably as we have in the past or as our investors expect us to in the future, the market price of our common stock will likely decline when it becomes apparent that the market expectations may not be realized. In addition to our operating results, many economic and seasonal factors outside of our control could have an adverse effect on the price of our common stock and increase fluctuations in our quarterly earnings. These factors include certain of the risks discussed herein, demographic changes, operating results of other healthcare companies, changes in our financial estimates or recommendations of securities analysts, speculation in the press or investment community, the possible effects of war, terrorist and other hostilities, adverse weather conditions, the level of seasonal illnesses, managed care contract negotiations and terminations, changes in general conditions in the economy or the financial markets or other developments affecting the healthcare industry.

An incident involving one or more of our patients or the failure by one or more of our facilities to provide appropriate care could result in increased regulatory burdens, governmental investigations, negative publicity and adversely affect the trading price of our common stock.

Because the patients we treat suffer from severe mental health and chemical dependency disorders, patient incidents, including deaths, assaults and elopements, occur from time to time. If one or more of our facilities experiences an adverse patient incident or is found to have failed to provide appropriate patient care, an admissions hold, loss of accreditation, license revocation or other adverse regulatory action could be taken against us. Any such patient incident or adverse regulatory action could result in governmental investigations, judgments or fines and have a material adverse effect on our business, financial condition and results of operations. In addition, we have been and could become the subject of negative publicity or unfavorable media attention, whether warranted or unwarranted, that could have a significant, adverse effect on the trading price of our common stock or adversely impact our reputation and how our referral sources and payors view us.

We have been and could become the subject of governmental investigations, regulatory actions and whistleblower lawsuits.

Healthcare companies in both the U.S. and the U.K. are subject to numerous investigations by various governmental agencies. Certain of our facilities have received, and other facilities may receive, government inquiries from, and may be subject to investigation by, governmental agencies. If we incur significant costs responding to or resolving these or future inquiries or investigations, our business, financial condition and results of operations could be adversely affected.

Further, under the False Claims Act, private parties are permitted to bring qui tam or "whistleblower" lawsuits against companies that submit false claims for payments to, or improperly retain overpayments from, the government. Because qui tam lawsuits are filed under seal, we could be named in one or more such lawsuits of which we are not aware. We may also be subject to substantial reputational harm as a result of the public announcement of any investigation into such claims.

Our revenue and results of operations are significantly affected by payments received from the government and third-party payors.

A significant portion of our revenue is derived from government healthcare programs. For the year ended December 31, 2017, we derived approximately 38% of our revenue from the Medicare and Medicaid programs and 32% of our revenue from public funded sources in the U.K. (including the NHS, CCGs and Local Authorities). See "— Structural shifts in the U.K. behavioral healthcare market may adversely affect us" for further details on U.K. funding risks to which we are subject.

Government payors in the U.S., such as Medicaid, generally reimburse us on a fee-for-service basis based on predetermined reimbursement rate schedules. As a result, we are limited in the amount we can record as revenue for our services from these government programs, and if we have a cost increase, we typically will not be able to recover this increase. In addition, the federal government and many state governments, are operating under significant budgetary pressures, and they may seek to reduce payments under their Medicaid programs for services such as those we provide. Government payors also tend to pay on a slower schedule. In addition to limiting the amounts they will pay for the services we provide their members, government payors may, among other things, impose prior authorization and concurrent utilization review programs that may further limit the services for which they will pay and shift patients to lower levels of care and reimbursement. Therefore, if governmental entities reduce the amounts they will pay for our services, or if they elect not to continue paying for such services altogether, or if a total or partial repeal of PPACA results in significant contraction of the number of individuals covered by state Medicaid programs, our business, financial condition or results of operations could be adversely affected. In addition, if governmental entities slow their payment cycles further, our cash flow from operations could be negatively affected.

Commercial payors such as managed care organizations, private health insurance programs and labor unions generally reimburse us for the services rendered to insured patients based upon contractually determined rates. These commercial payors are under significant pressure to control healthcare costs. In addition to limiting the amounts they will pay for the services we provide their members, commercial payors may, among other things, impose prior authorization and concurrent utilization review programs that may further limit the services for which they will pay and shift patients to lower levels of care and reimbursement. These actions may reduce the amount of revenue we derive from commercial payors.

Changes in these government programs in recent years have resulted in limitations on reimbursement and, in some cases, reduced levels of reimbursement for healthcare services. Payments from federal and state government healthcare programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations, requirements for utilization review, and federal and state funding restrictions, all of which could materially increase or decrease program payments, as well as affect the cost of providing service to patients and the timing of payments to facilities. We are unable to predict the effect of recent and future policy changes on our operations. In addition, since most states operate with balanced budgets and since the Medicaid program is often a state's largest program, some states can be expected to enact or consider enacting legislation formulated to reduce their Medicaid expenditures. Furthermore, the potential repeal, replacement or modification of PPACA, may negatively affect the availability of taxpayer funds for Medicare and Medicaid programs. If the rates paid or the scope of services covered by government payors are reduced, there could be a material adverse effect on our business, financial condition and results of operations.

In addition to changes in government reimbursement programs, our ability to negotiate favorable contracts with private payors, including managed care providers, significantly affects the financial condition and operating results of our facilities in the U.S. Management expects third-party payors to aggressively manage reimbursement levels and cost controls. Reductions in reimbursement amounts received from third-party payors could have a material adverse effect on our business, financial condition and results of operations.

Our substantial debt could adversely affect our financial health and prevent us from fulfilling our obligations under our financing arrangements.

As of December 31, 2017, we had approximately $3.2 billion of total debt (net of debt issuance costs, discounts and premiums of $50.4 million), which included approximately $1.8 billion of debt under our Amended and Restated Senior Credit Facility (including approximately $380.0 million of Senior Secured Term A Loans and approximately $1.4 billion of Senior Secured Term B Loans), $150.0 million of debt under our 6.125% Senior Notes (the "6.125% Senior Notes"), $300.0 million of debt under our 5.125% Senior Notes (the "5.125% Senior Notes"), $650.0 million of debt under our 5.625% Senior Notes, $390.0 million of debt under our 6.500% Senior Notes and $21.9 million of Lee County (Florida) Industrial Development Authority Healthcare Facilities Revenue Bonds, Series 2010 with stated interest rates of 9.0% and 9.5% (the "9.0% and 9.5% Revenue Bonds"). See "Item 1. Business—Financing Transactions" for additional details regarding our outstanding indebtedness.

Our substantial debt could have important consequences to our business. For example, it could:

- increase our vulnerability to general adverse economic and industry conditions;
- make it more difficult for us to satisfy our other financial obligations;
- restrict us from making strategic acquisitions or cause us to make non-strategic divestitures;
- require us to dedicate a substantial portion of our cash flow from operations to payments on our debt (including scheduled repayments on our outstanding term loan borrowings under the Amended and Restated Senior Credit Facility), thereby reducing the availability of our cash flow to fund working capital, capital expenditures and other general corporate purposes;
- expose us to interest rate fluctuations because the interest on the Amended and Restated Senior Credit Facility is imposed at variable rates;
- make it more difficult for us to satisfy our obligations to our lenders, resulting in possible defaults on and acceleration of such debt;
- limit our flexibility in planning for, or reacting to, changes in our business and the industry in which we operate;
- place us at a competitive disadvantage compared to our competitors that have less debt;
- limit our ability to borrow additional funds; and
- limit our ability to pay dividends, redeem stock or make other distributions.

In addition, the terms of our financing arrangements contain restrictive covenants that limit our ability to engage in activities that may be in our long-term best interests. Our failure to comply with those covenants could result in an event of default which, if not cured or waived, could result in the acceleration of all of our debts, including the Amended and Restated Senior Credit Facility and the Senior Notes.

Servicing our debt will require a significant amount of cash. Our ability to generate sufficient cash to service our debt depends on many factors beyond our control.

Our ability to make payments on and to refinance our debt, to fund planned capital expenditures and to maintain sufficient working capital will depend on our ability to generate cash in the future. This, to a certain extent, is subject to general economic, financial, competitive, legislative, regulatory and other factors that are beyond our control.

We cannot assure you that our business will generate sufficient cash flow from operations or that future borrowings will be available to us under the Amended and Restated Senior Credit Facility or from other sources in an amount sufficient to enable us to service our debt or to fund our other liquidity needs. If our cash flow and capital resources are insufficient to allow us to make scheduled payments on our debt, we may need to reduce or delay capital expenditures, sell assets, seek additional capital or restructure or refinance all or a portion of our debt on or before the maturity thereof, any of which could have a material adverse effect on our business, financial condition or results of operations. We cannot assure you that we will be able to refinance any of our debt on commercially reasonable terms or at all, or that the terms of that debt will allow any of the above alternative measures or that these measures would satisfy our scheduled debt service obligations. If we are unable to generate sufficient cash flow to repay or refinance our debt on favorable terms, it could significantly adversely affect our financial condition and the value of our outstanding debt. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations.

We are subject to a number of restrictive covenants, which may restrict our business and financing activities.

Our financing arrangements impose, and the terms of any future debt may impose, operating and other restrictions on us. Such restrictions affect, and in many respects limit or prohibit, among other things, our and our subsidiaries' ability to:

- incur or guarantee additional debt and issue certain preferred stock;
- pay dividends on our common stock or redeem, repurchase or retire our equity interests or subordinated debt;
- transfer or sell our assets;
- make certain payments or investments;
- make capital expenditures;
- create certain liens on assets;
- create restrictions on the ability of our subsidiaries to pay dividends or make other payments to us;
- engage in certain transactions with our affiliates; and
- merge or consolidate with other companies.

The Amended and Restated Senior Credit Facility also requires us to meet certain financial ratios, including a fixed charge coverage ratio and a consolidated leverage ratio. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources —Amended and Restated Senior Credit Facility"

The restrictions may prevent us from taking actions that management believes would be in the best interests of our business, and may make it difficult for us to successfully execute our business strategy or effectively compete with companies that are not similarly restricted. We also may incur future debt obligations that might subject us to additional restrictive covenants that could affect our financial and operational flexibility. Our ability to comply with these covenants in future periods will largely depend on the pricing of our products and services, our success at implementing cost reduction initiatives and our ability to successfully implement our overall business strategy. We cannot assure you that we will be granted waivers or amendments to our financing arrangements if for any reason we are unable to comply with our financial covenants. The breach of any of these covenants and restrictions could result in a default under the indentures governing the Senior Notes or under the Amended and Restated Senior Credit Facility, which could result in an acceleration of our debt.

Despite our current debt level, we may incur significant additional amounts of debt, which could further exacerbate the risks associated with our substantial debt.

We may incur substantial additional debt, including additional notes and other debt, in the future. Although the indentures governing our outstanding Senior Notes and our Amended and Restated Senior Credit Facility contain restrictions on the incurrence of additional debt, these restrictions are subject to a number of significant qualifications and exceptions, and under certain circumstances, the amount of debt that could be incurred in compliance with these restrictions could be substantial. If new debt is added to our existing debt levels, the related risks that we now face would intensify and we may not be able to meet all our debt obligations.

If we default on our obligations to pay our debt, we may not be able to make payments on our financing arrangements.

Any default under the agreements governing our debt, including a default under the Amended and Restated Senior Credit Facility or the indentures governing our Senior Notes, and the remedies sought by the holders of such debt, could adversely affect our ability to pay the principal, premium, if any, and interest on the Senior Notes and substantially decrease the market value of the Senior Notes. If we are unable to generate sufficient cash flows and are otherwise unable to obtain funds necessary to meet required payments of principal, premium, if any, and interest on our debt, or if we otherwise fail to comply with the various covenants, including financial and operating covenants, in the instruments governing our debt (including the Amended and Restated Senior Credit Facility and the indentures governing the Senior Notes), we would be in default under the terms of the agreements governing such debt. In the event of such default, the holders of such debt could elect to declare all the funds borrowed thereunder to be due and payable, the lenders under the Amended and Restated Senior Credit Facility could elect to terminate their commitments or cease making further loans and institute foreclosure proceedings against our assets, or we could be forced to apply all available cash flows to repay such debt, and, in any such case, we could ultimately be forced into bankruptcy or liquidation. Because the indentures governing the Senior Notes and the agreement governing the Amended and Restated Senior Credit Facility have customary cross-default provisions, if the debt under the Senior Notes or the Amended and Restated Senior Credit Facility is accelerated, we may be unable to repay or refinance the amounts due.

Expanding our international operations poses additional risks to our business.

Our business or financial performance may be adversely affected due to the risks of operating internationally, including but not limited to the following: economic and political instability, failure to comply with foreign laws and regulations and adverse changes in the health care policy of the U.K. (including decreases in funding for the services provided by our U.K. facilities), adverse changes in law and regulations affecting our operations in the U.K., difficulties and costs of staffing and managing our operations in the U.K. If any of these events were to materialize, they could lead to disruption of our business, significant expenditures and/or damages to our reputation, which could have a material adverse effect on our results of operations, financial condition or prospects.

As a company based outside of the U.K., we need to take certain actions to be more easily accepted in the U.K. For example, we may need to engage in a public relations campaign to emphasize service quality and company philosophy, preserve local management continuity and business practices and be transparent in our dealings with local governments and taxing authorities. Such efforts require significant time and effort on the part of our management team. Our results of operation could suffer if these efforts are not successful.

With significant operations in the U.K., our business and operations may be adversely affected by economic and political conditions in the U.K.

The global financial markets continue to experience significant volatility as a result of, among other things, economic and political instability in the wake of the referendum in the U.K. on June 23, 2016, in which the voters approved an exit from the European Union, or Brexit. Following the vote on Brexit, stock markets worldwide experienced significant declines and certain currency exchange rates fluctuated substantially, and the outlook for the global economy in 2018 and beyond remains uncertain as negotiations commence to determine the future terms of the U.K.'s relationship with the European Union. Such global market instability may hinder future economic growth, which could adversely affect our assets, business, cash flow, condition (financial or otherwise), liquidity, prospects and results of operations.

Our facilities face competition for staffing that may increase our labor costs and reduce our profitability.

Our operations depend on the efforts, abilities, and experience of our management and medical support personnel, including our addiction counselors, therapists, nurses, pharmacists, licensed counselors, clinical technicians, and mental health technicians, as well as our psychiatrists and other professionals. We compete with other healthcare providers in recruiting and retaining qualified management, program directors, physicians (including psychiatrists) and support personnel responsible for the daily operations of our business, financial condition or results of operations.

With respect to our facilities in the U.K., we compete with various providers, including the NHS, staffing agencies and other employers, in attracting and retaining qualified management, medical, nursing, care and teaching personnel. Competition for such employees is growing and could lead to increases in our personnel and recruiting costs, which would in turn adversely impact our operating costs and margins. Competitors, in particular the NHS, may offer more attractive wages, pension plans or other benefits than us and we may not be able to provide similar offerings to our prospective employees as a result of cost or other reasons.

A shortage of nurses, qualified addiction counselors, and other medical support personnel has been a significant operating issue facing us and other healthcare providers, particularly for our facilities in the U.K. Such shortages may require us to enhance wages and benefits to recruit and retain nurses, qualified addiction counselors, and other medical support personnel or require us to hire more expensive temporary or contract personnel. The use of temporary or contract personnel could also heighten the risk one of our facilities experiences an adverse patient incident. Further, because we generally recruit our personnel from the local area where the relevant facility is located, the availability in certain areas of suitably qualified personnel can be limited, particularly care home management, qualified teaching personnel and nurses. In addition, certain of our facilities are required to maintain specified staffing levels. To the extent we cannot meet those levels, we may be required to limit the services provided by these facilities, which would have a corresponding adverse effect on our net operating revenue. Certain of our treatment facilities are located in remote geographical areas, far from population centers, which increases this risk.

We cannot predict the degree to which we will be affected by the future availability or cost of attracting and retaining talented medical support staff. If our general labor and related expenses increase, we may not be able to raise our rates correspondingly. Our failure either to recruit and retain qualified management, psychiatrists, therapists, counselors, nurses and other medical support personnel or control our labor costs could have a material adverse effect on our results of operations.

Our acquisition strategy exposes us to a variety of operational and financial risks.

A principal element of our business strategy is to grow by acquiring other companies and assets in the behavioral healthcare industry. Growth, especially rapid growth, through acquisitions exposes us to a variety of operational and financial risks. We summarize the most significant of these risks below.

Integration risks

We must integrate our acquisitions with our existing operations. This process includes the integration of the various components of our business and of the businesses we have acquired or may acquire in the future, including the following:

- additional psychiatrists, other physicians and employees who are not familiar with our operations;
- patients who may elect to switch to another behavioral healthcare provider;
- regulatory compliance programs; and
- disparate operating, information and record keeping systems and technology platforms.

Integrating a new facility could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow and distract management and other key personnel from day-to-day operations.

We may not be able to successfully combine the operations of acquired facilities with our operations, and even if such integration is accomplished, we may never realize the potential benefits of the acquisition. The integration of acquisitions with our operations requires significant attention from management, may impose substantial demands on our operations or other projects and may impose challenges on the combined business including, but not limited to, consistencies in business standards, procedures, policies, business cultures and internal controls and compliance. Certain acquisitions involve a capital outlay, and the return that we achieve on any capital invested may be less than the return that we would achieve on our other projects or investments. If we fail to complete the integration of acquired facilities, we may never fully realize the potential benefits of the related acquisitions.

Successful integration depends on the ability to effect any required changes in operations or personnel, which may entail unforeseen liabilities. The integration of acquired businesses may expose us to certain risks, including the following: difficulty in integrating these businesses in a cost-effective manner, including the establishment of effective management information and financial control systems; unforeseen legal, regulatory, contractual, employment or other issues arising out of the combination; combining corporate cultures; maintaining employee morale and retaining key employees; potential disruptions to our on-going business caused by our senior management's focus on integrating these businesses; and performance of the combined assets not meeting our expectations or plans. A failure to properly integrate these businesses could have a corresponding material adverse effect on our business, results of operations, financial condition or prospects.

Benefits may not materialize

When evaluating potential acquisition targets, we identify potential synergies and cost savings that we expect to realize upon the successful completion of the acquisition and the integration of the related operations. We may, however, be unable to achieve or may otherwise never realize the expected benefits. Our ability to realize the expected benefits from potential cost savings and revenue improvement opportunities is subject to significant business, economic and competitive uncertainties and contingencies, many of which are beyond our control, such as changes to government regulation governing or otherwise impacting the behavioral healthcare industry, reductions in reimbursement rates from third-party payors, reductions in service levels under our contracts, operating difficulties, client preferences, changes in competition and general economic or industry conditions. If we are unsuccessful in implementing these improvements or if we do not achieve our expected results, it may adversely impact our business, financial condition or results of operations.

Assumptions of unknown liabilities

Facilities that we acquire may have unknown or contingent liabilities, including, but not limited to, liabilities for uncertain tax positions, liabilities for failure to comply with healthcare laws and regulations and liabilities for unresolved litigation or regulatory reviews. Although we typically attempt to exclude significant liabilities from our acquisition transactions and seek indemnification from the sellers of such facilities, the purchase agreement with Priory contained minimal representations and warranties about the entities and business that we acquired. In addition, we have no indemnification rights against the sellers under the Priory purchase agreement and all of the purchase price consideration was paid at closing of the Priory acquisition. Therefore, we may incur material liabilities for the past activities of acquired entities and facilities. Even in those acquisitions in which we have such rights, we may experience difficulty enforcing the sellers' obligations, or we may incur material liabilities for the past activities of acquired facilities. Such liabilities and related legal or other costs and/or resulting damage to a facility's reputation could negatively impact our business, financial condition or results of operations.

Competing for acquisitions

We face competition for acquisition candidates primarily from other for-profit healthcare companies, as well as from not-for-profit entities. Some of our competitors may have greater resources than we do. As a result, we may pay more to acquire a target business or may agree to less favorable deal terms than we would have otherwise. Our principal competitors for acquisitions have included Universal Health Services and private equity firms. Also, suitable acquisitions may not be accomplished due to unfavorable terms. Further, the cost of an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for an acquired facility, the acquired facility's results of operations, the fair value of assets acquired and liabilities assumed, effects of subsequent legislation and limits on rate increases. In addition, we may have to pay cash, incur debt, or issue equity securities to pay for any such acquisition, which could adversely affect our financial results, result in dilution to our stockholders, result in increased fixed obligations or impede our ability to manage our operations. There can be no assurances that we will be able to acquire facilities at historical or expected rates or on favorable terms.

Managing growth

Some of the facilities we have acquired or may acquire in the future may have had significantly lower operating margins prior to the time of our acquisition or may have had operating losses prior to such acquisition. If we fail to improve the operating margins of the facilities we acquire, operate such facilities profitably or effectively integrate the operations of the acquired facilities, our results of operations could be negatively impacted.

Joint ventures may use significant resources, may be unsuccessful and could expose us to unforeseen liabilities.

As part of our growth strategy, we have completed, or have announced plans to complete, a number of joint ventures and strategic alliances. These joint ventures may involve significant cash expenditures, debt incurrence, additional operating losses and expenses, and compliance risks that could negatively impact our business, financial condition or results of operations. Further, there is often a significant delay between our formation of a joint venture and the time that a de novo facility can be constructed and have a positive financial impact on our results of operations.

The nature of a joint venture requires us to consult with and share certain decision-making powers with unaffiliated third parties, some of which may be not-for-profit healthcare systems. If our joint venture partners do not fulfill their obligations, the affected joint venture may not be able to operate according to its business or strategic plans. In that case, our financial condition and results of operations may be materially adversely affected or we may be required to increase our level of financial commitment to the joint venture. Moreover, differences in economic or business interests or goals among joint venture participants could result in delayed decisions, failures to agree on major issues and even litigation. If these differences cause the joint ventures to deviate from their business or strategic plans, or if our joint venture partners take actions contrary to our policies, objectives or the best interests of the joint venture, our business, financial condition and results of operation could be negatively impacted. In addition, our relationships with not-for-profit healthcare systems and the joint venture agreements that govern these relationships are intended to be structured to comply with current revenue rulings published by the Internal Revenue Service ("IRS"), as well as case law relevant to joint ventures between for-profit and not-for-profit healthcare entities. Material changes in these authorities could adversely affect our relationships with not-for-profit healthcare systems and related joint venture arrangements.

The majority of our revenue from our operations in the U.K. is not guaranteed and is being generated either from spot purchasing or under framework agreements where no volume commitments are given. In addition, there can be no assurance that we can achieve any fee rate increases in the future or will not suffer any fee rate decreases.

Any decline in demand for our services in the U.K. from publicly funded entities or private payers or any failure by us to extend current agreements or enter into alternative agreements on comparable terms with such entities could have an adverse effect on our average daily census ("ADC"), which would have a corresponding negative impact on our business, results of operations and financial condition. Further, there can be no assurances that we will be able to implement fee rate increases, which are a driver of our revenue from our operations, or not suffer from any decline in fee rates in the future. Should the effect of any increase in annual wages or other operating costs of the business exceed the effect of any increase in our fee rates or should our fee rates suffer a decline, we would have to absorb any costs that cannot be offset by our fees, which could have a negative impact on our business, results of operations and financial condition.

Publicly funded entities

A significant portion of our services funded by U.K. publicly funded entities are commissioned on a spot-purchase basis at prices determined by prevailing market conditions. It is generally a matter for the relevant commissioner to determine whether to use our services, and there is no guarantee that previous spot market purchasing activity by a commissioner will continue in the future or at all. We also have a number of fixed-term framework agreements which grant us preferred provider status with Local Authorities or the NHS typically lasting between one to three years. While we and the commissioners typically agree on pricing for 12 months, at times with discounts related to the number of beds purchased, the commissioners do not make minimum purchasing commitments under such agreements. As such, commissioners may decide to place existing and new service users with our competitors, including their own in-house service providers, on short notice. We also have a small number of fixed-period block contracts, where a set number of beds are paid for at a discount to spot prices regardless of occupancy. While we may have flexibility to increase spot rates for new admissions, any fee increases under our block contracts are restricted by the terms and conditions of those block contracts.

The rates that we charge publicly-funded entities for our services are negotiated individually with commissioners and historically have been subject to annual review on April 1 of each year, with customary adjustments based on the Retail Prices Index ("RPI"), Consumer Price Index ("CPI") or sector specific costs indices. However, the current economic climate and the U.K. government's overriding economic policy to reduce the budget deficit means that, in the short term at least, commissioners are resistant to fee increases, often expecting that efficiency savings be made to offset inflationary cost increases in accordance with national policy. As a result, there can be no assurance that we can maintain the payment terms of our arrangements with publicly funded entities, including with respect to the timing of payments.

Further, following expiration of contracts there can be no assurance that negotiations with commissioners will result in the extension or renewal of existing arrangements or the entering into of alternative arrangements for those services. Commissioners may also require that following the expiration date of current agreements with us, they contract with us on a spot basis rather than through a block arrangement or reduce the number of beds subject to block arrangements. Even if we are successful in extending current agreements or in entering into alternative arrangements, the duration of such extensions or arrangements is uncertain, and we may be unsuccessful in implementing rate increases under such agreements.

In addition, changing commissioning structures and practices, such as those under the Health and Social Care Act 2012, involve tendering processes that could result in failing to remain or become an approved provider. There are currently a number of commissioning initiatives involving public and independent providers that could change the distribution of in-patient beds in the U.K. Certain services that were historically commissioned centrally by NHS England are moving towards more local commissioning to better meet patient needs and to enhance local care pathways. These initiatives could cause our ADC to decrease in areas where there is surplus capacity or more focus on community-based treatment. Further, if we are not invited to participate in initiatives or do not meet the local commissioning standards, our ADC could be adversely affected.

Private payers

Although we have agreements in place with a number of private medical insurance ("PMI") plans where pricing is generally agreed annually, there is no obligation on the PMI plans to refer its members to us or to pay for its members to use our services. Further, we may not be able to renew our existing arrangements with PMI plans on terms comparable to what it has achieved in the past. Fee rates for self-paying individuals are adjusted on January 1 of each year depending on capacity and demand in the relevant service markets. Fees paid or reimbursed by PMI plans are typically adjusted in line with specific contract terms and are generally based on RPI and specific wage indices. Demand in both the PMI market and the self-pay is dependent on economic conditions, which impacts the number of people with sufficient income or capital to pay for insurance coverage or treatment themselves.

Structural shifts in the U.K. behavioral healthcare market may adversely affect us.

Publicly funded entities

Payments for our services by publicly funded entities in the U.K., particularly the NHS and Local Authorities, account for the vast majority of our U.K. revenue. We expect publicly funded entities in the U.K. to continue to generate the significant majority of our revenue from our operations in the U.K. Budget constraints, public spending cuts or other financial pressures could cause such publicly funded entities to spend less money on the type of services that we provide, or political or U.K. government policy changes could mean that fewer of such services are purchased by publicly funded entities from independent sector providers in favor of protecting NHS and Local Authority in-house services.

While the outsourcing by the NHS in England of healthcare services has been increasing in recent years, the need of the NHS in England to achieve substantial efficiency savings is likely to result in continued funding pressure in the pricing of such services. For instance, Monitor (now part of NHS Improvement), the NHS economic regulator, has, under NHS Tariff Rules, determined national prices across a range of NHS services and has issued extensive guidance on how they are to be applied, including provision for local variations to national tariffs, subject to approval by Monitor. While none of our services are currently subject to national prices, the future application of any national prices regime upon our services could have a material adverse impact on our revenue.

In addition, the allocation of funding responsibility for adult social care may be subject to change at some time in the future under the provisions of the Care Act 2014 under which individuals identified as being required to pay for their own care under the relevant means test will be required to take funding responsibility up to a specified lifetime monetary cap, with Local Authorities responsible for the remainder of expenses for personal care, excluding "daily living" expenses. This would potentially place greater funding responsibility with public sector bodies over the longer term, which would potentially exacerbate the current funding challenges faced by such bodies.

Private payers

Payments for our services in the U.K. by PMI plans account for a small portion of our U.K. revenue. In addition, payments for our services in the U.K. by self-pay patients, who purchase treatment on a spot basis account for a small portion of our U.K. revenue. Many of the patients who use our acute healthcare services in the U.K. do so because their PMI plan recognizes our facilities as being an appropriate provider of the psychiatric treatment services required by the patient. Our ability to attract patients who are funded by PMI plans could be adversely impacted if one or more PMI plans withdraws recognition status from our facilities, for example, as a result of a change in a PMI plan's recognition status standards. In addition, many PMI plans have been changing the terms of their policies and shortening the length of time they will cover a stay at one of our U.K. facilities.

There can be no assurance that the entities or individuals who fund our services will not reduce or cease spending on the types of services that we provide or that alternative service or funding models for mental healthcare, learning disabilities care, specialist education or elderly care will not emerge. Any such funding or structural change in the markets where we operate could have a material adverse effect on our ADC, which would have a corresponding negative impact on our business, results of operations and financial condition.

We are reliant upon maintaining strong relationships with commissioners employed by publicly funded entities, psychiatric and other medical consultants, and any reorganization of such publicly funded entities may result in the loss of those relationships.

The relationships that we have with commissioners is a key driver of referrals for our facilities in the U.K. Referrals to our U.K. business by the NHS accounted for a significant percentage of our revenue for the year ended December 31, 2017. Should there be a major reorganization of publicly funded entities, such as the NHS reorganization announced in 2010 and implemented between 2012 and 2013, we may need to rebuild such relationships which could result in a decrease in the number of referrals made to our facilities, which could have a corresponding material adverse effect on our business, results of operations, financial condition or prospects. Any actual or perceived deterioration in service quality, any serious incidents at our facilities or any other event that could cause commissioners to prefer other service providers over us could also adversely impact referrals from commissioners. Further, our business also depends, in part, on psychiatric and other medical consultants referring their patients to us for treatment either as in-patients or day patients. From time to time, consultants may decide to relocate or reposition their practices, retire or refer patients elsewhere with the result that there is a decrease in the number of referrals made to our facilities. A deterioration in relationships with commissioners or consultants or the decision by one or more commissioners or consultants to refer patients to our competitors or to stop all referrals would have an adverse effect on the ADC at our facilities in the U.K., which would have a corresponding negative impact on our business, results of operations and financial condition.

Our operating costs are subject to increases, including due to statutorily mandated increases in the wages and salaries of our staff.

The most significant operating expense for our facilities is wage costs, which represent the staff costs incurred in providing our services and running our facilities, and which are primarily driven by the number of employees and pay rates. The number of employees employed by us is primarily linked to the number of facilities we operate and the number of individuals cared for by us. While we can reduce the number of employees should occupancy rates decrease at our facilities, there is a limit on the extent to which this can be done without impacting quality of our services.

Furthermore, in April 2016, a new "National Living Wage" was introduced across the U.K. which was increased in April 2017 and is scheduled to increase again in April 2018 with further annual increases expected until at least 2020. These changes to the National Living Wage have and will increase our operating costs and, unless we can increase revenue or reduce other costs, will reduce our margins.

In the U.K., there has been an increase in enforcement action by HMRC against employers who do not pay the NMW, particularly for fixed allowance payments for sleep-in shifts in the care sector. The industry standard practice has been to pay a fixed allowance to employees who sleep at sites at night with a "top-up" if an employee is woken and provides care to residents during the

night. Our U.K. facilities have elected to join the SCCS established by HMRC to mitigate our exposure to potential back-pay liability. Nevertheless, we may be subject to (i) increased payments to employees for sleep-in shifts on an on-going basis; (ii) payments of up to 6 years of arrears to employees or former employees who have carried out sleep-in shifts at our U.K. facilities; and (iii) payments of interest and penalties to HMRC, all of which would have a corresponding negative impact on our business, results of operations and financial condition.

We also have a number of recurring costs including insurance, utilities and rental costs, and may face increases to other recurring costs such as regulatory compliance costs. There can be no assurance that any of our recurring costs will not grow at a faster rate than our revenue. As a result, any increase in our operating costs could have a material adverse effect on our business, results of operations and financial condition.

We care for a large number of vulnerable individuals with complex needs and any care quality deficiencies could adversely impact our brand, reputation and ability to market our services effectively.

Our future growth will partly depend on our ability to maintain our reputation for providing quality patient care and, through successful sales and marketing activities, increased demand for our services. Factors such as health and safety incidents, problems at our facilities, regulatory enforcement actions, negative press or general customer dissatisfaction could lead to deterioration in the level of our quality ratings or the public perception of the quality of our services (including as a result of negative publicity about our industry generally), which in turn could lead to a loss of patient placements, referrals and self-pay patients or service users. Any impairment of our reputation, loss of goodwill or damage to the value of our brand name could have a material adverse effect on our business, results of operations and financial condition.

Many of our service users have complex medical conditions or special needs, are vulnerable and often require a substantial level of care and supervision. There is a risk that one or more service users could be harmed by one or more of our employees, either intentionally, through negligence or by accident. Further, individuals cared for by us have in the past engaged, and may in the future engage, in behavior that results in harm to themselves, our employees or to one or more other individuals, including members of the public. A serious incident involving harm to one or more service users or other individuals could result in negative publicity. Such negative publicity could have a material adverse effect on our brand, reputation and ADC, which would have a corresponding negative impact on our business, results of operations and financial condition. Furthermore, the damage to our reputation or to the reputation of the relevant facility from any such incident could be exacerbated by any failure on our part to respond effectively to such incident.

We are and in the future may become involved in legal proceedings based on negligence or breach of a contractual or statutory duty from service users or their family members or from employees or former employees.

From time to time, we are subject to complaints and claims from service users and their family members alleging professional negligence, medical malpractice or mistreatment. We are also subject to claims for unlawful detention from time to time when patients allege they should not have been detained under the Mental Health Act or where the appropriate procedures were not correctly followed.

Similarly, there may be substantial claims from employees in respect of personal injuries sustained in the performance of their duties, particularly in respect of incidents involving patients detained under the Mental Health Act and where future employment prospects are impaired. Current or former employees may also make claims against us in relation to breaches of employment legislation.

We may also be involved in coroner's inquests (or the Scottish equivalent) where there is a fatality at one of our facilities in the U.K. resulting in an adverse coroner's verdict or civil claims by individuals or criminal prosecutions by regulatory authorities. Any fines imposed by the courts are likely to be substantial in view of the Sentencing Council guidelines published in November 2015, which materially increase fines for corporate manslaughter and certain health and safety offenses. There may also be safeguarding incidents at our facilities which, depending on the circumstances, may result in custodial sentences or other criminal sanctions for the member of staff involved.

The incurrence of any legal fees, damage awards or other fines as summarized above as well as any impact on our brand or reputation as a result of being involved in any legal proceedings are likely to have a material adverse impact on our business, results of operations and financial condition.

We handle sensitive personal data which are protected by numerous U.S. and U.K. laws in the ordinary course of business and any failure to maintain the confidentiality of such data could result in legal liability and reputational harm.

We process and store sensitive personal data as part of our business. In the event of a security breach, sensitive personal data could become public. We are currently not aware of any material incidences of potential data breach; however, there can be no assurance that such breaches will not arise in future. Although we have in place policies and procedures to prevent such breaches, breaches could occur either as a result of a breach by us or as a result of a breach by a third party to whom we have provided sensitive personal data, and as a result, we could face liability under data protection laws.

In addition to U.S. data protection laws, we are subject to similar, and in some cases more restrictive, U.K. data protection laws. For example, the GDPR will provide heightened data protection requirements once effective in May 2018, including more stringent consent requirements, data protection and security measures and requirements to appoint a data protection officer. While we are taking appropriate steps to ensure compliance with U.K. data protection laws and regulations, we cannot guarantee that our facilities will not be subject to data breaches which could have a material adverse effect on our business, financial condition, or results of operations.

Liability under data protection laws may result in sanctions, including substantial fines and/or may cause us to suffer damage to our brand and reputation, which could have a material adverse effect on our business, results of operations and financial condition.

We may be subject to liabilities from claims brought against us or our facilities.

We are subject to medical malpractice lawsuits and other legal actions in the ordinary course of business. Some of these actions may involve large claims, as well as significant defense costs. We cannot predict the outcome of these lawsuits or the effect that findings in such lawsuits may have on us. All professional and general liability insurance we purchase is subject to policy limitations and in some cases, an insurance company may defend us subject to a reservation of rights. Management believes that, based on our past experience and actuarial estimates, our insurance coverage is adequate considering the claims arising from the operations of our facilities. While we continuously monitor our coverage, our ultimate liability for professional and general liability claims could change materially from our current estimates. If such policy limitations should be partially or fully exhausted in the future, or payments of claims exceed our estimates or are not covered by our insurance, it could have a material adverse effect on our business, financial condition or results of operations. Further, insurance premiums have increased year over year and insurance coverage may not be available at a reasonable cost, especially given the significant increase in insurance premiums generally experienced in the healthcare industry.

We carry a large self-insured retention and may be responsible for significant amounts not covered by insurance. In addition, our insurance may be inadequate, premiums may increase and, if there is a significant deterioration in our claims experience, insurance may not be available on acceptable terms.

We maintain liability insurance intended to cover service user, third-party and employee personal injury claims. Due to the structure of our insurance program under which we carry a large self-insured retention, there may be substantial claims in respect of which the liability for damages and costs falls to us before being met by any insurance underwriter. There may also be claims in excess of our insurance coverage or claims which are not covered by our insurance due to other policy limitations or exclusions or where we have failed to comply with the terms of the policy. Furthermore, there can be no assurance that we will be able to obtain liability insurance coverage in the future on acceptable terms, or without substantial premium increases or at all, particularly if there is a deterioration in our claim experience history. A successful claim against us not covered by or in excess of our insurance coverage could have a material adverse effect on our business, results of operations and financial condition.

Foreign currency exchange rate fluctuations could materially impact our consolidated financial position and results of operations.

We have significant U.K. operations. Accordingly, we translate revenue and other results denominated in a foreign currency into U.S. dollars ("USD") for our consolidated financial statements. During periods of a strengthening USD or weakening British pound ("GBP"), our reported international revenue and expenses could be reduced because foreign currencies may translate into fewer USD. Following the Brexit vote and subsequent developments, the GBP dropped to its lowest level against the USD in more than 30 years. If the exchange rate further declines, our results of operations will be negatively impacted in future periods.

In all jurisdictions in which we operate, we are also subject to laws and regulations that govern foreign investment, foreign trade and currency exchange transactions. These laws and regulations may limit our ability to repatriate cash as dividends or otherwise to the U.S. and may limit our ability to convert foreign currency cash flows into USD.

We incur significant transaction related costs in connection with acquisitions.

We incur substantial costs in connection with acquisitions, including transaction-related expenses. In addition, we may incur additional costs to maintain employee morale, retain key employees, and to formulate and execute integration plans. Although we expect that the elimination of duplicative costs, as well as the realization of other efficiencies related to the integration of acquired businesses, should allow us to more than offset incremental transaction and acquisition-related costs over time, this net benefit may not be achieved in the near term, or at all.

Our ability to grow our business through organic expansion either by developing new facilities or by modifying existing facilities is dependent upon many factors.

Our ability to grow our business through organic expansion is dependent on capacity and occupancy at our facilities. Should our facilities reach maximum occupancy, we may need to implement other growth strategies either by developing new facilities or by modifying existing facilities.

Our facilities typically need to be purpose-designed in order to enable the type and quality of service that we provide. Consequently, we must either develop sites to create facilities or purchase or lease existing facilities, which may require substantial modification. We must be able to identify suitable sites and there is no guarantee that such sites will be available at all, or at an economically viable cost or in areas of sufficient demand for our services. The subsequent successful development and construction of a new facility is contingent upon, among other things, negotiation of construction contracts, regulatory permits and planning consents and satisfactory completion of construction. Similarly, our ability to expand existing facilities is also dependent upon various factors, including identification of appropriate expansion projects, permitting, licensure, financing, integration into our relationships with payors and referral sources, and margin pressure as new facilities are filled with patients.

Delays caused by difficulties in respect of any of the above factors may lead to cost overruns and longer periods before a return is generated on an investment, if at all. We may incur significant capital expenditure but due to a regulatory, planning or other reason, may find that we are prevented from opening a new facility or modifying an existing facility. Moreover, even when incurring such development capital expenditure, there is no guarantee that we can fill beds when they become available. Upon operational commencement of a new facility, we typically expect that it will take approximately 12-18 months to reach our targeted occupancy level. Any delays or stoppages in our projects, the unsatisfactory completion or construction of such projects or the failure of such projects to increase our occupancy levels could have a material adverse effect on our ADC, which would have a corresponding negative impact on our business, results of operations and financial condition.

We may fail to deal with clinical waste in accordance with applicable regulations or otherwise be in breach of relevant medical, health and safety or environmental laws and regulations.

As part of our normal business activities, we produce and store clinical waste which may produce effects harmful to the environment or human health. The storage and transportation of such waste is strictly regulated. Our waste disposal services are outsourced and should the relevant service provider fail to comply with relevant regulations, we could face sanctions or fines which could adversely affect our brand, reputation, business or financial condition. Health and safety risks are inherent in the services that we provide and are constantly present in our facilities, primarily in respect of food and water quality, as well as fire safety and the risk that service users may cause harm to themselves, other service users or employees. From time to time, we have experienced, like other providers of similar services, undesirable health and safety incidents. Some of our activities are particularly exposed to significant medical risks relating to the transmission of infections or the prescription and administration of drugs for residents and patients. If any of the above medical or health and safety risks were to materialize, we may be held liable, fined and any registration certificate could be suspended or withdrawn for failure to comply with applicable regulations, which may have a material adverse impact on our business, results of operations and financial condition.

The value of our real estate assets will be subject to fluctuations in the U.K. real estate market.

We hold a large portfolio of real estate assets, including significant real estate assets in the U.K. The value of our U.K. property portfolio is subject to, among other things, the conditions of the real estate market in the U.K. The average values of real estate in the U.K., as in other European countries, experienced sharp declines from 2007 as a result of the credit crisis, economic recession and reduced confidence in global financial markets. Although real estate asset values have recovered and stabilized in recent years in the U.K., there can be no assurance that this improvement will continue or be sustainable. Real estate asset values could decline substantially, particularly if the U.K. economy or the Eurozone economy as a whole were to suffer a further recession or debt crisis, and could result in declines in the carrying values of our real estate assets (and the value at which we could dispose of such assets). Any of the above may have a material adverse effect on our business, results of operations and financial condition.

Our business could be disrupted if our information systems fail or if our databases are destroyed or damaged.

Our information technology platform supports, among other things, management control of patient administration, billing and financial information and reporting processes. For example, patients in our U.K. facilities and some of our U.S. facilities have an Electronic Patient Record that allows our caregivers and nurses to see all information about a patient's care and treatment. Although

we have taken measures to mitigate potential information technology security risks and have information technology continuity plans across our business intended to minimize the impact of information technology failures, there can be no assurance that such measures and plans will be effective. Any failure in or breach of our information technology systems could adversely impact our business, results of operations and financial condition.

We are subject to volatility in the global capital and credit markets as well as significant developments in macroeconomic and political conditions that are out of our control.

Our business can be affected by a number of factors that are beyond our control, such as general macroeconomic conditions, conditions in the financial services markets, geopolitical conditions and other general political and economic developments. These conditions and developments may continue to put pressure on the economy in the U.K., which could have a negative effect on our business. There may be a shortage of liquidity and credit in the U.K. or worldwide and this can be exacerbated by adverse developments in global or national political and/or macroeconomic conditions. In particular, we have historically financed the development of new facilities and the modification of our existing facilities through a variety of sources, including our own cash reserves and debt financing. While we intend to seek to finance new and existing developments from similar sources in the future, there may be insufficient cash reserves to fund the budgeted capital expenditure and market conditions and other factors may prevent us from obtaining debt financing on appropriate terms or at all. In addition, market conditions may limit the number of financial institutions that are willing to provide financing to landlords with whom we wish to contract to build homes for learning disability services, new schools or new mental health facilities which can then be made available to us under a long-term operating lease. If conditions in the U.K. or the global economy remain uncertain or weaken further, this could materially adversely impact our ADC, which would have a corresponding negative impact on our business, results of operations and financial condition.

Failure to comply with the international and U.S. laws and regulations applicable to our international operations could subject us to penalties and other adverse consequences.

We face several risks inherent in conducting business internationally, including compliance with international and U.S. laws and regulations that apply to our international operations. These laws and regulations include U.S. laws such as the Foreign Corrupt Practices Act and other U.S. federal laws and regulations established by the Office of Foreign Asset Control, local laws such as the U.K. Bribery Act 2010 or other local laws which prohibit corrupt payments to governmental officials or certain payments or remunerations to customers. Given the high level of complexity of these laws, however, there is a risk that some provisions may be inadvertently breached by us, for example through fraudulent or negligent behavior of individual employees, our failure to comply with certain formal documentation requirements, or otherwise. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or our employees, implementation of compliance programs, and prohibitions on the conduct of our business. Any such violations could include prohibitions on our ability to conduct business in the U.K. and could materially damage our reputation, our brand, our international expansion efforts, our ability to attract and retain employees, our business and our operating results. Our success depends, in part, on our ability to anticipate these risks and manage these challenges.

We are subject to taxation in the U.S. and certain foreign jurisdictions. Any adverse development in the tax laws of such jurisdictions or any disagreement with our tax positions could have a material adverse effect on our business, financial condition or results of operations. In addition, our effective tax rate could change materially as a result of certain changes in our mix of U.S. and foreign earnings and other factors, including changes in tax laws.

We are subject to taxation in, and to the tax laws and regulations of, the U.S. and certain foreign jurisdictions as a result of our operations and our corporate and financing structure. Adverse developments in these tax laws or regulations, or any change in position regarding the application, administration or interpretation thereof, in any applicable jurisdiction, could have a material adverse effect on our business, financial condition or results of operations. In addition, the tax authorities in any applicable jurisdiction may disagree with the tax treatment or characterization of any of our transactions, which, if successfully challenged by such tax authorities, could have a material adverse effect on our business, financial condition or results of operations. Certain changes in the mix of our earnings between jurisdictions and assumptions used in the calculation of income taxes, among other factors, could have a material adverse effect on our overall effective tax rate. In addition, the Tax Act makes significant changes to the rules applicable to the taxation of corporations. The Company is currently in the process of analyzing the effects of the Tax Act on the Company. It is uncertain at this time whether the application of these new rules will have any material and adverse impact on our operating results, cash flows and financial condition.

A worsening of the economic and employment conditions in the geographies in which we operate could materially affect our business and future results of operations.

During periods of high unemployment, governmental entities often experience budget deficits as a result of increased costs and lower than expected tax collections. These budget deficits at the federal, state and local levels have decreased, and may continue to decrease, spending for health and human service programs, including Medicare and Medicaid in the U.S., which are significant payor sources for our facilities. In periods of high unemployment, we also face the risk of potential declines in the population covered under private insurance, patient decisions to postpone or decide against receiving behavioral healthcare services, potential increases in the uninsured and underinsured populations we serve and further difficulties in collecting patient co-payment and deductible receivables.

A sizable portion of our revenue from certain residential recovery, eating disorder facilities, comprehensive treatment centers and youth programs is from self-payors. Accordingly, a sustained downturn in the U.S. economy could restrain the ability of our patients and the families of our students to pay for services.

Furthermore, the availability of liquidity and capital resources to fund the continuation and expansion of many business operations worldwide has been limited in recent years. Our ability to access the capital markets on acceptable terms may be severely restricted at a time when we would like, or need, access to those markets, which could have a negative impact on our growth plans, our flexibility to react to changing economic and business conditions and our ability to refinance existing debt (including debt under our Amended and Restated Senior Credit Facility and the Senior Notes). A sustained economic downturn or other economic conditions could also adversely affect the counterparties to our agreements, including the lenders under the Amended and Restated Senior Credit Facility, causing them to fail to meet their obligations to us.

Our reimbursement may be adversely affected by the repeal, replacement or modification of PPACA.

On January 20, 2017, Donald Trump became President of the United States. During the 2016 election cycle, Republicans also assumed control of both the United States Senate and House of Representatives. Shortly after his inauguration, President Trump issued an executive order that, among other things, stated that it was the intent of his administration to repeal PPACA. Several bills have been introduced and voted upon in the House of Representatives and United States Senate that would either repeal and replace or simply repeal PPACA, although no such comprehensive legislation has been enacted to-date. The Tax Act does, however, effectively repeal the individual mandate to obtain and maintain health insurance by eliminating the tax penalty associated with failing to do so.

If PPACA is repealed, with or without a replacement, we may experience a significant decrease in reimbursement from state Medicaid programs. We may also experience a significant increase in uncompensated care if many of our patients who currently obtain private health insurance coverage or Medicaid coverage under the provisions of PPACA are no longer able to maintain that coverage. Finally, PPACA currently works in conjunction with MHPAEA to require that third-party payors reimburse providers of certain mental health and substance abuse treatment services on an out-of-network basis. If PPACA or this particular provision thereof is repealed, we may experience a significant decrease in out-of-network reimbursement at certain of our facilities.

If we fail to comply with extensive laws and government regulations, we could suffer penalties or be required to make significant changes to our operations.

Companies operating in the behavioral healthcare industry in the U.S. are required to comply with extensive and complex laws and regulations at the federal, state and local government levels relating to, among other things: billing practices and prices for services; relationships with physicians and other referral sources; necessity and quality of medical care; condition and adequacy of facilities; qualifications of medical and support personnel; confidentiality, privacy and security issues associated with health-related information and PHI; EMTALA compliance; handling of controlled substances; certification, licensure and accreditation of our facilities; operating policies and procedures; activities regarding competitors; state and local land use and zoning requirements; and addition or expansion of facilities and services.

Among the laws applicable to our operations are the federal Anti-Kickback Statute, the Stark Law, the federal False Claims Act, and similar state laws. These laws impact the relationships that we may have with physicians and other potential referral sources. We have a variety of financial relationships with physicians and other professionals who refer patients to our facilities, including employment contracts, leases and professional service agreements. The OIG has issued certain safe harbor regulations that outline practices that are deemed acceptable under the Anti-Kickback Statute, and similar regulatory exceptions have been promulgated by CMS under the Stark Law. While we endeavor to ensure that our arrangements with referral sources comply with an applicable safe harbor to the Anti-Kickback Statute where possible, certain of our current arrangements with physicians and other potential referral sources may not qualify for such protection. Failure to meet a safe harbor does not mean that the arrangement automatically violates the Anti-Kickback Statute, but may subject the arrangement to greater scrutiny. Moreover, while we believe that our arrangements with physicians comply with applicable Stark Law exceptions, the Stark Law is a strict liability statute for which no intent to violate the law is required.

These laws and regulations are extremely complex, and, in many cases, we do not have the benefit of regulatory or judicial interpretation. In the future, it is possible that different interpretations of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our arrangements for facilities, equipment,

personnel, services, capital expenditure programs and operating expenses. A determination that we have violated one or more of these laws could subject us to liabilities, including civil penalties, exclusion of one or more facilities from participation in the government healthcare programs and, for violations of certain laws and regulations, criminal penalties. Even the public announcement that we are being investigated for possible violations of these laws could cause our reputation to suffer and have a material adverse effect on our business, financial condition or results of operations. In addition, we cannot predict whether other similar legislation or regulations at the federal or state level will be adopted, what form such legislation or regulations may take or what their impact on us may be.

The construction and operation of healthcare facilities in the U.S. are subject to extensive federal, state and local regulation relating to, among other things, the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting, compliance with building codes and environmental protection. Additionally, such facilities are subject to periodic inspection by government authorities to assure their continued compliance with these various standards. If we fail to adhere to these standards, we could be subject to monetary penalties or restrictions on our ability to operate.

All of our facilities that handle and dispense controlled substances must comply with strict federal and state regulations regarding the purchase, storage, distribution and disposal of such controlled substances. The potential for theft or diversion of such controlled substances for illegal uses has led the federal government as well as a number of states and localities to adopt stringent regulations not applicable to many other types of healthcare providers. Compliance with these regulations is expensive and these costs may increase in the future.

Property owners and local authorities have attempted, and may in the future attempt, to use or enact zoning ordinances to eliminate our ability to operate a given treatment facility or program. Local governmental authorities in some cases also have attempted to use litigation and the threat of prosecution to force the closure of certain comprehensive treatment facilities. If any of these attempts were to succeed or if their frequency were to increase, our revenue would be adversely affected and our operating results might be harmed. In addition, such actions may require us to litigate which would increase our costs.

Many of our U.S. facilities are also accredited by third-party accreditation agencies such as The Joint Commission or CARF. If any of our existing healthcare facilities lose their accreditation or any of our new facilities fail to receive accreditation, such facilities could become ineligible to receive reimbursement under Medicare or Medicaid.

Federal, state and local regulations determine the capacity at which many of our U.S. facilities may be operated. State licensing standards require many of our U.S. facilities to have minimum staffing levels; minimum amounts of residential space per student or patient and adhere to other minimum standards. Local regulations require us to follow land use guidelines at many of our U.S. facilities, including those pertaining to fire safety, sewer capacity and other physical plant matters.

Similarly, providers of behavioral healthcare services in the U.K. are also subject to a highly regulated business environment. Failure to comply with regulations, lapses in the standards of care, the receipt of poor ratings or lower ratings, the receipt of a negative report that leads to a determination of regulatory noncompliance, or the failure to cure any defect noted in an inspection report could lead to substantial penalties, including the loss of registration or closure of one or more facilities as well as damage to reputation.

Our operations in the U.K. are subject to a high level of regulation and supervision, ranging from the initial establishment of new facilities, which are subject to registration and licensing requirements, to the recruitment and appointment of staff, occupational health and safety, duty of care to service users, clinical and educational standards, conduct of our professional and support staff, the environment, public health and other areas. The regulatory requirements differ across our divisions, though almost all of our activity in England in relation to mental healthcare, elderly care and learning disability care are regulated by the CQC and in Scotland, Wales and Northern Ireland, its local equivalent. In addition, our children's homes, residential schools and colleges in England are regulated by OFSTED, and in Scotland and Wales by their local equivalent, and all of our schools must be licensed by the Department for Education. See "Item 1. Business—Regulation—U.K. Overview" for further details on the key U.K. regulations to which we are subject.

Inspections by CQC, OFSTED, and other regulators can be carried out on both an announced and unannounced basis depending on the specific regulatory provisions relating to the different healthcare, social care and specialist education services we provide.

A failure to comply with regulations, the receipt of a poor rating or a lower rating, or the receipt of a negative report that leads to a determination of regulatory non-compliance or our failure to cure any defect noted in an inspection report could result in reputational damage, fines, the revocation or suspension of the registration of any facility or service or a decrease in, or cessation of, the services provided by us at any given facility. Additionally, where placements are funded by Local Authorities, most Local Authorities monitor performance and where there are shortcomings may impose punitive measures. These can, for example, include the suspension of new placements (known in the industry as "embargoes") and, in extreme cases, removal of all residents placed by that authority, which in turn may affect the level of referrals from other publicly funded entities and our occupancy levels.

Furthermore, new regulations or regulatory bodies may be introduced in the future or existing regulations and regulatory bodies may be amended or replaced and we may not adapt to such changes quickly enough, or in a cost-efficient manner. For example, the U.K. government appointed Monitor (now part of NHS Improvement) as the market regulator for healthcare providers in 2012 by way of a licensing regime. Any failure by us to comply with the licensing regime could result in Monitor revoking our license, which would mean we would be unable to operate. In addition, such regulatory changes may preclude management from executing its business plan as intended, including the timing for new developments and openings.

We cannot guarantee that current laws, regulations and regulatory assessment methodologies will not be modified or replaced in the future. There can be no assurance that our business, results of operations and financial condition will not be adversely affected by any future regulatory developments or that the cost of compliance with new regulations will not be material.

If we fail to cultivate new or maintain established relationships with referral sources, our business, financial condition or results of operations could be adversely affected.

Our ability to grow or even to maintain our existing level of business depends significantly on our ability to establish and maintain close working relationships with physicians, managed care companies, insurance companies, educational consultants and other referral sources. We may not be able to maintain our existing referral source relationships or develop and maintain new relationships in existing or new markets. If we lose existing relationships with our referral sources, the number of people to whom we provide services may decline, which may adversely affect our revenue. If we fail to develop new referral relationships, our growth may be restrained.

We may be required to spend substantial amounts to comply with statutes and regulations relating to privacy and security of PHI.

There are currently numerous legislative and regulatory initiatives in both the U.S. and the U.K. addressing patient privacy and information security concerns. In particular, federal regulations issued under HIPAA require our U.S. facilities to comply with standards to protect the privacy, security and integrity of PHI. These requirements include the adoption of certain administrative, physical, and technical safeguards; development of adequate policies and procedures, training programs and other initiatives to ensure the privacy of PHI is maintained; entry into appropriate agreements with so-called business associates; and affording patients certain rights with respect to their PHI, including notification of any breaches. Compliance with these regulations requires substantial expenditures, which could negatively impact our business, financial condition or results of operations. In addition, our management has spent, and may spend in the future, substantial time and effort on compliance measures.

In addition to HIPAA, we are subject to similar, and in some cases more restrictive, state and federal privacy regulations. For example, the federal government and some states impose laws governing the use and disclosure of health information pertaining to mental health and/or substance abuse treatment that are more stringent than the rules that apply to healthcare information generally. As public attention is drawn to the issues of the privacy and security of medical information, states may revise or expand their laws concerning the use and disclosure of health information, or may adopt new laws addressing these subjects.

Violations of the privacy and security regulations could subject our operations to substantial civil monetary penalties and substantial other costs and penalties associated with a breach of data security, including criminal penalties. We may also be subject to substantial reputational harm if we experience a substantial security breach involving PHI.

We are subject to uncertainties regarding recent health reform and budget legislation.

Recent developments with respect to the implementation of PPACA have created uncertainty for many healthcare providers. For example, the Tax Act will effectively repeal the individual health insurance mandate imposed under PPACA by eliminating the tax penalty associated with failure to obtain and maintain coverage. Additionally, President Trump's administration has taken certain executive actions that may promote the availability of alternative forms of health insurance outside PPACA's requirements and otherwise affect the implementation of PPACA. We cannot predict how these changes to, or the potential repeal, replacement or further modification of, PPACA will affect our business, results of operations, cash flow, capital resources and liquidity, or whether we will be able to adapt successfully thereto.

We are similarly unable to guarantee that current U.K. laws, regulations and regulatory assessment methodologies will not be modified or replaced in the future. Additionally, there is a risk that budget constraints, public spending cuts (such as the cuts announced by the U.K. government in the 2010 Comprehensive Spending Review and implemented in the 2011 and 2012 government budgets) or other financial pressures could cause the NHS to reduce funding for the types of services that we provide. Such policy changes in the U.K. could lead to fewer services being purchased by publicly funded entities or material changes being made to their procurement practices, any of which could materially reduce our revenue. These and other future developments and amendments may negatively impact our operations, which could have a material adverse effect on our business, financial condition or results of operations. See "—Expanding our operations internationally poses additional risks to our business."

Finally, the allocation of funding responsibility for adult social care will be subject to change over the next few years under the provisions of the Care Act 2014 with individuals identified as being required to pay for their own care under the relevant means test being required to take funding responsibility up to a specified lifetime monetary cap, with Local Authorities then becoming responsible for the continued funding of personal care, but not 'daily living' expenses. This will potentially place greater funding responsibility with public sector bodies over the longer term, which will potentially exacerbate the current funding challenges faced by such bodies.

The industry trend on value-based purchasing may negatively impact our revenue.

There is a trend in the healthcare industry toward value-based purchasing of healthcare services. These value-based purchasing programs include both public reporting of quality data and preventable adverse events tied to the quality and efficiency of care provided by facilities. Governmental programs including Medicare and Medicaid currently require hospitals to report certain quality data to receive full reimbursement updates. In addition, Medicare does not reimburse for care related to certain preventable adverse events. Many large commercial payors currently require hospitals to report quality data, and several commercial payors do not reimburse hospitals for certain preventable adverse events.

We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively impact our revenue if we are unable to meet quality standards established by both governmental and private payers.

We operate in a highly competitive industry, and competition may lead to declines in patient volumes.

The healthcare industry is highly competitive, and competition among healthcare providers (including hospitals) for patients, physicians and other healthcare professionals has intensified in recent years. There are other healthcare facilities that provide behavioral and other mental health services comparable to those offered by our facilities in each of the geographical areas in which we operate. Some of our competitors are owned by tax-supported governmental agencies or by non-profit corporations and may have certain financial advantages not available to us, including endowments, charitable contributions, tax-exempt financing and exemptions from sales, property and income taxes. Some of our for-profit competitors are local, independent operators or physician groups with strong established reputations within the surrounding communities, which may adversely affect our ability to attract a sufficiently large number of patients in markets where we compete with such providers. We also face competition from other for-profit entities, who may possess greater financial, marketing or research and development resources than us or may invest more funds in renovating their facilities or developing technology.

If our competitors are better able to attract patients, recruit and retain physicians and other healthcare professionals, expand services or obtain favorable managed care contracts at their facilities, we may experience a decline in patient volume and our results of operations may be adversely affected.

The NHS is the principal provider of secure mental healthcare services in the U.K., with approximately 70% of the total beds in secure mental healthcare services in the U.K. As the preferred provider, there is often a bias toward referrals to NHS, and therefore NHS facilities have maintained high occupancy rates. As a result of budget constraints, independent operators have emerged to satisfy the demand for mental health services not supplied by the NHS. In addition to the NHS, we face competition in the U.K. from independent sector providers and other publicly funded entities for individuals requiring care and for appropriate sites on which to develop or expand facilities in the U.K. Should we fail to compete effectively with our peers and competitors in the industry, or if the competitive environment intensifies, individuals may be referred elsewhere for services that we provide, negatively impacting our ability to secure referrals and limiting the expansion of our business.

The trend by insurance companies and managed care organizations to enter into sole-source contracts may limit our ability to obtain patients.

Insurance companies and managed care organizations in the U.S. are entering into sole-source contracts with healthcare providers, which could limit our ability to obtain patients since we do not offer the range of services required for these contracts. Moreover, private insurers, managed care organizations and, to a lesser extent, Medicaid and Medicare, are beginning to carve-out specific services, including mental health and substance abuse services, and establish small, specialized networks of providers for such services at fixed reimbursement rates. Continued growth in the use of carve-out arrangements could materially adversely affect our business to the extent we are not selected to participate in such networks or if the reimbursement rate in such networks is not adequate to cover the cost of providing the service.

Our performance depends on our ability to recruit and retain quality psychiatrists and other physicians.

The success and competitive advantage of our facilities depends, in part, on the number and quality of the psychiatrists and other physicians on the medical staffs of our facilities and our maintenance of good relations with those medical professionals. Although we employ psychiatrists and other physicians at many of our facilities, psychiatrists and other physicians generally are not employees of our facilities, and, in a number of our markets, they have admitting privileges at competing hospitals providing acute or inpatient behavioral healthcare services. Such physicians (including psychiatrists) may terminate their affiliation with us at any time or admit their patients to competing healthcare facilities or hospitals. If we are unable to attract and retain sufficient numbers of quality psychiatrists and other physicians by providing adequate support personnel and facilities that meet the needs of those psychiatrists and other physicians, they may stop referring patients to our facilities and our results of operations may decline.

It may become difficult for us to attract and retain an adequate number of psychiatrists and other physicians to practice in certain of the communities in which our facilities are located. Our failure to recruit psychiatrists and other physicians to these communities or the loss of such medical professionals in these communities could make it more difficult to attract patients to our facilities and thereby may have a material adverse effect on our business, financial condition or results of operations. Additionally, our ability to recruit psychiatrists and other physicians is closely regulated. The form, amount and duration of assistance we can provide to recruited psychiatrists and other physicians is limited by the Stark Law, the Anti-Kickback Statute, state anti-kickback statutes, and related regulations.

Some of our employees are represented by labor unions and any work stoppage could adversely affect our business.

Increased labor union activity could adversely affect our labor costs. As of December 31, 2017, labor unions represented approximately 460 of our employees at five of our U.S. facilities through eight collective bargaining agreements. The Royal College of Nursing represents nursing employees at our facilities in the U.K. We cannot assure you that employee relations will remain stable. Furthermore, there is a possibility that work stoppages could occur as a result of union activity, which could increase our labor costs and adversely affect our business, financial condition or results of operations. To the extent that a greater portion of our employee base unionizes and the terms of any collective bargaining agreements are significantly different from our current compensation arrangements, it is possible that our labor costs could increase materially and our business, financial condition or results of operations could be adversely affected.

We depend on key management personnel, and the departure of one or more of our key executives or a significant portion of our local facility management personnel could harm our business.

The expertise and efforts of our senior executives and the chief executive officer, chief financial officer, medical directors, physicians and other key members of our facility management personnel are important to the success of our business. The loss of the services of one or more of our senior executives, including our U.K. senior management team, or of a significant portion of our facility management personnel could significantly undermine our management expertise and our ability to provide efficient, quality healthcare services at our facilities, which could harm our business.

We could face risks associated with, or arising out of, environmental, health and safety laws and regulations.

We are subject to various federal, foreign, state and local laws and regulations that:

- regulate certain activities and operations that may have environmental or health and safety effects, such as the generation, handling and disposal of medical wastes;
- impose liability for costs of cleaning up, and damages to natural resources from, past spills, waste disposals on and off-site, or other releases of hazardous materials or regulated substances; and
- regulate workplace safety.

Compliance with these laws and regulations could increase our costs of operation. Violation of these laws may subject us to significant fines, penalties or disposal costs, which could negatively impact our results of operations, financial condition or cash flows. We could be responsible for the investigation and remediation of environmental conditions at currently or formerly owned, operated or leased sites, as well as for associated liabilities, including liabilities for natural resource damages, third-party property damage or personal injury resulting from lawsuits that could be brought by the government or private litigants, relating to our operations, the operations of facilities or the land on which our facilities are located. We may be subject to these liabilities regardless of whether we operate, lease or own the facility, and regardless of whether such environmental conditions were created by us or by a prior owner or tenant, or by a third party or a neighboring facility whose operations may have affected such facility or land. That is because liability for contamination under certain environmental laws can be imposed on current or past owners, lessors or operators of a site without regard to fault. We cannot assure you that environmental conditions relating to our prior, existing or future sites or those of predecessor companies whose liabilities we may have assumed or acquired will not have a material adverse effect on our business, financial condition or results of operations.

State efforts to regulate the construction or expansion of healthcare facilities in the U.S. could impair our ability to operate and expand our operations.

A majority of the states in which we operate facilities in the U.S. have enacted certificate of need ("CON") laws that regulate the construction or expansion of healthcare facilities, certain capital expenditures or changes in services or bed capacity. In giving approval for these actions, these states consider the need for additional or expanded healthcare facilities or services. Our failure to obtain necessary state approval could (i) result in our inability to acquire a targeted facility, complete a desired expansion or make a desired replacement, (ii) make a facility ineligible to receive reimbursement under the Medicare or Medicaid programs or (iii) result in the revocation of a facility's license or imposition of civil or criminal penalties, any of which could harm our business.

In addition, significant CON reforms have been proposed in a number of states that would increase the capital spending thresholds and provide exemptions of various services from review requirements. In the past, we have not experienced any material adverse effects from such requirements, but we cannot predict the impact of these changes upon our operations.

We may be unable to extend leases at expiration, which could harm our business, financial condition or results of operations.

We lease the real property on which a number of our facilities are located. Our lease agreements generally give us the right to renew or extend the term of the leases and, in certain cases, purchase the real property. These renewal and purchase rights generally are based upon either prescribed formulas or fair market value. Management expects to renew, extend or exercise purchase options with respect to our leases in the normal course of business; however, there can be no assurance that these rights will be exercised in the future or that we will be able to satisfy the conditions precedent to exercising any such renewal, extension or purchase options. Furthermore, the terms of any such options that are based on fair market value are inherently uncertain and could be unacceptable or unfavorable to us depending on the circumstances at the time of exercise. If we are not able to renew or extend our existing leases, or purchase the real property subject to such leases, at or prior to the end of the existing lease terms, or if the terms of such options are unfavorable or unacceptable to us, our business, financial condition or results of operations could be adversely affected.

Controls designed to reduce inpatient services may reduce our revenue.

Controls imposed by Medicare, Medicaid and commercial third-party payors designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payor-required preadmission authorization and utilization review and by payor pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. For example, PPACA expanded the potential use of prepayment review by Medicare contractors by eliminating certain statutory restrictions on its use. Utilization review is also a requirement of most non-governmental managed-care organizations and other third-party payors. Although we are unable to predict the effect these controls and changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material adverse effect on our financial condition and results of operations.

Additionally, the outsourcing of behavioral healthcare to the private sector is a relatively recent development in the U.K. There has been some opposition to outsourcing. While we anticipate that the NHS will continue to rely increasingly upon outsourcing, we cannot assure you that the outsourcing trend will continue. The absence of future growth in the outsourcing of behavioral healthcare services could have a material adverse impact on our business, financial condition and results of operations.

Although we have facilities in 39 states, the U.K. and Puerto Rico, we have substantial operations in the U.K., Pennsylvania, California and Arkansas, which makes us especially sensitive to regulatory, economic, environmental and competitive conditions and changes in those locations.

For the year ended December 31, 2017, our revenue in the U.K. represented approximately 36% of our total revenue. Revenue from Pennsylvania, California and Arkansas represented approximately 7%, 5% and 5% of our total revenue for the year ended December 31, 2017, respectively. This concentration makes us particularly sensitive to legislative, regulatory, economic, environmental and competition changes in those locations. Any material change in the current payment programs or regulatory, economic, environmental or competitive conditions in these locations could have a disproportionate effect on our overall business results. If our facilities in these locations are adversely affected by changes in regulatory and economic conditions, our business, financial condition or results of operations could be adversely affected.

In addition, some of our facilities are located in hurricane-prone areas. In 2017 and at other times in the past, hurricanes have had a disruptive effect on the operations of facilities and the patient populations in hurricane-prone areas. Our business activities could be significantly disrupted by a particularly active hurricane season or even a single storm, and our property insurance may not be adequate to cover losses from such storms or other natural disasters.

We are required to treat patients with emergency medical conditions regardless of ability to pay.

In accordance with our internal policies and procedures, as well as EMTALA, we provide a medical screening examination to any individual who comes to one of our hospitals seeking medical treatment (whether or not such individual is eligible for insurance benefits and regardless of ability to pay) to determine if such individual has an emergency medical condition. If it is determined that such person has an emergency medical condition, we provide such further medical examination and treatment as is required to stabilize the patient's medical condition, within the facility's capability, or arrange for the transfer of the individual to another medical facility in accordance with applicable law and the treating hospital's written procedures. Our hospitals may face substantial civil penalties if we fail to provide appropriate screening and stabilizing treatment or fail to facilitate other appropriate transfers as required by EMTALA.

An increase in uninsured or underinsured patients or the deterioration in the collectability of the accounts of such patients could harm our results of operations.

Collection of receivables from third-party payors and patients is critical to our operating performance. Our primary collection risks relate to uninsured patients and the portion of the bill that is the patient's responsibility, which primarily includes co-payments and deductibles. We estimate our provisions for doubtful accounts based on general factors such as payor source, the aging of the receivables and historical collection experience. At December 31, 2017, our allowance for doubtful accounts represented approximately 12% of our accounts receivable balance as of such date. We routinely review accounts receivable balances in conjunction with these factors and other economic conditions that might ultimately affect the collectability of the patient accounts and make adjustments to our allowances as warranted. Significant changes in business office operations, payor mix, economic conditions or trends in federal and state governmental health coverage (including the repeal, replacement or modification of PPACA) could affect our collection of accounts receivable, cash flow and results of operations. If we experience unexpected increases in the growth of uninsured and underinsured patients or in bad debt expenses, our results of operations will be harmed.

A cyber security incident could cause a violation of HIPAA and other privacy laws and regulations or result in a loss of confidential data.

A cyber-attack that bypasses our information technology ("IT") security systems causing an IT security breach, loss of PHI or other data subject to privacy laws, loss of proprietary business information, or a material disruption of our IT business systems, could have a material adverse impact on our business, financial condition or results of operations. In addition, our future results of operations, as well as our reputation, could be adversely impacted by theft, destruction, loss, or misappropriation of PHI, other confidential data or proprietary business information.

Failure to maintain effective internal control over financial reporting in accordance with Section 404 of the Sarbanes-Oxley Act of 2002 (the "Sarbanes-Oxley Act"), could have a material adverse effect on our business.

We are required to maintain internal control over financial reporting under Section 404 of the Sarbanes-Oxley Act. If we are unable to maintain adequate internal control over financial reporting, we may be unable to report our financial information on a timely basis, may suffer adverse regulatory consequences or violations of NASDAQ listing rules and may breach the covenants under our financing arrangements. There could also be a negative reaction in the financial markets due to a loss of investor confidence in us and the reliability of our financial statements. If we or our independent registered public accounting firm identify any material weakness in our internal control over financial reporting in the future (including any material weakness in the controls of businesses we have acquired), their correction could require additional remedial measures which could be costly, time-consuming and could have a material adverse effect on our business.

We are responsible for an underfunded pension liability related to our acquisition of Partnerships in Care. In addition, we may be required to increase funding of the pension plans and/or be subject to restrictions on the use of excess cash.

Partnerships in Care is the sponsor of a defined benefit pension plan (the Partnerships in Care Limited Pension and Life Assurance Plan) that covers approximately 180 members in the U.K., most of whom are inactive and retired former employees. As of May 1, 2005, this plan was closed to new participants but then-current participants continue to accrue benefits, and effective May 2015, active participants no longer accrued benefits. As of December 31, 2017, the net deficit recognized under U.S. GAAP in respect of this plan was £6.5 million.

Future sales of common stock by our existing stockholders may cause our stock price to fall.

The market price of our common stock could decline as a result of sales by our existing stockholders in the market, or the perception that these sales could occur. These sales might also make it more difficult for us to sell equity securities at a time and price that we deem appropriate. Certain current and former members of our management and stockholders have demand and piggyback registration rights with respect to shares of our common stock beneficially owned by them. The presence of additional shares of our common stock trading in the public market, as a result of the exercise of such registration rights, may have an adverse effect on the market price of our securities.

If securities or industry analysts do not publish research or reports about our business, if they were to change their recommendations regarding our stock adversely or if our operating results do not meet their expectations, our stock price and trading volume could decline.

The trading market for our common stock will be influenced by the research and reports that industry or securities analysts publish about us. If one or more of these analysts cease coverage of us or fail to publish regular reports on us, we could lose visibility in the financial markets, which in turn could cause our stock price or trading volume to decline. Moreover, if one or more of the analysts who cover us downgrade our stock or if our operating results do not meet their expectations, our stock price could decline.

We incur substantial costs as a result of being a public company.

As a public company, we incur significant legal, accounting, insurance and other expenses, including costs associated with public company reporting requirements. We incur costs associated with complying with the requirements of the Sarbanes-Oxley Act, the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Dodd-Frank Act"), and related rules implemented by the SEC and NASDAQ. Enacted in July 2010, the Dodd-Frank Act contains significant corporate governance and executive compensation-related provisions, some of which the SEC has implemented by adopting additional rules and regulations in areas such as executive compensation. The expenses incurred by public companies generally for reporting and corporate governance purposes have been increasing. Management expects these laws and regulations to increase our legal and financial compliance costs and to make some activities more time-consuming and costly, although management is currently unable to estimate these costs with any degree of certainty. These laws and regulations could make it more difficult or costly for us to obtain certain types of insurance, including director and officer liability insurance, and we may be forced to accept reduced policy limits and coverage or incur substantially higher costs to obtain the same or similar coverage. These laws and regulations could also make it more difficult for us to attract and retain qualified persons to serve on our board of directors, our board committees or as our executive officers. Furthermore, if we are unable to satisfy our obligations as a public company, we could be subject to delisting of our common stock, fines, sanctions and other regulatory action and potentially civil litigation.

Provisions of our charter documents or Delaware law could delay or prevent an acquisition of us, even if the acquisition would be beneficial to our stockholders, and could make it more difficult for stockholders to change management.

Provisions of our amended and restated certificate of incorporation and amended and restated bylaws may discourage, delay or prevent a merger, acquisition or other change in control that stockholders may consider favorable, including transactions in which stockholders might otherwise receive a premium for their shares. This is because these provisions may prevent or frustrate attempts by stockholders to replace or remove our management. These provisions include:

- a classified board of directors;
- a prohibition on stockholder action through written consent;
- a requirement that special meetings of stockholders be called only upon a resolution approved by a majority of our directors then in office;
- advance notice requirements for stockholder proposals and nominations; and
- the authority of the board of directors to issue preferred stock with such terms as the board of directors may determine.

Section 203 of the Delaware General Corporation Law ("DGCL") prohibits a publicly-held Delaware corporation from engaging in a business combination with an interested stockholder, generally a person that together with its affiliates owns or within the last three years has owned 15% of voting stock, for a period of three years after the date of the transaction in which the person became an interested stockholder, unless the business combination is approved in a prescribed manner. Although we have elected not to be subject to Section 203 of the DGCL, our amended and restated certificate of incorporation contains provisions that have the same effect as Section 203, except that they provide that Waud Capital Partners, L.L.C. ("WCP"), its affiliates and any investment fund managed by WCP and any persons to whom WCP sells at least five percent (5%) of our outstanding voting stock will be deemed to have been approved by our board of directors, and thereby not subject to the restrictions set forth in our amended and restated certificate of incorporation that have the same effect as Section 203 of the DGCL. Accordingly, the provision in our amended and restated certificate of incorporation that adopts a modified version of Section 203 of the DGCL may discourage, delay or prevent a change in control of us.

As a result of these provisions in our charter documents and Delaware law, the price investors may be willing to pay in the future for shares of our common stock may be limited.

We do not anticipate paying any cash dividends in the foreseeable future.

We intend to retain our future earnings, if any, for use in our business or for other corporate purposes and do not anticipate that cash dividends with respect to common stock will be paid in the foreseeable future. Any decision as to the future payment of dividends will depend on our results of operations, financial position and such other factors as our board of directors, in its discretion, deems relevant. In addition, the terms of our debt substantially limit our ability to pay dividends. As a result, capital appreciation, if any, of our common stock will be a stockholder's sole source of gain for the foreseeable future.

Item 1B. Unresolved Staff Comments.

None.

Item 2. Properties.

The following table lists, by state or country, the number of behavioral healthcare facilities directly or indirectly owned and operated by us as of December 31, 2017:

State	Facilities	Operated Beds
Alaska	1	—
Arizona	3	425
Arkansas	7	713
California	22	462
Delaware	2	93
Florida	6	482
Georgia	5	332
Illinois	1	164
Indiana	8	303
Iowa	1	—
Kansas	1	—
Louisiana	6	372
Maine	4	—
Maryland	3	—
Massachusetts	13	120
Michigan	6	343
Mississippi	3	412
Missouri	2	313
Montana	1	108
Nevada	4	144
New Hampshire	2	—
New Jersey	1	—
New Mexico	2	207
North Carolina	11	477
Ohio	2	146
Oklahoma	1	108
Oregon	6	—
Pennsylvania	31	1,413
Rhode Island	2	—
South Carolina	1	42
South Dakota	1	126
Tennessee	6	533
Texas	4	397
Utah	6	147
Vermont	1	—
Virginia	6	215
Washington	6	135
West Virginia	7	—
Wisconsin	13	35
International		
Puerto Rico	1	172
United Kingdom	373	8,865
	582	17,804

See "Business — U.S. Operations" and "Business— U.K. Operations— Description of U.K. Facilities" for a summary description of our U.S. and U.K. facilities that we own and lease. We currently lease approximately 61,000 square feet of office space at 6100 Tower Circle, Franklin, Tennessee, for our corporate headquarters. Our headquarters and facilities are generally well maintained and in good operating condition.

Item 3. Legal Proceedings.

We are, from time to time, subject to various claims and legal actions that arise in the ordinary course of our business, including claims for damages for personal injuries, medical malpractice, breach of contract, tort and employment related claims. In these actions, plaintiffs request a variety of damages, including, in some instances, punitive and other types of damages that may not be covered by insurance. In addition, healthcare companies are subject to numerous investigations by various governmental agencies. Under the federal False Claims Act, private parties have the right to bring *qui tam,* or "whistleblower," suits against companies that submit false claims for payments to, or improperly retain overpayments from, the government. Some states have adopted similar state whistleblower and false claims provisions. Certain of our individual facilities have received, and from time to time, other facilities may receive, government inquiries from, and may be subject to investigation by, federal and state agencies. In the opinion of management, we are not currently a party to any proceeding that would have a material adverse effect on our business, financial condition or results of operations.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

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

Our common stock is listed for trading on The NASDAQ Global Select Market under the symbol "ACHC." The following table sets forth the high and low sales prices per share of our common stock as reported on The NASDAQ Global Select Market for the two most recent fiscal years:

	High	Low
Year ended December 31, 2016:		
First Quarter	$65.89	$49.77
Second Quarter	$65.00	$50.30
Third Quarter	$57.29	$46.99
Fourth Quarter	$50.18	$32.54
Year ended December 31, 2017:		
First Quarter	$47.39	$32.69
Second Quarter	$49.99	$40.37
Third Quarter	$54.34	$44.26
Fourth Quarter	$48.35	$26.92

Stockholders

As of February 27, 2018, there were approximately 495 holders of record of our common stock.

Recent Sales of Unregistered Securities

None.

Issuer Purchases of Equity Securities

During the three months ended December 31, 2017, the Company withheld shares of Company common stock to satisfy employee minimum statutory tax withholding obligations payable upon the vesting of restricted stock, as follows:

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs
October 1 – October 31	590	$ 33.25	—	—
November 1 – November 30	4,670	$ 29.42	—	—
December 1 – December 31	893	31.83	—	—
Total	6,153			

Dividends

We have never declared or paid dividends on our common stock. We currently intend to retain all available funds and any future earnings to fund the development and growth of our business and to repay indebtedness, and therefore we do not anticipate paying any cash dividends in the foreseeable future. Additionally, because we are a holding company, our ability to pay dividends on our common stock is limited by restrictions on the ability of our subsidiaries to pay dividends or make distributions to us, including restrictions under the terms of the agreements governing our indebtedness. Any future determination to pay dividends will be at the discretion of our board of directors, subject to compliance with covenants in current and future agreements governing our indebtedness (including our Amended and Restated Senior Credit Facility and the indenture governing our Senior Notes), and will depend upon our results of operations, financial condition, capital requirements and other factors that our board of directors deems relevant.

Item 6. Selected Financial Data.

The selected financial data presented below for the years ended December 31, 2017, 2016 and 2015, and as of December 31, 2017 and 2016, is derived from our audited consolidated financial statements included elsewhere in this Annual Report on Form 10-K. The selected financial data for the years ended December 31, 2014 and 2013, and as of December 31, 2015, 2014 and 2013, is derived from our audited consolidated financial statements not included herein. The selected consolidated financial data below should be read in conjunction with the "Management's Discussion and Analysis of Financial Condition and Results of Operations" and with our consolidated financial statements and notes thereto included elsewhere in this Annual Report on Form 10-K. The selected financial data presented below does not give effect to our acquisitions prior to the respective date of such acquisitions.

	Year Ended December 31,				
	2017	2016	2015	2014	2013
	(In thousands, except per share data)				
Income Statement Data:					
Revenue before provision for doubtful accounts	$2,877,234	$2,852,823	$1,829,619	$1,030,784	$ 735,109
Provision for doubtful accounts	(40,918)	(41,909)	(35,127)	(26,183)	(21,701)
Revenue	2,836,316	2,810,914	1,794,492	1,004,601	713,408
Salaries, wages and benefits(1)	1,536,160	1,541,854	973,732	575,412	407,962
Professional fees	196,223	185,486	116,463	52,482	37,171
Supplies	114,439	117,425	80,663	48,422	37,569
Rents and leases	76,775	73,348	32,528	12,201	10,049
Other operating expenses	331,827	312,556	206,746	110,654	80,572
Depreciation and amortization	143,010	135,103	63,550	32,667	17,090
Interest expense, net	176,007	181,325	106,742	48,221	37,250
Debt extinguishment costs	810	4,253	10,818	—	9,350
Loss on divestiture	—	178,809	—	—	—
(Gain) loss on foreign currency derivatives	—	(523)	1,926	(15,262)	—
Transaction-related expenses	24,267	48,323	36,571	13,650	7,150
Income from continuing operations, before income taxes	236,798	32,955	164,753	126,154	69,245
Provision for income taxes	37,209	28,779	53,388	42,922	25,975
Income from continuing operations	199,589	4,176	111,365	83,232	43,270
Income (loss) from discontinued operations, net of income taxes	—	—	111	(192)	(691)
Net income	199,589	4,176	111,476	83,040	42,579
Net loss attributable to noncontrolling interests	246	1,967	1,078	—	—
Net income attributable to Acadia Healthcare Company, Inc.	$ 199,835	$ 6,143	$ 112,554	$ 83,040	$ 42,579
Income from continuing operations per share basic	$ 2.30	$ 0.07	$ 1.65	$ 1.51	$ 0.87
Income from continuing operations per share diluted	$ 2.30	$ 0.07	$ 1.64	$ 1.50	$ 0.86
Balance Sheet Data (as of end of period):					
Cash and cash equivalents	$ 67,290	$ 57,063	$ 11,215	$ 94,040	$ 4,569
Total assets	6,424,502	6,024,726	4,279,208	2,206,955	1,213,623
Total debt	3,239,888	3,287,809	2,240,744	1,079,635	606,100
Total equity	2,572,871	2,167,724	1,683,028	880,965	480,710

(1) Salaries, wages and benefits for the years ended December 31, 2017, 2016, 2015, 2014 and 2013 include $23.5 million, $28.3 million, $20.5 million, $10.1 million and $5.2 million, respectively, of equity-based compensation expense.

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

You should read the following discussion and analysis of our financial condition and results of operations with our audited consolidated financial statements and notes thereto included elsewhere in this Annual Report on Form 10-K.

Forward-Looking Statements

This Annual Report on Form 10-K contains "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements include any statements that address future results or occurrences. In some cases you can identify forward-looking statements by terminology such as "may," "might," "will," "would," "should," "could" or the negative thereof. Generally, the words "anticipate," "believe," "continue," "expect," "intend," "estimate," "project," "plan" and similar expressions identify forward-looking statements. In particular, statements about our expectations, beliefs, plans, objectives, assumptions or future events or performance contained are forward-looking statements.

We have based these forward-looking statements on our current expectations, assumptions, estimates and projections. While we believe these expectations, assumptions, estimates and projections are reasonable, such forward-looking statements are only predictions and involve known and unknown risks, uncertainties and other factors, many of which are outside of our control, which could cause our actual results, performance or achievements to differ materially from any results, performance or achievements expressed or implied by such forward-looking statements. These risks, uncertainties and other factors include, but are not limited to:

- our significant indebtedness, our ability to meet our debt obligations, and our ability to incur substantially more debt;
- difficulties in successfully integrating the operations of acquired facilities or realizing the potential benefits and synergies of our acquisitions and joint ventures;
- our ability to implement our business strategies in the U.S. and the U.K. and adapt to the regulatory and business environment in the U.K.;
- potential difficulties operating our business in light of political and economic instability in the U.K. and globally following the referendum in the U.K. on June 23, 2016, in which voters approved an exit from the European Union, or Brexit;
- the impact of fluctuations in foreign exchange rates, including the devaluations of the GBP relative to the USD following the Brexit vote;
- the impact of payments received from the government and third-party payors on our revenue and results of operations including the significant dependence of our U.K. facilities on payments received from the NHS;
- our ability to recruit and retain quality psychiatrists and other physicians;
- the impact of competition for staffing on our labor costs and profitability;
- the impact of increases to our labor costs;
- the occurrence of patient incidents, which could result in negative media coverage, adversely affect the price of our securities and result in incremental regulatory burdens and governmental investigations;
- our future cash flow and earnings;
- our restrictive covenants, which may restrict our business and financing activities;
- our ability to make payments on our financing arrangements;
- the impact of the economic and employment conditions in the U.S. and the U.K. on our business and future results of operations;
- compliance with laws and government regulations;
- the impact of claims brought against us or our facilities;
- the impact of governmental investigations, regulatory actions and whistleblower lawsuits;
- the impact of healthcare reform in the U.S. and abroad, including the potential repeal, replacement or modification of PPACA;
- the impact of our highly competitive industry on patient volumes;
- our dependence on key management personnel, key executives and local facility management personnel;
- our acquisition, joint venture and de novo strategies, which expose us to a variety of operational and financial risks, as well as legal and regulatory risks;
- the impact of state efforts to regulate the construction or expansion of healthcare facilities on our ability to operate and expand our operations;
- our potential inability to extend leases at expiration;

- the impact of controls designed to reduce inpatient services on our revenue;
- the impact of different interpretations of accounting principles on our results of operations or financial condition;
- the impact of environmental, health and safety laws and regulations, especially in locations where we have concentrated operations;
- the impact of an increase in uninsured and underinsured patients or the deterioration in the collectability of the accounts of such patients on our results of operations;
- the risk of a cyber-security incident and any resulting violation of laws and regulations regarding information privacy or other negative impact;
- the impact of laws and regulations relating to privacy and security of patient health information and standards for electronic transactions;
- our ability to cultivate and maintain relationships with referral sources;
- the impact of a change in the mix of our U.S. and U.K. earnings, adverse changes in our effective tax rate and adverse developments in tax laws generally;
- changes in interpretations, assumptions and expectations regarding the Tax Act, including additional guidance that may be issued by federal and state taxing authorities;
- failure to maintain effective internal control over financial reporting;
- the impact of fluctuations in our operating results, quarter to quarter earnings and other factors on the price of our securities;
- the impact of the trend for insurance companies and managed care organizations to enter into sole source contracts on our ability to obtain patients;
- the impact of value-based purchasing programs on our revenue; and
- those risks and uncertainties described from time to time in our filings with the SEC.

Given these risks and uncertainties, you are cautioned not to place undue reliance on such forward-looking statements. These risks and uncertainties may cause our actual future results to be materially different than those expressed in our forward-looking statements. These forward-looking statements are made only as of the date of this Annual Report on Form 10-K. We do not undertake and specifically decline any obligation to update any such statements or to publicly announce the results of any revisions to any such statements to reflect future events or developments.

Overview

Our business strategy is to acquire and develop behavioral healthcare facilities and improve our operating results within our facilities and our other behavioral healthcare operations. We strive to improve the operating results of our facilities by providing high-quality services, expanding referral networks and marketing initiatives while meeting the increased demand for behavioral healthcare services through expansion of our current locations as well as developing new services within existing locations. At December 31, 2017, we operated 582 behavioral healthcare facilities with approximately 17,800 beds in 39 states, the U.K. and Puerto Rico. During the year ended December 31, 2017, we acquired one facility and added 750 new beds (exclusive of the acquisition), including 588 added to existing facilities and 162 added through the opening of two de novo facilities. For the year ending December 31, 2018, we expect to add more than 800 total beds exclusive of acquisitions.

We are the leading publicly traded pure-play provider of behavioral healthcare services, with operations in the U.S. and the U.K. Management believes that we are positioned as a leading platform in a highly fragmented industry under the direction of an experienced management team that has significant industry expertise. Management expects to take advantage of several strategies that are more accessible as a result of our increased size and geographic scale, including continuing a national marketing strategy to attract new patients and referral sources, increasing our volume of out-of-state referrals, providing a broader range of services to new and existing patients and clients and selectively pursuing opportunities to expand our facility and bed count in the U.S. and U.K.

Acquisitions

2017 Acquisition

On November 13, 2017, we completed the acquisition of Aspire, an education facility with 36 beds located in Scotland, for cash consideration of approximately $21.3 million.

2016 U.S. Acquisitions

On June 1, 2016, we completed the acquisition of Pocono Mountain, an inpatient psychiatric facility with 108 beds located in Henryville, Pennsylvania, for cash consideration of approximately $25.4 million.

On May 1, 2016, we completed the acquisition of TrustPoint, an inpatient psychiatric facility with 100 beds located in Murfreesboro, Tennessee, for cash consideration of approximately $62.7 million.

On April 1, 2016, we completed the acquisition of Serenity Knolls, an inpatient psychiatric facility with 30 beds located in Forest Knolls, California, for cash consideration of approximately $10.0 million.

Priory

On February 16, 2016, we completed the acquisition of Priory for a total purchase price of approximately $2.2 billion, including cash consideration of approximately $1.9 billion and the issuance of 4,033,561 shares of our common stock to shareholders of Priory. Priory was the leading independent provider of behavioral healthcare services in the U.K. operating 324 facilities with approximately 7,100 beds at the acquisition date.

The CMA in the U.K. reviewed our acquisition of Priory. On July 14, 2016, the CMA announced that our acquisition of Priory was referred for a phase 2 investigation unless we offered acceptable undertakings to address the CMA's competition concerns relating to the provision of behavioral healthcare services in certain markets. On July 28, 2016, the CMA announced that we had offered undertakings to address the CMA's concerns and that, in lieu of a phase 2 investigation, the CMA would consider our undertakings.

On October 18, 2016, we signed a definitive agreement with BC Partners for the sale of 21 existing U.K. behavioral health facilities and one de novo behavioral health facility with an aggregate of approximately 1,000 beds. On November 10, 2016, the CMA accepted our undertakings to sell the U.K. Disposal Group to BC Partners and confirmed that the divestiture satisfied the CMA's concerns about the impact of our acquisition of Priory on competition for the provision of behavioral healthcare services in certain markets in the U.K. As a result of the CMA's acceptance of our undertakings, our acquisition of Priory was not referred for a phase 2 investigation. On November 30, 2016, we completed the sale of the U.K. Disposal Group to BC Partners for £320 million cash.

Revenue

Our revenue is primarily derived from services rendered to patients for inpatient psychiatric and substance abuse care, outpatient psychiatric care and adolescent residential treatment. We receive payments from the following sources for services rendered in our facilities: (i) state governments under their respective Medicaid and other programs; (ii) commercial insurers; (iii) the federal government under the Medicare program administered by CMS; (iv) public funded sources in the U.K. (including the NHS, CCGs and Local Authorities in England, Scotland and Wales); and (v) individual patients and clients. Revenue is recorded in the period in which services are provided at established billing rates less contractual adjustments based on amounts reimbursable by Medicare or Medicaid under provisions of cost or prospective reimbursement formulas or amounts due from other third-party payors at contractually determined rates.

Results of Operations

The following table illustrates our consolidated results of operations from continuing operations for the respective periods shown (dollars in thousands):

	Year Ended December 31,					
	2017		2016		2015	
	Amount	%	Amount	%	Amount	%
Revenue before provision for doubtful accounts	$2,877,234		$2,852,823		$1,829,619	
Provision for doubtful accounts	(40,918)		(41,909)		(35,127)	
Revenue	2,836,316	100.0%	2,810,914	100.0%	1,794,492	100.0%
Salaries, wages and benefits	1,536,160	54.2%	1,541,854	54.9%	973,732	54.3%
Professional fees	196,223	6.9%	185,486	6.6%	116,463	6.5%
Supplies	114,439	4.0%	117,425	4.2%	80,663	4.5%
Rents and leases	76,775	2.7%	73,348	2.6%	32,528	1.8%
Other operating expenses	331,827	11.7%	312,556	11.1%	206,746	11.5%
Depreciation and amortization	143,010	5.0%	135,103	4.8%	63,550	3.5%
Interest expense, net	176,007	6.2%	181,325	6.4%	106,742	6.0%
Debt extinguishment costs	810	0.0%	4,253	0.1%	10,818	0.6%
Loss on divestiture	—	— %	178,809	6.4%	—	— %
(Gain) loss on foreign currency derivatives	—	— %	(523)	— %	1,926	0.1%
Transaction related expenses	24,267	0.9%	48,323	1.7%	36,571	2.0%
	2,599,518	91.6%	2,777,959	98.8%	1,629,739	90.8%
Income from continuing operations, before income taxes	236,798	8.4%	32,955	1.2%	164,753	9.2%
Provision for income taxes	37,209	1.3%	28,779	1.0%	53,388	3.0%
Income from continuing operations	$ 199,589	7.1%	$ 4,176	0.2%	$ 111,365	6.2%

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

Revenue before provision for doubtful accounts. Revenue before provision for doubtful accounts increased $24.4 million, or 0.9%, to $2.9 billion for the year ended December 31, 2017 from $2.9 billion for the year ended December 31, 2016. The increase related primarily to revenue generated during the year ended December 31, 2017 from the facilities acquired in our 2016 Acquisitions, particularly the acquisition of Priory, offset by the reduction in revenue before provision for doubtful accounts related to the U.K. Divestiture of $154.7 million and the decline in the exchange rate between USD and GBP of $45.5 million. Same-facility revenue before provision for doubtful accounts increased by $138.2 million, or 5.5%, for the year ended December 31, 2017 compared to the year ended December 31, 2016, resulting from same-facility growth in patient days of 3.6% and an increase in same-facility revenue per day of 1.9%. Consistent with the same-facility patient day growth in 2016, the growth in same-facility patient days for the year ended December 31, 2017 compared to the year ended December 31, 2016 resulted from the addition of beds to our existing facilities and ongoing demand for our services.

Provision for doubtful accounts. The provision for doubtful accounts was $40.9 million for the year ended December 31, 2017, or 1.4% of revenue before provision for doubtful accounts, compared to $41.9 million for the year ended December 31, 2016, or 1.5% of revenue before provision for doubtful accounts.

Salaries, wages and benefits. Salaries, wages and benefits ("SWB") expense was $1.5 billion for the year ended December 31, 2017 compared to $1.5 billion for the year ended December 31, 2016, a decrease of $5.7 million. SWB expense included $23.5 million and $28.3 million of equity-based compensation expense for the years ended December 31, 2017 and 2016, respectively. Excluding equity-based compensation expense, SWB expense was $1.5 billion, or 53.3% of revenue, for the year ended December 31, 2017, compared to $1.5 billion, or 53.8% of revenue, for the year ended December 31, 2016. The slight decrease in SWB expense, excluding equity-based compensation expense, was primarily attributable to the reduction in expense related to the U.K. Divestiture and the decline in the exchange rate between USD and GBP offset by SWB expense incurred by the facilities acquired in our 2016 Acquisitions, particularly the acquisition of Priory. Same-facility SWB expense was $1.3 billion for the year ended December 31, 2017, or 50.9% of revenue compared to $1.3 billion for the year ended December 31, 2016, or 51.0% of revenue.

Professional fees. Professional fees were $196.2 million for the year ended December 31, 2017, or 6.9% of revenue, compared to $185.5 million for the year ended December 31, 2016, or 6.6% of revenue. The $10.7 million increase was primarily attributable professional fees incurred by the facilities acquired in our 2016 Acquisitions, particularly the acquisition of Priory, and higher contract labor costs in our U.K. Facilities offset by the reduction in expense related to the U.K. Divestiture and the decline in the exchange rate between USD and GBP. Same-facility professional fees were $160.1 million for the year ended December 31, 2017, or 6.2% of revenue, compared to $145.0 million, for the year ended December 31, 2016, or 5.9% of revenue.

Supplies. Supplies expense was $114.4 million for the year ended December 31, 2017, or 4.0% of revenue, compared to $117.4 million for the year ended December 31, 2016, or 4.2% of revenue. The $3.0 million decrease was primarily attributable to the reduction in expense related to the U.K. Divestiture and the decline in the exchange rate between USD and GBP offset by supplies expense incurred by the facilities acquired in our 2016 Acquisitions, particularly the acquisition of Priory. Same-facility supplies expense was $103.5 million for the year ended December 31, 2017, or 4.0% of revenue, compared to $100.2 million for the year ended December 31, 2016, or 4.1% of revenue.

Rents and leases. Rents and leases were $76.8 million for the year ended December 31, 2017, or 2.7% of revenue, compared to $73.3 million for the year ended December 31, 2016, or 2.6% of revenue. The $3.4 million increase was primarily attributable to rents and leases incurred by the facilities acquired in our 2016 Acquisitions, particularly the acquisition of Priory slightly offset by the reduction in expense related to the U.K. Divestiture and the decline in the exchange rate between USD and GBP. Same-facility rents and leases were $58.0 million for the year ended December 31, 2017, or 2.2% of revenue, compared to $57.5 million for the year ended December 31, 2016, or 2.3% of revenue.

Other operating expenses. Other operating expenses consisted primarily of purchased services, utilities, insurance, travel and repairs and maintenance expenses. Other operating expenses were $331.8 million for the year ended December 31, 2017, or 11.7% of revenue, compared to $312.6 million for the year ended December 31, 2016, or 11.1% of revenue. The $19.2 million increase was primarily attributable to other operating expenses incurred by the facilities acquired in our 2016 Acquisitions, particularly the acquisition of Priory slightly offset by the reduction in expense related to the U.K. Divestiture and the decline in the exchange rate between USD and GBP. Same-facility other operating expenses were $297.8 million for the year ended December 31, 2017, or 11.4% of revenue, compared to $273.3 million for the year ended December 31, 2016, or 11.1% of revenue.

Depreciation and amortization. Depreciation and amortization expense was $143.0 million for the year ended December 31, 2017, or 5.0% of revenue, compared to $135.1 million for the year ended December 31, 2016, or 4.8% of revenue. The increase in depreciation and amortization was attributable to depreciation associated with capital expenditures during 2016 and 2017 and real estate acquired as part of the 2016 Acquisitions, particularly the acquisition of Priory, offset by reduction in expense related to the U.K. Divestiture and the decline in the exchange rate between USD and GBP.

Interest expense. Interest expense was $176.0 million for the year ended December 31, 2016 compared to $181.3 million for the year ended December 31, 2016. The decrease in interest expense was primarily a result of the lower interest rates in connection with amendments to the Amended and Restated Senior Credit Facility and the debt paydown on November 30, 2016 using proceeds from the U.K. Divestiture. Interest expense was also impacted by higher interest rates applicable to our variable rate debt, borrowings under the Amended and Restated Senior Credit Facility and the issuance of the 6.500% Senior Notes on February 16, 2016.

Debt extinguishment costs. Debt extinguishment costs for the year ended December 30, 2017 represent $0.5 million of charges and $0.3 of non-cash charges recorded in connection with the Third Repricing Amendment to the Amended and Restated Senior Credit Facility. Debt extinguishment costs for the year ended December 31, 2016 represent $1.1 million of cash charges and $3.2 million of non-cash charges recorded in connection with the Tranche B-2 Repricing Amendment and the Refinancing Amendment.

Loss on divestiture. As part of our divestitures in the U.K. and U.S., we recorded $178.8 million of loss on divestiture for the year ended December 31, 2016, which included an allocation of goodwill to the disposal groups of approximately $106.9 million, loss on the sale of properties of approximately $45.0 million, transaction-related expenses of approximately $26.8 million and write-off of intangible assets of approximately $0.1 million.

Gain on foreign currency derivatives. We entered into foreign currency forward contracts during the year ended December 31, 2016 in connection with (i) acquisitions in the U.K. and (ii) certain transfers of cash between the U.S. and the U.K. under our cash management and foreign currency risk management programs. Exchange rate changes between the contract date and the settlement date resulted in a gain on foreign currency derivatives of $0.5 million for the year ended December 31, 2016.

Transaction-related expenses. Transaction-related expenses were $24.3 million for the year ended December 31, 2017 compared to $48.3 million for the year ended December 31, 2016. Transaction-related expenses represent costs incurred in the respective periods, primarily related to the 2016 Acquisitions, the U.K. Divestiture and the related integration efforts, as summarized below (in thousands):

	Year Ended December 31,	
	2017	2016
Severance and contract termination costs	$ 14,709	$ 12,415
Legal, accounting and other fees	9,558	21,058
Advisory and financing commitment fees	—	14,850
	$ 24,267	$ 48,323

Provision for income taxes. For the year ended December 31, 2017, the provision for income taxes was $37.2 million, reflecting an effective tax rate of 15.7%, compared to $28.8 million, reflecting an effective tax rate of 87.3%, for 2016. The decrease in the effective tax rate for the year ended December 31, 2017 was primarily attributable to the Company's estimate of the one-time tax benefit on revaluation of deferred tax items pursuant to the enactment of the Tax Act as well as changes in the foreign exchange rate between USD and GBP in 2017 and the disparity between the accounting treatment and the tax treatment of the U.K. Divestiture on November 30, 2016. The Company will continue to analyze the effects of the Tax Act on its financial statements and operations. Additional impacts from the enactment of the Tax Act will be recorded as they are identified during the measurement period as provided for in Staff Accounting Bulletin 118 ("SAB 118").

Year Ended December 31, 2016 Compared to the Year Ended December 31, 2015

Revenue before provision for doubtful accounts. Revenue before provision for doubtful accounts increased $1.0 billion, or 55.9%, to $2.9 billion for the year ended December 31, 2016 from $1.8 billion for the year ended December 31, 2015. The increase related primarily to revenue generated during the year ended December 31, 2016 from the facilities acquired in our 2015 and 2016 Acquisitions, particularly the acquisition of Priory. The decrease in the GBP to USD exchange rate had an unfavorable impact on revenue before provision for doubtful accounts of $35.6 million for the year ended December 31, 2016. Same-facility revenue before provision for doubtful accounts increased by $127.2 million, or 7.5%, for the year ended December 31, 2016 compared to the year ended December 31, 2015, primarily resulting from same-facility growth in patient days of 7.2%. Consistent with the same-facility patient day growth in 2015, the growth in same-facility patient days for the year ended December 31, 2016 compared to the year ended December 31, 2015 resulted from the addition of beds to our existing facilities and ongoing demand for our services.

Provision for doubtful accounts. The provision for doubtful accounts was $41.9 million for the year ended December 31, 2016, or 1.5 % of revenue before provision for doubtful accounts, compared to $35.1 million for the year ended December 31, 2015, or 1.9% of revenue before provision for doubtful accounts. The same-facility provision for doubtful accounts was $35.3 million for the year ended December 31, 2016, or 1.9% of revenue before provision for doubtful accounts, compared to $31.5 million for the year ended December 31, 2015, or 1.9% of revenue before provision for doubtful accounts.

Salaries, wages and benefits. Salaries, wages and benefits expense was $1.5 billion for the year ended December 31, 2016 compared to $973.7 million for the year ended December 31, 2015, an increase of $568.1 million. SWB expense included $28.3 million and $20.5 million of equity-based compensation expense for the years ended December 31, 2016 and 2015, respectively. Excluding equity-based compensation expense, SWB expense was $1.5 billion, or 53.8% of revenue, for the year ended December 31, 2016, compared to $953.3 million, or 53.1% of revenue, for the year ended December 31, 2015. The $560.3 million increase in SWB expense, excluding equity-based compensation expense, was primarily attributable to SWB expense incurred by the facilities acquired in our 2015 and 2016 Acquisitions, particularly the acquisition of Priory. Same-facility SWB expense was $895.0 million for the year ended December 31, 2016, or 50.2% of revenue, compared to $830.8 million for the year ended December 31, 2015, or 50.0% of revenue.

Professional fees. Professional fees were $185.5 million for the year ended December 31, 2016, or 6.6 % of revenue, compared to $116.5 million for the year ended December 31, 2015, or 6.5% of revenue. The $69.0 million increase was primarily attributable to professional fees incurred by the facilities acquired in our 2015 and 2016 Acquisitions, particularly the acquisition of Priory. Same-facility professional fees were $92.8 million for the year ended December 31, 2016, or 5.2% of revenue, compared to $95.0 million, for the year ended December 31, 2015, or 5.7% of revenue.

Supplies. Supplies expense was $117.4 million for the year ended December 31, 2016, or 4.2% of revenue, compared to $80.7 million for the year ended December 31, 2015, or 4.5% of revenue. The $36.7 million increase was primarily attributable to supplies expense incurred by the facilities acquired in our 2015 and 2016 Acquisitions, particularly the acquisition of Priory. Same-facility supplies expense was $79.5 million for the year ended December 31, 2016, or 4.5% of revenue, compared to $74.2 million for the year ended December 31, 2015, or 4.5% of revenue.

Rents and leases. Rents and leases were $73.3 million for the year ended December 31, 2016, or 2.6% of revenue, compared to $32.5 million for the year ended December 31, 2015, or 1.8% of revenue. The $40.8 million increase was primarily attributable to rents and leases incurred by the facilities acquired in our 2015 and 2016 Acquisitions, particularly the acquisition of Priory. Same-facility rents and leases were $31.5 million for the year ended December 31, 2016, or 1.8% of revenue, compared to $29.6 million for the year ended December 31, 2015, or 1.8% of revenue.

Other operating expenses. Other operating expenses consisted primarily of purchased services, utilities, insurance, travel and repairs and maintenance expenses. Other operating expenses were $312.6 million for the year ended December 31, 2016, or 11.1% of revenue, compared to $206.7 million for the year ended December 31, 2015, or 11.5% of revenue. The $105.9 million increase was primarily attributable to other operating expenses incurred by the facilities acquired in our 2015 and 2016 Acquisitions, particularly the acquisition of Priory. Same-facility other operating expenses were $202.6 million for the year ended December 31, 2016, or 11.4% of revenue, compared to $188.4 million for the year ended December 31, 2015, or 11.3% of revenue.

Depreciation and amortization. Depreciation and amortization expense was $135.1 million for the year ended December 31, 2016, or 4.8% of revenue, compared to $63.6 million for the year ended December 31, 2015, or 3.5% of revenue. The increase in depreciation and amortization was attributable to depreciation associated with capital expenditures during 2015 and 2016 and real estate acquired as part of the 2015 and 2016 Acquisitions, particularly the acquisition of Priory.

Interest expense. Interest expense was $181.3 million for the year ended December 31, 2016 compared to $106.7 million for the year ended December 31, 2015. The increase in interest expense was primarily a result of borrowings under the Amended and Restated Senior Credit Facility, the issuance of the 5.625% Senior Notes on February 11, 2015 and September 21, 2015 and the issuance of the 6.500% Senior Notes on February 16, 2016.

Debt extinguishment costs. Debt extinguishment costs for the year ended December 31, 2016 represent $1.1 million of cash charges and $3.2 million of non-cash charges recorded in connection with the Tranche B-2 Repricing Amendment and the Refinancing Amendment. Debt extinguishment costs for the year ended December 31, 2015 represent $7.5 million of cash charges and $3.3 million of non-cash charges recorded in connection with the repayment of $97.5 million of 12.875% Senior Notes.

Loss on divestiture. As part of our divestitures in the U.K. and U.S., we recorded $178.8 million of loss on divestiture for the year ended December 31, 2016, which included an allocation of goodwill to the disposal groups of approximately $106.9 million, loss on the sale of properties of approximately $45.0 million, transaction-related expenses of approximately $26.8 million and write-off of intangible assets of approximately $0.1 million.

(Gain) loss on foreign currency derivatives. We entered into foreign currency forward contracts during the years ended December 31, 2016 and 2015 in connection with (i) acquisitions in the U.K. and (ii) certain transfers of cash between the U.S. and the U.K. under our cash management and foreign currency risk management programs. Exchange rate changes between the contract date and the settlement date resulted in a gain on foreign currency derivatives of $0.5 million for the year ended December 31, 2016, compared to a loss of $1.9 million for the year ended December 31, 2015.

Transaction-related expenses. Transaction-related expenses were $48.3 million for the year ended December 31, 2016 compared to $36.6 million for the year ended December 31, 2015. Transaction-related expenses represent costs incurred in the respective periods, primarily related to the 2015 and 2016 Acquisitions, as summarized below (in thousands):

	Year Ended December 31,	
	2016	2015
Legal, accounting and other fees	$ 21,058	$ 17,768
Advisory and financing commitment fees	14,850	10,337
Severance and contract termination costs	12,415	8,466
	$ 48,323	$ 36,571

Provision for income taxes. For the year ended December 31, 2016, the provision for income taxes was $28.8 million, reflecting an effective tax rate of 87.3%, compared to $53.4 million, reflecting an effective tax rate of 32.4%, for 2015. The change in the tax rate for the year ended December 31, 2016 is primarily attributable to the disparity between the accounting treatment and the tax treatment of the U.K. Divestiture on November 30, 2016.

Liquidity and Capital Resources

Cash provided by continuing operating activities for the year ended December 31, 2017 was $401.3 million compared to $371.7 million for the year ended December 31, 2016. The increase in cash provided by continuing operating activities was primarily attributable to cash provided by continuing operating activities from our 2016 Acquisitions offset by the U.K. Divestiture and the decline in the exchange rate between USD and GBP. Days sales outstanding as of December 31, 2017 was 38 compared to 34 as of December 31, 2016. As of December 31, 2017 and December 31, 2016, we had working capital of $94.2 million and $85.1 million, respectively.

Cash used in investing activities for the year ended December 31, 2017 was $336.5 million compared to $660.4 million for the year ended December 31, 2016. Cash used in investing activities for the year ended December 31, 2017 primarily consisted of $274.2 million of cash paid for capital expenditures and $41.1 million of cash paid for real estate. Cash paid for capital expenditures for the year ended December 31, 2017 consisted of $70.8 million of routine capital expenditures and $203.4 million of expansion capital expenditures. We define expansion capital expenditures as those that increase the capacity of our facilities or otherwise enhance revenue. Routine or maintenance capital expenditures were approximately 2.5% of revenue for the year ended December 31, 2017. Cash used in investing activities for the year ended December 31, 2016 primarily consisted of $683.5 million of cash paid for acquisitions, $307.5 million of cash paid for capital expenditures and $40.8 million of cash paid for real estate acquisitions partially offset by cash received on divestitures of $373.3 million.

Cash used in financing activities for the year ended December 31, 2017 was $60.1 million compared to cash provided by financing activities of $358.8 million for the year ended December 31, 2016. Cash used in financing activities for the year ended December 31, 2017 primarily consisted of principal payments on long-term debt of $34.8 million, repayment of long-term debt of $22.5 million and common stock withheld for minimum statutory taxes of $3.5 million. Cash provided by financing activities for the year ended December 31, 2016 primarily consisted of long-term debt borrowings of $1.5 billion, borrowings on our revolving credit facility of $179.0 million and an issuance of common stock of $685.1 million, partially offset by repayment of assumed Priory debt of $1.4 billion, payment on revolving credit facility of $337.0 million, repayment of long-term debt of $200.6 million, principal payments on long-term debt of $49.9 million, payment of debt issuance costs of $36.6 million and common stock withheld for minimum statutory taxes of $8.8 million.

We had total available cash and cash equivalents of $67.3 million, $57.1 million and $11.2 million as of December 31, 2017, 2016 and 2015, respectively, of which approximately $20.4 million, $41.4 million and $9.2 million was held by our foreign subsidiaries, respectively. Our strategic plan does not require the repatriation of foreign cash in order to fund our operations in the U.S., and it is our current intention to permanently reinvest our foreign cash and cash equivalents outside of the U.S. On December 22, 2017, the Tax Act was enacted into law. The Tax Act provides for significant changes to the U.S. tax code that impact businesses. Effective January 1, 2018, the Tax Act reduces the U.S. federal tax rate for corporations from 35% to 21% for U.S. taxable income and requires a one-time remeasurement of deferred taxes to reflect their value at a lower tax rate of 21%. While we are still evaluating the full impact of the legislation, we expect the substantial reduction of the federal corporate tax rate to benefit our financial results and cash flow in future periods. We believe the change will not result in a U.S. tax liability on those foreign earnings which have not previously been repatriated to the U.S., with future foreign earnings potentially not subject to U.S. income taxes when repatriated.

Amended and Restated Senior Credit Facility

We entered into a Senior Secured Credit Facility (the "Senior Secured Credit Facility") on April 1, 2011. On December 31, 2012, we entered into the Amended and Restated Credit Agreement which amended and restated the Senior Secured Credit Facility. We have amended the Amended and Restated Credit Agreement from time to time as described in our prior filings with the SEC.

On February 6, 2015, we entered into the Seventh Amendment to our Amended and Restated Credit Agreement. The Seventh Amendment added Citibank, N.A. as an "L/C Issuer" under the Amended and Restated Credit Agreement in order to permit the rollover of CRC's existing letters of credit into the Amended and Restated Credit Agreement and increased both the Company's Letter of Credit Sublimit and Swing Line Sublimit to $20.0 million.

On February 11, 2015, we entered into the First Incremental Amendment to our Amended and Restated Credit Agreement. The First Incremental Amendment activated a new $500.0 million incremental Tranche B-1 Facility that was added to the Amended and Restated Senior Secured Credit Facility, subject to limited conditionality provisions. Borrowings under the Tranche B-1 Facility were used to fund a portion of the purchase price for our acquisition of CRC.

On April 22, 2015, we entered into an Eighth Amendment to our Amended and Restated Credit Agreement. The Eighth Amendment changed the definition of "Change of Control" in part to remove a provision whose purpose was, when calculating whether a majority of incumbent directors have approved new directors, that any incumbent director that became a director as a result of a threatened or actual proxy contest was not counted in such calculation.

On January 25, 2016, we entered into the Ninth Amendment to our Amended and Restated Credit Agreement. The Ninth Amendment modified certain definitions and provides increased flexibility to us in terms of our financial covenants. Our baskets for permitted investments were also increased to provide increased flexibility for us to invest in non-wholly owned subsidiaries, joint ventures and foreign subsidiaries. As a result of the Ninth Amendment, we may invest in non-wholly owned subsidiaries and joint ventures up to 10.0% of our and our subsidiaries' total assets in any consecutive four fiscal quarter period, and up to 12.5% of our and our subsidiaries' total assets during the term of the Amended and Restated Credit Agreement. We may also invest in foreign subsidiaries that are not loan parties up to 10% of our and our subsidiaries' total assets in any consecutive four fiscal quarter period, and up to 15% of our and our subsidiaries' total assets during the term of the Amended and Restated Credit Agreement. The foregoing permitted investments are subject to an aggregate cap of 25% of our and our subsidiaries' total assets in any fiscal year.

On February 16, 2016, we entered into the Second Incremental Facility Amendment to our Amended and Restated Credit Agreement. The Second Incremental Amendment activated a new $955.0 million incremental Term Loan B facility and added $135.0 million to the Term Loan A facility to our Amended and Restated Senior Secured Credit Facility, subject to limited conditionality provisions. Borrowings under the Tranche B-2 Facility were used to fund a portion of the purchase price for the acquisition of Priory and the fees and expenses for such acquisition and the related financing transactions. Borrowings under the TLA Facility were used to pay down the majority of our $300.0 million revolving credit facility.

On May 26, 2016, we entered into a Tranche B-1 Repricing Amendment to the Amended and Restated Credit Agreement. The Tranche B-1 Repricing Amendment reduced the Applicable Rate with respect to the Tranche B-1 Facility from 3.5% to 3.0% in the case of Eurodollar Rate loans and 2.5% to 2.0% in the case of Base Rate Loans.

On September 21, 2016, we entered into a Tranche B-2 Repricing Amendment to the Amended and Restated Credit Agreement. The Tranche B-2 Repricing Amendment reduced the Applicable Rate with respect to the Tranche B-2 Facility from 3.75% to 3.00% in the case of Eurodollar Rate loans and 2.75% to 2.00% in the case of Base Rate Loans. In connection with the Tranche B-2 Repricing Amendment, we recorded a debt extinguishment charge of $3.4 million, including the discount and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of income.

On November 22, 2016, we entered into a Tenth Amendment to the Amended and Restated Credit Agreement. The Tenth Amendment, among other things, (i) amended the negative covenant regarding dispositions, (ii) modified the collateral package to release any real property with a fair market value of less than $5.0 million and (iii) changed certain investment, indebtedness and lien baskets.

On November 30, 2016, we entered into a Refinancing Facilities Amendment to the Amended and Restated Credit Agreement. The Refinancing Amendment increased our line of credit on our revolving credit facility to $500.0 million from $300.0 million and reduced our TLA Facility to $400.0 million from $600.6 million. In addition, the Refinancing Amendment extended the maturity date for the Refinancing Facilities to November 30, 2021 from February 13, 2019, and lowered our effective interest rate on our line of credit on our revolving credit facility and TLA Facility by 50 basis points. In connection with the Refinancing Amendment, we recorded a debt extinguishment charge of $0.8 million, including the write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of income.

On May 10, 2017, we entered into the Third Repricing Amendment to the Amended and Restated Credit Agreement. The Third Repricing Amendment reduced the Applicable Rate with respect to the Tranche B-1 Facility and the Tranche B-2 Facility from 3.0% to 2.75% in the case of Eurodollar Rate loans and 2.0% to 1.75% in the case of Base Rate Loans. In connection with the Third Repricing Amendment, we recorded a debt extinguishment charge of $0.8 million, including the discount and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of operations.

We had $493.4 million of availability under the revolving line of credit and had standby letters of credit outstanding of $6.6 million related to security for the payment of claims required by our workers' compensation insurance program as of December 31, 2017. Borrowings under the revolving line of credit are subject to customary conditions precedent to borrowing. The Amended and Restated Credit Agreement requires quarterly term loan principal repayments of our TLA Facility of $5.0 million for March 31, 2018 to December 31, 2019, $7.5 million for March 31, 2020 to December 31, 2020, and $10.0 million for March 31, 2021 to September 30, 2021, with the remaining principal balance of the TLA Facility due on the maturity date of November 30, 2021. We are required to repay the Tranche B-1 Facility in equal quarterly installments of $1.3 million on the last business day of each March, June, September and December, with the outstanding principal balance of the Tranche B-1 Facility due on February 11, 2022. We are required to repay the Tranche B-2 Facility in equal quarterly installments of approximately $2.4 million on the last business day of each March, June, September and December, with the outstanding principal balance of the Tranche B-2 Facility due on February 16, 2023. On December 29, 2017, the Company made an additional payment of $22.5 million, including $7.7 million on the Tranche B-1 Facility and $14.8 million on the Tranche B-2 Facility.

Borrowings under the Amended and Restated Credit Agreement are guaranteed by each of our wholly-owned domestic subsidiaries (other than certain excluded subsidiaries) and are secured by a lien on substantially all of our and such subsidiaries' assets. Borrowings with respect to the TLA Facility and our revolving credit facility (collectively, "Pro Rata Facilities") under the Amended and Restated Credit Agreement bear interest at a rate tied to Acadia's Consolidated Leverage Ratio (defined as consolidated funded debt net of up to $40.0 million of unrestricted and unencumbered cash to consolidated EBITDA, in each case as defined in the Amended and Restated Credit Agreement). The Applicable Rate (as defined in the Amended and Restated Credit Agreement) for the Pro Rata Facilities was 2.75% for Eurodollar Rate Loans (as defined in the Amended and Restated Credit Agreement) and 1.75% for Base Rate Loans (as defined in the Amended and Restated Credit Agreement) at December 31, 2017. Eurodollar Rate Loans with respect to the Pro Rata Facilities bear interest at the Applicable Rate plus the Eurodollar Rate (as defined in the Amended and Restated Credit Agreement) (based upon the LIBOR Rate (as defined in the Amended and Restated Credit Agreement) prior to commencement of the interest rate period). Base Rate Loans with respect to the Pro Rata Facilities bear interest at the Applicable Rate plus the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate and (iii) the Eurodollar Rate plus 1.0%. As of December 31, 2017, the Pro Rata Facilities bore interest at a rate of LIBOR plus 2.75%. In addition, we are required to pay a commitment fee on undrawn amounts under our revolving credit facility.

The interest rates and the unused line fee on unused commitments related to the Pro Rata Facilities are based upon the following pricing tiers:

Pricing Tier	Consolidated Leverage Ratio	Eurodollar Rate Loans	Base Rate Loans	Commitment Fee
1	< 3.50:1.0	1.75%	0.75%	0.20%
2	>3.50:1.0 but < 4.00:1.0	2.00%	1.00%	0.25%
3	>4.00:1.0 but < 4.50:1.0	2.25%	1.25%	0.30%
4	>4.50:1.0 but < 5.25:1.0	2.50%	1.50%	0.35%
5	>5.25:1.0	2.75%	1.75%	0.40%

Eurodollar Rate Loans with respect to the Tranche B-1 Facility bear interest at the Tranche B-1 Facility Applicable Rate (as defined below) plus the Eurodollar Rate (subject to a floor of 0.75% and based upon the LIBOR Rate prior to commencement of the interest rate period). Base Rate Loans bear interest at the Tranche B-1 Facility Applicable Rate plus the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate and (iii) the Eurodollar Rate plus 1.0%. As used herein, the term "Tranche B-1 Facility Applicable Rate" means, with respect to Eurodollar Rate Loans, 3.0%, and with respect to Base Rate Loans, 2.0%. The Tranche B-2 Facility bears interest as follows: Eurodollar Rate Loans bear interest at the Applicable Rate (as defined in the Amended and Restated Credit Agreement) plus the Eurodollar Rate (subject to a floor of 0.75% and based upon the LIBOR Rate prior to commencement of the interest rate period) and Base Rate Loans bear interest at the Applicable Rate plus the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate and (iii) the Eurodollar Rate plus 1.0%. As used herein, the term "Applicable Rate" means, with respect to Eurodollar Rate Loans, 3.0%, and with respect to Base Rate Loans, 2.0%.

The lenders who provided the Tranche B-1 Facility and Tranche B-2 Facility are not entitled to benefit from the Company's maintenance of its financial covenants under the Amended and Restated Credit Agreement. Accordingly, if we fail to maintain its financial covenants, such failure shall not constitute an event of default under the Amended and Restated Credit Agreement with respect to the Tranche B-1 Facility or the Tranche B-2 Facility until and unless the Amended and Restated Senior Credit Facility is accelerated or the commitment of the lenders to make further loans is terminated.

The Amended and Restated Credit Agreement requires us and our subsidiaries to comply with customary affirmative, negative and financial covenants, including a fixed charge coverage ratio, consolidated leverage ratio and consolidated senior secured leverage ratio. We may be required to pay all of our indebtedness immediately if we default on any of the numerous financial or other restrictive covenants contained in any of its material debt agreements. We may be required to pay all of our indebtedness immediately if we default on any of the numerous financial or other restrictive covenants contained in any of our material debt agreements. Set forth below is a brief description of such covenants, all of which are subject to customary exceptions, materiality thresholds and qualifications:

a) the affirmative covenants include the following: (i) delivery of financial statements and other customary financial information; (ii) notices of events of default and other material events; (iii) maintenance of existence, ability to conduct business, properties, insurance and books and records; (iv) payment of taxes; (v) lender inspection rights; (vi) compliance with laws; (vii) use of proceeds; (viii) further assurances; and (ix) additional collateral and guarantor requirements.

b) the negative covenants include limitations on the following: (i) liens; (ii) debt (including guarantees); (iii) investments; (iv) fundamental changes (including mergers, consolidations and liquidations); (v) dispositions; (vi) sale leasebacks; (vii) affiliate transactions; (viii) burdensome agreements; (ix) restricted payments; (x) use of proceeds; (xi) ownership of subsidiaries; (xii) changes to line of business; (xiii) changes to organizational documents, legal name, state of formation,

form of entity and fiscal year; (xiv) prepayment or redemption of certain senior unsecured debt; and (xv) amendments to certain material agreements. The Company is generally not permitted to issue dividends or distributions other than with respect to the following: (w) certain tax distributions; (x) the repurchase of equity held by employees, officers or directors upon the occurrence of death, disability or termination subject to cap of $500,000 in any fiscal year and compliance with certain other conditions; (y) in the form of capital stock; and (z) scheduled payments of deferred purchase price, working capital adjustments and similar payments pursuant to the merger agreement or any permitted acquisition.

c) The financial covenants include maintenance of the following:

- the fixed charge coverage ratio may not be less than 1.25:1.00 as of the end of any fiscal quarter;
- the total leverage ratio may not be greater than the following levels as of the end of each fiscal quarter listed below:

	March 31	June 30	September 30	December 31
2017	6.75x	6.75x	6.50x	6.50x
2018	6.50x	6.25x	6.00x	6.00x
2019	5.75x	5.75x	5.50x	5.50x
2020	5.25x	5.25x	5.25x	5.00x

- the secured leverage ratio may not be greater than the following levels as of the end of each fiscal quarter listed below:

December 31, 2017 - June 30, 2018	3.75x
September 30, 2018 and each fiscal quarter thereafter	3.50x

As of December 31, 2017, the Company was in compliance with all of the above covenants.

Senior Notes

6.125% Senior Notes Due 2021

On March 12, 2013, we issued $150.0 million of 6.125% Senior Notes due 2021. The 6.125% Senior Notes mature on March 15, 2021 and bear interest at a rate of 6.125% per annum, payable semi-annually in arrears on March 15 and September 15 of each year.

5.125% Senior Notes due 2022

On July 1, 2014, we issued $300.0 million of 5.125% Senior Notes due 2022. The 5.125% Senior Notes mature on July 1, 2022 and bear interest at a rate of 5.125% per annum, payable semi-annually in arrears on January 1 and July 1 of each year.

5.625% Senior Notes due 2023

On February 11, 2015, we issued $375.0 million of 5.625% Senior Notes due 2023. On September 21, 2015, we issued $275.0 million of additional 5.625% Senior Notes. The additional notes formed a single class of debt securities with the 5.625% Senior Notes issued in February 2015. Giving effect to this issuance, we have outstanding an aggregate of $650.0 million of 5.625% Senior Notes. The 5.625% Senior Notes mature on February 15, 2023 and bear interest at a rate of 5.625% per annum, payable semi-annually in arrears on February 15 and August 15 of each year.

6.500% Senior Notes due 2024

On February 16, 2016, we issued $390.0 million of 6.500% Senior Notes due 2024. The 6.500% Senior Notes mature on March 1, 2024 and bear interest at a rate of 6.500% per annum, payable semi-annually in arrears on March 1 and September 1 of each year, beginning on September 1, 2016.

The indentures governing the Senior Notes contain covenants that, among other things, limit the Company's ability and the ability of its restricted subsidiaries to: (i) pay dividends, redeem stock or make other distributions or investments; (ii) incur additional debt or issue certain preferred stock; (iii) transfer or sell assets; (iv) engage in certain transactions with affiliates; (v) create restrictions on dividends or other payments by the restricted subsidiaries; (vi) merge, consolidate or sell substantially all of the Company's assets; and (vii) create liens on assets.

The Senior Notes issued by the Company are guaranteed by each of the Company's subsidiaries that guarantee the Company's obligations under the Amended and Restated Senior Credit Facility. The guarantees are full and unconditional and joint and several.

The Company may redeem the Senior Notes at its option, in whole or part, at the dates and amounts set forth in the indentures.

9.0% and 9.5% Revenue Bonds

On November 11, 2012, in connection with the acquisition of The Pavilion at HealthPark, LLC ("Park Royal"), we assumed debt of $23.0 million. The fair market value of the debt assumed was $25.6 million and resulted in a debt premium balance being recorded as of the acquisition date. The debt consisted of $7.5 million and $15.5 million of Lee County (Florida) Industrial Development Authority Healthcare Facilities Revenue Bonds, Series 2010 with stated interest rates of 9.0% and 9.5%, respectively. The 9.0% bonds in the amount of $7.5 million have a maturity date of December 1, 2030 and require yearly principal payments beginning in 2013. The 9.5% bonds in the amount of $15.5 million have a maturity date of December 1, 2040 and require yearly principal payments beginning in 2031. The principal payments establish a bond-sinking fund to be held with the trustee and shall be sufficient to redeem the principal amounts of the 9.0% and 9.5% Revenue Bonds on their respective maturity dates. As of December 31, 2017 and 2016, $2.3 million was recorded within other assets on the consolidated balance sheets related to the debt service reserve fund requirements. The yearly principal payments, which establish a bond sinking fund, will increase the debt service reserve fund requirements. The bond premium amount of $2.6 million is amortized as a reduction of interest expense over the life of the 9.0% and 9.5% Revenue Bonds using the effective interest method.

Contractual Obligations

The following table presents a summary of contractual obligations (dollars in thousands):

	Payments Due by Period				
	Less Than 1 Year	1-3 Years	3-5 Years	More Than 5 Years	Total
Long-term debt(1)	$199,973	$405,354	$1,508,021	$2,006,944	$4,120,292
Operating leases	69,613	124,712	107,691	835,369	1,137,385
Purchase and other obligations(2)	4,307	7,404	33,899	27,085	72,695
Total obligations and commitments	$273,893	$537,470	$1,649,611	$2,869,398	$5,330,372

(1) Amounts include required principal and interest payments. The projected interest payments reflect interest rates in place on our variable-rate debt as of December 31, 2017.

(2) Amounts relate to purchase obligations, including capital lease payments.

Off-Balance Sheet Arrangements

As of December 31, 2017, we had standby letters of credit outstanding of $6.6 million related to security for the payment of claims as required by our workers' compensation insurance program.

Market Risk

Interest Rate Risk

Our interest expense is sensitive to changes in market interest rates. Our long-term debt outstanding at December 31, 2017 was composed of $1.5 billion of fixed-rate debt and $1.7 billion of variable-rate debt with interest based on LIBOR plus an applicable margin. A hypothetical 10% increase in interest rates (which would equate to a 0.42% higher rate on our variable rate debt) would decrease our net income and cash flows by $5.0 million on an annual basis based upon our borrowing level at December 31, 2017.

Foreign Currency Risk

The functional currency for our U.K. facilities is the British pound or GBP. Our revenue and earnings are sensitive to changes in the GBP to USD exchange rate from the translation of our earnings into USD at exchange rates that may fluctuate. Based upon the level of our U.K. operations relative to the Company as a whole, a hypothetical 10% change (which would equate to an increase or decrease in the exchange rate of 0.13) would cause a change in our net income of $10.1 million for the year ended December 31, 2017.

In May 2016, we entered into multiple cross currency swap agreements with an aggregate notional amount of $650.0 million to manage foreign currency exchange risk by effectively converting a portion of our fixed-rate USD denominated senior notes, including the semi-annual interest payments thereunder, to fixed-rate, GBP-denominated debt of £449.3 million. The cross currency swap agreements limit the impact of changes in the exchange rate on our cash flows and leverage. Following the Brexit vote, the GBP dropped to its lowest level against the USD in more than 30 years. If the exchange rate remains low, our results of operations will be negatively impacted in future periods.

Critical Accounting Policies

Our consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the U.S. In preparing our financial statements, we are required to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenue, and expenses included in the financial statements. Estimates are based on historical experience and other available information, the results of which form the basis of such estimates. While management believes our estimation processes are reasonable, actual results could differ from our estimates. The following accounting policies are considered critical to the portrayal of our financial condition and operating performance and involve highly subjective and complex assumptions and assessments:

Revenue and Accounts Receivable

Our revenue is primarily derived from services rendered to patients for inpatient psychiatric and substance abuse care, outpatient psychiatric care and adolescent residential treatment. We receive payments from the following sources for services rendered in our facilities: (i) state governments under their respective Medicaid and other programs; (ii) commercial insurers; (iii) the federal government under the Medicare program administered by CMS; (iv) public funded sources in the U.K. (including the NHS, CCGs and local authorities in England, Scotland and Wales); and (v) individual patients and clients. Revenue is recorded in the period in which services are provided at established billing rates less contractual adjustments based on amounts reimbursable by Medicare or Medicaid under provisions of cost or prospective reimbursement formulas or amounts due from other third-party payors at contractually determined rates.

The following table presents revenue by payor type and as a percentage of revenue before provision for doubtful accounts for the years ended December 31, 2017, 2016 and 2015 (in thousands):

	Year Ended December 31,					
	2017		2016		2015	
	Amount	%	Amount	%	Amount	%
Commercial	$ 569,242	19.8%	$ 534,468	18.7%	$ 423,077	23.1%
Medicare	281,270	9.8%	266,868	9.4%	214,125	11.7%
Medicaid	796,375	27.7%	725,508	25.4%	609,805	33.3%
NHS	937,595	32.6%	1,021,888	35.8%	356,965	19.5%
Self-Pay	249,978	8.7%	268,160	9.4%	174,850	9.6%
Other	42,774	1.4%	35,931	1.3%	50,797	2.8%
Revenue before provision for doubtful accounts	2,877,234	100.0%	2,852,823	100.0%	1,829,619	100.0%
Provision for doubtful accounts	(40,918)		(41,909)		(35,127)	
Revenue	$2,836,316		$2,810,914		$1,794,492	

The following tables present a summary of our aging of accounts receivable as of December 31, 2017 and 2016:

December 31, 2017

	Current	30-90	90-150	>150	Total
Commercial	15.3%	8.7%	3.2%	6.9%	34.1%
Medicare	9.4%	1.6%	0.5%	1.1%	12.6%
Medicaid	19.8%	6.4%	2.5%	5.2%	33.9%
NHS	7.0%	3.4%	0.2%	0.0%	10.6%
Self-Pay	1.8%	1.4%	1.4%	3.2%	7.8%
Other	0.3%	0.3%	0.2%	0.2%	1.0%
Total	53.6%	21.8%	8.0%	16.6%	100.0%

December 31, 2016

	Current	30-90	90-150	>150	Total
Commercial	15.8%	8.5%	3.0%	5.3%	32.6%
Medicare	12.0%	1.6%	0.8%	1.2%	15.6%
Medicaid	18.7%	6.5%	2.9%	5.5%	33.6%
NHS	5.1%	3.4%	0.6%	0.4%	9.5%
Self-Pay	1.8%	1.5%	1.5%	3.3%	8.1%
Other	0.1%	0.1%	0.1%	0.3%	0.6%
Total	53.5%	21.6%	8.9%	16.0%	100.0%

Medicaid accounts receivable as of December 31, 2017 and 2016 included approximately $0.9 million and $1.2 million, respectively, of accounts pending Medicaid approval.

Allowance for Contractual Discounts

We derive a significant portion of our revenue from Medicare, Medicaid and other payors that receive discounts from established billing rates. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex, subject to interpretation and adjustment, and may include multiple reimbursement mechanisms for different types of services provided in our inpatient facilities and cost settlement provisions. Management estimates the allowance for contractual discounts on a payor-specific basis given its interpretation of the applicable regulations or contract terms. The services authorized and provided and related reimbursement are often subject to interpretation that could result in payments that differ from our estimates. Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management.

Settlements under cost reimbursement agreements with third-party payors are estimated and recorded in the period in which the related services are rendered and are adjusted in future periods as final settlements are determined. Final determination of amounts earned under the Medicare and Medicaid programs often occurs in subsequent years because of audits by such programs, rights of appeal and the application of numerous technical provisions. In the opinion of management, adequate provision has been made for any adjustments and final settlements. However, there can be no assurance that any such adjustments and final settlements will not have a material effect on our financial condition or results of operations. Our cost report receivables were $9.0 million and $7.4 million at December 31, 2017 and 2016, respectively, and were included in other current assets in the consolidated balance sheets. Management believes that these receivables are properly stated and are not likely to be settled for a significantly different amount. The net adjustments to estimated cost report settlements resulted in increases to revenue of $0.2 million, $0.7 million and $1.9 million for the years ended December 31, 2017, 2016 and 2015, respectively.

Management believes that we are in substantial compliance with all applicable laws and regulations and is not aware of any material pending or threatened investigations involving allegations of wrongdoing. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs.

Allowance for Doubtful Accounts

Our ability to collect outstanding patient receivables from third-party payors is critical to our operating performance and cash flows. The primary collection risk with regard to patient receivables relates to uninsured patient accounts or patient accounts for which primary insurance has paid, but the portion owed by the patient remains outstanding. We estimate uncollectible accounts and establish an allowance for doubtful accounts in order to adjust accounts receivable to estimated net realizable value. In evaluating the collectability of accounts receivable, we consider a number of factors, including the age of the accounts, historical collection experience, current economic conditions, and other relevant factors. Accounts receivable that are determined to be uncollectible based on our policies are written off to the allowance for doubtful accounts. Significant changes in payor mix or business office operations could have a significant impact on our results of operations and cash flows.

Insurance

The Company is subject to medical malpractice and other lawsuits due to the nature of the services the Company provides. A portion of the Company's professional liability risk is insured through a wholly-owned insurance subsidiary. The Company's wholly-owned insurance subsidiary insures the Company for professional liability losses up to $78.0 million in the aggregate. The insurance subsidiary has obtained reinsurance with unrelated commercial insurers for professional liability risks of $75.0 million in excess of a retention level of $3.0 million. The reserve for professional and general liability risks was estimated based on historical claims, demographic factors, industry trends, severity factors, and other actuarial assumptions. The estimated accrual for professional and general liabilities could be significantly affected should current and future occurrences differ from historical claim trends and expectations. While claims are monitored closely when estimating professional and general liability accruals, the complexity of the claims and wide range of potential outcomes often hampers timely adjustments to the assumptions used in these estimates. The professional and general liability reserve was $55.0 million as of December 31, 2017, of which $22.8 million was included in other accrued liabilities and $32.2 million was included in other long-term liabilities. The professional and general liability reserve was $52.3 million as of December 31, 2016, of which $11.7 million was included in other accrued liabilities and $40.6 million was included in other long-term liabilities. The Company estimates receivables for the portion of professional and general liability reserves that are recoverable under the Company's insurance policies. Such receivable was $22.7 million as of December 31, 2017, of which $17.6 million was included in other current assets and $5.1 million was included in other assets, and such receivable was $25.9 million as of December 31, 2016, of which $6.5 million was included in other current assets and $19.4 million was included in other assets.

The Company's statutory workers' compensation program is fully insured with a $0.5 million deductible per accident. The workers' compensation liability was $18.5 million as of December 31, 2017, of which $10.0 million was included in accrued salaries and benefits and $8.5 million was included in other long-term liabilities, and such liability was $16.6 million as of December 31, 2016, of which $10.0 million was included in accrued salaries and benefits and $6.6 million was included in other long-term liabilities. The reserve for workers compensation claims was based upon independent actuarial estimates of future amounts that will be paid to claimants. Management believes that adequate provisions have been made for workers' compensation and professional and general liability risk exposures.

Property and Equipment and Other Long-Lived Assets

Property and equipment are recorded at cost. Depreciation is calculated on the straight-line basis over the estimated useful lives of the assets, which typically range from 10 to 50 years for buildings and improvements, three to seven years for equipment and the shorter of the lease term or estimated useful lives for leasehold improvements. When assets are sold or retired, the corresponding cost and accumulated depreciation are removed from the related accounts and any gain or loss is recorded in the period of sale or retirement. Repair and maintenance costs are expensed as incurred. Depreciation expense was $143.0 million, $134.8 million and $63.0 million for the years ended December 31, 2017, 2016 and 2015, respectively.

The carrying values of long-lived assets are reviewed for possible impairment whenever events, circumstances or operating results indicate that the carrying amount of an asset may not be recoverable. If this review indicates that the asset will not be recoverable, as determined based upon the undiscounted cash flows of the operating asset over the remaining useful lives, the carrying value of the asset will be reduced to its estimated fair value. Fair value estimates are based on independent appraisals, market values of comparable assets or internal evaluations of future net cash flows.

Goodwill and Indefinite-Lived Intangible Assets

Our goodwill and other indefinite-lived intangible assets, which consist of licenses and accreditations and certificates of need intangible assets that are not amortized, are evaluated for impairment annually during the fourth quarter or more frequently if events indicate that the carrying value of a reporting unit may not be recoverable. We have two operating segments, U.S. Facilities and U.K. Facilities, for segment reporting purposes, each of which represents a reporting unit for purposes of the Company's goodwill impairment test. Potential impairment is noted for a reporting unit if its carrying value exceeds the fair value of the reporting unit. For a reporting unit with potential impairment of goodwill, we determine the implied fair value of goodwill. If the carrying value of goodwill exceeds its implied fair value, an impairment loss is recorded. Our annual impairment tests of goodwill and other indefinite-lived intangibles in 2017, 2016 and 2015 resulted in no impairment charges.

Income Taxes

We use the asset and liability method of accounting for income taxes. Under this method, deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes and net operating loss and tax credit carryforwards. The amount of deferred taxes on these temporary differences is determined using the tax rates that are expected to apply in the period when the asset is realized or the liability is settled, as applicable, based on tax rates and laws in the respective tax jurisdiction enacted as of the balance sheet date.

We review our deferred tax assets for recoverability and establish a valuation allowance based on historical taxable income, projected future taxable income, applicable tax strategies, and the expected timing of the reversals of existing temporary differences. A valuation allowance is provided when it is more likely than not that some portion or all of the deferred tax assets will not be realized.

We report a liability for unrecognized tax benefits resulting from uncertain tax positions taken or expected to be taken in a tax return. We recognize interest and penalties, if any, related to unrecognized tax benefits in income tax expense.

We also have accruals for taxes and associated interest that may become payable in future years as a result of audits by tax authorities. We accrue for tax contingencies when it is more likely than not that a liability to a taxing authority has been incurred and the amount of the contingency can be reasonably estimated. Although we believe that the positions taken on previously filed tax returns are reasonable, we nevertheless have established tax and interest reserves in recognition that various taxing authorities may challenge the positions taken by us resulting in additional liabilities for taxes and interest. These amounts are reviewed as circumstances warrant and adjusted as events occur that affect our potential liability for additional taxes, such as lapsing of applicable statutes of limitations, conclusion of tax audits, additional exposure based on current calculations, identification of new issues, release of administrative guidance, or rendering of a court decision affecting a particular tax issue.

Financial Accounting Standards Board Accounting Standards Codification 740 requires us to recognize the effect of tax law changes in the period of enactment. However, the SEC staff issued SAB 118 which will allow us to record provisional amounts during a measurement period similarly to the measurement period used when accounting for business combinations. We will continue to assess the impact of the recently enacted tax law on our business and consolidated financial statements.

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

Information with respect to this Item is provided under the caption "Market Risk" under "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations."

Item 8. Financial Statements and Supplementary Data.

Information with respect to this Item is contained in our consolidated financial statements beginning on Page F-1 of this Annual Report on Form 10-K.

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

None.

Item 9A. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures

As of the end of the period covered by this report, our management conducted an evaluation, with the participation of our chief executive officer and chief financial officer, of the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")). Based on this evaluation, our chief executive officer and chief financial officer have concluded that our disclosure controls and procedures are effective to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms and that such information is accumulated and communicated to management, including our chief executive officer and chief financial officer, as appropriate to allow timely decisions regarding required disclosure.

Reports on Internal Control Over Financial Reporting

Pursuant to Section 404 of the Sarbanes-Oxley Act of 2002, we have included a report of management's assessment of the design and operating effectiveness of our internal controls as part of this report. Our independent registered public accounting firm also reported on the effectiveness of internal control over financial reporting. Management's report and the independent registered public accounting firm's report are included in our consolidated financial statements beginning on page F-1 of this report under the captions entitled "Management's Report on Internal Control Over Financial Reporting" and "Report of Independent Registered Public Accounting Firm."

Changes in Internal Control Over Financial Reporting

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2017 that have materially affected or are reasonably likely to materially affect our internal control over financial reporting.

Item 9B. Other Information.

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

Directors

The information with respect to our directors set forth under the caption "Election of Directors" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 3, 2018 is incorporated herein by reference.

Audit Committee

The information with respect to our Audit Committee and our audit committee financial experts serving on the Audit Committee is set forth under the caption "Corporate Governance – Committees of the Board of Directors – Audit Committee" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 3, 2018 is incorporated herein by reference.

Executive Officers

The information with respect to our executive officers set forth under the caption "Management – Executive Officers" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 3, 2018 is incorporated herein by reference.

Section 16(a) Compliance

The information with respect to compliance with Section 16(a) of the Exchange Act set forth under the caption "Security Ownership of Certain Beneficial Owners and Management—Section 16(a) Beneficial Ownership Reporting Compliance" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 3, 2018 is incorporated herein by reference.

Stockholder Nominees

The information with respect to the procedures by which stockholders may recommend nominees to the Board of Directors set forth under the caption "Corporate Governance – Nomination of Directors – Nominations by Our Stockholders" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 3, 2018 is incorporated herein by reference.

Corporate Governance Documents

We have adopted a Code of Conduct that applies to all of our directors, officers and employees and a Code of Ethics for Senior Financial Officers. These documents, as well as the charters of the Audit Committee, Compensation Committee and Nominating and Governance Committee, are available on our website at www.acadiahealthcare.com on the Investors webpage under the caption "Corporate Governance." Upon the written request of any person, we will furnish, without charge, a copy of any of these documents. Requests should be directed to Acadia Healthcare Company, Inc., 6100 Tower Circle, Suite 1000, Franklin, Tennessee 37067, Attention: Christopher L. Howard, Esq. We intend to disclose any amendments to our Code of Ethics and any waiver from a provision of our code, as required by the SEC, on our website.

Item 11. Executive Compensation

The information with respect to the compensation of our executive officers set forth under the captions "Executive Compensation" and "Compensation Discussion and Analysis" and the information set forth under the captions "Director Compensation," "Corporate Governance – Compensation Committee Interlocks and Insider Participation," and "Compensation Committee Report" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 3, 2018 is incorporated herein by reference.

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

The information with respect to security ownership of certain beneficial owners and management and related stockholder matters set forth under the caption "Security Ownership of Certain Beneficial Owners and Management" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 3, 2018 is incorporated herein by reference.

Equity Compensation Plan Information

The following table provides information as of December 31, 2017 with respect to compensation plans (including individual compensation arrangements) under which shares of Common Stock are authorized for issuance:

Plan Category	Number of Securities to be Issued upon Exercise of Outstanding Options, Warrants and Rights	Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights	Number of Securities Remaining Available for Future Issuance under Equity Compensation Plans(1)
Equity Compensation Plans Approved by Stockholders(2)	2,491,252(3)	$ 53.44	4,498,687
Equity Compensation Plans Not Approved by Stockholders(4)	15,000	$ 5.64	—
Total	2,506,252	$ 47.89	4,498,687

(1) Excludes shares to be issued upon exercise of outstanding options and vesting of outstanding restricted stock units.
(2) Represents securities issued or available for issuance under the Acadia Healthcare Company, Inc. Incentive Compensation Plan.
(3) Includes 721,818 shares that may be issued upon vesting of outstanding restricted stock units that vest over three years, assuming that maximum performance goals are attained in all three years.
(4) Includes stock options issued pursuant to the PHC, Inc. 2004 Non-Employee Director Stock Option Plan. On November 1, 2011, we issued options to purchase shares of our Common Stock as replacements for PHC, Inc. options.

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

The information with respect to certain relationships and related transactions and director independence set forth under the captions "Certain Relationships and Related Transactions" and "Corporate Governance – Independence of the Board of Directors" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 3, 2018 is incorporated herein by reference.

Item 14. Principal Accountant Fees and Services

The information with respect to the fees paid to and services provided by our principal accountants set forth under the caption "Ratification of Appointment of Independent Registered Public Accounting Firm" in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 3, 2018 is incorporated herein by reference.

PART IV

Item 15. Exhibits and Financial Statement Schedules.

(a) The following documents are filed as part of this Annual Report on Form 10-K:

1. *Consolidated Financial Statements*:

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

2. *Financial Statement Schedules*:

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

3. *Exhibits*:

Exhibit No.	Exhibit Description
2.1	Agreement and Plan of Merger, dated May 23, 2011, by and among Acadia Healthcare Company, Inc. (the "Company"), Acadia Merger Sub, LLC and PHC, Inc. (a)
2.2	Agreement and Plan of Merger, dated February 17, 2011, by and among the Company (f/k/a Acadia Healthcare Company, LLC), Acadia—YFCS Acquisition Company, Inc., Acadia—YFCS Holdings, Inc., Youth & Family Centered Services, Inc., each of the stockholders who are signatories thereto, and TA Associates, Inc., solely in the capacity as Stockholders' Representative. (b)
2.3	Asset Purchase Agreement, dated as of March 15, 2011, between Universal Health Services, Inc. and PHC, Inc. for the acquisition of MeadowWood Behavioral Health System. (c)
2.4	Membership Interest Purchase Agreement, dated December 30, 2011, by and among Hermitage Behavioral, LLC, Haven Behavioral Healthcare Holdings, LLC and Haven Behavioral Healthcare, Inc. (d)
2.5	Asset Purchase Agreement, dated August 28, 2012, by and between Timberline Knolls, LLC, and TK Behavioral, LLC. (e)
2.6	Acquisition Agreement, dated November 21, 2012, by and among (i) Behavioral Centers of America, LLC, (ii) Behavioral Centers of America Holdings, LLC, (iii) Linden BCA Blocker Corp., (iv) SBOF-BCA Holdings Corporation, (v) HEP BCA Holdings Corp. (vi) Siguler Guff Small Buyout Opportunities Fund, LP, and Siguler Guff Small Buyout Opportunities Fund (F), LP, (vii) Health Enterprise Partners, L.P., HEP BCA Co-Investors, LLC, (viii) Linden Capital Partners A, LP, (ix) Commodore Acquisition Sub, LLC, and (x) the Company (the "BCA Purchase Agreement"). (f)
2.7	Amendment No. 1, dated as of December 31, 2012, to the BCA Purchase Agreement. (g)
2.8	Membership Interest Purchase Agreement, dated November 23, 2012 by and among 2C4K, L.P., ARTC Acquisitions, Inc., Acadia Vista, LLC and the Company. (f)
2.9	Amendment, dated as of December 31, 2012, to Membership Interest Purchase Agreement by and among 2C4K, LP, ARTC Acquisitions, Inc., Acadia Vista, LLC and the Company. (g)
2.10	Stock Purchase Agreement, dated as of March 29, 2013, by and among First Ten Broeck Tampa, Inc., UMC Ten Broeck, Inc., Capestrano Holding 12, Inc., Donald R. Dizney, David A. Dizney and Acadia Merger Sub, LLC. (h)
2.11	Agreement, dated June 3, 2014, by and among Partnerships in Care Holdings Limited, The Royal Bank of Scotland plc, Piper Holdco 2, Ltd. and the Company. (i)
2.12	Agreement and Plan of Merger, dated as of October 29, 2014, by and among the Company, Copper Acquisition Co., Inc. and CRC Health Group, Inc. (j)
2.13	Sale and Purchase Deed, dated as of December 31, 2015, by and among Whitewell UK Investments 1 Limited, the institutional sellers named therein, Appleby Trust (Jersey) Limited, the management sellers named therein, and the Company. (ee)

Exhibit No.	Exhibit Description
2.14	Amendment to Sale and Purchase Deed, by and among Whitewell UK Investments 1 Limited, the institutional sellers named therein, Appleby Trust (Jersey) Limited, the management sellers named therein, and the Company. (dd)
3.1	Amended and Restated Certificate of Incorporation, as filed on October 28, 2011 with the Secretary of State of the State of Delaware, as amended by the Certificate of Amendment filed on May 25, 2017. (kk)
3.2	Amended and Restated Bylaws of the Company, as amended May 25, 2017. (kk)
4.1	Indenture, dated as of March 12, 2013, among the Company, the Guarantors named therein and U.S. Bank National Association, as Trustee. (l)
4.2	Form of 6.125% Senior Note due 2021. (Included in Exhibit 4.1)
4.3	Registration Rights Agreement, dated March 12, 2013, among the Company, the Guarantors named therein and Merrill Lynch, Pierce, Fenner & Smith Incorporated. (l)
4.4	Indenture, dated as of July 1, 2014, among the Company, the Guarantors named therein and U.S. Bank National Association, as Trustee. (m)
4.5	Supplemental Indenture, dated as of August 4, 2014, to the Indenture, dated as of July 1, 2014, among the Company, the Guarantors named therein and U.S. Bank National Association, as Trustee. (n)
4.6	Form of 5.125% Senior Note due 2022. (Included in Exhibit 4.4)
4.7	Registration Rights Agreement, dated July 1, 2014, among the Company, the Guarantors named therein and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC. (m)
4.8	Indenture, dated February 11, 2015, by and among the Company, the Guarantors named therein and U.S. Bank National Association, as Trustee. (o)
4.9	Form of 5.625% Senior Note due 2023. (Included in Exhibit 4.8)
4.10	Registration Rights Agreement, dated February 11, 2015, by and among the Company, the Guarantors named therein and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as Representatives of the Initial Purchasers. (o)
4.11	Registration Rights Agreement, dated September 21, 2015, by and among the Company, the Guarantors named therein and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as Representatives of the Initial Purchasers. (bb)
4.12	Indenture, dated February 16, 2016, by and among the Company, the Guarantors named therein and U.S. Bank National Association, as Trustee. (ff)
4.13	Form of 6.500% Senior Note due 2024. (Included in Exhibit 4.12)
4.14	Registration Rights Agreement, dated February 16, 2016, by and among the Company, the Guarantors named therein and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as Representatives of the Initial Purchasers. (ff)
4.15	Amended and Restated Stockholders Agreement, dated as of October 29, 2014, by and among the Company and each of the stockholders named therein. (j)
4.16	Specimen Acadia Healthcare Company, Inc. Common Stock Certificate to be issued to holders of Acadia Healthcare Company, Inc. Common Stock. (p)
4.17	Third Amended and Restated Registration Rights Agreement, dated as of December 31, 2015, by and among the Company and each of the parties named therein. (cc)
4.18	Joinder, dated February 16, 2016, to the Third Amended and Restated Registration Rights Agreement dated as of December 31, 2015, by and among the Company and each of the parties named therein. (ff)
10.1	Amended and Restated Credit Agreement, dated December 31, 2012, by and among Bank of America, NA (Administrative Agent, Swing Line Lender and L/C Issuer) and the Company (f/k/a Acadia Healthcare Company, LLC), the guarantors listed on the signature pages thereto, and the lenders listed on the signature pages thereto (the "Credit Agreement"). (g)
10.2	First Amendment, dated March 11, 2013, to the Credit Agreement. (l)
10.3	Second Amendment, dated June 28, 2013, to the Credit Agreement. (q)

Exhibit No.	Exhibit Description
10.4	Third Amendment, dated September 30, 2013, to the Credit Agreement. (r)
10.5	Fourth Amendment, dated February 13, 2014, to the Credit Agreement. (s)
10.6	Fifth Amendment, dated June 16, 2014, to the Credit Agreement. (t)
10.7	Sixth Amendment, dated December 15, 2014, to the Credit Agreement. (u)
10.8	Seventh Amendment, dated February 6, 2015, to the Credit Agreement. (o)
10.9	First Incremental Facility Amendment, dated February 11, 2015, to the Credit Agreement. (o)
10.10	Eighth Amendment, dated April 22, 2015, to the Credit Agreement. (aa)
10.11	Ninth Amendment, dated January 25, 2016, to the Credit Agreement. (ee)
10.12	Second Incremental Facility Amendment, dated February 16, 2016, to the Credit Agreement. (ff)
10.13	Tranche B-1 Repricing Amendment, dated May 26, 2016, to the Credit Agreement. (gg)
10.14	Tranche B-2 Repricing Amendment, dated September 21, 2016, to the Credit Agreement. (hh)
10.15	Tenth Amendment, dated November 22, 2016, to the Credit Agreement. (ii)
10.16	Refinancing Facilities Amendment, dated November 30, 2016, to the Credit Agreement. (jj)
10.17	Third Repricing Amendment, dated May 10, 2017, to the Amended and Restated Credit Agreement. (jj)
†10.18	Amended and Restated Employment Agreement, dated April 7, 2014, among the Company, Acadia Management Company, Inc. and Joey A. Jacobs. (v)
†10.19	Amended and Restated Employment Agreement, dated April 7, 2014, among the Company, Acadia Management Company, Inc. and Brent Turner. (v)
†10.20	Amended and Restated Employment Agreement, dated April 7, 2014, among the Company, Acadia Management Company, Inc. and Ronald M. Fincher. (v)
†10.21	Amended and Restated Employment Agreement, dated April 7, 2014, among the Company, Acadia Management Company, Inc. and Christopher L. Howard. (v)
†10.22	Employment Agreement, dated April 7, 2014, by and among the Company, Acadia Management Company, Inc. and David M. Duckworth. (v)
†10.23	Employment Agreement, dated as of May 23, 2011, by and between the Company and Bruce A. Shear. (b)
†10.24	PHC, Inc.'s 2004 Non-Employee Director Stock Option Plan. (w)
†10.25	Acadia Healthcare Company, Inc. Incentive Compensation Plan, effective May 23, 2013. (x)
†10.26	First Amendment, effective May 19, 2016, to the Acadia Healthcare Company, Inc. Incentive Compensation Plan. (y)
†10.27	Form of Restricted Stock Unit Agreement. (b)
†10.28	Form of Incentive Stock Option Agreement. (b)
†10.29	Form of Non-Qualified Stock Option Agreement. (b)
†10.30	Form of Restricted Stock Agreement. (b)
†10.31	Form of Stock Appreciation Rights Agreement. (b)
†10.32	Acadia Healthcare Company, Inc. Nonqualified Deferred Compensation Plan, effective February 1, 2013. (z)
†10.33	Nonmanagement Director Compensation Program, effective January 1, 2013. (z)
10.34	Form of Indemnification Agreement (for directors and officers affiliated with Waud Capital Partners or Bain Capital). (k)
10.35	Form of Indemnification Agreement (for directors and officers not affiliated with Waud Capital Partners or Bain Capital). (k)
21*	Subsidiaries of the Company.

Exhibit No.	Exhibit Description
23*	Consent of Independent Registered Public Accounting Firm.
31.1*	Rule 13a-14(a) Certification of the Chief Executive Officer of the Company pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2*	Rule 13a-14(a) Certification of the Chief Financial Officer of the Company pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1*	Section 1350 Certification of Chairman of the Board and Chief Executive Officer of the Company pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2*	Section 1350 Certification of Chief Financial Officer of the Company pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS**	XBRL Instance Document.
101.SCH**	XBRL Taxonomy Extension Schema Document.
101.CAL**	XBRL Taxonomy Calculation Linkbase Document.
101.LAB**	XBRL Taxonomy Labels Linkbase Document.
101.PRE**	XBRL Taxonomy Presentation Linkbase Document.

† Indicates management contract or compensatory plan or arrangement.

* Filed herewith.

** The XBRL related information in Exhibit 101 to this Annual Report on Form 10-K shall not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, or otherwise subject to liability of that section and shall not be incorporated by reference into any filing or other document pursuant to the Securities Act of 1933, as amended, except as shall be expressly set forth by specific reference in such filing or document.

(a) Incorporated by reference to exhibits filed with PHC, Inc.'s Current Report on Form 8-K filed May 25, 2011 (File No. 001-33323).

(b) Incorporated by reference to exhibits filed with the Company's registration statement on Form S-4, as amended (File No. 333-175523), originally filed with the SEC on July 13, 2011.

(c) Incorporated by reference to exhibits filed with PHC, Inc.'s Current Report on Form 8-K filed March 18, 2011 (File No. 001-33323).

(d) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 5, 2012 (File No. 001-35331).

(e) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed September 4, 2012 (File No. 001-35331).

(f) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed November 27, 2012 (File No. 001-35331).

(g) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 2, 2013 (File No. 001-35331).

(h) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed April 4, 2013 (File No. 001-35331).

(i) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed June 6, 2014 (File No. 001-35331).

(j) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed October 30, 2014 (File No. 001-35331).

(k) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed November 1, 2011 (File No. 001-35331).

(l) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed March 12, 2013 (File No. 001-35331).

(m) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed July 2, 2014 (File No. 001-35331).

(n) Incorporated by reference to exhibits filed with the Company's registration statement on Form S-4 filed August 8, 2014 (File No. 333-198004).

(o) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed February 12, 2015 (File No. 001-35331).

(p) Incorporated by reference to exhibits filed with the Company's registration statement on Form S-1, as amended (File No. 333-175523), originally filed with the SEC on November 23, 2011.

(q) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended June 30, 2013 (File No. 001-35331).
(r) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended September 30, 2013 (File No. 001-35331).
(s) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed February 19, 2014 (File No. 001-35331).
(t) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed June 17, 2014 (File No. 001-35331).
(u) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed December 15, 2014 (File No. 001-35331).
(v) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed April 11, 2014 (File No. 001-35331).
(w) Incorporated by reference to exhibits filed with PHC, Inc.'s registration statement on Form S-8 filed April 5, 2005 (File No. 333-123842).
(x) Incorporated by reference to exhibits filed with the Company's registration statement on Form S-8 filed July 30, 2013 (File No. 333-190232).
(y) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended June 30, 2016 (File No. 001-35331).
(z) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended March 31, 2013 (File No. 001-35331).
(aa) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended March 31, 2015 (File No. 001-35331).
(bb) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed September 21, 2015 (File No. 001-35331).
(cc) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 4, 2016 (File No. 001-35331).
(dd) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 8, 2016 (File No. 001-35331).
(ee) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 27, 2016 (File No. 001-35331).
(ff) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed February 16, 2016 (File No. 001-35331).
(gg) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed May 26, 2016 (File No. 001-35331).
(hh) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed September 21, 2016 (File No. 001-35331).
(ii) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed November 30, 2016 (File No. 001-35331).
(jj) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed May 10, 2017 (File No. 001-35331).
(kk) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed May 25, 2017 (File No. 001-35331).

Item 16. Form 10-K Summary.

None.

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MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f). Under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting as of December 31, 2017 based on the framework in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (COSO). Based on that evaluation, our management concluded that our internal control over financial reporting was effective as of December 31, 2017.

Our accompanying consolidated financial statements have been audited by the independent registered public accounting firm of Ernst & Young LLP. Reports of the independent registered public accounting firm, including the independent registered public accounting firm's report on our internal control over financial reporting, are included in this report.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
Acadia Healthcare Company, Inc.

Opinion on Internal Control over Financial Reporting

We have audited Acadia Healthcare Company, Inc.'s internal control over financial reporting as of December 31, 2017, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, Acadia Healthcare Company, Inc. (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2017, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets as of December 31, 2017 and 2016, the related consolidated statements of income, comprehensive income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2017, and the related notes and our report dated February 27, 2018 expressed an unqualified opinion thereon.

Basis for Opinion

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

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

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

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 27, 2018

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
Acadia Healthcare Company, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Acadia Company, Inc. (the Company) as of December 31, 2017 and 2016, the related consolidated statements of income, comprehensive income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2017, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2017 and 2016, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2017, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2017, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated February 27, 2018 expressed an unqualified opinion thereon.

Basis for Opinion

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

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

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2006.
Nashville, Tennessee
February 27, 2018

Acadia Healthcare Company, Inc.
Consolidated Balance Sheets

	December 31, 2017	December 31, 2016
	(In thousands, except share and per share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 67,290	$ 57,063
Accounts receivable, net of allowance for doubtful accounts of $39,803 and $38,916, respectively	296,925	263,327
Other current assets	107,335	107,537
Total current assets	471,550	427,927
Property and equipment:		
Land	450,342	411,331
Building and improvements	2,370,918	2,031,819
Equipment	400,596	318,020
Construction in progress	173,693	157,114
Less accumulated depreciation	(347,419)	(214,589)
Property and equipment, net	3,048,130	2,703,695
Goodwill	2,751,174	2,681,188
Intangible assets, net	87,348	83,310
Deferred tax assets – noncurrent	3,731	3,780
Derivative instruments	12,997	73,509
Other assets	49,572	51,317
Total assets	$ 6,424,502	$ 6,024,726
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 34,830	$ 34,805
Accounts payable	102,299	80,034
Accrued salaries and benefits	99,047	105,068
Other accrued liabilities	141,213	122,958
Total current liabilities	377,389	342,865
Long-term debt	3,205,058	3,253,004
Deferred tax liabilities – noncurrent	80,333	78,520
Other liabilities	166,434	164,859
Total liabilities	3,829,214	3,839,248
Redeemable noncontrolling interests	22,417	17,754
Equity:		
Preferred stock, $0.01 par value; 10,000,000 shares authorized; no shares issued	—	—
Common stock, $0.01 par value; 180,000,000 shares authorized; 87,060,114 and 86,688,199 issued and outstanding as of December 31, 2017 and 2016, respectively	871	867
Additional paid-in capital	2,517,545	2,496,288
Accumulated other comprehensive loss	(374,118)	(549,570)
Retained earnings	428,573	220,139
Total equity	2,572,871	2,167,724
Total liabilities and equity	$ 6,424,502	$ 6,024,726

See accompanying notes.

Acadia Healthcare Company, Inc.
Consolidated Statements of Income

	Year Ended December 31,		
	2017	2016	2015
	(In thousands, except per share amounts)		
Revenue before provision for doubtful accounts	$2,877,234	$2,852,823	$1,829,619
Provision for doubtful accounts	(40,918)	(41,909)	(35,127)
Revenue	2,836,316	2,810,914	1,794,492
Salaries, wages and benefits (including equity-based compensation expense of $23,467, $28,345 and $20,472, respectively)	1,536,160	1,541,854	973,732
Professional fees	196,223	185,486	116,463
Supplies	114,439	117,425	80,663
Rents and leases	76,775	73,348	32,528
Other operating expenses	331,827	312,556	206,746
Depreciation and amortization	143,010	135,103	63,550
Interest expense, net	176,007	181,325	106,742
Debt extinguishment costs	810	4,253	10,818
Loss on divestiture	—	178,809	—
(Gain) loss on foreign currency derivatives	—	(523)	1,926
Transaction-related expenses	24,267	48,323	36,571
Total expenses	2,599,518	2,777,959	1,629,739
Income from continuing operations before income taxes	236,798	32,955	164,753
Provision for income taxes	37,209	28,779	53,388
Income from continuing operations	199,589	4,176	111,365
Income from discontinued operations, net of income taxes	—	—	111
Net income	199,589	4,176	111,476
Net loss attributable to noncontrolling interests	246	1,967	1,078
Net income attributable to Acadia Healthcare Company, Inc.	$ 199,835	$ 6,143	$ 112,554
Basic earnings attributable to Acadia Healthcare Company, Inc. stockholders:			
Income from continuing operations	$ 2.30	$ 0.07	$ 1.65
Income from discontinued operations	—	—	—
Net income	$ 2.30	$ 0.07	$ 1.65
Diluted earnings attributable to Acadia Healthcare Company, Inc. stockholders:			
Income from continuing operations	$ 2.30	$ 0.07	$ 1.64
Income from discontinued operations	—	—	—
Net income	$ 2.30	$ 0.07	$ 1.64
Weighted-average shares outstanding:			
Basic	86,948	85,701	68,085
Diluted	87,060	85,972	68,391

See accompanying notes.

Acadia Healthcare Company, Inc.
Consolidated Statements of Comprehensive Income

	Year Ended December 31,		
	2017	2016	2015
		(In thousands)	
Net income	$199,589	$ 4,176	$111,476
Other comprehensive loss:			
Foreign currency translation gain (loss)	207,341	(477,772)	(40,103)
(Loss) gain on derivative instruments, net of tax of $(22.9) million, $29.1 million and $0, respectively	(33,431)	40,598	—
Pension liability adjustment, net of tax of $0.4 million, $(1.3) million and $(6.9) million, respectively	1,542	(7,749)	3,826
Other comprehensive gain (loss)	175,452	(444,923)	(36,277)
Comprehensive income (loss)	375,041	(440,747)	75,199
Comprehensive loss attributable to noncontrolling interests	246	1,967	1,078
Comprehensive income (loss) attributable to Acadia Healthcare Company, Inc.	$375,287	$(438,780)	$ 76,277

See accompanying notes.

Acadia Healthcare Company, Inc.
Consolidated Statements of Equity
(In thousands)

	Common Stock		Additional Paid-in Capital	Other Comprehensive Loss	Retained Earnings	Total
	Shares	Amount				
Balance at January 1, 2015	59,212	$ 592	$ 847,301	$ (68,370)	$101,442	$ 880,965
Common stock issued under stock incentive plans	384	4	1,811	—	—	1,815
Common stock withheld for minimum statutory taxes	—	—	(9,577)	—	—	(9,577)
Equity-based compensation expense	—	—	20,472	—	—	20,472
Excess tax benefit from equity awards	—	—	309	—	—	309
Issuance of common stock, net	11,150	111	711,406	—	—	711,517
Other comprehensive loss	—	—	—	(36,277)	—	(36,277)
Other	—	—	1,250	—	—	1,250
Net income attributable to Acadia Healthcare Company, Inc. stockholders	—	—	—	—	112,554	112,554
Balance at December 31, 2015	70,746	707	1,572,972	(104,647)	213,996	1,683,028
Common stock issued under stock incentive plans	408	5	1,379	—	—	1,384
Common stock withheld for minimum statutory taxes	—	—	(10,230)	—	—	(10,230)
Equity-based compensation expense	—	—	28,345	—	—	28,345
Issuance of common stock, net	15,534	155	901,824	—	—	901,979
Other comprehensive loss	—	—	—	(444,923)	—	(444,923)
Other	—	—	1,998	—	—	1,998
Net income attributable to Acadia Healthcare Company, Inc. stockholders	—	—	—	—	6,143	6,143
Balance at December 31, 2016	86,688	867	2,496,288	(549,570)	220,139	2,167,724
Common stock issued under stock incentive plans	372	4	2,065	—	—	2,069
Common stock withheld for minimum statutory taxes	—	—	(5,524)	—	—	(5,524)
Equity-based compensation expense	—	—	23,467	—	—	23,467
Cumulative effect of change in accounting principle	—	—	—	—	8,599	8,599
Other comprehensive gain	—	—	—	175,452	—	175,452
Other	—	—	1,249	—	—	1,249
Net income attributable to Acadia Healthcare Company, Inc. stockholders	—	—	—	—	199,835	199,835
Balance at December 31, 2017	87,060	$ 871	$2,517,545	$ (374,118)	$428,573	$2,572,871

See accompanying notes.

Acadia Healthcare Company, Inc.
Consolidated Statements of Cash Flows

	Year Ended December 31,		
	2017	2016	2015
		(In thousands)	
Operating activities:			
Net income	$ 199,589	$ 4,176	$ 111,476
Adjustments to reconcile net income to net cash provided by continuing operating activities:			
Depreciation and amortization	143,010	135,103	63,550
Amortization of debt issuance costs	9,855	10,324	6,709
Equity-based compensation expense	23,467	28,345	20,472
Deferred income tax expense	31,372	28,647	43,613
(Income) loss from discontinued operations, net of taxes	—	—	(111)
Debt extinguishment costs	810	4,253	10,818
Loss on divestiture	—	178,809	—
(Gain) loss on foreign currency derivatives	—	(523)	1,926
Other	11,412	4,715	1,615
Change in operating assets and liabilities, net of effect of acquisitions:			
Accounts receivable, net	(28,570)	(15,718)	(24,954)
Other current assets	20,808	(20,648)	(2,717)
Other assets	(3,176)	(4,354)	(8,021)
Accounts payable and other accrued liabilities	(10,113)	22,693	6,868
Accrued salaries and benefits	(8,988)	(8,572)	1,658
Other liabilities	11,794	4,484	9,236
Net cash provided by continuing operating activities	401,270	371,734	242,138
Net cash used in discontinued operating activities	(1,693)	(10,256)	(1,735)
Net cash provided by operating activities	399,577	361,478	240,403
Investing activities:			
Cash paid for acquisitions, net of cash acquired	(18,191)	(683,455)	(574,777)
Cash paid for capital expenditures	(274,177)	(307,472)	(276,047)
Cash paid for real estate acquisitions	(41,057)	(40,757)	(26,622)
Settlement of foreign currency derivatives	—	523	(1,926)
Cash received on divestitures	—	373,266	—
Other	(3,101)	(2,470)	(5,099)
Net cash used in investing activities	(336,526)	(660,365)	(884,471)
Financing activities:			
Borrowings on long-term debt	—	1,480,000	1,150,000
Borrowings on revolving credit facility	—	179,000	468,000
Principal payments on revolving credit facility	—	(337,000)	(310,000)
Principal payments on long-term debt	(34,805)	(49,941)	(31,965)
Repayment of assumed debt	—	(1,348,389)	(904,467)
Repayment of long-term debt	(22,500)	(200,594)	(97,500)
Payment of debt issuance costs	—	(36,649)	(26,421)
Payment of premium on senior notes	—	—	(7,480)
Issuances of common stock, net	—	685,097	331,308
Common stock withheld for minimum statutory taxes, net	(3,455)	(8,846)	(7,762)
Excess tax benefit from equity awards	—	—	309
Other	686	(3,837)	(420)
Net cash (used in) provided by financing activities	(60,074)	358,841	563,602
Effect of exchange rate changes on cash	7,250	(14,106)	(2,359)
Net increase (decrease) in cash and cash equivalents	10,227	45,848	(82,825)
Cash and cash equivalents at beginning of the period	57,063	11,215	94,040
Cash and cash equivalents at end of the period	$ 67,290	$ 57,063	$ 11,215

(continued on next page)

Acadia Healthcare Company, Inc.
Consolidated Statements of Cash Flows (continued)

	Year Ended December 31,		
	2017	2016	2015
		(In thousands)	
Supplemental Cash Flow Information:			
Cash paid for interest	$159,098	$ 161,146	$ 87,034
Cash paid for income taxes	$ 10,291	$ 15,483	$ 6,911
Effect of acquisitions:			
Assets acquired, excluding cash	$ 19,649	$ 2,516,880	$ 1,988,634
Liabilities assumed	(1,458)	(1,616,543)	(1,024,515)
Issuance of common stock in connection with acquisition	—	(216,882)	(380,210)
Redeemable noncontrolling interest resulting from acquisitions	—	—	(9,132)
Cash paid for acquisitions, net of cash acquired	$ 18,191	$ 683,455	$ 574,777

See accompanying notes.

Acadia Healthcare Company, Inc.
Notes to Consolidated Financial Statements
December 31, 2017

1. Description of Business and Basis of Presentation

Description of Business

Acadia Healthcare Company, Inc. (the "Company") develops and operates inpatient psychiatric facilities, residential treatment centers, group homes, substance abuse facilities and facilities providing outpatient behavioral healthcare services to serve the behavioral health and recovery needs of communities throughout the United States ("U.S."), the United Kingdom ("U.K.") and Puerto Rico. At December 31, 2017, the Company operated 582 behavioral healthcare facilities with approximately 17,800 beds in 39 states, the U.K. and Puerto Rico.

Basis of Presentation

The business of the Company is conducted through limited liability companies, partnerships and C-corporations. The Company's consolidated financial statements include the accounts of the Company and all subsidiaries controlled by the Company through its' direct or indirect ownership of majority interests and exclusive rights granted to the Company as the controlling member of an entity. All intercompany accounts and transactions have been eliminated in consolidation.

The accompanying consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("GAAP"). The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates. The majority of the Company's expenses are "cost of revenue" items. Costs that could be classified as general and administrative expenses include the Company's corporate office costs, which were $76.4 million, $86.8 million and $68.3 million for the years ended December 31, 2017, 2016 and 2015, respectively.

Certain reclassifications have been made to prior years to conform to the current year presentation.

2. Summary of Significant Accounting Policies

Cash and Cash Equivalents

The Company considers all highly liquid investments with original maturities of three months or less to be cash equivalents. At times, cash and cash equivalent balances may exceed federally insured limits. Management believes that the Company mitigates any risks by depositing cash and investing in cash equivalents with major financial institutions.

Revenue and Accounts Receivable

Revenue is primarily derived from services rendered to patients for inpatient psychiatric and substance abuse care, outpatient psychiatric care and adolescent residential treatment. The Company receives payments from the following sources for services rendered in our facilities: (i) state governments under their respective Medicaid and other programs; (ii) commercial insurers; (iii) the federal government under the Medicare program administered by CMS; (iv) public funded sources in the U.K. (including the NHS, Clinical Commissioning Groups ("CCGs") and local authorities in England, Scotland and Wales); and (v) individual patients and clients. Revenue is recorded in the period in which services are provided at established billing rates less contractual adjustments based on amounts reimbursable by Medicare or Medicaid under provisions of cost or prospective reimbursement formulas or amounts due from other third-party payors at contractually determined rates.

The following table presents the percentage of revenue before provision for doubtful accounts generated by each payor type:

	Year Ended December 31,		
	2017	2016	2015
Commercial	19.8%	18.7%	23.1%
Medicare	9.8	9.4	11.7
Medicaid	27.7	25.4	33.3
U.K. public funded sources	32.6	35.8	19.5
Self-Pay	8.7	9.4	9.6
Other	1.4	1.3	2.8
Revenue before provision for doubtful accounts	100%	100%	100%

On a combined basis, revenue related to the Medicare and Medicaid programs were 38%, 35% and 45% of all revenue before provision for doubtful accounts for the years ended December 31, 2017, 2016 and 2015, respectively. The Company's concentration of credit risk from other payors is reduced by the large number of payors and their geographic dispersion. The Company generated approximately 36%, 38% and 20% of its revenue for the years ended December 31, 2017, 2016 and 2015, respectively, from facilities located in the U.K.

Allowance for Contractual Discounts

The Company derives a significant portion of its revenue from Medicare, Medicaid and other payors that receive discounts from established billing rates. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex, subject to interpretation and adjustment, and may include multiple reimbursement mechanisms for different types of services provided in the Company's inpatient facilities and cost settlement provisions. Management estimates the allowance for contractual discounts on a payor-specific basis given its interpretation of the applicable regulations or contract terms. The services authorized and provided and related reimbursement are often subject to interpretation that could result in payments that differ from the Company's estimates. Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management.

Settlements under cost reimbursement agreements with third-party payors are estimated and recorded in the period in which the related services are rendered and are adjusted in future periods as final settlements are determined. Final determination of amounts earned under the Medicare and Medicaid programs often occurs in subsequent years because of audits by such programs, rights of appeal and the application of numerous technical provisions. In the opinion of management, adequate provision has been made for any adjustments and final settlements. However, there can be no assurance that any such adjustments and final settlements will not have a material effect on the Company's financial condition or results of operations. The Company's cost report receivables were $9.0 million and $7.4 million at December 31, 2017 and 2016, respectively, and were included in other current assets in the consolidated balance sheets. Management believes that these receivables are properly stated and are not likely to be settled for a significantly different amount. The net adjustments to estimated cost report settlements resulted in increases to revenue of $0.2 million, $0.7 million and $1.9 million for the years ended December 31, 2017, 2016 and 2015, respectively.

Management believes that we are in substantial compliance with all applicable laws and regulations and is not aware of any material pending or threatened investigations involving allegations of wrongdoing. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs.

Allowance for Doubtful Accounts

The Company's ability to collect outstanding patient receivables from third-party payors is critical to its operating performance and cash flows. The primary collection risk with regard to patient receivables relates to uninsured patient accounts or patient accounts for which primary insurance has paid, but the portion owed by the patient remains outstanding. The Company estimates uncollectible accounts and establishes an allowance for doubtful accounts in order to adjust accounts receivable to estimated net realizable value. In evaluating the collectability of accounts receivable, the Company considers a number of factors, including the age of the accounts, historical collection experience, current economic conditions, and other relevant factors. Accounts receivable that are determined to be uncollectible based on the Company's policies are written off to the allowance for doubtful accounts. Significant changes in payor mix or business office operations could have a significant impact on the Company's results of operations and cash flows.

A summary of activity in the Company's allowance for doubtful accounts is as follows (in thousands):

	Balance at Beginning of Period	Additions Charged to Costs and Expenses	Accounts Written Off, Net of Recoveries	Balance at End of Period
Year ended December 31, 2015	$ 22,449	$ 35,127	$ (28,244)	$ 29,332
Year ended December 31, 2016	29,332	41,909	(32,325)	38,916
Year ended December 31, 2017	38,916	40,918	(40,031)	39,803

Charity Care

The Company provides care without charge to patients who are financially unable to pay for the healthcare services they receive based on Company policies and federal and state poverty thresholds. The costs of providing charity care services were $6.6 million, $7.1 million and $4.6 million for the years ended December 31, 2017, 2016 and 2015, respectively. The estimated cost of charity care services was determined using a ratio of cost to gross charges determined from our most recently filed Medicare cost reports and applying that ratio to the gross charges associated with providing charity care for the period.

Insurance

The Company is subject to medical malpractice and other lawsuits due to the nature of the services the Company provides. A portion of the Company's professional liability risk is insured through a wholly-owned insurance subsidiary. The Company's wholly-owned insurance subsidiary insures the Company for professional liability losses up to $78.0 million in the aggregate. The insurance subsidiary has obtained reinsurance with unrelated commercial insurers for professional liability risks of $75.0 million in excess of a retention level of $3.0 million. The reserve for professional and general liability risks was estimated based on historical claims, demographic factors, industry trends, severity factors, and other actuarial assumptions. The estimated accrual for professional and general liabilities could be significantly affected should current and future occurrences differ from historical claim trends and expectations. While claims are monitored closely when estimating professional and general liability accruals, the complexity of the claims and wide range of potential outcomes often hampers timely adjustments to the assumptions used in these estimates. The professional and general liability reserve was $55.0 million as of December 31, 2017, of which $22.8 million was included in other accrued liabilities and $32.2 million was included in other long-term liabilities. The professional and general liability reserve was $52.3 million as of December 31, 2016, of which $11.7 million was included in other accrued liabilities and $40.6 million was included in other long-term liabilities. The Company estimates receivables for the portion of professional and general liability reserves that are recoverable under the Company's insurance policies. Such receivable was $22.7 million as of December 31, 2017, of which $17.6 million was included in other current assets and $5.1 million was included in other assets, and such receivable was $25.9 million as of December 31, 2016, of which $6.5 million was included in other current assets and $19.4 million was included in other assets.

The Company's statutory workers' compensation program is fully insured with a $0.5 million deductible per accident. The workers' compensation liability was $18.5 million as of December 31, 2017, of which $10.0 million was included in accrued salaries and benefits and $8.5 million was included in other long-term liabilities, and such liability was $16.6 million as of December 31, 2016, of which $10.0 million was included in accrued salaries and benefits and $6.6 million was included in other long-term liabilities. The reserve for workers compensation claims was based upon independent actuarial estimates of future amounts that will be paid to claimants. Management believes that adequate provisions have been made for workers' compensation and professional and general liability risk exposures.

Property and Equipment and Other Long-Lived Assets

Property and equipment are recorded at cost. Depreciation is calculated on the straight-line basis over the estimated useful lives of the assets, which typically range from 10 to 50 years for buildings and improvements, three to seven years for equipment and the shorter of the lease term or estimated useful lives for leasehold improvements. When assets are sold or retired, the corresponding cost and accumulated depreciation are removed from the related accounts and any gain or loss is recorded in the period of sale or retirement. Repair and maintenance costs are expensed as incurred. Depreciation expense was $143.0 million, $134.8 million and $63.0 million for the years ended December 31, 2017, 2016 and 2015, respectively.

The carrying values of long-lived assets are reviewed for possible impairment whenever events, circumstances or operating results indicate that the carrying amount of an asset may not be recoverable. If this review indicates that the asset will not be recoverable, as determined based upon the undiscounted cash flows of the operating asset over the remaining useful lives, the carrying value of the asset will be reduced to its estimated fair value. Fair value estimates are based on independent appraisals, market values of comparable assets or internal evaluations of future net cash flows.

Goodwill and Indefinite-Lived Intangible Assets

The Company's goodwill and other indefinite-lived intangible assets, which consist of licenses and accreditations and certificates of need intangible assets that are not amortized, are evaluated for impairment annually during the fourth quarter or more frequently if events indicate that the carrying value of a reporting unit may not be recoverable. The Company has two operating segments, U.S. Facilities and U.K. Facilities, for segment reporting purposes, each of which represents a reporting unit for purposes of the Company's goodwill impairment test. Potential impairment is noted for a reporting unit if its carrying value exceeds the fair value of the reporting unit. For a reporting unit with potential impairment of goodwill, the Company determines the implied fair value of goodwill. If the carrying value of goodwill exceeds its implied fair value, an impairment loss is recorded. The Company's annual impairment tests of goodwill and other indefinite-lived intangibles in 2017, 2016 and 2015 resulted in no impairment charges.

Other Current Assets

Other current assets consisted of the following (in thousands):

	As of December 31,	
	2017	2016
Other receivables	$ 30,455	$ 44,975
Prepaid expenses	27,320	27,455
Insurance receivable – current portion	17,588	6,472
Income taxes receivable	15,056	11,714
Workers' compensation deposits – current portion	10,000	10,000
Inventory	4,787	4,633
Other	2,129	2,288
Other current assets	$107,335	$107,537

Other Accrued Liabilities

Other accrued liabilities consisted of the following (in thousands):

	As of December 31,	
	2017	2016
Accrued expenses	$ 37,268	$ 37,323
Accrued interest	36,370	33,616
Unearned income	31,342	28,805
Insurance liability – current portion	22,788	11,672
Accrued property taxes	3,945	2,732
Income taxes payable	1,012	527
Other	8,488	8,283
Other accrued liabilities	$141,213	$122,958

Stock Compensation

The Company measures and recognizes the cost of employee services received in exchange for awards of equity instruments based on the grant-date fair value in accordance with Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") 718, "*Compensation – Stock Compensation*." The Company uses the Black-Scholes valuation model to determine grant-date fair value for equity awards and uses straight-line amortization of share-based compensation expense over the requisite service period of the respective awards.

Earnings Per Share

Basic and diluted earnings per share are calculated in accordance with FASB ASC 260, "*Earnings Per Share*," based on the weighted-average number of shares outstanding in each period and dilutive stock options, non-vested shares and warrants, to the extent such securities have a dilutive effect on earnings per share.

Income Taxes

The Company uses the asset and liability method of accounting for income taxes. Under this method, deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes and net operating loss and tax credit carryforwards. The amount of deferred taxes on these temporary differences is determined using the tax rates that are expected to apply in the period when the asset is realized or the liability is settled, as applicable, based on tax rates and laws in the respective tax jurisdiction enacted as of the balance sheet date.

The Company reviews its deferred tax assets for recoverability and establishes a valuation allowance based on historical taxable income, projected future taxable income, applicable tax strategies, and the expected timing of the reversals of existing temporary differences. A valuation allowance is provided when it is more likely than not that some portion or all of the deferred tax assets will not be realized.

The Company records a liability for unrecognized tax benefits resulting from uncertain tax positions taken or expected to be taken in a tax return. The Company recognizes interest and penalties, if any, related to unrecognized tax benefits in income tax expense.

The Tax Act was enacted on December 22, 2017. The Tax Act reduces the U.S. federal corporate tax rate from 35% to 21%, requires companies to pay a one-time transition tax on earnings of certain foreign subsidiaries that were previously tax deferred and creates new taxes on certain foreign sourced earnings. See additional disclosure described in Note 9 – Income Taxes. ASC 740 "Income Taxes" ("ASC 740") requires the Company to recognize the effect of the tax law changes in the period of enactment. However, the Securities and Exchange Commission (the "SEC") staff issued Staff Accounting Bulletin 118 ("SAB 118") which will allow the Company to record provisional amounts during a measurement period similarly to the measurement period used when accounting for business combinations. The Company will continue to assess the impact of the recently enacted tax law on its business and consolidated financial statements.

Recent Accounting Pronouncements

In August 2017, the FASB issued Accounting Standards Update ("ASU") 2017-12, *"Derivatives and Hedging (Topic 815): Targeted Improvements to Accounting for Hedging Activities"* ("ASU 2017-12"). ASU 2017-12 amends the hedge accounting model to enable entities to better portray the economics of their risk management activities in the financial statements and simplifies the application of hedge accounting in certain situations. ASU 2017-12 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2018. Early adoption is permitted. Management is evaluating the impact of ASU 2017-12 on the Company's consolidated financial statements.

In January 2017, the FASB issued ASU 2017-04, *"Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment"* ("ASU 2017-04"). ASU 2017-04 simplifies the measurement of goodwill by eliminating the requirement to calculate the implied fair value of goodwill (step 2 of the current impairment test) to measure the goodwill impairment charge. Instead, entities will record impairment charges based on the excess of a reporting unit's carrying amount over its fair value. ASU 2017-04 is effective for fiscal years beginning after December 15, 2019. Early adoption is permitted. Management is evaluating the impact of ASU 2017-04 on the Company's consolidated financial statements.

In March 2016, the FASB issued ASU 2016-09, *"Improvements to Employee Share-Based Payment Accounting"* ("ASU 2016-09"). ASU 2016-09 includes multiple provisions intended to simplify various aspects of the accounting for share-based payments. ASU 2016-09 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2016. The Company adopted ASU 2016-09 as of January 1, 2017 as described in Note 9 – Income Taxes.

In March 2016, the FASB issued ASU 2016-02, *"Leases"* ("ASU 2016-02"). ASU 2016-02's core principle is to increase transparency and comparability among organizations by recognizing lease assets and liabilities on the balance sheet and disclosing key information. ASU 2016-02 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2018. Additionally, ASU 2016-02 would permit both public and nonpublic organizations to adopt the new standard early. Management believes the primary effect of adopting the new standard will be to record right-of-use assets and obligations for current operating leases. Management is evaluating the impact ASU 2016-02 will have on the Company's consolidated financial statements, internal controls, policies and procedures.

In May 2014, the FASB and the International Accounting Standards Board issued ASU 2014-09, *"Revenue from Contracts with Customers (Topic 606)"* ("ASU 2014-09"). ASU 2014-09's core principle is that a company will recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. ASU 2014-09 requires companies to exercise more judgment and recognize revenue in accordance with the standard's core principle by applying the following five steps:

Step 1: Identify the contract with a customer.
Step 2: Identify the performance obligations in the contract.
Step 3: Determine the transaction price.
Step 4: Allocate the transaction price to the performance obligations in the contract.
Step 5: Recognize revenue when (or as) the entity satisfies a performance obligation.

ASU 2014-09 also includes a cohesive set of quantitative and qualitative disclosure requirements about the nature, amount, timing, and uncertainty of revenue and cash flows arising from the entity's contracts with customers.

ASU 2014-09 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2017. Additionally, ASU 2014-09 would permit both public and nonpublic organizations to adopt the new revenue standard early, but not before the original public organization effective date (that is, annual periods beginning after December 15, 2016). ASU 2014-09

requires retrospective application using either a full retrospective adoption or a modified retrospective adoption approach. Full retrospective adoption requires entities to apply the standard as if it had been in effect since the inception of all its contracts with customers presented in the financial statements. Modified retrospective adoption requires entities to apply the standard retrospectively to the most current period presented in the financial statements, requiring the cumulative effect of the retrospective application as an adjustment to the opening balance of retained earnings at the date of initial application.

The Company will adopt ASU 2014-09 using the modified retrospective method effective January 1, 2018 and will use a portfolio approach to group contracts with similar characteristics and analyze historical cash collections trends. The Company anticipates that, as a result of certain changes required by ASU 2014-09, the majority of its provision for doubtful accounts will be recorded as a direct reduction to revenue instead of being presented as a separate line item. Management does not anticipate ASU 2014-09 will have a significant impact on the Company's consolidated financial statements.

3. Earnings Per Share

The following table sets forth the computation of basic and diluted earnings per share for the years ended December 31, 2017, 2016 and 2015 (in thousands except per share amounts):

	Year Ended December 31,		
	2017	2016	2015
Numerator:			
Basic and diluted earnings per share attributable to Acadia Healthcare Company, Inc.:			
Income from continuing operations	$199,835	$ 6,143	$112,443
Income from discontinued operations	—	—	111
Net income attributable to Acadia Healthcare Company, Inc.	$199,835	$ 6,143	$112,554
Denominator:			
Weighted average shares outstanding for basic earnings per share	86,948	85,701	68,085
Effects of dilutive instruments	112	271	306
Shares used in computing diluted earnings per common share	87,060	85,972	68,391
Basic earnings per share attributable to Acadia Healthcare Company, Inc.:			
Income from continuing operations	$ 2.30	$ 0.07	$ 1.65
Income from discontinued operations	—	—	—
Net income attributable to Acadia Healthcare Company, Inc.:	$ 2.30	$ 0.07	$ 1.65
Diluted earnings per share attributable to Acadia Healthcare Company, Inc.:			
Income from continuing operations	$ 2.30	$ 0.07	$ 1.64
Income from discontinued operations	—	—	—
Net income attributable to Acadia Healthcare Company, Inc.:	$ 2.30	$ 0.07	$ 1.64

Approximately 1.4 million, 1.1 million and 0.8 million shares of common stock issuable upon exercise of outstanding stock options were excluded from the calculation of diluted earnings per share for the years ended December 31, 2017, 2016 and 2015, respectively, because their effect would have been anti-dilutive.

4. Acquisitions

2017 Acquisition

On November 13, 2017, we completed the acquisition of Aspire Scotland, an education facility with 36 beds located in Scotland, for cash consideration of approximately $21.3 million.

2016 U.S. Acquisitions

On June 1, 2016, the Company completed the acquisition of Pocono Mountain Recovery Center ("Pocono Mountain"), an inpatient psychiatric facility with 108 beds located in Henryville, Pennsylvania, for cash consideration of approximately $25.4 million.

On May 1, 2016, the Company completed the acquisition of TrustPoint Hospital ("TrustPoint"), an inpatient psychiatric facility with 100 beds located in Murfreesboro, Tennessee, for cash consideration of approximately $62.7 million.

On April 1, 2016, the Company completed the acquisition of Serenity Knolls ("Serenity Knolls"), an inpatient psychiatric facility with 30 beds located in Forest Knolls, California, for cash consideration of approximately $10.0 million.

Priory

On February 16, 2016, the Company completed the acquisition of Priory Group No. 1 Limited ("Priory") for a total purchase price of approximately $2.2 billion, including cash consideration of approximately $1.9 billion and the issuance of 4,033,561 shares of its common stock to shareholders of Priory. Priory was the leading independent provider of behavioral healthcare services in the U.K. operating 324 facilities with approximately 7,100 beds at February 16, 2016.

The Competition and Markets Authority (the "CMA") in the U.K. reviewed the Company's acquisition of Priory. On July 14, 2016, the CMA announced that the Company's acquisition of Priory was referred for a phase 2 investigation unless the Company offered acceptable undertakings to address the CMA's competition concerns relating to the provision of behavioral healthcare services in certain markets. On July 28, 2016, the CMA announced that the Company had offered undertakings to address the CMA's concerns and that, in lieu of a phase 2 investigation, the CMA would consider the Company's undertakings.

On October 18, 2016, the Company signed a definitive agreement with BC Partners ("BC Partners") for the sale of 21 existing U.K. behavioral health facilities and one de novo behavioral health facility with an aggregate of approximately 1,000 beds (collectively, the "U.K. Disposal Group"). On November 10, 2016, the CMA accepted the Company's undertakings to sell the U.K. Disposal Group to BC Partners and confirmed that the divestiture satisfied the CMA's concerns about the impact of the Company's acquisition of Priory on competition for the provision of behavioral healthcare services in certain markets in the U.K. As a result of the CMA's acceptance of the undertakings, the Company's acquisition of Priory was not referred for a phase 2 investigation. On November 30, 2016, the Company completed the sale of the U.K. Disposal Group to BC Partners for £320 million cash (the "U.K. Divestiture").

In conjunction with the sale, the Company recorded a loss on divestiture of $175.0 million in the consolidated statements of income for the year ended December 31, 2016. The loss on divestiture consisted of an allocation of goodwill to the U.K. Disposal Group of $106.9 million, loss on the sale of properties of $42.0 million and estimated transaction-related expenses of $26.1 million. The allocation of goodwill was based on the fair value of the U.K. Disposal Group relative to the total fair value of the Company's U.K. Facilities segment.

The consolidated statements of income for the year ended December 31, 2016 include revenue of $154.7 million and income from continuing operations before income taxes of $81.2 million related to the U.K. Disposal Group excluding the loss on divestiture. The consolidated statements of income for the year ended December 31, 2015 include revenue of $58.5 million and income from continuing operations before income taxes of $17.0 million related to the U.K. Disposal Group excluding the loss on divestiture.

Summary of Acquisitions

The Company selectively seeks opportunities to expand and diversify its base of operations by acquiring additional facilities. Approximately $31.4 million of the goodwill associated with domestic acquisitions completed in 2016 is deductible for federal income tax purposes. The fair values assigned to certain assets and liabilities assumed, at the date of acquisition dates, during the year ended December 31, 2016 in connection with Priory, Serenity Knolls, Trustpoint and Pocono Mountain acquisitions (collectively the "2016 Acquisitions") were as follows (in thousands):

	Priory	Other	Total
Cash	$ 10,253	$ 2,488	$ 12,741
Accounts receivable	57,832	4,264	62,096
Prepaid expenses and other current assets	7,921	103	8,024
Property and equipment	1,598,156	35,400	1,633,556
Goodwill	679,265	96,052	775,317
Intangible assets	23,200	338	23,538
Other assets	8,862	47	8,909
Total assets acquired	2,385,489	138,692	2,524,181
Accounts payable	24,203	749	24,952
Accrued salaries and benefits	39,588	918	40,506
Other accrued expenses	48,305	391	48,696
Deferred tax liabilities - noncurrent	56,462	269	56,731
Debt	1,348,389	—	1,348,389
Other liabilities	61,311	30,243	91,554
Total liabilities assumed	1,578,258	32,570	1,610,828
Net assets acquired	$ 807,231	$106,122	$ 913,353

Other

The qualitative factors comprising the goodwill acquired in the 2016 Acquisitions include efficiencies derived through synergies expected by the elimination of certain redundant corporate functions and expenses, the ability to leverage call center referrals to a broader provider base, coordination of services provided across the combined network of facilities, achievement of operating efficiencies by benchmarking performance, and applying best practices throughout the combined companies.

Transaction-related expenses comprised the following costs for the years ended December 31, 2017, 2016 and 2015 (in thousands):

	Year Ended December 31,		
	2017	2016	2015
Severance and contract termination costs	$14,709	$12,415	$ 8,466
Legal, accounting and other fees	9,558	21,058	17,768
Advisory and financing commitment fees	—	14,850	10,337
	$24,267	$48,323	$36,571

5. Other Intangible Assets

Other identifiable intangible assets and related accumulated amortization consisted of the following as of December 31, 2017 and 2016 (in thousands):

	Gross Carrying Amount		Accumulated Amortization	
	December 31, 2017	December 31, 2016	December 31, 2017	December 31, 2016
Intangible assets subject to amortization:				
Contract intangible assets	$ 2,100	$ 2,100	$ (2,100)	$ (2,100)
Non-compete agreements	1,147	1,147	(1,147)	(1,147)
	3,247	3,247	(3,247)	(3,247)
Intangible assets not subject to amortization:				
Licenses and accreditations	12,266	12,228	—	—
Trade names	60,586	57,538	—	—
Certificates of need	14,496	13,544	—	—
	87,348	83,310	—	—
Total	$ 90,595	$ 86,557	$ (3,247)	$ (3,247)

Amortization expense related to definite-lived intangible assets was $0.4 million and $0.5 million for the years ended December 31, 2016 and 2015, respectively. All the Company's defined-lived intangible assets are fully amortized. The Company's licenses and accreditations, trade names and certificate of need intangible assets have indefinite lives and are, therefore, not subject to amortization.

6. Long-Term Debt

Long-term debt consisted of the following (in thousands):

	December 31, 2017	December 31, 2016
Amended and Restated Senior Credit Facility:		
Senior Secured Term A Loans	$ 380,000	$ 400,000
Senior Secured Term B Loans	1,398,400	1,435,450
Senior Secured Revolving Line of Credit	—	—
6.125% Senior Notes due 2021	150,000	150,000
5.125% Senior Notes due 2022	300,000	300,000
5.625% Senior Notes due 2023	650,000	650,000
6.500% Senior Notes due 2024	390,000	390,000
9.0% and 9.5% Revenue Bonds	21,920	22,175
Less: unamortized debt issuance costs, discount and premium	(50,432)	(59,816)
	3,239,888	3,287,809
Less: current portion	(34,830)	(34,805)
Long-term debt	$ 3,205,058	$ 3,253,004

Amended and Restated Senior Credit Facility

The Company entered into a senior secured credit facility (the "Senior Secured Credit Facility") on April 1, 2011. On December 31, 2012, the Company entered into an Amended and Restated Credit Agreement (the "Amended and Restated Credit Agreement") which amended and restated the Senior Secured Credit Facility (the "Amended and Restated Senior Credit Facility"). The Company has amended the Amended and Restated Credit Agreement from time to time as described in the Company's prior filings with the SEC.

On January 25, 2016, the Company entered into the Ninth Amendment (the "Ninth Amendment") to the Amended and Restated Credit Agreement. The Ninth Amendment modified certain definitions and provided increased flexibility to the Company in terms of its financial covenants. The Company's baskets for permitted investments were also increased to provide increased flexibility for it to

invest in non-wholly owned subsidiaries, joint ventures and foreign subsidiaries. The Company may now invest in non-wholly owned subsidiaries and joint ventures up to 10.0% of the Company and its subsidiaries' total assets in any four consecutive fiscal quarter period, and up to 12.5% of the Company and its subsidiaries' total assets during the term of the Amended and Restated Credit Agreement. The Company may also invest in foreign subsidiaries that are not loan parties up to 10% of the Company and its subsidiaries' total assets in any consecutive four fiscal quarter period, and up to 15% of the Company and its subsidiaries' total assets during the term of the Amended and Restated Credit Agreement. The foregoing permitted investments are subject to an aggregate cap of 25% of the Company and its subsidiaries' total assets in any fiscal year.

On February 16, 2016, the Company entered into a Second Incremental Facility Amendment (the "Second Incremental Amendment") to the Amended and Restated Credit Agreement. The Second Incremental Amendment activated a new $955.0 million incremental Term Loan B facility Tranche B-2 (the "Tranche B-2 Facility") and added $135.0 million to the Term Loan A facility (the "TLA Facility") to the Amended and Restated Senior Credit Facility, subject to limited conditionality provisions. Borrowings under the Tranche B-2 Facility were used to fund a portion of the purchase price for the acquisition of Priory and the fees and expenses for such acquisition and the related financing transactions. Borrowings under the TLA Facility were used to pay down the majority of our $300.0 million revolving credit facility.

On May 26, 2016, the Company entered into a Tranche B-1 Repricing Amendment (the "Tranche B-1 Repricing Amendment") to the Amended and Restated Credit Agreement. The Tranche B-1 Repricing Amendment reduced the Applicable Rate with respect to the Term Loan B facility Tranche B-1 (the "Tranche B-1 Facility") from 3.5% to 3.0% in the case of Eurodollar Rate loans and 2.5% to 2.0% in the case of Base Rate Loans.

On September 21, 2016, the Company entered into a Tranche B-2 Repricing Amendment (the "Tranche B-2 Repricing Amendment") to the Amended and Restated Credit Agreement. The Tranche B-2 Repricing Amendment reduced the Applicable Rate with respect to the Tranche B-2 Facility from 3.75% to 3.0% in the case of Eurodollar Rate loans and 2.75% to 2.0% in the case of Base Rate Loans. In connection with the Tranche B-2 Repricing Amendment, the Company recorded a debt extinguishment charge of $3.4 million, including the discount and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of income.

On November 22, 2016, the Company entered into a Tenth Amendment (the "Tenth Amendment") to the Amended and Restated Credit Agreement. The Tenth Amendment, among other things, (i) amended the negative covenant regarding dispositions, (ii) modified the collateral package to release any real property with a fair market value of less than $5.0 million and (iii) changed certain investment, indebtedness and lien baskets.

On November 30, 2016, the Company entered into a Refinancing Facilities Amendment (the "Refinancing Amendment") to the Amended and Restated Credit Agreement. The Refinancing Amendment increased the Company's line of credit on its revolving credit facility to $500.0 million from $300.0 million and reduced its TLA Facility to $400.0 million from $600.6 million (together, the "Refinancing Facilities"). In addition, the Refinancing Amendment extended the maturity date for the Refinancing Facilities to November 30, 2021 from February 13, 2019, and lowered the Company's effective interest rate on the line of credit on its revolving credit facility and TLA Facility by 50 basis points. In connection with the Refinancing Amendment, the Company recorded a debt extinguishment charge of $0.8 million, including the write-off of deferred financing costs, which was recorded in debt extinguishment in the consolidated statements of income.

On May 10, 2017, the Company entered into a Third Repricing Amendment (the "Third Repricing Amendment") to the Amended and Restated Credit Agreement. The Third Repricing Amendment reduced the Applicable Rate with respect to the Tranche B-1 Facility and the Tranche B-2 Facility from 3.0% to 2.75% in the case of Eurodollar Rate loans and from 2.0% to 1.75% in the case of Base Rate Loans. In connection with the Third Repricing Amendment, the Company recorded a debt extinguishment charge of $0.8 million, including the discount and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of operations.

The Company had $493.4 million of availability under the revolving line of credit and had standby letters of credit outstanding of $6.6 million related to security for the payment of claims required by its workers' compensation insurance program as of December 31, 2017. Borrowings under the revolving line of credit are subject to customary conditions precedent to borrowing. The Amended and Restated Credit Agreement requires quarterly term loan principal repayments of our TLA Facility of $5.0 million for March 31, 2018 to December 31, 2019, $7.5 million for March 31, 2020 to December 31, 2020, and $10.0 million for March 31, 2021 to September 30, 2021, with the remaining principal balance of the TLA Facility due on the maturity date of November 30, 2021. The Company is required to repay the Tranche B-1 Facility in equal quarterly installments of $1.3 million on the last business day of each March, June, September and December, with the outstanding principal balance of the Tranche B-1 Facility due on February 11, 2022. The Company is required to repay the Tranche B-2 Facility in equal quarterly installments of approximately $2.4 million on the last business day of each March, June, September and December, with the outstanding principal balance of the Tranche B-2 Facility due on February 16, 2023. On December 29, 2017, the Company made an additional payment of $22.5 million, including $7.7 million on the Tranche B-1 Facility and $14.8 million on the Tranche B-2 Facility.

Borrowings under the Amended and Restated Senior Credit Facility are guaranteed by each of the Company's wholly-owned domestic subsidiaries (other than certain excluded subsidiaries) and are secured by a lien on substantially all of the assets of the Company and such subsidiaries. Borrowings with respect to the TLA Facility and the Company's revolving credit facility (collectively, "Pro Rata Facilities") under the Amended and Restated Credit Agreement bear interest at a rate tied to Acadia's Consolidated Leverage Ratio (defined as consolidated funded debt net of up to $40.0 million of unrestricted and unencumbered cash to consolidated EBITDA, in each case as defined in the Amended and Restated Credit Agreement). The Applicable Rate (as defined in the Amended and Restated Credit Agreement) for the Pro Rata Facilities was 2.75% for Eurodollar Rate Loans (as defined in the Amended and Restated Credit Agreement) and 1.75% for Base Rate Loans (as defined in the Amended and Restated Credit Agreement) at December 31, 2017. Eurodollar Rate Loans with respect to the Pro Rata Facilities bear interest at the Applicable Rate plus the Eurodollar Rate (as defined in the Amended and Restated Credit Agreement) (based upon the LIBOR Rate (as defined in the Amended and Restated Credit Agreement) prior to commencement of the interest rate period). Base Rate Loans with respect to the Pro Rata Facilities bear interest at the Applicable Rate plus the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate and (iii) the Eurodollar Rate plus 1.0%. As of December 31, 2017, the Pro Rata Facilities bore interest at a rate of LIBOR plus 2.75%. In addition, the Company is required to pay a commitment fee on undrawn amounts under the revolving line of credit.

The Amended and Restated Credit Agreement requires the Company and its subsidiaries to comply with customary affirmative, negative and financial covenants, including a fixed charge coverage ratio, consolidated leverage ratio and senior secured leverage ratio. The Company may be required to pay all of its indebtedness immediately if it defaults on any of the numerous financial or other restrictive covenants contained in any of its material debt agreements. As of December 31, 2017, the Company was in compliance with such covenants.

Senior Notes

6.125% Senior Notes due 2021

On March 12, 2013, the Company issued $150.0 million of 6.125% Senior Notes due 2021 (the "6.125% Senior Notes"). The 6.125% Senior Notes mature on March 15, 2021 and bear interest at a rate of 6.125% per annum, payable semi-annually in arrears on March 15 and September 15 of each year.

5.125% Senior Notes due 2022

On July 1, 2014, the Company issued $300.0 million of 5.125% Senior Notes due 2022 (the "5.125% Senior Notes"). The 5.125% Senior Notes mature on July 1, 2022 and bear interest at a rate of 5.125% per annum, payable semi-annually in arrears on January 1 and July 1 of each year.

5.625% Senior Notes due 2023

On February 11, 2015, the Company issued $375.0 million of 5.625% Senior Notes due 2023 (the "5.625% Senior Notes"). On September 21, 2015, the Company issued $275.0 million of additional 5.625% Senior Notes. The additional notes formed a single class of debt securities with the 5.625% Senior Notes issued in February 2015. Giving effect to this issuance, the Company has outstanding an aggregate of $650.0 million of 5.625% Senior Notes. The 5.625% Senior Notes mature on February 15, 2023 and bear interest at a rate of 5.625% per annum, payable semi-annually in arrears on February 15 and August 15 of each year.

6.500% Senior Notes due 2024

On February 16, 2016, the Company issued $390.0 million of 6.500% Senior Notes due 2024 (the "6.500% Senior Notes"). The 6.500% Senior Notes mature on March 1, 2024 and bear interest at a rate of 6.500% per annum, payable semi-annually in arrears on March 1 and September 1 of each year, beginning on September 1, 2016.

The indentures governing the 6.125% Senior Notes, 5.125% Senior Notes, 5.625% Senior Notes and 6.500% Senior Notes (together, the "Senior Notes") contain covenants that, among other things, limit the Company's ability and the ability of its restricted subsidiaries to: (i) pay dividends, redeem stock or make other distributions or investments; (ii) incur additional debt or issue certain preferred stock; (iii) transfer or sell assets; (iv) engage in certain transactions with affiliates; (v) create restrictions on dividends or other payments by the restricted subsidiaries; (vi) merge, consolidate or sell substantially all of the Company's assets; and (vii) create liens on assets.

The Senior Notes issued by the Company are guaranteed by each of the Company's subsidiaries that guarantee the Company's obligations under the Amended and Restated Senior Credit Facility. The guarantees are full and unconditional and joint and several.

The Company may redeem the Senior Notes at its option, in whole or part, at the dates and amounts set forth in the indentures.

9.0% and 9.5% Revenue Bonds

On November 11, 2012, in connection with the acquisition of Park Royal, the Company assumed debt of $23.0 million. The fair market value of the debt assumed was $25.6 million and resulted in a debt premium balance being recorded as of the acquisition date. The debt consisted of $7.5 million and $15.5 million of Lee County (Florida) Industrial Development Authority Healthcare Facilities Revenue Bonds, Series 2010 with stated interest rates of 9.0% and 9.5% ("9.0% and 9.5% Revenue Bonds"), respectively. The 9.0% bonds in the amount of $7.5 million have a maturity date of December 1, 2030 and require yearly principal payments beginning in 2013. The 9.5% bonds in the amount of $15.5 million have a maturity date of December 1, 2040 and require yearly principal payments beginning in 2031. The principal payments establish a bond sinking fund to be held with the trustee and shall be sufficient to redeem the principal amounts of the 9.0% and 9.5% Revenue Bonds on their respective maturity dates. As of December 30, 2017 and December 31, 2016, $2.3 million was recorded within other assets on the consolidated balance sheets related to the debt service reserve fund requirements. The yearly principal payments, which establish a bond sinking fund, will increase the debt service reserve fund requirements. The bond premium amount of $2.6 million is amortized as a reduction of interest expense over the life of the revenue bonds using the effective interest method.

Debt Issuance Costs

Debt issuance costs are deferred and amortized to interest expense over the term of the related debt. Debt issuance costs at December 31, 2017 were $46.5 million, net of accumulated amortization of $27.5 million. Debt issuance costs at December 31, 2016 were $55.3 million, net of accumulated amortization of $18.9 million. Amortization expense related to debt issuance costs, which is included in interest expense on the consolidated statements of operations, was $8.6 million, $8.6 million and $5.1 million, respectively, for the years ended December 31, 2017, 2016 and 2015.

Other

The aggregate maturities of long-term debt as of December 31, 2017 were as follows (in thousands):

2018	$ 34,830
2019	34,855
2020	44,880
2021	474,910
2022	767,240
Thereafter	1,933,605
Total	$3,290,320

7. Equity

Preferred Stock

The Company's amended and restated certificate of incorporation provides that up to 10,000,000 shares of preferred stock may be issued. The Board of Directors has the authority to issue preferred stock in one or more series and to fix for each series the voting powers (full, limited or none), and the designations, preferences and relative participating, optional or other special rights and qualifications, limitations or restrictions on the stock and the number of shares constituting any series and the designations of this series, without any further vote or action by the stockholders.

Common Stock

On March 3, 2016, the Company held a Special Meeting of Stockholders, where the Company's stockholders approved an amendment to the Company's Amended and Restated Certificate of Incorporation to increase the number of authorized shares of Common Stock from 90,000,000 to 180,000,000 (the "Amendment"). On March 3, 2016, the Company filed the Amendment with the Secretary of State of the State of Delaware. Holders of the Company's common stock are entitled to one vote for each share held of record on all matters on which stockholders may vote. There are no preemptive, conversion, redemption or sinking fund provisions applicable to shares of the Company's common stock. In the event of liquidation, dissolution or winding up, holders of the Company's common stock are entitled to share ratably in the assets available for distribution, subject to any prior rights of any holders of preferred stock then outstanding. Delaware law prohibits the Company from paying any dividends unless it has capital surplus or net profits available for this purpose. In addition, the Amended and Restated Senior Credit Facility imposes restrictions on the Company's ability to pay dividends.

Equity Offerings

On January 12, 2016, the Company completed the offering of 11,500,000 shares of common stock (including shares sold pursuant to the exercise of the over-allotment option that the Company granted to the underwriters as part of the offering) at a price of $61.00 per share. The net proceeds to the Company from the sale of the shares, after deducting the underwriting discount of $15.8 million and additional offering-related costs of $0.7 million, were $685.0 million. The Company used the net offering proceeds to fund a portion of the purchase price for the acquisition of Priory.

On February 16, 2016, the Company completed the acquisition of Priory for a total purchase price of approximately $2.2 billion including cash consideration of approximately $1.9 billion and the issuance of 4,033,561 shares of common stock to shareholders of Priory.

8. Equity-Based Compensation

Equity Incentive Plans

The Company issues stock-based awards, including stock options, restricted stock and restricted stock units, to certain officers, employees and non-employee directors under the Acadia Healthcare Company, Inc. Incentive Compensation Plan (the "Equity Incentive Plan"). As of December 31, 2017, a maximum of 8,200,000 shares of the Company's common stock were authorized for issuance as stock options, restricted stock and restricted stock units or other share-based compensation under the Equity Incentive Plan, of which 4,498,687 were available for future grant. Stock options may be granted for terms of up to ten years. The Company recognizes expense on all share-based awards on a straight-line basis over the requisite service period of the entire award. Grants to employees generally vest in annual increments of 25% each year, commencing one year after the date of grant. The exercise prices of stock options are equal to the closing price of the Company's common stock on the most recent trading date prior to the date of grant.

The Company recognized $23.5 million, $28.3 million and $20.5 million in equity-based compensation expense for the years ended December 31, 2017, 2016 and 2015, respectively. Stock compensation expense for the year ended December 31, 2017 included forfeiture adjustments and restricted stock unit adjustments based on actual performance compared to vesting targets of $(5.7) million. As of December 31, 2017, there was $42.5 million of unrecognized compensation expense related to unvested options, restricted stock and restricted stock units, which is expected to be recognized over the remaining weighted average vesting period of 1.2 years.

As of December 31, 2017, there were no warrants outstanding and exercisable. The Company recognized a deferred income tax benefit of $9.2 million and $10.7 million for the years ended December 31, 2017 and 2016, respectively, related to equity-based compensation expense.

Stock option activity during 2016 and 2017 was as follows (aggregate intrinsic value in thousands):

	Number of Options	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (in years)	Aggregate Intrinsic Value
Options outstanding at January 1, 2016	694,743	$ 42.87	7.70	$ 20,717
Options granted	503,850	57.98	9.28	297
Options exercised	(57,397)	31.92	N/A	1,530
Options cancelled	(140,250)	57.13	N/A	N/A
Options outstanding at December 31, 2016	1,000,946	49.42	7.80	8,166
Options granted	259,300	42.25	9.30	205
Options exercised	(87,367)	25.92	N/A	1,636
Options cancelled	(198,313)	54.71	N/A	N/A
Options outstanding at December 31, 2017	974,566	$ 47.89	7.46	$ 3,802
Options exercisable at December 31, 2016	288,959	$ 42.81	6.22	$ 6,111
Options exercisable at December 31, 2017	405,634	$ 41.20	6.05	$ 3,549

Restricted stock activity during 2016 and 2017 was as follows:

	Number of Shares	Weighted Average Grant-Date Fair Value
Unvested at January 1, 2016	944,562	$ 52.74
Granted	387,347	55.38
Cancelled	(122,178)	57.02
Vested	(365,312)	47.18
Unvested at December 31, 2016	844,419	$ 55.76
Granted	404,224	42.38
Cancelled	(145,981)	55.03
Vested	(292,794)	53.07
Unvested at December 31, 2017	809,868	$ 50.19

Restricted stock unit activity during 2016 and 2017 was as follows:

	Number of Units	Weighted Average Grant-Date Fair Value
Unvested at January 1, 2016	218,084	$ 56.97
Granted	230,750	56.95
Cancelled	—	—
Vested	(175,235)	52.71
Unvested at December 31, 2016	273,599	$ 59.68
Granted	219,840	43.23
Cancelled	—	—
Vested	(132,530)	58.67
Unvested at December 31, 2017	360,909	$ 50.04

The grant-date fair value of the Company's stock options is estimated using the Black-Scholes option pricing model. The following table summarizes the grant-date fair value of options and the assumptions used to develop the fair value estimates for options granted during the years ended December 31, 2017 and 2016:

	December 31, 2017	December 31, 2016
Weighted average grant-date fair value of options	$ 14.39	$ 18.96
Risk-free interest rate	2.0%	1.4%
Expected volatility	33%	33%
Expected life (in years)	5.5	5.5

The Company's estimate of expected volatility for stock options is based upon the volatility of guideline companies given the lack of sufficient historical trading experience of the Company's common stock. The risk-free interest rate is the approximate yield on U.S. Treasury Strips having a life equal to the expected option life on the date of grant. The expected life is an estimate of the number of years an option will be held before it is exercised.

9. Income Taxes

The Company adopted ASU 2016-09 as of January 1, 2017, which changes how the Company accounts for share-based awards for tax purposes. Income tax effects of share-based awards are now recognized in the income statement, instead of through equity, when the awards vest.

Excess tax benefits/deficiencies are generated when the deduction for tax purposes is greater/less than the compensation cost for financial reporting purposes. Upon adoption of ASU 2016-09, the Company no longer records excess tax benefits/deficiencies in additional paid-in capital as a component of equity. Instead, excess tax benefits/deficiencies are included in the provision for income taxes on the consolidated statements of operations. These changes are recorded prospectively as of January 1, 2017, which resulted in an increase in our income tax provision of $1.7 million, or an increase in the effective tax rate of 0.7%, for the year ended December 31, 2017. Prior periods have not been adjusted. An adjustment for prior period excess tax benefits of $8.6 million is recorded as a cumulative-effect adjustment in retained earnings at December 31, 2017 as the Company adopted ASU 2016-09 using the modified retrospective transition method. Excess tax benefits were previously required to be included in financing activities on the consolidated statement of cash flows and are now required to be included in operating activities. The changes to the consolidated statement of cash flows are recorded prospectively as of January 1, 2017. Additionally, the Company has elected not to adjust its policy on accounting for forfeitures and will continue to estimate forfeiture rates.

Income tax expense (benefit) from continuing operations consists of the following for the periods presented (in thousands):

	Year Ended December 31,		
	2017	2016	2015
Current:			
Federal	$ 3,325	$ 572	$ (218)
State	680	(863)	4,078
Foreign	1,832	423	5,915
Total current	5,837	132	9,775
Deferred:			
Federal	27,179	45,077	40,635
State	4,408	1,491	5,349
Foreign	(215)	(17,921)	(2,371)
Total deferred provision	31,372	28,647	43,613
Provision for income taxes	$37,209	$ 28,779	$53,388

A reconciliation of the U.S. federal statutory rate, from continuing operations, to the effective tax rate is as follows for the periods presented:

	Year Ended December 31,		
	2017	2016	2015
U.S. federal statutory rate on income before income taxes	35.0%	35.0%	35.0%
Impact of foreign operations	(14.1)	(13.5)	(10.0)
Impact of foreign divestiture	—	39.2	—
Effects of statutory rate change	(8.5)	(14.5)	—
State income taxes, net of federal tax effect	2.1	7.5	4.8
Permanent differences	1.8	8.3	4.2
Transaction related items	—	25.9	—
Change in valuation allowance	1.6	2.8	1.2
Unrecognized tax benefit release	(0.8)	(7.2)	—
Other	(1.4)	3.8	(2.8)
Effective income tax rate	15.7%	87.3%	32.4%

The domestic and foreign components of income (loss) from continuing operations before income taxes are as follows (in thousands):

	Year Ended December 31,		
	2017	2016	2015
Foreign	$120,905	$(144,717)	$ 28,316
Domestic	115,893	177,672	136,437
Total	$236,798	$ 32,955	$164,753

The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and liabilities of the Company at December 31, 2017 and December 31, 2016 were as follows (in thousands):

	December 31,	
	2017	2016
Deferred tax assets:		
Net operating losses and tax credit carryforwards – federal and state	$ 29,409	$ 37,638
Bad debt allowance	827	15,381
Accrued compensation and severance	14,179	23,379
Pension reserves	1,494	697
Insurance reserves	13,483	17,468
Leases	5,332	2,926
Accrued expenses	3,114	—
Interest carryforwards	5,074	—
Other assets	1,747	2,038
Total gross deferred tax assets	74,659	99,527
Less: valuation allowance	(21,155)	(16,031)
Deferred tax assets	53,504	83,496
Deferred tax liabilities:		
Fixed asset basis difference	(54,214)	(45,510)
Prepaid items	(1,490)	(1,324)
Intangible assets	(70,820)	(77,655)
Accrued expenses	—	(4,531)
Other liabilities	(3,582)	(29,216)
Total deferred tax liabilities	(130,106)	(158,236)
Total net deferred tax liability	$ (76,602)	$ (74,740)

The Company records a valuation allowance to reduce its net deferred tax assets to the amount that is more likely than not to be realized. As of December 31, 2017 and 2016, the Company carried a valuation allowance against deferred tax assets of $21.2 million and $16.0 million, respectively.

The domestic net operating loss carryforwards are approximately $28.4 million as of December 31, 2016. There are no domestic net operating loss carryforwards at December 31, 2017. The foreign net operating loss carryforwards as of December 31, 2017 and 2016 are approximately $93.9 million and $92.2 million, respectively, and have no expiration.

The Company has state net operating loss carryforwards at December 31, 2017 and 2016 of approximately $256.9 million and $223.3 million, respectively. These net operating loss carryforwards, if not used to offset future taxable income, will expire from 2018 to 2036. In addition, the Company has certain state tax credits of $0.9 million which will begin to expire in 2026 if not utilized.

Income taxes receivable was $15.1 million and $11.7 million at December 31, 2017 and 2016, respectively, and was included in other current assets in the consolidated balance sheets. Income taxes payable of $1.0 million and $0.5 million at December 31, 2017 and 2016 was included in other accrued liabilities in the consolidated balance sheets.

The Company has recorded income taxes payable related to unrecognized tax benefits of $6.4 million and $7.8 million at December 31, 2017 and 2016, respectively, in other liabilities in the consolidated balance sheets. A reconciliation of the beginning and ending amount of unrecognized income tax benefits net of the federal benefit is as follows (in thousands):

	2017	2016	2015
Balance at January 1	$ 6,949	$ 4,511	$ 2,923
Additions based on tax positions related to the current year	5,488	—	1,516
Additions for tax positions of prior years	95	5,427	2,874
Reductions as a result of the lapse of applicable statutes of limitations	(6,428)	(2,989)	(2,802)
Balance at December 31	$ 6,104	$ 6,949	$ 4,511

The Company recognizes interest and penalties related to unrecognized tax benefits in its consolidated balance sheets. As of December 31, 2017 and 2016, the cumulative amounts recognized were $0.1 million and $0.9 million, respectively. It is possible the amount of unrecognized tax benefit could change in the next twelve months as a result of a lapse of the statute of limitations and settlements with taxing authorities; however, management does not anticipate the change will have a material impact on the Company's consolidated financial statements.

The Company's uncertain tax positions are related to tax years that remain subject to examination by the relevant taxing authorities. The Company and its subsidiaries file income tax returns in federal and in many state and local jurisdictions as well as foreign jurisdictions. The Company may be subject to examination by the Internal Revenue Service ("IRS") for calendar year 2014 through 2016. Additionally, any net operating losses that were generated in prior years and utilized in these years may also be subject to examination by the IRS. In foreign jurisdictions, the Company may be subject to examination for calendar years 2013 through 2016. Generally, for state tax purposes, the Company's 2011 through 2016 tax years remain open for examination by the tax authorities. At the date of this report there were no audits or inquires that had progressed sufficiently to predict their ultimate outcome.

One of the Company's Puerto Rico subsidiaries was granted a tax exemption for which a tax credit of up to 15% of eligible payroll expenses is available to offset up to 50% of the income taxes attributed to that entity.

It is the Company's intention to utilize its earnings in the foreign operations for an indefinite period of time. At December 31, 2017, there were no undistributed earnings of the foreign subsidiaries as the cumulative net loss of its foreign subsidiaries exceeds the cumulative earnings from its foreign subsidiaries. The cumulative net loss of the Company's foreign subsidiaries includes a loss on divestiture of $175.0 million related to the U.K. Divestiture on November 30, 2016. If a deferred tax liability for undistributed foreign earnings becomes required, it would be significantly impacted by the Tax Act, the source location and amount of the distribution, the underlying tax rate already paid on the earnings, foreign withholding taxes, foreign currency translation adjustment and the opportunity to use foreign tax credits.

U.S. Tax Reform

On December 22, 2017, Public Law 115-97, informally referred to as The Tax Cuts and Jobs Act (the "Tax Act") was enacted into law. The Tax Act provides for significant changes to the U.S. tax code that impact businesses. Effective January 1, 2018, the Tax Act reduces the U.S. federal tax rate for corporations from 35% to 21%, for U.S. taxable income. The Tax Act requires a one-time

remeasurement of deferred taxes to reflect their value at a lower tax rate of 21%. The Tax Act includes other changes, including, but not limited to, requiring a one-time transition tax on certain repatriated earnings of foreign subsidiaries that is payable over eight years, a general elimination of U.S. federal income taxes on dividends from foreign subsidiaries, a new provision designed to tax global intangible low-taxed income, a limitation of the deduction for net operating losses, elimination of net operating loss carrybacks, immediate deductions for depreciation expense for certain qualified property, additional limitations on the deductibility of executive compensation and limitations on the deductibility of interest.

At December 31, 2017, the Company has not completed its accounting for the tax effects of enactment of the Tax Act; however, in certain cases, as described below, the Company has made a reasonable estimate of the effects on our existing deferred tax balances. In other cases, the Company has not been able to make a reasonable estimate and continues to account for those items based on its existing accounting under ASC 740 and the provisions of the tax laws that were in effect immediately prior to enactment of the Tax Act. For the items for which the Company was able to determine a reasonable estimate, the Company recognized a provisional amount of $20.2 million, which is included as a component of income tax expense from continuing operations.

ASC 740 requires the Company to recognize the effect of tax law changes in the period of enactment. However, the SEC staff issued SAB 118 which will allow the Company to record provisional amounts during a measurement period similarly to the measurement period used when accounting for business combinations. The Company will continue to assess the impact of the recently enacted tax law on its business and consolidated financial statements.

Provisional Amounts

Deferred Tax Assets and Liabilities

The Company remeasured certain deferred tax assets and liabilities based on the rates at which they are expected to reverse in the future, which is generally 21%. As a result of the reduction in the corporate income tax rate, the Company is required to revalue its net deferred tax assets and liabilities to account for the future impact of lower corporate tax rates on this deferred amount and record any change in the value of such asset or liability as a one-time non-cash charge or benefit on its income statement. However, the Company is still analyzing certain aspects of the Tax Act and refining its calculations, which could potentially affect the measurement of these balances or potentially give rise to new deferred tax amounts. The provisional amount recorded related to the remeasurement of our deferred tax balance was $20.2 million.

U.S. Tax on Foreign Earnings

The one-time transition tax is based on total post-1986 earnings and profits that the Company previously deferred from U.S. income taxes. The Company has not made sufficient progress on the earnings and profits analysis for its foreign subsidiaries to reasonably estimate the effects of the one-time transition tax and, therefore, has not recorded provisional amounts. The Company continues to apply ASC 740 based on the provisions of the tax laws in effect immediately prior to the Tax Act being enacted. Since the Company had previously determined these amounts were indefinitely reinvested, no deferred taxes have been recorded at December 31, 2017.

The Company's accounting for Global Intangible Low-Taxed Income, Foreign-Derived Intangible Income, the Base Erosion and Anti-Abuse Tax and any remaining impacts of the foreign income provisions of the Tax Act is incomplete. The Company has not yet been able to make reasonable estimates of the effects of these items. Therefore, no provisional amounts have been recorded as of December 31, 2017.

10. Derivatives

The Company entered into foreign currency forward contracts during the years ended December 31, 2017 and 2016 in connection with (i) acquisitions in the U.K. and (ii) certain transfers of cash between the U.S. and U.K. under the Company's cash management and foreign currency risk management programs. Foreign currency forward contracts limit the economic risk of changes in the exchange rate between US Dollars ("USD") and British Pounds ("GBP") associated with cash transfers.

The foreign currency contracts entered into during the year ended December 31, 2016 resulted in gains of $0.5 million which have been recorded in the consolidated statements of income.

In May 2016, the Company entered into multiple cross currency swap agreements with an aggregate notional amount of $650.0 million to manage foreign currency risk by effectively converting a portion of its fixed-rate USD-denominated senior notes, including the semi-annual interest payments thereunder, to fixed-rate GBP-denominated debt of £449.3 million. The senior notes effectively converted include $150.0 million aggregate principal amount of 6.125% Senior Notes, $300.0 million aggregate principal amount of 5.125% Senior Notes and $200.0 million aggregate principal amount of 5.625% Senior Notes. During the term of the swap

agreements, the Company will receive semi-annual interest payments in USD from the counterparties at fixed interest rates, and the Company will make semi-annual interest payments in GBP to the counterparties at fixed interest rates. The interest payments under the cross-currency swap agreements result in £24.7 million of annual cash flows, from the Company's U.K. business being converted to $35.8 million (at a 1.45 exchange rate). The interest rates applicable to the GBP interest payments are substantially the same as the interest rates in place for the existing USD-denominated debt. At maturity, the Company will repay the principal amounts listed above in GBP and receive the principal amount in USD.

The Company has designated the cross currency swap agreements and certain forward contracts entered into during 2016 and 2017 as qualifying hedging instruments and is accounting for these as net investment hedges. At December 31, 2017 and 2016, the fair value of these derivatives are $13.0 million and $73.5 million, respectively, and are recorded as an asset within derivative instruments on the consolidated balance sheets. The gains and losses resulting from fair value adjustments to the cross currency swap agreements are recorded in accumulated other comprehensive income as the swaps are effective in hedging the designated risk. Cash flows related to the cross currency swaps are included in operating activities in the consolidated statements of cash flows.

11. Fair Value Measurements

The carrying amounts reported for cash and cash equivalents, accounts receivable, other current assets, accounts payable and other current liabilities approximate fair value because of the short-term maturity of these instruments.

The carrying amounts and fair values of the Company's Amended and Restated Senior Credit Facility, 6.125% Senior Notes, 5.125% Senior Notes, 5.625% Senior Notes, 6.500% Senior Notes, 9.0% and 9.5% Revenue Bonds, derivative instruments and contingent consideration liability as of December 31, 2017 and 2016 were as follows (in thousands):

	Carrying Amount		Fair Value	
	December 31,		December 31,	
	2017	2016	2017	2016
Amended and Restated Senior Credit Facility	$1,749,185	$1,799,993	$1,749,185	$1,799,993
6.125% Senior Notes due 2021	$ 148,098	$ 147,574	$ 150,134	$ 152,186
5.125% Senior Notes due 2022	$ 296,174	$ 295,442	$ 296,914	$ 293,595
5.625% Senior Notes due 2023	$ 641,891	$ 640,574	$ 651,519	$ 640,574
6.500% Senior Notes due 2024	$ 382,251	$ 381,268	$ 397,541	$ 389,847
9.0% and 9.5% Revenue Bonds	$ 22,289	$ 22,959	$ 22,289	$ 22,959
Derivative instruments	$ 12,997	$ 73,509	$ 12,997	$ 73,509
Contingent consideration liabilities	$ —	$ 107	$ —	$ 107

The Company's Amended and Restated Senior Credit Facility, 6.125% Senior Notes, 5.125% Senior Notes, 5.625% Senior Notes, 6.500% Senior Notes and 9.0% and 9.5% Revenue Bonds were categorized as Level 2 in the GAAP fair value hierarchy. Fair values were based on trading activity among the Company's lenders and the average bid and ask price as determined using published rates.

The fair values of the derivative instruments were categorized as Level 2 in the GAAP fair value hierarchy and were based on observable market inputs including applicable exchange rates and interest rates.

The fair value of the contingent consideration liabilities were categorized as Level 3 in the GAAP fair value hierarchy. The contingent consideration liabilities were valued using a probability-weighted discounted cash flow method. This analysis reflected the contractual terms of the purchase agreements and utilized assumptions with regard to future earnings, probabilities of achieving such future earnings and a discount rate.

12. Leases

The Company is obligated under certain operating leases to rent space for its facilities and other office space. The original terms of the leases typically range from five to 30 years, with optional renewal periods.

Aggregate minimum lease payments under non-cancelable operating leases with original or remaining lease terms in excess of one year were as follows as of December 31, 2017 (in thousands):

2018	$ 69,613
2019	64,556
2020	60,156
2021	56,620
2022	51,071
Thereafter	835,369
Total minimum rental obligations	$1,137,385

During the years ended December 31, 2017, 2016 and 2015, rent expense was $76.8 million, $73.3 million and $32.5 million, respectively.

13. Commitments and Contingencies

The Company is, from time to time, subject to various claims, governmental investigations and regulatory actions that arise in the ordinary course of the Company's business, including claims for damages for personal injuries, medical malpractice, overpayments, breach of contract, tort and employment related claims. In these actions, plaintiffs request a variety of damages, including, in some instances, punitive and other types of damages that may not be covered by insurance. In addition, healthcare companies are subject to numerous investigations by various governmental agencies. Under the federal False Claims Act, private parties have the right to bring *qui tam*, or "whistleblower," suits against companies that submit false claims for payments to, or improperly retain overpayments from, the government. Some states have adopted similar state whistleblower and false claims provisions. Certain of our individual facilities have received, and from time to time, other facilities may receive, government inquiries from, and may be subject to investigation by, federal and state agencies. In the opinion of management, the Company is not currently a party to any proceeding that would individually or in the aggregate have a material adverse effect on the Company's business, financial condition or results of operations.

14. Noncontrolling Interests

Noncontrolling interests in the consolidated financial statements represents the portion of equity held by noncontrolling partners in non-wholly owned subsidiaries the Company controls. At December 31, 2017, certain of these non-wholly owned subsidiaries operated three facilities. The Company owns between 60% and 75% of the equity interests in the entity that owns each facility, and noncontrolling partners own the remaining equity interests. The initial value of the noncontrolling interests is based on the fair value of contributions, and the Company consolidates the operations of each facility based on its equity ownership and its control of the entity. The noncontrolling interests are reflected as redeemable noncontrolling interests on the accompanying consolidated balance sheets based on put rights that could require the Company to purchase the noncontrolling interests upon the occurrence of a change in control.

The components of redeemable noncontrolling interests are as follows (in thousands):

Balance at January 1, 2016	$ 8,055
Acquisition of redeemable noncontrolling interests	11,666
Net loss attributable to noncontrolling interests	(1,967)
Balance at December 31, 2016	17,754
Acquisition of redeemable noncontrolling interests	4,909
Net loss attributable to noncontrolling interests	(246)
Balance at December 31, 2017	$22,417

15. Segment Information

The Company operates in one line of business, which is operating acute inpatient psychiatric facilities, specialty treatment facilities, residential treatment centers and facilities providing outpatient behavioral healthcare services. As management reviews the operating results of its facilities in the United States (the "U.S. Facilities") and its facilities in the United Kingdom (the "U.K. Facilities") separately to assess performance and make decisions, the Company's operating segments include its U.S. Facilities and U.K. Facilities. At December 31, 2017, the U.S. Facilities included 209 behavioral healthcare facilities with approximately 8,900 beds in 39 states and Puerto Rico, and the U.K. Facilities included 373 behavioral healthcare facilities with approximately 8,900 beds in the U.K.

The following tables set forth the financial information by operating segment, including a reconciliation of Segment EBITDA to income from continuing operations before income taxes (in thousands):

	Year Ended December 31,		
	2017	2016	2015
Revenue:			
U.S. Facilities	$1,809,844	$1,698,525	$1,426,205
U.K. Facilities	1,026,472	1,110,361	360,698
Corporate and Other	—	2,028	7,589
	$2,836,316	$2,810,914	$1,794,492
Segment EBITDA(1):			
U.S. Facilities	$ 475,260	$ 443,341	$ 377,587
U.K. Facilities	198,566	245,046	90,035
Corporate and Other	(69,467)	(79,797)	(62,790)
	$ 604,359	$ 608,590	$ 404,832

	Year Ended December 31,		
	2017	2016	2015
Segment EBITDA(1)	$ 604,359	$ 608,590	$ 404,832
Plus (less):			
Equity-based compensation expense	(23,467)	(28,345)	(20,472)
Debt extinguishment costs	(810)	(4,253)	(10,818)
Loss on divestiture	—	(178,809)	—
Gain (loss) on foreign currency derivatives	—	523	(1,926)
Transaction-related expenses	(24,267)	(48,323)	(36,571)
Interest expense, net	(176,007)	(181,325)	(106,742)
Depreciation and amortization	(143,010)	(135,103)	(63,550)
Income from continuing operations before income taxes	$ 236,798	$ 32,955	$ 164,753

	U.S. Facilities	U.K. Facilities	Corporate and Other	Consolidated
Goodwill:				
Balance at January 1, 2017	$ 2,041,795	$ 639,393	$ —	$2,681,188
Increase from 2017 acquisition	—	15,302	—	15,302
Foreign currency translation	—	60,770	—	60,770
Purchase price allocation and other	797	(6,883)	—	(6,086)
Balance at December 31, 2017	$ 2,042,592	$ 708,582	$ —	$2,751,174

	December 31,	
	2017	2016
Assets(2):		
U.S. Facilities	$3,567,126	$3,382,167
U.K. Facilities	2,647,150	2,441,018
Corporate and Other	210,226	201,541
	$6,424,502	$6,024,726

(1) Segment EBITDA is defined as income from continuing operations before provision for income taxes, equity-based compensation expense, debt extinguishment costs, gain on foreign currency derivatives, transaction-related expenses, interest expense and depreciation and amortization. The Company uses Segment EBITDA as an analytical indicator to measure the performance of the Company's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA is commonly used as an analytical indicator within the health care industry, and also serves as a measure of leverage capacity and debt service ability. Segment EBITDA should not be considered as a measure of financial performance under generally accepted accounting principles, and the items excluded from Segment EBITDA are significant components in understanding and assessing financial performance. Because Segment EBITDA is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to varying calculations, Segment EBITDA, as presented, may not be comparable to other similarly titled measures of other companies.

(2) Assets include property and equipment for the U.S. Facilities of $1.2 billion, U.K. Facilities of $1.8 billion and corporate and other of $49.2 million at December 31, 2017. Assets include property and equipment for the U.S. Facilities of $1.0 billion, U.K. Facilities of $1.7 billion and corporate and other of $27.1 million at December 31, 2016.

16. Employee Benefit Plans

Defined Contribution Plan

The Company maintains a qualified defined contribution 401(k) plan covering substantially all of its employees in the U.S. The Company may, at its discretion, make contributions to the plan. The Company contributed $0.2 million, $0.1 million, and $0.1 million to the 401(k) plan for the years ended December 31, 2017, 2016 and 2015, respectively.

Partnerships in Care Pension Plan

As part of the acquisition of Partnerships in Care on July 1, 2014, the Company assumed a frozen contributory defined benefit retirement plan ("Partnerships in Care Pension Plan") covering substantially all of the employees of Partnerships in Care and its subsidiaries prior to May 1, 2005 at which time, the Partnerships in Care Plan was frozen to new participants. Effective May 2015, the active participants no longer accrue benefits. The benefits under the Partnerships in Care Pension Plan were primarily based on years of service and final average earnings

The Company accounts for the Partnerships in Care Pension Plan in accordance with ASC 715-30 "Compensation — Defined Benefit Plans", ("ASC 715-30"). In accordance with ASC 715-30, the Company recognizes the unfunded liability of the Partnerships in Care Pension Plan on the Company's consolidated balance sheet and unrecognized gains (losses) and prior service credits (costs) as changes in other comprehensive income (loss). The measurement date of the Partnerships in Care Pension Plan's assets and liabilities coincides with the Company's year-end. The Company's pension benefit obligation is measured using actuarial calculations that incorporate discount rates, rate of compensation increases, when applicable, expected long-term returns on plan assets and consider expected age of retirement and mortality. Expected return on plan assets is determined by using the specific asset distribution at the measurement date.

The following table summarizes the funded status (unfunded liability) of the Partnerships in Care Pension Plan based upon actuarial valuations prepared as of December 31, 2017 and 2016 (in thousands):

	2017	2016
Projected benefit obligation	$67,288	$64,162
Fair value of plan assets	58,493	53,462
Unfunded liability	$ 8,795	$10,700

The following table summarizes changes in the Partnerships in Care Pension Plan net pension liability as of December 31, 2017 and 2016 (in thousands):

	2017	2016
Net pension liability at beginning of period	$10,700	$ 2,821
Employer contributions	(809)	(740)
Net pension expense (benefit)	426	339
Pension liability adjustment	(2,544)	8,781
Foreign currency translation gain (loss)	1,022	(501)
Net pension liability at end of period	$ 8,795	$10,700

A pension liability of $8.8 million and $10.7 million were recorded within other liabilities on the consolidated balance sheets as of December 31, 2017 and 2016. The following assumptions were used to determine the plan benefit obligation:

Discount rate	2.5%	2.7%
Compensation increase rate	2.3%	2.4%
Measurement date	December 31, 2017	December 31, 2016

A summary of the components of net pension plan expense for the year ended December 31, 2017 and 2016 is as follows (in thousands):

	2017	2016
Interest cost on projected benefit obligation	$ 1,738	$ 1,964
Expected return on assets	(1,312)	(1,625)
Total pension plan expense (benefit)	$ 426	$ 339

Assumptions used to determine the net periodic pension plan expense for the year ended December 31, 2017 and 2016 were as follows:

	2017	2016
Discount rate	2.5%	2.7%
Expected long-term rate of return on plan assets	2.5%	2.7%

The Company recognizes changes in the funded status of the pension plan as a direct increase or decrease to stockholders' equity through accumulated other comprehensive income. The accumulated other comprehensive income (loss) related to the Partnerships in Care Pension Plan for the years ended December 31, 2017, 2016 and 2015 was $(4.1) million ($(4.5) million net of taxes), $(7.4) million ($6.1 million net of taxes) and $2.6 million ($(1.7) million net of taxes), respectively.

The trustees of the Partnerships in Care Pension Plan are required to invest assets in the best interest of the Partnerships in Care Pension Plan's members and also ensure liquid assets are available to make benefit payments as they become due. Performance of the Partnerships in Care Pension Plan's assets are monitored quarterly, at a minimum, and asset allocations are adjusted as needed. The Partnerships in Care Pension Plan's weighted-average asset allocations by asset category as of December 31, 2017 and 2016 were as follows:

	December 31, 2017	December 31, 2016
Cash and cash equivalents	0.7%	1.5%
U.K. government obligation	19.0%	14.5%
Annuity contracts	38.6%	41.6%
Equity securities	29.4%	26.3%
Debt securities	9.9%	12.1%
Other	2.4%	4.0%

As of December 31, 2017 and 2016, the Partnerships in Care Pension Plan cash and cash equivalents were classified as Level 1 in the GAAP fair value hierarchy. Fair values were based on utilizing quoted prices (unadjusted) in active markets for identical assets. The U.K. government obligations, annuity contracts, equity securities, debt securities and other investments were classified as Level 2 in the GAAP fair value hierarchy. Fair values were based on data points that are observable, such as quoted prices, interest rates and yield curves.

17. Other Comprehensive Loss

The components of accumulated other comprehensive loss are as follows (in thousands):

	Foreign Currency Translation Adjustments	Change in Fair Value of Derivative Instruments	Pension Plan	Total
Balance at January 1, 2015	$ (66,206)	$ —	$ (2,164)	$ (68,370)
Foreign currency translation loss	(40,103)	—	—	(40,103)
Pension liability adjustment, net of tax of $0.9 million	—	—	3,826	3,826
Balance at December 31, 2015	(106,309)	—	1,662	(104,647)
Foreign currency translation loss	(477,772)	—	—	(477,772)
Gain on derivative instruments, net of tax of $29.1 million	—	40,598	—	40,598
Pension liability adjustment, net of tax of $(1.3) million	—	—	(7,749)	(7,749)
Balance at December 31, 2016	(584,081)	40,598	(6,087)	(549,570)
Foreign currency translation gain	207,341	—	—	207,341
Loss on derivative instruments, net of tax of $(22.9) million	—	(33,431)	—	(33,431)
Pension liability adjustment, net of tax of $0.4 million	—	—	1,542	1,542
Balance at December 31, 2017	$ (376,740)	$ 7,167	$ (4,545)	$(374,118)

18. Quarterly Information (Unaudited)

The tables below present summarized unaudited quarterly results of operations for the years ended December 31, 2017 and 2016. Management believes that all necessary adjustments have been included in the amounts stated below for a fair presentation of the results of operations for the periods presented when read in conjunction with the Company's consolidated financial statements for the years ended December 31, 2017 and 2016. Results of operations for a particular quarter are not necessarily indicative of results of operations for an annual period and are not predictive of future periods.

	Quarter Ended			
	March 31,	June 30,	September 30,	December 31,
	(In thousands except per share amounts)			
2017:				
Revenue	$679,194	$715,896	$ 716,714	$ 724,512
Income from continuing operations before income taxes	$ 48,484	$ 66,216	$ 61,459	$ 60,639
Net income attributable to Acadia Healthcare Company, Inc. stockholders	$ 34,958	$ 49,630	$ 45,618	$ 69,629(1)
Basic earnings per share attributable to Acadia Healthcare Company, Inc. stockholders	$ 0.40	$ 0.57	$ 0.52	$ 0.80(1)
Diluted earnings per share attributable to Acadia Healthcare Company, Inc. stockholders	$ 0.40	$ 0.57	$ 0.52	$ 0.80(1)
2016:				
Revenue	$616,813	$756,548	$ 734,665	$ 702,888
Income from continuing operations before income taxes	$ 32,479	$ 73,852	$ (115,814)(2)	$ 42,438(3)
Net income attributable to Acadia Healthcare Company, Inc. stockholders	$ 25,688	$ 56,445	$ (117,808)(2)	$ 41,818(3)
Basic earnings per share attributable to Acadia Healthcare Company, Inc. stockholders	$ 0.31	$ 0.65	$ (1.36)(2)	$ 0.48(3)
Diluted earnings per share attributable to Acadia Healthcare Company, Inc. stockholders	$ 0.31	$ 0.65	$ (1.36)(2)	$ 0.48(3)

(1) Includes a one-time tax benefit of $20.2 million on revaluation of deferred tax items pursuant to the enactment of the Tax Act.

(2) Includes loss on divestiture of $174.7 million and debt extinguishment costs of $3.4 million, or $142.0 million net of taxes, in connection with the U.K. Divestiture and the repricing of our Tranche B-2 Facility.

(3) Includes loss on divestiture of $4.0 million and debt extinguishment costs of $0.8 million, or $3.1 million net of taxes, in connection with the Company's divestitures and the Refinancing Amendment.

19. Financial Information for the Company and Its Subsidiaries

The Company conducts substantially all of its business through its subsidiaries. The 6.125% Senior Notes, 5.125% Senior Notes, 5.625% Senior Notes and 6.500% senior notes are jointly and severally guaranteed on an unsecured senior basis by all of the Company's subsidiaries that guarantee the Company's obligations under the Amended and Restated Senior Credit Facility. Presented below is condensed consolidating financial information for the Company and its subsidiaries as of December 31, 2017 and 2016, and for the years ended December 31, 2017, 2016 and 2015. The information segregates the parent company (Acadia Healthcare Company, Inc.), the combined wholly-owned subsidiary guarantors, the combined non-guarantor subsidiaries and eliminations.

Acadia Healthcare Company, Inc.
Condensed Consolidating Balance Sheets
December 31, 2017
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Current assets:					
Cash and cash equivalents	$ —	$ 46,860	$ 20,430	$ —	$ 67,290
Accounts receivable, net	—	230,890	66,035	—	296,925
Other current assets	—	85,746	21,589	—	107,335
Total current assets	—	363,496	108,054	—	471,550
Property and equipment, net	—	1,086,802	1,961,328	—	3,048,130
Goodwill	—	1,936,057	815,117	—	2,751,174
Intangible assets, net	—	57,628	29,720	—	87,348
Deferred tax assets – noncurrent	2,370	—	3,731	(2,370)	3,731
Derivative instruments	12,997	—	—	—	12,997
Investment in subsidiaries	5,429,386	—	—	(5,429,386)	—
Other assets	381,913	38,860	7,807	(379,008)	49,572
Total assets	$5,826,666	$3,482,843	$2,925,757	$(5,810,764)	$6,424,502
Current liabilities:					
Current portion of long-term debt	$ 34,550	$ —	$ 280	$ —	$ 34,830
Accounts payable	—	70,767	31,532	—	102,299
Accrued salaries and benefits	—	69,057	29,990	—	99,047
Other accrued liabilities	36,196	27,676	77,341	—	141,213
Total current liabilities	70,746	167,500	139,143	—	377,389
Long-term debt	3,183,049	—	401,017	(379,008)	3,205,058
Deferred tax liabilities – noncurrent	—	27,975	54,728	(2,370)	80,333
Other liabilities	—	103,112	63,322	—	166,434
Total liabilities	3,253,795	298,587	658,210	(381,378)	3,829,214
Redeemable noncontrolling interests	—	—	22,417	—	22,417
Total equity	2,572,871	3,184,256	2,245,130	(5,429,386)	2,572,871
Total liabilities and equity	$5,826,666	$3,482,843	$2,925,757	$(5,810,764)	$6,424,502

Acadia Healthcare Company, Inc.
Condensed Consolidating Balance Sheets
December 31, 2016
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Current assets:					
Cash and cash equivalents	$ —	$ 15,681	$ 41,382	$ —	$ 57,063
Accounts receivable, net	—	209,124	54,203	—	263,327
Other current assets	—	61,724	45,813	—	107,537
Total current assets	—	286,529	141,398	—	427,927
Property and equipment, net	—	940,880	1,762,815	—	2,703,695
Goodwill	—	1,935,260	745,928	—	2,681,188
Intangible assets, net	—	56,676	26,634	—	83,310
Deferred tax assets – noncurrent	13,522	—	4,606	(14,348)	3,780
Derivative instruments	73,509	—	—	—	73,509
Investment in subsidiaries	4,885,865	—	—	(4,885,865)	—
Other assets	493,294	40,480	7,189	(489,646)	51,317
Total assets	$5,466,190	$3,259,825	$2,688,570	$(5,389,859)	$6,024,726
Current liabilities:					
Current portion of long-term debt	$ 34,550	$ —	$ 255	$ —	$ 34,805
Accounts payable	—	49,205	30,829	—	80,034
Accrued salaries and benefits	—	72,835	32,233	—	105,068
Other accrued liabilities	33,616	24,375	64,967	—	122,958
Total current liabilities	68,166	146,415	128,284	—	342,865
Long-term debt	3,230,300	—	512,350	(489,646)	3,253,004
Deferred tax liabilities – noncurrent	—	40,574	52,294	(14,348)	78,520
Other liabilities	—	101,938	62,921	—	164,859
Total liabilities	3,298,466	288,927	755,849	(503,994)	3,839,248
Redeemable noncontrolling interests	—	—	17,754	—	17,754
Total equity	2,167,724	2,970,898	1,914,967	(4,885,865)	2,167,724
Total liabilities and equity	$5,466,190	$3,259,825	$2,688,570	$(5,389,859)	$6,024,726

Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Comprehensive Income
Year Ended December 31, 2017
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Revenue before provision for doubtful accounts	$ —	$1,746,656	$1,130,578	$ —	$2,877,234
Provision for doubtful accounts	—	(35,636)	(5,282)	—	(40,918)
Revenue	—	1,711,020	1,125,296	—	2,836,316
Salaries, wages and benefits	23,467	902,180	610,513	—	1,536,160
Professional fees	—	93,991	102,232	—	196,223
Supplies	—	75,248	39,191	—	114,439
Rents and leases	—	33,365	43,410	—	76,775
Other operating expenses	—	217,900	113,927	—	331,827
Depreciation and amortization	—	66,482	76,528	—	143,010
Interest expense, net	61,872	81,274	32,861	—	176,007
Debt extinguishment costs	810	—	—	—	810
Transaction-related expenses	—	11,236	13,031	—	24,267
Total expenses	86,149	1,481,676	1,031,693	—	2,599,518
(Loss) income from continuing operations before income taxes	(86,149)	229,344	93,603	—	236,798
Equity in earnings of subsidiaries	259,282	—	—	(259,282)	—
(Benefit from) provision for income taxes	(26,456)	69,882	(6,217)	—	37,209
Income (loss) from continuing operations	199,589	159,462	99,820	(259,282)	199,589
Income from discontinued operations, net of income taxes	—	—	—	—	—
Net income (loss)	199,589	159,462	99,820	(259,282)	199,589
Net loss attributable to noncontrolling interests	—	—	246	—	246
Net income attributable to Acadia Healthcare Company, Inc.	$199,589	$ 159,462	$ 100,066	$ (259,282)	$ 199,835
Other comprehensive income:					
Foreign currency translation gain	—	—	207,341	—	207,341
Loss on derivative instruments	(33,431)	—	—	—	(33,431)
Pension liability adjustment, net	—	—	1,542	—	1,542
Other comprehensive income	(33,431)	—	208,883	—	175,452
Comprehensive income (loss)	$166,158	$ 159,462	$ 308,949	$ (259,282)	$ 375,287

Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Comprehensive Income
Year Ended December 31, 2016
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Revenue before provision for doubtful accounts	$ —	$1,662,734	$1,190,089	$ —	$2,852,823
Provision for doubtful accounts	—	(38,349)	(3,560)	—	(41,909)
Revenue	—	1,624,385	1,186,529	—	2,810,914
Salaries, wages and benefits	28,345	865,104	648,405	—	1,541,854
Professional fees	—	89,062	96,424	—	185,486
Supplies	—	76,246	41,179	—	117,425
Rents and leases	—	34,540	38,808	—	73,348
Other operating expenses	—	206,308	106,248	—	312,556
Depreciation and amortization	—	58,018	77,085	—	135,103
Interest expense, net	50,921	75,848	54,556	—	181,325
Debt extinguishment costs	4,253	—	—	—	4,253
Loss on divestiture	—	778	178,031	—	178,809
Gain on foreign currency derivatives	(523)	—	—	—	(523)
Transaction-related expenses	—	32,173	16,150	—	48,323
Total expenses	82,996	1,438,077	1,256,886	—	2,777,959
(Loss) income from continuing operations before income taxes	(82,996)	186,308	(70,357)	—	32,955
Equity in earnings of subsidiaries	65,560	—	—	(65,560)	—
(Benefit from) provision for income taxes	(21,612)	68,335	(17,944)	—	28,779
Income (loss) from continuing operations	4,176	117,973	(52,413)	(65,560)	4,176
Income from discontinued operations, net of income taxes	—	—	—	—	—
Net income (loss)	4,176	117,973	(52,413)	(65,560)	4,176
Net loss attributable to noncontrolling interests	—	—	1,967	—	1,967
Net income attributable to Acadia Healthcare Company, Inc.	$ 4,176	$ 117,973	$ (50,446)	$ (65,560)	$ 6,143
Other comprehensive income:					
Foreign currency translation loss	—	—	(477,772)	—	(477,772)
Gain on derivative instruments	40,598	—	—	—	40,598
Pension liability adjustment, net	—	—	(7,749)	—	(7,749)
Other comprehensive income	40,598	—	(485,521)	—	(444,923)
Comprehensive income (loss)	$ 44,774	$ 117,973	$ (535,967)	$ (65,560)	$ (438,780)

Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Comprehensive Income
Year Ended December 31, 2015
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Revenue before provision for doubtful accounts	$ —	$1,415,016	$ 414,603	$ —	$1,829,619
Provision for doubtful accounts	—	(32,614)	(2,513)	—	(35,127)
Revenue	—	1,382,402	412,090	—	1,794,492
Salaries, wages and benefits	20,472	726,215	227,045	—	973,732
Professional fees	—	83,422	33,041	—	116,463
Supplies	—	65,077	15,586	—	80,663
Rents and leases	—	29,094	3,434	—	32,528
Other operating expenses	—	170,018	36,728	—	206,746
Depreciation and amortization	—	41,768	21,782	—	63,550
Interest expense, net	68,533	17,476	20,733	—	106,742
Debt extinguishment costs	10,818	—	—	—	10,818
Loss on foreign currency derivatives	1,926	—	—	—	1,926
Transaction-related expenses	—	24,914	11,657	—	36,571
Total expenses	101,749	1,157,984	370,006	—	1,629,739
(Loss) income from continuing operations before income taxes	(101,749)	224,418	42,084	—	164,753
Equity in earnings of subsidiaries	176,178	—	—	(176,178)	—
(Benefit from) provision for income taxes	(37,047)	85,765	4,670	—	53,388
Income (loss) from continuing operations	111,476	138,653	37,414	(176,178)	111,365
Income from discontinued operations, net of income taxes	—	111	—	—	111
Net income (loss)	111,476	138,764	37,414	(176,178)	111,476
Net loss attributable to noncontrolling interests	—	—	1,078	—	1,078
Net income attributable to Acadia Healthcare Company, Inc.	$ 111,476	$ 138,764	$ 38,492	$ (176,178)	$ 112,554
Other comprehensive income:					
Foreign currency translation loss	—	—	(40,103)	—	(40,103)
Pension liability adjustment, net	—	—	3,826	—	3,826
Other comprehensive income	—	—	(36,277)	—	(36,277)
Comprehensive income (loss)	$ 111,476	$ 138,764	$ 2,215	$ (176,178)	$ 76,277

Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Cash Flows
Year Ended December 31, 2017
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Operating activities:					
Net income (loss)	$ 199,589	$ 159,462	$ 99,820	$ (259,282)	$ 199,589
Adjustments to reconcile net income (loss) to net cash (used in) provided by continuing operating activities:					
Equity in earnings of subsidiaries	(259,282)	—	—	259,282	—
Depreciation and amortization	—	66,482	76,528	—	143,010
Amortization of debt issuance costs	10,270	—	(415)	—	9,855
Equity-based compensation expense	23,467	—	—	—	23,467
Deferred income tax expense	1,236	28,882	1,254	—	31,372
Debt extinguishment costs	810	—	—	—	810
Other	4,189	2,498	4,725	—	11,412
Change in operating assets and liabilities, net of effect of acquisitions:					
Accounts receivable, net	—	(21,791)	(6,779)	—	(28,570)
Other current assets	—	(6,429)	27,237	—	20,808
Other assets	24,549	(3,277)	101	(24,549)	(3,176)
Accounts payable and other accrued liabilities	—	4,909	(15,022)	—	(10,113)
Accrued salaries and benefits	—	(3,974)	(5,014)	—	(8,988)
Other liabilities	—	8,794	3,000	—	11,794
Net cash provided by (used in) continuing operating activities	4,828	235,556	185,435	(24,549)	401,270
Net cash used in discontinued operating activities	—	(1,693)	—	—	(1,693)
Net cash provided by (used in) operating activities	4,828	233,863	185,435	(24,549)	399,577
Investing activities:					
Cash paid for acquisitions, net of cash acquired	—	—	(18,191)	—	(18,191)
Cash paid for capital expenditures	—	(161,312)	(112,865)	—	(274,177)
Cash paid for real estate acquisitions	—	(37,047)	(4,010)	—	(41,057)
Other	—	(7,944)	4,843	—	(3,101)
Net cash used in investing activities	—	(206,303)	(130,223)	—	(336,526)
Financing activities:					
Principal payments on long-term debt	(34,550)	(14,250)	(10,554)	24,549	(34,805)
Repayment of long-term debt	(22,500)	—	—	—	(22,500)
Common stock withheld for minimum statutory taxes, net	(3,455)	—	—	—	(3,455)
Other	(539)	1,225	—	—	686
Cash provided by (used in) intercompany activity	56,216	16,644	(72,860)	—	—
Net cash (used in) provided by financing activities	(4,828)	3,619	(83,414)	24,549	(60,074)
Effect of exchange rate changes on cash	—	—	7,250	—	7,250
Net increase in cash and cash equivalents	—	31,179	(20,952)	—	10,227
Cash and cash equivalents at beginning of the period	—	15,681	41,382	—	57,063
Cash and cash equivalents at end of the period	$ —	$ 46,860	$ 20,430	$ —	$ 67,290

Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Cash Flows
Year Ended December 31, 2016
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Operating activities:					
Net income (loss)	$ 4,176	$ 117,973	$ (52,413)	$ (65,560)	$ 4,176
Adjustments to reconcile net income (loss) to net cash (used in) provided by continuing operating activities:					
Equity in earnings of subsidiaries	(65,560)	—	—	65,560	—
Depreciation and amortization	—	58,018	77,085	—	135,103
Amortization of debt issuance costs	10,751	—	(427)	—	10,324
Equity-based compensation expense	28,345	—	—	—	28,345
Deferred income tax (benefit) expense	(2,172)	50,611	(19,792)	—	28,647
Loss from discontinued operations, net of taxes	—	—	—	—	—
Debt extinguishment costs	4,253	—	—	—	4,253
Loss on divestiture	—	778	178,031	—	178,809
(Gain) loss on foreign currency derivatives	(523)	—	—	—	(523)
Other	—	4,022	693	—	4,715
Change in operating assets and liabilities, net of effect of acquisitions:					
Accounts receivable, net	—	(24,017)	8,299	—	(15,718)
Other current assets	—	(3,138)	(17,510)	—	(20,648)
Other assets	(3,109)	(4,048)	(306)	3,109	(4,354)
Accounts payable and other accrued liabilities	—	(45,552)	68,245	—	22,693
Accrued salaries and benefits	—	3,844	(12,416)	—	(8,572)
Other liabilities	—	4,050	434	—	4,484
Net cash (used in) provided by continuing operating activities	(23,839)	162,541	229,923	3,109	371,734
Net cash used in discontinued operating activities	—	(10,256)	—	—	(10,256)
Net cash (used in) provided by operating activities	(23,839)	152,285	229,923	3,109	361,478
Investing activities:					
Cash paid for acquisitions, net of cash acquired	—	(103,359)	(580,096)	—	(683,455)
Cash paid for capital expenditures	—	(177,593)	(129,879)	—	(307,472)
Cash paid for real estate acquisitions	—	(28,956)	(11,801)	—	(40,757)
Settlement of foreign currency derivatives	—	523	—	—	523
Cash received for divestiture	370,000	7,859	(4,593)	—	373,266
Other	—	(1,573)	(897)	—	(2,470)
Net cash used in investing activities	370,000	(303,099)	(727,266)	—	(660,365)
Financing activities:					
Borrowings on long-term debt	1,480,000	—	—	—	1,480,000
Borrowings on revolving credit facility	179,000	—	—	—	179,000
Principal payments on revolving credit facility	(337,000)	—	—	—	(337,000)
Principal payments on long-term debt	(49,706)	(293,000)	(3,344)	296,109	(49,941)
Repayment of assumed debt	(1,348,389)	—	—	—	(1,348,389)
Repayment of long-term debt	(200,594)	—	—	—	(200,594)
Payment of debt issuance costs	(36,649)	—	—	—	(36,649)
Issuance of common stock	685,097	—	—	—	685,097
Common stock withheld for minimum statutory taxes, net	(8,846)	—	—	—	(8,846)
Other	(1,149)	(2,688)	—	—	(3,837)
Cash (used in) provided by intercompany activity	(707,925)	460,196	546,947	(299,218)	—
Net cash provided by (used in) financing activities	(346,161)	164,508	543,603	(3,109)	358,841
Effect of exchange rate changes on cash	—	—	(14,106)	—	(14,106)
Net increase in cash and cash equivalents	-	13,694	32,154	—	45,848
Cash and cash equivalents at beginning of the period	—	1,987	9,228	—	11,215
Cash and cash equivalents at end of the period	$ —	$ 15,681	$ 41,382	$ —	$ 57,063

Acadia Healthcare Company, Inc.
Condensed Consolidating Statement of Cash Flows
Year Ended December 31, 2015
(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Operating activities:					
Net income (loss)	$ 111,476	$ 138,764	$ 37,414	$ (176,178)	$ 111,476
Adjustments to reconcile net income (loss) to net cash (used in) provided by continuing operating activities:					
Equity in earnings of subsidiaries	(176,178)	—	—	176,178	—
Depreciation and amortization	—	41,768	21,782	—	63,550
Amortization of debt issuance costs	7,147	—	(438)	—	6,709
Equity-based compensation expense	20,472	—	—	—	20,472
Deferred income tax (benefit) expense	617	42,246	750	—	43,613
Loss from discontinued operations, net of taxes	—	(111)	—	—	(111)
Debt extinguishment costs	10,818	—	—	—	10,818
Loss (gain) on foreign currency derivatives	1,926	—	—	—	1,926
Other	—	1,582	33	—	1,615
Change in operating assets and liabilities, net of effect of acquisitions:					
Accounts receivable, net	—	(18,632)	(6,322)	—	(24,954)
Other current assets	—	(1,152)	(1,565)	—	(2,717)
Other assets	(1,100)	(8,567)	546	1,100	(8,021)
Accounts payable and other accrued liabilities	—	(7,583)	14,451	—	6,868
Accrued salaries and benefits	—	312	1,346	—	1,658
Other liabilities	—	9,350	(114)	—	9,236
Net cash (used in) provided by continuing operating activities	(24,822)	197,977	67,883	1,100	242,138
Net cash provided by discontinued operating activities	—	(1,735)	—	—	(1,735)
Net cash (used in) provided by operating activities	(24,822)	196,242	67,883	1,100	240,403
Investing activities:					
Cash paid for acquisitions, net of cash acquired	—	(254,848)	(319,929)	—	(574,777)
Cash paid for capital expenditures	—	(172,329)	(103,718)	—	(276,047)
Cash paid for real estate acquisitions	—	(25,293)	(1,329)	—	(26,622)
Settlement of foreign currency derivatives	—	(1,926)	—	—	(1,926)
Other	—	(5,099)	—	—	(5,099)
Net cash used in investing activities	—	(459,495)	(424,976)	—	(884,471)
Financing activities:					
Borrowings on long-term debt	1,150,000	—	—	—	1,150,000
Borrowings on revolving credit facility	468,000	—	—	—	468,000
Principal payments on revolving credit facility	(310,000)	—	—	—	(310,000)
Principal payments on long-term debt	(31,965)	—	(1,315)	1,315	(31,965)
Repayment of assumed debt	(904,467)	—	—	—	(904,467)
Repayment of long-term debt	(97,500)	—	—	—	(97,500)
Payment of debt issuance costs	(26,421)	—	—	—	(26,421)
Payment of premium on senior notes	(7,480)	—	—	—	(7,480)
Issuance of common stock, net	331,308	—	—	—	331,308
Common stock withheld for minimum statutory taxes, net	(7,762)	—	—	—	(7,762)
Excess tax benefit from equity awards	309	—	—	—	309
Other	—	(420)	—	—	(420)
Cash (used in) provided by intercompany activity	(539,200)	191,334	350,281	(2,415)	—
Net cash provided by (used in) financing activities	24,822	190,914	348,966	(1,100)	563,602
Effect of exchange rate changes on cash	—	(2,359)	—	—	(2,359)
Net (decrease) increase in cash and cash equivalents	—	(74,698)	(8,127)	—	(82,825)
Cash and cash equivalents at beginning of the period	—	76,685	17,355	—	94,040
Cash and cash equivalents at end of the period	$ —	$ 1,987	$ 9,228	$ —	$ 11,215

SIGNATURES

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

Acadia Healthcare Company, Inc.

By: /s/ JOEY A. JACOBS
Joey A. Jacobs
Chairman of the Board and Chief Executive Officer

Dated: February 27, 2018

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

Signature	Title	Date
/s/ JOEY A. JACOBS Joey A. Jacobs	Chairman of the Board and Chief Executive Officer (Principal Executive Officer)	February 27, 2018
/s/ DAVID M. DUCKWORTH David M. Duckworth	Chief Financial Officer (Principal Financial Officer and Principal Accounting Officer)	February 27, 2018
/s/ E. PEROT BISSELL E. Perot Bissell	Director	February 27, 2018
/s/ CHRISTOPHER R. GORDON Christopher R. Gordon	Director	February 27, 2018
/s/ VICKY B. GREGG Vicky B. Gregg	Director	February 27, 2018
/s/ WILLIAM F. GRIECO William F. Grieco	Director	February 27, 2018
/s/ WADE D. MIQUELON Wade D. Miquelon	Director	February 27, 2018
/s/ WILLIAM M. PETRIE William M. Petrie	Director	February 27, 2018
/s/ HARTLEY R. ROGERS Hartley R. Rogers	Director	February 27, 2018
/s/ REEVE B. WAUD Reeve B. Waud	Director	February 27, 2018

EXHIBIT 21

LIST OF SUBSIDIARIES

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction of Incorporation or Organization
Abilene Legacy Sub, LLC	Delaware
dba Abilene Behavioral Health	
Abilene Holding Company, LLC	Delaware
Acadia Assurance Company	Tennessee
Acadia Chattanooga Holdings, LLC	Tennessee
Acadia Columbus JV Holdings, LLC	Delaware
Acadia Crestwyn Holdings, LLC	Delaware
Acadia Greenville Holdings, LLC	Delaware
Acadia JV Holdings, LLC	Delaware
Acadia LaPlace Holdings, LLC	Delaware
Acadia Management Company, LLC	Delaware
Acadia Merger Sub, LLC	Delaware
Acadia New Bedford Holdings, LLC	Delaware
Acadia Reading Holdings, LLC	Delaware
Acadia Realty Holdings, LLC	Delaware
Acadia South Florida Holdings, LLC	Delaware
Acadiana Addiction Center, LLC	Delaware
dba Acadiana Addiction Center	
Advanced Treatment Systems, LLC	Virginia
dba Coatesville Treatment Center	
dba Lebanon Treatment Center	
Affinity Healthcare Holdings Limited	United Kingdom
Affinity Healthcare Limited	United Kingdom
Affinity Hospitals Holding Limited	United Kingdom
Affinity Hospitals Group Limited	United Kingdom
Affinity Hospitals Limited	United Kingdom
AHC- WW Jersey Limited	Jersey
Amore (Ben Madigan) Limited	United Kingdom
Amore (Bourne) Limited	United Kingdom
Amore Care Limited	United Kingdom
Amore Care (Holdings) Limited	United Kingdom
Amore (Cockermouth) Limited	United Kingdom
Amore (Coventry) Limited	Isle of Man
Amore Elderly Care Holdings Limited	United Kingdom
Amore Elderly Care Limited	United Kingdom
Amore Elderly Care (Wednesfield) Limited	United Kingdom
Amore Group (Holdings) Limited	United Kingdom
Amore (Ings Road) Limited	United Kingdom
Amore (Prestwick) Limited	United Kingdom
Amore (Stoke 1) Limited	United Kingdom
Amore (Stoke 2) Limited	United Kingdom
Amore (Warrenpoint) Limited	United Kingdom
Amore (Watton) Limited	United Kingdom
Amore (Wednesfield 1) Limited	United Kingdom
Amore (Wednesfield 2) Limited	United Kingdom
Ascent Acquisition—CYPDC, LLC	Arkansas
dba Ascent Acquisition—CYPDC	
Ascent Acquisition—PSC, LLC	Arkansas
dba Ascent Acquisition—PSC	
Ascent Acquisition, LLC	Arkansas
dba Ascent Children's Health Services	
dba Ascent	
Aspen Education Group, Inc.	California

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction of Incorporation or Organization
Aspen Youth, Inc.	California
Aspire Scotland Holdings Limited.	United Kingdom
Aspire Scotland Limited.	United Kingdom
Atlanta Recovery Center, LLC	Delaware
ATS of Cecil County, LLC	Virginia
dba Cumberland Treatment Center	
dba Elkton Treatment Center	
dba Pine Heights Treatment Center	
ATS of Delaware, LLC	Virginia
dba Claymont Treatment Center	
ATS of North Carolina, LLC	Virginia
dba Carolina Treatment Center of Fayetteville	
dba Carolina Treatment Center Of Pinehurst	
dba Carolina Treatment Center Of Goldsboro	
dba Cumberland County Treatment Center	
dba Mountain Health Solutions – North Wilkesboro	
dba Mountain Health Solutions – Asheville	
dba Winston-Salem Comprehensive Treatment Center	
Austin Behavioral Hospital, LLC	Delaware
dba Cross Creek Hospital	
dba Cross Creek Behavioral Hospital	
Austin Eating Disorders Partners, LLC	Missouri
dba McCallum Place Austin	
dba Cedar Springs Austin	
Autism (GB) Limited	United Kingdom
Autism Tasce Services Limited.	United Kingdom
Azure Acres Treatment Center, LLC	Delaware
Baton Rouge Treatment Center, LLC	Louisiana
dba Baton Rouge Treatment Center	
dba North Louisiana Treatment Center	
dba North Shore Treatment Center	
Bayside Marin, Inc.	Delaware
dba Bayside Marin I	
dba Bayside Marin II	
dba Bayside Marin III	
dba Bayside Marin IV	
dba Bayside San Francisco	
BCA of Detroit, LLC	Delaware
dba BCA Stonecrest Center	
dba StoneCrest Center	
Beckley Treatment Center, LLC	West Virginia
dba Beckley Treatment Center	
Belmont Behavioral Hospital, LLC	Delaware
dba Philadelphia Children's Crisis Response Center	
Belmont Physician Services, LLC	Delaware
Bethlehem Behavioral Health, LLC	Delaware
BGI of Brandywine, LLC	Virginia
dba Bowling Green at Brandywine	
Blenheim Healthcare Limited	United Kingdom
Blue Ridge Mountain Recovery Center, LLC	Delaware
Bowling Green Inn of Pensacola, LLC	Virginia
dba Twelve Oaks	
dba Twelve Oaks Treatment Center	
dba Wellness Resource Center	
Bowling Green Inn of South Dakota, Inc.	Virginia
dba Keystone Treatment Center	
Burnside Care Limited	United Kingdom

Name of Subsidiary (including dba name, if applicable)	Jurisdiction of Incorporation or Organization
California Treatment Services, LLC	California
dba Recovery Solutions of Santa Ana	
Canopy Cove, LLC	Delaware
Capestrano Investment Company, Inc.	Puerto Rico
Capestrano Realty Company, Inc.	Puerto Rico
CAPS of Virginia, LLC	Virginia
Cartersville Center, LLC	Georgia
dba Cartersville Center	
dba Cartersville Comprehensive Treatment Center	
Cascade Behavioral Holding Company, LLC	Delaware
Cascade Behavioral Hospital, LLC	Delaware
dba Cascade Behavioral Health	
Care Continuums Limited	United Kingdom
Castlecare Group Limited	United Kingdom
Castlecare Holdings Limited	United Kingdom
Castle Homes Limited	United Kingdom
Castle Homes Care Limited	United Kingdom
Castlecare Cymru Limited	United Kingdom
Castlecare Education Limited	United Kingdom
Cedar Crest Clinic	Texas
Center for Behavioral Health-HA, LLC	Pennsylvania
Center for Behavioral Health-ME, Inc.	Maine
dba Discovery House	
Center for Behavioral Health-PA, LLC	Pennsylvania
Centerpointe Community Based Services, LLC	Indiana
Charleston Treatment Center, LLC	West Virginia
dba Charleston Treatment Center	
Cheadle Royal Healthcare Limited	United Kingdom
Cheadle Royal Hospital Limited	United Kingdom
Cheadle Royal Residential Services Limited	United Kingdom
Chelfham Senior School Limited	United Kingdom
Clarksburg Treatment Center, LLC	West Virginia
dba Clarksburg Treatment Center	
Clearbrook Treatment Centers, LLC	Pennsylvania
dba Huntington Creek Recovery Center	
Clearbrook Treatment Centers Land, LLC	Pennsylvania
CO Developments Limited	United Kingdom
Cockermouth Propco Limited	United Kingdom
Commodore Acquisition Sub, LLC	Delaware
Community Addiction Services Limited	United Kingdom
Conquest Care Homes (Norfolk) Limited	United Kingdom
Conquest Care Homes (Peterborough) Limited	United Kingdom
Conquest Care Homes (Soham) Limited	United Kingdom
Conway Behavioral Health, LLC	Delaware
Cotswold Care Services Limited	United Kingdom
Coxlease Holdings Limited	United Kingdom
Coxlease School Limited	United Kingdom
CPCA, LLC	Delaware
dba Ann Arbor Treatment Center	
dba Cedar Rapids Treatment Center	
dba Holland Treatment Center	
dba Midcoast Treatment Center	
dba Western Michigan Treatment Center	
Craegmoor Group Limited	United Kingdom
Craegmoor Limited	United Kingdom
Craegmoor Care (Holdings) Limited	United Kingdom
Craegmoor Facilities Company Limited	United Kingdom

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction of Incorporation or Organization
Craegmoor Group (No. 1) Limited	United Kingdom
Craegmoor Group (No. 2) Limited	United Kingdom
Craegmoor Group (No. 3) Limited	United Kingdom
Craegmoor Group (No. 5) Limited	United Kingdom
Craegmoor Group (No. 6) Limited	United Kingdom
Craegmoor (Harbour Care) Limited	United Kingdom
Craegmoor Healthcare Company Limited	United Kingdom
Craegmoor Holdings Limited	United Kingdom
Craegmoor Homes Limited	United Kingdom
Craegmoor Hospitals (Holdings) Limited	United Kingdom
Craegmoor Learning (Holdings) Limited	United Kingdom
Craegmoor Supporting You Limited	United Kingdom
CRC ED Treatment, LLC	Delaware
dba Center for Hope of the Sierras	
dba Montecatini	
dba Montecatini II	
dba Carolina House	
dba Carolina House-Raleigh	
dba Montecatini Outpatient Treatment Center	
CRC Group, LLC	Delaware
CRC Health, LLC	Delaware
dba eGetgoing	
CRC Health Oregon, LLC	Oregon
dba Allied Health Services Portland -Alder	
dba Allied Health Services Ontario	
dba Allied Health Services Portland—Belmont	
dba Allied Health Services East	
dba Allied Health Services Portland—Burnside	
dba Allied Health Services Beaverton	
dba Allied Health Services—Medford	
dba Health Services Treasure Valley	
dba Willamette Valley Treatment Center	
dba Allied Health Services for Drug Recovery	
CRC Health Tennessee, LLC	Tennessee
dba New Life Lodge	
dba New Life Recovery Services-Cookeville	
dba Mirror Lake Recovery Center	
dba New Life Recovery Services-Jacksboro	
dba New Life Recovery Services-Jamestown	
dba New Life Recovery Services-Knoxville	
dba New Life Recovery Services-Knoxville West	
CRC Health Treatment Clinics, LLC	Delaware
dba North Florida Treatment Center	
dba Maricopa County Comprehensive Treatment Center	
dba Hattiesburg Comprehensive Treatment Center	
dba Gulf Coast Comprehensive Treatment Center	
dba Jackson Comprehensive Treatment Center	
dba Shelbyville Comprehensive Treatment Center	
dba Southaven Comprehensive Treatment Center	
dba Kentuckian Comprehensive Treatment Center	
CRC Recovery, Inc.	Delaware
dba Midcoast Treatment Center	
dba Cedar Rapids Treatment Center	
dba Ann Arbor Treatment Center	
dba Western Michigan Treatment Center	
CRC Wisconsin RD, LLC	Wisconsin
dba Burkwood Treatment Center	

Name of Subsidiary (including dba name, if applicable)	Jurisdiction of Incorporation or Organization
Crestwyn Health Group, LLC	Tennessee
Crossroads Regional Hospital, LLC	Delaware
dba Longleaf Hospital	
Cumberland Behavioral Health, LLC	Delaware
Delta Medical Services, LLC	Tennessee
Detroit Behavioral Institute, LLC	Massachusetts
dba Capstone Academy	
dba Detroit Behavioral Institute – Capstone Program	
dba Detroit Capstone	
DHG Services, LLC	Delaware
Discovery House, LLC	Pennsylvania
Discovery House-BC, LLC	Pennsylvania
Discovery House-BR, Inc.	Maine
Discovery House CC, LLC	Pennsylvania
Discovery House CU, LLC	Pennsylvania
Discovery House-Group, LLC	Delaware
Discovery House-HZ, LLC	Pennsylvania
Discovery House-LT, Inc.	Utah
Discovery House MA, Inc.	Maine
Discovery House Monroeville, LLC	Pennsylvania
Discovery House-NC, LLC	Pennsylvania
Discovery House of Central Maine, Inc.	Maine
Discovery House TV, Inc.	Utah
Discovery House-UC, Inc.	Utah
Discovery House Utah, Inc.	Utah
Discovery House WC, Inc.	Maine
DMC-Memphis, LLC	Tennessee
Duffy's Napa Valley Rehab, LLC	Delaware
Dunhall Property Limited	United Kingdom
East Indiana Treatment Center, LLC	Indiana
dba East Indiana Treatment Center	
Eastwood Grange Company Limited	United Kingdom
El Paso Behavioral Hospital, LLC	Delaware
Employee Management Services Limited	United Kingdom
Evansville Treatment Center, LLC	Indiana
dba Evansville Treatment Center	
Fanplate Limited	United Kingdom
Farleigh Schools Limited	United Kingdom
Farm Place Limited	United Kingdom
FenX Healthcare, LLC	Delaware
Ferguson Care Limited	United Kingdom
Four Circles Recovery Center, LLC	Delaware
dba Four Circles Evolution	
Fulford Grange Medical Centre Limited	United Kingdom
Galaxy Cafe Limited	United Kingdom
Galax Treatment Center, LLC	Virginia
dba Life Center of Galax	
dba New River Treatment Center	
dba Clinch Valley Treatment Center	
Galaxy UK Leisure Limited	United Kingdom
Generations BH, LLC	Ohio
Gifford Street Wellness Center, LLC	Delaware
Greymount Properties Limited	United Kingdom
Greenbrier Acquisition, LLC	Delaware
Greenbrier Holdings, L.L.C.	Louisiana
Greenbrier Hospital, L.L.C.	Louisiana
Greenbrier Realty, L.L.C.	Louisiana

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction of Incorporation or Organization
Greenleaf Center, LLC	Delaware
dba Greenleaf Center	
dba Greenleaf Behavioral Health Hospital	
Greenville Behavioral Health, LLC	Delaware
Grovedraft Limited	United Kingdom
Habilitation Center, LLC	Arkansas
dba Millcreek of Arkansas	
Habit Opco, LLC	Delaware
dba Habit OPCO – West Lebanon	
dba Habit OPCO – Manchester	
dba Habit OPCO – Wareham	
dba Habit OPCO – Lynn	
dba Habit OPCO – Boston	
dba Habit OPCO – Brattleboro	
dba Habit OPCO – Pottstown	
dba Habit OPCO – Suburban Treatment Associates	
dba Habit OPCO – Strathmore Treatment Associates	
dba Habit OPCO – Allentown	
dba Habit OPCO – Dunmore	
dba Habit OPCO – Pottstown	
dba Habit OPCO – Taunton	
dba Habit OPCO – Springfield	
dba Habit OPCO – Fitchburg	
dba Habit OPCO – Fall River	
dba Habit OPCO – Lowell	
dba Habit OPCO – Watsontown	
Harbour Care (UK) Limited	United Kingdom
HCP Polaris Investment, LLC	Delaware
Health & Care Services (NW) Limited	United Kingdom
Health & Care Services (UK) Limited	United Kingdom
Heddfan Care Limited	United Kingdom
Helden Homes Limited	United Kingdom
Hendersonville Recovery Center, LLC	Delaware
Henryville Inn, LLC	Pennsylvania
Hermitage Behavioral, LLC	Delaware
Highbank Private Hospital Limited	United Kingdom
High Quality Lifestyles Limited	United Kingdom
HMHI Cedar Crest, LLC	Delaware
dba Cedar Crest Hospital & RTC	
Huntington Treatment Center, LLC	West Virginia
dba Huntington Treatment Center	
Independent Community Living (Holdings) Limited	England and Wales
Indianapolis Treatment Center, LLC	Indiana
dba Indianapolis Treatment Center	
IVRTC, LLC	Delaware
J C Care Limited	United Kingdom
Jacques Hall Development Limited	United Kingdom
Jacques Hall Limited	United Kingdom
Johnston Care Limited	United Kingdom
Kids Behavioral Health of Montana, Inc.	Montana
dba Acadia Montana	
Lambs Support Services Limited	United Kingdom
Lakeland Hospital Acquisition, LLC	Georgia
dba Lakeland Regional Hospital	
dba Lakeland Behavioral Health System	
Lansdowne Road Limited	United Kingdom
Libra Health Limited	United Kingdom

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction of Incorporation or Organization
Libra Nursing Homes Limited	United Kingdom
Life Works Community Limited	United Kingdom
Lothlorien Community Limited	United Kingdom
Manor Hall Specialist Care Partnerships Limited	England and Wales
Mark College Limited	United Kingdom
Medical Imaging (Essex) Limited	United Kingdom
McCallum Group, LLC	Missouri
McCallum Properties, LLC	Missouri
Middleton St George Healthcare Limited	United Kingdom
Millcreek School of Arkansas, LLC	Arkansas
Millcreek Schools, LLC	Mississippi
Milwaukee Health Services System, LLC	California
dba 10th Street Clinic	
dba River's Shore Clinic	
dba Madison Health Services	
dba Valley Health Services	
dba Wausau Health Services	
dba Appleton Comprehensive Treatment Center	
dba Madison East Comprehensive Treatment Center	
dba 10th Street Comprehensive Treatment Center	
dba River's Shore Comprehensive Treatment Center	
dba Wausau Comprehensive Treatment Center	
dba North West Wisconsin Comprehensive Treatment Center	
Mississippi Comprehensive Treatment Centers, LLC	Delaware
Mount Bachelor Educational Center, Inc.	Oregon
Mount Carmel Behavioral Healthcare, LLC	Delaware
New Directions (Bexhill) Limited	United Kingdom
New Directions (Hastings) Limited	United Kingdom
New Directions (Robertsbridge) Limited	United Kingdom
New Directions (St. Leonards on Sea) Limited	United Kingdom
Next Generation Behavioral Health, LLC	Delaware
North Hill House Limited	United Kingdom
Northeast Behavioral Health, LLC	Delaware
Notteor 6 Limited	United Kingdom
Ochsner-Acadia, LLC	Delaware
dba River Place Behavioral Health	
Ohio Hospital for Psychiatry, LLC	Ohio
Ohio Treatment Center, LLC	Delaware
dba Cleveland Comprehensive Treatment Center	
dba Canton Comprehensive Treatment Center	
dba Toledo Comprehensive Treatment Center	
Options Treatment Center Acquisition Corporation	Indiana
dba Options Behavioral Health System	
dba Options Treatment Center	
dba YFCS OPT	
Parkcare Homes Limited	United Kingdom
Parkcare Homes (No. 2) Limited	United Kingdom
Park Royal Fee Owner, LLC	Delaware
Parkersburg Treatment Center, LLC	West Virginia
dba Parkersburg Treatment Center	
Partnerships in Care Limited	England and Wales
Partnerships in Care 1 Limited	England and Wales
Partnerships in Care (Albion) Limited	England and Wales
Partnerships in Care (Brunswick) Limited	England and Wales
Partnerships in Care (Beverley) Limited	England and Wales
Partnerships in Care (Cardiff) Limited	England and Wales
Partnerships in Care (Cleveland) Limited	England and Wales

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction of Incorporation or Organization
Partnerships in Care (Cleveland) Holding Company Limited	England and Wales
Partnerships in Care (Cleveland) Property Holding Company Limited	England and Wales
Partnerships in Care (Ivydene) Limited	England and Wales
Partnerships in Care (Meadow View) Limited	United Kingdom
Partnerships in Care (Nelson) Limited	England and Wales
Partnership in Care (Oaktree) Limited	England and Wales
Partnerships in Care (Oak Vale) Holding Company Limited	England and Wales
Partnerships in Care (Oak Vale) Limited	England and Wales
Partnerships in Care (Oak Vale) Property Holding Company Limited	England and Wales
Partnerships in Care (Pastoral) Limited	England and Wales
Partnerships in Care (Rhondda) Limited	England and Wales
Partnerships in Care Scotland Limited	England and Wales
Partnerships in Care (Schools) Limited	England and Wales
Partnerships in Care (Vancouver) Holding Company Limited	England and Wales
Partnerships in Care (Vancouver) Limited	England and Wales
Partnerships in Care (Vancouver) Property Holding Company Limited	England and Wales
Partnerships in Care Investments 1 Limited	England and Wales
Partnerships in Care Investments 2 Limited	England and Wales
Partnerships in Care Management Limited	England and Wales
Partnerships in Care Management 2 Limited	England and Wales
Partnerships in Care Property Holding Company Limited	England and Wales
Partnerships in Care Property 1 Limited	England and Wales
Partnerships in Care Property 2 Limited	England and Wales
Partnerships in Care Property 3 Limited	England and Wales
Partnerships in Care Property 4 Limited	England and Wales
Partnerships in Care Property 6 Limited	England and Wales
Partnerships in Care Property 7 Limited	England and Wales
Partnerships in Care Property 8 Limited	England and Wales
Partnerships in Care Property 9 Limited	England and Wales
Partnerships in Care Property 10 Limited	England and Wales
Partnerships in Care Property 11 Limited	England and Wales
Partnerships in Care Property 12 Limited	England and Wales
Partnerships in Care Property 14 Limited	England and Wales
Partnerships in Care Property 15 Limited	England and Wales
Partnerships in Care Property 16 Limited	England and Wales
Partnerships in Care Property 17 Limited	England and Wales
Partnerships in Care Property 19 Limited	England and Wales
Partnerships in Care Property 20 Limited	England and Wales
Partnerships in Care Property 21 Limited	England and Wales
Partnerships in Care Property 22 Limited	England and Wales
Partnerships in Care Property 24 Limited	England and Wales
Partnerships in Care Property 26 Limited	England and Wales
Partnerships in Care Property 27 Limited	England and Wales
Partnerships in Care Property 28 Limited	England and Wales
Partnerships in Care Property 29 Limited	England and Wales
Partnerships in Care Property 30 Limited	England and Wales
Partnerships in Care Property 31 Limited	England and Wales
Partnerships in Care UK 1 Limited	England and Wales
Partnerships in Care UK 2 Limited	England and Wales
Peninsula Autism Support and Services Limited	United Kingdom
PHC MeadowWood, LLC	Delaware

Name of Subsidiary *(including dba name, if applicable)*	Jurisdiction of Incorporation or Organization
PHC of Michigan, LLC	Massachusetts
dba Harbor Oaks Hospital	
dba Pioneer Healthcare of Michigan	
dba Wellplace Michigan	
PHC of Nevada, Inc.	Massachusetts
dba Harmony Healthcare	
PHC of Utah, Inc.	Massachusetts
dba Highland Ridge Hospital	
dba Wellplace Utah	
PHC of Virginia, LLC	Massachusetts
dba Mount Regis Center	
Philadelphia Crisis Response Center, LLC	Delaware
Piney Ridge Treatment Center, LLC	Delaware
dba Piney Ridge Treatment Center	
dba Piney Ridge Center	
dba Ridgeview Group Home	
Pocono Mountain Recovery Center, LLC	Pennsylvania
Pocono Mountain Recovery Center Land, LLC	Pennsylvania
Polaris Hospital Holdings, LLC	Nevada
Positive Living Limited	United Kingdom
Priory Behavioural Health Limited	United Kingdom
Priory Bristol (Property) Limited	Cayman Islands
Priory Central Services Limited	United Kingdom
Priory Care Homes Holdings Limited	United Kingdom
Priory Chadwick Lodge (Property) Limited	Cayman Islands
Priory Coach House (Property) Limited	Cayman Islands
Priory Condover (Property) Limited	Cayman Islands
Priory Coombe House (Property) Limited	Cayman Islands
Priory Eastwood Grange (Property) Limited	Cayman Islands
Priory Eden Grove (Property) Limited	Cayman Islands
Priory Education Services Limited	United Kingdom
Priory Farm Place (Property) Limited	Cayman Islands
Priory Finance Company Limited	Cayman Islands
Priory Finance Property Holdings No. 1 Limited	United Kingdom
Priory Finance Property Holdings No. 2 Limited	United Kingdom
Priory Finance Property LLP	United Kingdom
Priory Grange (Holdings) Limited	United Kingdom
Priory Grange (Potters Bar) Limited	United Kingdom
Priory Grange (St Neots) Limited	United Kingdom
Priory Group Limited	United Kingdom
Priory Group No. 1 Limited	United Kingdom
Priory Group No. 2 Limited	United Kingdom
Priory Group No. 3 Limited	United Kingdom
Priory Health No. 1 Limited	United Kingdom
Priory Health No. 2 Limited	Cayman Islands
Priory Healthcare Europe Limited	United Kingdom
Priory Healthcare Finance Co Limited	United Kingdom
Priory Healthcare Holdings Limited	United Kingdom
Priory Healthcare Investments Limited	United Kingdom
Priory Healthcare Limited	United Kingdom
Priory Healthcare Services Limited	United Kingdom
Priory Healthcare Investments Trustee Limited	United Kingdom
Priory Investments Holdings Limited	Cayman Islands
Priory Hemel Grange (Property) Limited	Cayman Islands
Priory Holdings Company No. 1 Limited	Cayman Islands
Priory Holdings Company No. 2 Limited	Cayman Islands
Priory Holdings Company No. 3 Limited	Cayman Islands

Name of Subsidiary (including dba name, if applicable)	Jurisdiction of Incorporation or Organization
Priory Hove (Property) Limited	Cayman Islands
Priory Hospitals Limited	United Kingdom
Priory Jacques Hall (Property) Limited	Cayman Islands
Priory Marchwood (Property) Limited	Cayman Islands
Priory Mark College (Property) Limited	Cayman Islands
Priory New Education Services Limited	United Kingdom
Priory New Investments Limited	United Kingdom
Priory New Investments No. 2 Limited	United Kingdom
Priory New Investments No. 3 Limited	United Kingdom
Priory Nottingham (Property) Limited	Cayman Islands
Priory Old Acute Services Limited	United Kingdom
Priory Old Grange Services Limited	United Kingdom
Priory Old Forensic Services Limited	United Kingdom
Priory Old Schools Services Limited	United Kingdom
Priory Pension Trustee Limited	United Kingdom
Priory Rehabilitation Services Limited	United Kingdom
Priory Rehabilitation Services Holdings Limited	United Kingdom
Priory Roehampton (Property) Limited	Cayman Islands
Priory Securitisation Limited	United Kingdom
Priory Securitisation Holdings Limited	United Kingdom
Priory Services for Young People (IOM) Limited	Isle of Man
Priory Sheridan House (Property) Limited	Cayman Islands
Priory Sketchley Hall (Property) Limited	Cayman Islands
Priory Solutions (Property) Limited	Cayman Islands
Priory Specialist Health Division Limited	United Kingdom
Priory Specialist Health Limited	United Kingdom
Priory Sturt (Property) Limited	Cayman Islands
Priory Tadley Court (Property) Limited	Cayman Islands
Priory (Thetford 1) Limited	United Kingdom
Priory (Thetford 2) Limited	United Kingdom
Priory (Troup House) Limited	United Kingdom
Priory Unsted Park (Property) Limited	Cayman Islands
Priory Widnes (Property) Limited	Cayman Islands
Progress Adult Services Limited	United Kingdom
Progress Care (Holdings) Limited	United Kingdom
Progress Care and Education Limited	United Kingdom
Psychiatric Resource Partners, LLC	Delaware
Public Health Solutions Limited	United Kingdom
Quality Addiction Management, Inc.	Wisconsin
dba West Milwaukee Comprehensive Treatment Center	
dba Racine Comprehensive Treatment Center	
dba Madison West Comprehensive Treatment Center	
dba Waukesha Comprehensive Treatment Center	
dba Sheboygan Comprehensive Treatment Center	
dba Green Bay Comprehensive Treatment Center	
dba Beloit Comprehensive Treatment Center	
Quantum Care (UK) Limited	United Kingdom
R. J. Homes Limited	United Kingdom
Reading Behavioral Healthcare, LLC	Delaware
Rebound Behavioral Health, LLC	South Carolina
Red River Holding Company, LLC	Delaware
Red River Hospital, LLC	Delaware
dba Red River Hospital	
Rehabilitation Centers, LLC	Mississippi
dba Millcreek of Magee	
dba Millcreek of Pontotoc	
dba Millcreek of Mississippi	

Name of Subsidiary (including d/b/a name, if applicable)	Jurisdiction of Incorporation or Organization
Resolute Acquisition Corporation	Indiana
dba Resolute Treatment Center	
dba Resolute Treatment Facility	
dba YFCS REL	
dba Resolute	
dba Polaris Group Home	
dba Success Group Home	
Revona LLP	United Kingdom
Richmond Treatment Center, LLC	Indiana
dba Richmond Treatment Center	
R.I.S.A.T., LLC	Rhode Island
Riverview Behavioral Health, LLC	Texas
dba Vista Health Texarkana	
dba Riverview Behavioral Health	
RiverWoods Behavioral Health, LLC	Delaware
dba Riverwoods Behavioral Health	
dba Blue Ridge Mountain Recovery Center	
dba Acadia Riverwood	
Robinson Kay House (Bury) Limited	United Kingdom
Rock Crest Drive, LLC.	Pennsylvania
Rock Crest LLC Limited Liability Company	Pennsylvania
Rolling Hills Hospital, LLC	Oklahoma
Rossendale School Limited	United Kingdom
Rothcare Estates Limited	United Kingdom
RTC Resource Acquisition Corporation	Indiana
dba YFCS RES	
dba Resource Treatment Facility	
dba RTC Resource	
Sahara Health Systems, L.L.C.	Louisiana
San Diego Health Alliance	California
dba Capalina Clinic	
dba El Cajon Treatment Center	
dba Fashion Valley Clinic	
San Diego Treatment Services, LLC	California
dba Home Avenue Clinic	
dba Third Avenue Clinic	
San Juan Capestrano Hospital, Inc.	Puerto Rico
Sapphire Care Services Limited	United Kingdom
Serenity Knolls	California
Seven Hills Hospital, LLC	Delaware
Shaker Clinic, LLC	Ohio
Sheltered Living Incorporated	Texas
dba Life Healing Center of Santa Fe	
Sierra Tucson, LLC	Delaware
dba Sierra Tucson	
SJBH, LLC	Delaware
Skyway House, LLC	Delaware
Sober Living by the Sea, Inc.	California
dba Sunrise Recovery Ranch	
dba The Rose of Newport Beach	
dba The Victorian of Newport Beach	
dba Sober Living IOP	
dba The Landing at Newport Beach	
Solutions (Llangarron) Limited	United Kingdom
Solutions (Ross) Limited	United Kingdom
Sonora Behavioral Health Hospital, LLC	Delaware

Name of Subsidiary (including dba name, if applicable)	Jurisdiction of Incorporation or Organization
Southern Indiana Treatment Center, LLC	Indiana
dba Southern Indiana Treatment Center	
Southstone Behavioral Healthcare Center, LLC	Delaware
Southwestern Children's Health Services, Inc.	Arizona
dba Parc Place	
dba Parc Place Behavioral	
dba Oasis Behavioral Health Hospital	
Southwood Psychiatric Hospital, LLC	Pennsylvania
dba Southwood Psychiatric Hospital	
dba Intercare – Southwood Psychiatric Hospital	
dba Intercare – Southwood Psychiatric Hospital	
dba Lakewood Residential Program	
dba Prosperity House Residential Program	
dba Southwood Family Home Services	
dba Southwood School	
dba Southwood Outpatient Psychiatric Clinic	
dba Southwood Partial Hospitalization Program	
SP Cockermouth Limited	United Kingdom
Specialised Courses Offering Purposeful Education Limited	United Kingdom
Speciality Care Limited	United Kingdom
Speciality Care (Addison Court) Limited	United Kingdom
Speciality Care (EMI) Limited	United Kingdom
Speciality Care (Learning Disabilities) Limited	United Kingdom
Speciality Care (Medicare) Limited	United Kingdom
Speciality Care (Rehab) Limited	United Kingdom
Speciality Care (Rest Care) Limited	United Kingdom
Speciality Care (Rest Homes) Limited	United Kingdom
Speciality Care (UK Lease Homes) Limited	United Kingdom
Speciality Healthcare Limited	United Kingdom
Starlite Recovery Center, LLC	Delaware
Stoke 3 Limited	United Kingdom
Stoke Trustee LLP	United Kingdom
Stoke Trustee (No. 2) LLP	United Kingdom
Stone Crest Clinic	Michigan
Strathmore Care Services Limited	United Kingdom
Strathmore College Limited	United Kingdom
Structure House, LLC	Delaware
dba Wellspring at Structure House	
Success Acquisition, LLC	Indiana
Sturt House Clinic Limited	United Kingdom
SUWS of the Carolinas, Inc.	Delaware
dba SUWS Seasons	
Swift River Academy, L.L.C.	Delaware
Ten Broeck Tampa, LLC	Florida
dba North Tampa Behavioral Health	
Ten Lakes Center, LLC	Ohio
Texarkana Behavioral Associates, L.C.	Texas
dba Riverview Behavioral Health Outpatient Program	
dba Vantage Point Behavioral Health	
dba Vantage Point of Northwest Arkansas	
dba Vantage Point of the Ozarks	
dba Valley Behavioral Health System	
dba Valley Behavioral Health Outpatient Program	
dba Valley Behavioral Health System Outpatient Program	
dba Vista Health	
dba Riverview Behavioral Health	

Name of Subsidiary (including dba name, if applicable)	Jurisdiction of Incorporation or Organization
The Camp Recovery Center, LLC	California
dba Azure Acres	
dba Starlite Recovery Center	
dba The Camp Recovery Center	
dba Camp IOP-Campbell	
dba Camp IOP-Scotts Valley	
dba Camp IOP-Monterey	
dba Azure Acres IOP	
The Manor Clinic Limited	England and Wales
The Pavilion at HealthPark, LLC	Florida
dba Park Royal Hospital	
dba Park Royal Psychiatric Hospital at Healthpark	
dba Park Royal Outpatient Clinic	
The Refuge, A Healing Place, LLC	Florida
The Refuge-The Nest, LLC	Florida
The Refuge—Transitions, LLC	Florida
Thetford Trustee LLP	United Kingdom
Ticehurst House Private Clinic Limited	United Kingdom
TK Behavioral Holding Company, LLC	Delaware
TK Behavioral, LLC	Delaware
dba Timberline Knolls	
dba Timberline Knolls Residential Treatment Center	
Transcultural Health Development, Inc.	California
dba Coastal Recovery Center	
Treatment Associates, Inc.	California
dba Sacramento Treatment Center	
Treehome Limited	United Kingdom
TrustPoint Hospital, LLC	Tennessee
Valley Behavioral Health System, LLC	Delaware
dba Valley Behavioral Health	
dba Valley Behavioral Health System	
dba Vantage Point Behavioral Health	
dba Vantage Point of Northwest Arkansas	
Velocity Healthcare Limited	United Kingdom
Vermilion Hospital, LLC	Delaware
dba Vermilion Behavioral Health Systems	
dba Vermilion Behavioral Health System South	
dba Vermilion Behavioral Health System North	
dba Acadia Vermilion Hospital	
dba Optima Specialty Hospital	
Village Behavioral Health, LLC	Delaware
dba The Village	
Virginia Treatment Center, LLC	Virginia
dba Roanoke Treatment Center	
dba Lynchburg Treatment Center	
Vista Behavioral Holding Company, LLC	Delaware
Vista Behavioral Hospital, LLC	Delaware
dba Pacific Grove Hospital	
dba Vista Behavioral Hospital	
Vita Nova, LLC	Rhode Island
Volunteer Treatment Center, LLC	Tennessee
dba Volunteer Treatment Center	

Name of Subsidiary (including dba name, if applicable)	Jurisdiction of Incorporation or Organization
WCHS, Inc.	California
dba Colton Clinical Services	
dba Desert Treatment Clinic	
dba Kent Treatment Solutions	
dba Lynnwood Center	
dba Northwest Treatment Center	
dba Tri-Cities Treatment Center	
dba WCHS of Washington	
dba Kent Treatment Solutions	
dba Canyon Park Treatment Solutions	
dba Recovery Treatment Center	
dba Riverside Treatment Center	
dba The Renton Clinic	
dba Tacoma Treatment Solutions	
dba Temecula Valley Treatment Center	
dba Vancouver Treatment Solutions	
dba Spokane Treatment Solutions	
dba Anchorage Treatment Solutions	
dba Longview Treatment Solutions	
dba Kelso Treatment Solutions	
dba Grays Harbor Treatment Solutions	
Webster Wellness Professionals, LLC	Missouri
Wednesfield 3 Limited	United Kingdom
Wednesfield Trustee LLP	United Kingdom
Wednesfield Trustee (No. 2) LLP	United Kingdom
Wellplace, LLC	Massachusetts
dba Wellplace Utah	
dba Wellplace Pennsylvania	
Wheeling Treatment Center, LLC	West Virginia
dba Wheeling Treatment Center	
White Deer Realty, LLC	Pennsylvania
White Deer Run, LLC	Pennsylvania
dba Cove PREP	
dba White Deer Run of Lancaster	
dba New Perspectives at White Deer Run	
dba White Deer Run at Blue Mountain	
dba New Directions at Cove Forge	
dba Cove Forge Renewal Center	
dba White Deer Run of Allentown	
dba White Deer Run of Allenwood	
dba White Deer Run of Harrisburg	
dba White Deer Run of Lewisburg	
dba White Deer Run of Lancaster	
dba White Deer Run of New Castle	
dba White Deer Run of Williamsport	
dba White Deer Run of York	
dba Cove Forge Behavioral System at Erie	
dba Cove Forge Behavioral System at Pittsburg	
dba Cove Forge Behavioral System at Williamsburg	
dba Lehigh County Center for Recovery	
dba The HOPE Program of Cover Forge at Robinson	
dba White Deer Run Youth Assessment Center	
Whitewell UK Investments 1 Limited	United Kingdom
Whitewell UK Holding Company 1 Limited	United Kingdom
Wichita Treatment Center Inc.	Kansas
Williamson Treatment Center, LLC	West Virginia
Wilmington Treatment Center, LLC	Virginia

Yorkshire Parkcare Company Limited	United Kingdom
Youth And Family Centered Services of New Mexico, Inc.	New Mexico
dba Desert Hills of New Mexico	
Youth Care of Utah, Inc.	Delaware
dba Pine Ridge Academy	
dba Youth Care	
ZR Builders (Derby) Limited	United Kingdom

EXHIBIT 23

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

(1) Form S-3 (No. 333-218648) pertaining to the Acadia Healthcare Company, Inc. registration of shares of common stock;

(2) Form S-8 (No. 333-177990) pertaining to the Acadia Healthcare Company, Inc. Incentive Compensation Plan;

(3) Form S-8 (No. 333-190232) pertaining to the Acadia Healthcare Company, Inc. Incentive Compensation Plan;

(4) Form S-8 (No. 333-211505) pertaining to the Acadia Healthcare Company, Inc. Incentive Compensation Plan; and

(5) Post-Effective Amendment No. 1 to Form S-4 on Form S-8 (No. 333-175523) pertaining to the PHC, Inc. 2004 Non-Employee Director Stock Option Plan, the PHC, Inc. 2003 Stock Purchase and Option Plan, the PHC, Inc. 1995 Employee Stock Purchase Plan and the PHC, Inc. 1993 Stock Purchase and Option Plan;

of our reports dated February 27, 2018, with respect to the consolidated financial statements of Acadia Healthcare Company, Inc. and the effectiveness of internal control over financial reporting of Acadia Healthcare Company, Inc., included in this Annual Report (Form 10-K) of Acadia Healthcare Company, Inc. for the year ended December 31, 2017.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 27, 2018

EXHIBIT 31.1

CERTIFICATION

I, Joey A. Jacobs, certify that:

1. I have reviewed this annual report on Form 10-K of Acadia Healthcare Company, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles;

   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 27, 2018

/s/ Joey A. Jacobs
Joey A. Jacobs
Chairman of the Board and Chief Executive Officer

EXHIBIT 31.2

CERTIFICATION

I, David M. Duckworth, certify that:

1. I have reviewed this annual report on Form 10-K of Acadia Healthcare Company, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 27, 2018

/s/ David M. Duckworth
David M. Duckworth
Chief Financial Officer

EXHIBIT 32.1

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

In connection with the Annual Report of Acadia Healthcare Company, Inc. (the "Company") on Form 10-K for the year ended December 31, 2017, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Joey A. Jacobs, Chairman of the Board and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to my knowledge:

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

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

Date: February 27, 2018

/s/ Joey A. Jacobs
Joey A. Jacobs
Chairman of the Board and Chief Executive Officer

EXHIBIT 32.2

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

In connection with the Annual Report of Acadia Healthcare Company, Inc. (the "Company") on Form 10-K for the year ended December 31, 2017, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, David M. Duckworth, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to my knowledge:

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

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

Date: February 27, 2018

/s/ David M. Duckworth
David M. Duckworth
Chief Financial Officer

ASCENSION

Saint Thomas Health (Nashville, TN)
Summary Income Statement
Functional Organization
Actual For the Periods Ended
(Dollars in Thousands)

	FY 2017 YTD
GROSS PATIENT SERVICE REVENUE:	
Inpatient	$3,207,208
Outpatient	2,650,612
Total Gross Patient Service Revenue	**$5,857,820**
REVENUE DEDUCTIONS:	
Total Revenue Deductions	**$4,295,672**
Net Patient Service Revenue Before Bad Debts	**$1,562,148**
Total Bad Debts Deductions	80,422
Net Patient Service Revenue	**$1,481,726**
OTHER REVENUE:	
Total Other Operating Revenue	**$110,867**
Total Operating Revenue	**$1,592,593**
OPERATING EXPENSES:	
Salaries and Wages	$516,446
Employee Benefits	109,526
Purchased Services	251,404
Professional Fees	75,175
Supplies	272,527
Insurance	9,387
Interest	13,165
Income Tax Expense	190
Provider Tax Expense	44,372
Depreciation and Amortization	71,694
Other Operating Expense	109,602
Total Operating Expense	**$1,473,488**
Income (Loss) From Recurring Operations	**$119,105**
Inc From Recur Oper B4 Impar/Restrct Exp	**$119,105**
Impairment, Restructuring, NonRecuring	3,682
Income (Loss) from Operations	**$115,423**
NONOPERATING GAINS (LOSSES):	
Total Investment Income	$4,202
Donations	(1,256)
Other NonOperating Activity	35
NonOperating Gains (Losses), Net	**$2,980**

Net Income (Loss)	**$118,404**
Less Noncontrolling Interests	18,605
Net Income (Loss) Attributable to Controlling Interest	**$99,799**

ASCENSION

Saint Thomas Health (Nashville, TN)
Summary Balance Sheet - Rolling
Functional Organization
As Of
(Dollars in Thousands)

ASSETS	June FY 2017
CURRENT ASSETS:	
Cash	$22,364
Short-Term Investments	10
Accounts Receivable, Net	174,799
Estimated Sttlmnts from Third-Party Payor	9,153
Inventory	26,441
Other Current Assets	26,641
Total Current Assets	**$259,407**
LONG TERM INVESTMENTS:	
Restricted Funds	28,910
Other Long Term Investments	33,668
Long Term Investments	**$62,577**
PROPERTY AND EQUIPMENT:	
Total Buildings and Equipment	$1,360,217
Land and Improvements	46,526
Construction In Progress	29,573
Accumulated Depreciation	(869,971)
Property and Equipment, Net	**$566,345**
OTHER ASSETS:	
Investments in Unconsolidated Entities, net	$47,039
Capitalized Computer Software Costs, Net	23,210
Other Miscellaneous Assets	35,403
Other Long Term Assets	**$105,652**
Total Assets	**$993,981**

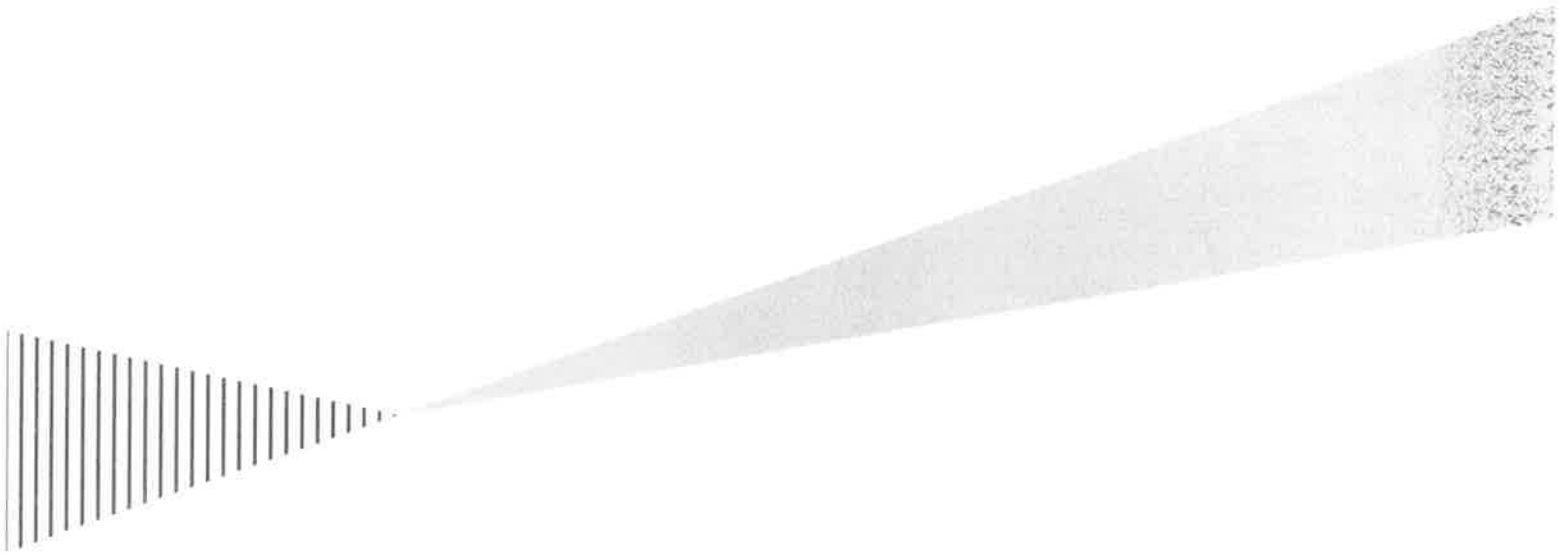
LIABILITES AND NET ASSETS	
CURRENT LIABILITIES:	
Current Portion of Long-Term Debt	$5,196
Accounts Payable	50,809
AR Credit Balances, Net	5,062
Total Accrued Liabilities	54,021

Estimated Settlemnt to Third-Party Payor	9,804
Current Portion Other Liabilities	158,247
Total Current Liabilities	**$283,139**
NONCURRENT LIABILITIES:	
Long-Term Debt:	
Centralized Debt Management System	$385,386
Net Long-Term Debt	**$385,386**
Other Long-Term Liabilities:	
Pension and Other PostRetirement Liability	20,154
Other Noncurrent Liabilities	17,582
Total Noncurrent Liabilities	**$423,122**
Total Liabilities	**$706,260**
NET ASSETS:	
Unrestricted Net Assets	$256,943
Temporarily Restricted Net Assets	27,348
Permanently Restricted Net Assets	3,430
Total Net Assets	**$287,721**
Total Liabilities and Net Assets	**$993,981**

Consolidated Financial Statements, Including Uniform Guidance Reports and Schedules

Ascension Health Alliance
d/b/a Ascension
Years Ended June 30, 2017 and 2016
With Reports of Independent Auditors

Ernst & Young LLP



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Ascension

Consolidated Financial Statements, Including Uniform Guidance Reports and Schedules

Years Ended June 30, 2017 and 2016

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Report of Independent Auditors

The Board of Directors
Ascension Health Alliance d/b/a Ascension

Report on Financial Statements

We have audited the accompanying consolidated financial statements of Ascension Health Alliance d/b/a Ascension, which comprise the consolidated balance sheets as of June 30, 2017 and 2016, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

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Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Ascension Health Alliance d/b/a Ascension at June 30, 2017 and 2016, and the consolidated results of their operations and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The schedule of expenditures of federal and state of Wisconsin awards, as required by Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* and the *State of Wisconsin Single Audit Guidelines*, is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we also have issued our report dated September 22, 2017, on our consideration of Ascension Health Alliance d/b/a Ascension's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Ascension Health Alliance d/b/a Ascension's internal control over financial reporting and compliance.

Ernst + Young LLP

September 22, 2017, except for the schedule
of expenditures of federal and state of
Wisconsin awards, for which the date is
November 27, 2017

Ascension

Consolidated Balance Sheets
(Dollars in Thousands)

	June 30, 2017	June 30, 2016
Assets		
Current assets:		
Cash and cash equivalents	**$ 857,605**	$ 696,237
Short-term investments	**103,857**	122,545
Accounts receivable, less allowance for doubtful accounts ($1,316,163 and $1,362,060 at June 30, 2017 and June 30, 2016, respectively)	**2,758,554**	2,746,506
Inventories	**354,041**	349,077
Due from brokers *(see Notes 4 and 5)*	**197,195**	313,717
Estimated third-party payor settlements	**133,715**	186,354
Other *(see Notes 4 and 5)*	**762,900**	978,744
Total current assets	**5,167,867**	5,393,180
Long-term investments *(see Notes 4 and 5)*	**16,999,371**	15,069,123
Property and equipment, net	**9,182,978**	9,020,005
Other assets:		
Investment in unconsolidated entities	**1,196,651**	1,115,871
Capitalized software costs, net	**880,819**	926,710
Other *(see Notes 4 and 5)*	**892,739**	908,580
Total other assets	**2,970,209**	2,951,161
Total assets	**$ 34,320,425**	$ 32,433,469

	June 30, 2017	June 30, 2016
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	$ **298,270**	$ 96,193
Long-term debt subject to short-term remarketing arrangements*	**999,785**	1,666,245
Accounts payable and accrued liabilities *(see Notes 4 and 5)*	**2,742,377**	2,500,748
Estimated third-party payor settlements	**480,694**	513,677
Due to brokers *(see Notes 4 and 5)*	**115,783**	105,660
Current portion of self-insurance liabilities	**206,787**	219,638
Other	**340,756**	292,044
Total current liabilities	**5,184,452**	5,394,205
Noncurrent liabilities:		
Long-term debt (senior and subordinated)	**5,699,440**	5,391,908
Self-insurance liabilities	**513,010**	513,985
Pension and other postretirement liabilities	**1,318,331**	1,298,653
Other *(see Notes 4 and 5)*	**1,191,068**	1,241,678
Total noncurrent liabilities	**8,721,849**	8,446,224
Total liabilities	**13,906,301**	13,840,429
Net assets:		
Unrestricted		
Controlling interest	**17,933,923**	16,498,086
Noncontrolling interests	**1,798,361**	1,429,444
Unrestricted net assets	**19,732,284**	17,927,530
Temporarily restricted	**468,938**	467,994
Permanently restricted	**212,902**	197,516
Total net assets	**20,414,124**	18,593,040
Total liabilities and net assets	$ **34,320,425**	$ 32,433,469

*Consists of variable rate demand bonds with put options that may be exercised at the option of the bondholders, with stated repayment installments through 2047, as well as certain serial mode bonds with scheduled remarketing/mandatory tender dates occurring prior to June 30, 2018. In the event that bonds are not remarketed upon the exercise of put options or the scheduled mandatory tenders, management would utilize other sources to access the necessary liquidity. Potential sources include liquidating investments, a draw on the line of credit totaling $1 billion, and issuing commercial paper. The commercial paper program is supported by $500 million of the $1 billion line of credit.

The accompanying notes are an integral part of the consolidated financial statements.

Ascension

Consolidated Statements of Operations and Changes in Net Assets

(Dollars in Thousands)

	Year Ended June 30, 2017	2016
Operating revenue:		
Net patient service revenue	$ 22,023,848	$ 21,301,133
Less provision for doubtful accounts	1,083,661	1,142,289
Net patient service revenue, less provision for doubtful accounts	20,940,187	20,158,844
Other revenue	1,693,038	1,739,490
Total operating revenue	22,633,225	21,898,334
Operating expenses:		
Salaries and wages	9,301,057	9,043,625
Employee benefits	1,829,642	1,748,110
Purchased services	1,931,021	1,500,887
Professional fees	1,299,517	1,369,103
Supplies	3,267,278	3,114,261
Insurance	177,352	160,232
Interest	223,356	194,962
Depreciation and amortization	1,083,684	1,032,541
Other	2,780,838	2,737,244
Total operating expenses before impairment, restructuring and nonrecurring losses, net	21,893,745	20,900,965
Income from operations before self-insurance trust fund investment return and impairment, restructuring and nonrecurring losses, net	739,480	997,369
Self-insurance trust fund investment return	43,621	(16,334)
Impairment, restructuring and nonrecurring losses, net	(230,407)	(227,832)
Income from operations	552,694	753,203
Nonoperating gains (losses):		
Investment return	1,420,160	(358,297)
Gain (loss) on extinguishment of debt	10,907	(13,594)
Gains (losses) on interest rate swaps	45,015	(86,536)
Income (loss) from unconsolidated entities	2,601	(40,649)
Contributions from business combinations	-	304,961
Other	(170,194)	(81,339)
Total nonoperating gains (losses), net	1,308,489	(275,454)
Excess of revenues and gains over expenses and losses	1,861,183	477,749
Less noncontrolling interests	222,266	16,365
Excess of revenues and gains over expenses and losses attributable to controlling interest	1,638,917	461,384

Continued on next page.

Ascension

Consolidated Statements of Operations and Changes in Net Assets (continued)

(Dollars in Thousands)

	Year Ended June 30, 2017	2016
Unrestricted net assets, controlling interest:		
Excess of revenues and gains over expenses and losses	**$ 1,638,917**	$ 461,384
Transfers to sponsors and other affiliates, net	**(5,062)**	(8,654)
Net assets released from restrictions for property acquisitions	**92,104**	45,058
Pension and other postretirement liability adjustments	**(301,182)**	(729,197)
Change in unconsolidated entities' net assets	**8,039**	(6,976)
Other	**2,795**	3,344
Increase (decrease) in unrestricted net assets, controlling interest, before gain (loss) from discontinued operations	**1,435,611**	(235,041)
Gain (loss) from discontinued operations	**226**	(16,230)
Increase (decrease) in unrestricted net assets, controlling interest	**1,435,837**	(251,271)
Unrestricted net assets, noncontrolling interests:		
Excess of revenues and gains over expenses and losses	**222,266**	16,365
Distributions of capital	**(139,477)**	(254,788)
Contributions of capital	**285,894**	96,150
Membership interest changes, net	**210**	-
Other	**24**	(891)
Increase (decrease) in unrestricted net assets, noncontrolling interests	**368,917**	(143,164)
Temporarily restricted net assets, controlling interest:		
Contributions and grants	**123,594**	140,210
Investment return	**29,410**	(4,643)
Net assets released from restrictions	**(153,648)**	(97,392)
Contributions from business combinations	**-**	16,091
Other	**1,588**	(4,181)
Increase in temporarily restricted net assets, controlling interest	**944**	50,085
Permanently restricted net assets, controlling interest:		
Contributions	**8,046**	5,298
Investment return	**7,263**	(1,706)
Contributions from business combinations	**-**	2,363
Other	**77**	(1,227)
Increase in permanently restricted net assets, controlling interest	**15,386**	4,728
Increase (decrease) in net assets	**1,821,084**	(339,622)
Net assets, beginning of year	**18,593,040**	18,932,662
Net assets, end of year	**$20,414,124**	$ 18,593,040

The accompanying notes are an integral part of the consolidated financial statements.

Ascension

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	Year Ended June 30, 2017	Year Ended June 30, 2016
Operating activities		
Increase (decrease) in net assets	$ **1,821,084**	$ (339,622)
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	**1,083,684**	1,032,541
Amortization of bond premiums and debt issuance costs	**(19,241)**	(20,714)
(Gain) loss on extinguishment of debt	**(10,907)**	13,594
Provision for doubtful accounts	**1,086,621**	1,148,342
Pension and other postretirement liability adjustments	**301,182**	729,197
Contributions from business combinations	**-**	(323,415)
Unrealized (gains) losses on investments, net	**(624,047)**	493,528
Change in fair value of interest rate swaps	**(70,119)**	84,433
Gain on sale of assets, net	**(250,594)**	(192,042)
Impairment and nonrecurring expenses	**40,482**	21,271
Transfers to sponsor and other affiliates, net	**5,062**	8,654
Restricted contributions, investment return, and other	**(144,085)**	(165,212)
Other restricted activity	**18,976**	(57,923)
(Contributions) distributions of noncontrolling interest, net	**(146,417)**	158,638
Other	**(234)**	(222)
Decrease (increase) in:		
Short-term investments	**11,268**	71,832
Accounts receivable	**(1,114,753)**	(1,190,839)
Inventories and other current assets	**(57,727)**	(65,000)
Due from brokers	**116,522**	(164,852)
Investments classified as trading	**(1,282,576)**	(523,002)
Other assets	**(79,142)**	126,227
Increase (decrease) in:		
Accounts payable and accrued liabilities	**206,615**	29,531
Estimated third-party payor settlements, net	**19,880**	128,440
Due to brokers	**10,123**	(25,401)
Other current liabilities	**55,323**	(119,736)
Self-insurance liabilities	**(13,751)**	(53,004)
Other noncurrent liabilities	**(180,709)**	(201,315)
Net cash provided by continuing operating activities	**782,520**	603,929
Net cash provided (used) by discontinued operations	**7,513**	(4,833)
Net cash provided by operating activities	**790,033**	599,096

Continued on next page.

Ascension

Consolidated Statements of Cash Flows (continued)

(Dollars in Thousands)

	Year Ended June 30, 2017	2016
Investing activities		
Property, equipment, and capitalized software additions, net	**$ (1,272,212)**	$ (1,139,060)
Proceeds from sale of property and equipment	**3,830**	13,643
Issuance of note receivable for business combination	**-**	(637,109)
Net proceeds from sale/acquisition of other assets	**354,933**	296,071
Net cash used by continuing investing activities	**(913,449)**	(1,466,455)
Net cash provided by discontinued operations - investing	**112,238**	151,344
Net cash used by investing activities	**(801,211)**	(1,315,111)
Financing activities		
Issuance of debt	**1,308,307**	5,154,869
Repayment of debt	**(1,407,063)**	(4,403,407)
Debt issuance costs paid	**(5,989)**	(16,462)
Decrease in assets under bond indenture agreements	**498**	18,303
Transfers to sponsors and other affiliates, net	**(10,062)**	(13,654)
Restricted contributions, investment return, and other	**140,438**	143,013
Contributions (distributions) of noncontrolling interest, net	**146,417**	(158,638)
Net cash provided by financing activities	**172,546**	724,024
Net increase in cash and cash equivalents	**161,368**	8,009
Cash and cash equivalents at beginning of year	**696,237**	688,228
Cash and cash equivalents at end of year	**$ 857,605**	$ 696,237

The accompanying notes are an integral part of the consolidated financial statements.

Ascension

Notes to Consolidated Financial Statements
(Dollars in Thousands)

June 30, 2017

1. Organization and Mission

Organizational Structure

Ascension Health Alliance, d/b/a Ascension (Ascension), is a Missouri nonprofit corporation formed on September 13, 2011. Ascension is the sole corporate member and parent organization of Ascension Health (d/b/a Ascension Healthcare), a Catholic national health system consisting primarily of nonprofit corporations that own and operate local healthcare facilities, or Ministry Markets, located in 23 states and the District of Columbia.

Ascension serves as the member or shareholder of various subsidiaries as listed below:

- Ascension Care Management
- Ascension Global Mission
- Ascension Healthcare
- Ascension Holdings
- Ascension Information Services
- Ascension Investment Management (AIM)
- Ascension Leadership Institute
- Ascension Ministry and Mission Fund
- Ascension Ministry Service Center
- Ascension Ventures (AV)
- AV Holding Company
- Consulting Network
- The Resource Group
- Smart Health Solutions

Ascension is also the majority investor in the Alpha Fund, LLC (Alpha Fund) as discussed in the Pooled Investment Fund note. Ascension and its member organizations are hereafter referred to collectively as the System.

1. Organization and Mission (continued)

Sponsorship

Ascension is sponsored by Ascension Sponsor, a Public Juridic Person. The Participating Entities of Ascension Sponsor are the Daughters of Charity of St. Vincent de Paul, St. Louise Province; the Congregation of St. Joseph; the Congregation of the Sisters of St. Joseph of Carondelet; the Congregation of Alexian Brothers of the Immaculate Conception Province, Inc. – American Province; and the Sisters of the Sorrowful Mother of the Third Order of St. Francis of Assisi – US/Caribbean Province.

Mission

The System directs its governance and management activities toward strong, vibrant, Catholic Ministries united in service and healing, and dedicates its resources to spiritually centered care which sustains and improves the health of the individuals and communities it serves. In accordance with the System's mission of service to those persons living in poverty and other vulnerable persons, each Ministry Market accepts patients regardless of their ability to pay. The System uses four categories to identify the resources utilized for the care of persons living in poverty and community benefit programs:

- Traditional charity care includes the cost of services provided to persons who cannot afford healthcare because of inadequate resources and/or who are uninsured or underinsured.

- Unpaid cost of public programs, excluding Medicare, represents the unpaid cost of services provided to persons covered by public programs for persons living in poverty and other vulnerable persons.

- Cost of other programs for persons living in poverty and other vulnerable persons includes unreimbursed costs of programs intentionally designed to serve the persons living in poverty and other vulnerable persons of the community, including substance abusers, the homeless, victims of child abuse, and persons with acquired immune deficiency syndrome.

- Community benefit consists of the unreimbursed costs of community benefit programs and services for the general community, not solely for the persons living in poverty, including health promotion and education, health clinics and screenings, and medical research.

1. Organization and Mission (continued)

Discounts are provided to all uninsured and underinsured patients, including those with the means to pay. Discounts provided to those patients who did not qualify for financial assistance are not included in the cost of providing care of persons living in poverty and other community benefit programs. The cost of providing care to persons living in poverty and other community benefit programs is estimated by reducing charges forgone by a factor derived from the ratio of each entity's total operating expenses to the entity's billed charges for patient care. Certain costs such as graduate medical education and certain other activities are excluded from total operating expenses for purposes of this computation.

The amount of traditional charity care provided, determined on the basis of cost, was $537,672 and $452,246 for the years ended June 30, 2017 and 2016, respectively. The amount of unpaid cost of public programs, cost of other programs for persons living in poverty and other vulnerable persons, and community benefit cost is reported in the accompanying supplementary information.

2. Significant Accounting Policies

Principles of Consolidation

All corporations and other entities for which operating control is exercised by the System or one of its member corporations are consolidated, and all significant inter-entity transactions have been eliminated in consolidation. Investments in entities where the System does not have operating control are recorded under the equity or cost method of accounting. Income (loss) from unconsolidated entities is included in consolidated excess of revenues and gains over expenses and losses in the accompanying Consolidated Statements of Operations and Changes in Net Assets as follows:

	Year Ended June 30,	
	2017	**2016**
Other revenue	**$ 105,473**	$ 114,085
Nonoperating gains (losses)	**2,601**	(40,649)

2. Significant Accounting Policies (continued)

Use of Estimates

Management has made estimates and assumptions that affect the reported amounts of certain assets, liabilities, revenues, and expenses. Actual results could differ from those estimates.

Fair Value of Financial Instruments

Carrying values of financial instruments classified as current assets and current liabilities approximate fair value. The fair values of financial instruments measured at fair value are disclosed in the Fair Value Measurements note.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and interest-bearing deposits with original maturities of three months or less.

Short-Term Investments

Short-term investments consist of investments with original maturities exceeding three months and up to one year.

Inventories

Inventories, consisting primarily of medical supplies and pharmaceuticals, are stated at the lower of cost or market value using first-in, first-out (FIFO) or a methodology that closely approximates FIFO.

2. Significant Accounting Policies (continued)

Long-Term Investments and Investment Return

Investments, excluding investments in unconsolidated entities, are measured at fair value, are classified as trading securities, and include pooled short-term investment funds; U.S. government, state, municipal and agency obligations; corporate and foreign fixed income securities; asset-backed securities; and equity securities. Investments also include alternative investments and other investments which are valued based on the net asset value of the investments, as further discussed in the Fair Value Measurements note. Investments also include derivatives held by the Alpha Fund, also measured at fair value, as discussed in the Pooled Investment Fund note.

Long-term investments include assets limited as to use of approximately $1,342,000 and $1,284,000, at June 30, 2017 and 2016, respectively, comprised primarily of investments placed in trust and held by captive insurance companies for the payment of self-insured claims and investments which are limited as to use, as designated by donors.

Purchases and sales of investments are accounted for on a trade-date basis. Investment returns consist of dividends, interest, and gains and losses. The cost of substantially all securities sold is based on the FIFO method. Investment returns, excluding returns of self-insurance trust funds, are reported as nonoperating gains (losses) in the Consolidated Statements of Operations and Changes in Net Assets, unless the return is restricted by donor or law. Investment returns of self-insurance trust funds are reported as a separate component of income from operations in the Consolidated Statements of Operations and Changes in Net Assets.

Property and Equipment

Property and equipment are stated at cost or, if donated, at fair market value at the date of the gift. Depreciation is determined on a straight-line basis over the estimated useful lives of the related assets. The range of estimated useful lives used in computing depreciation is as follows: buildings and leasehold improvements, 2 to 40 years; and equipment, 2 to 20 years. Depreciation expense in 2017 and 2016 was $851,540 and $825,681, respectively.

2. Significant Accounting Policies (continued)

A summary of property and equipment at June 30, 2017 and 2016 is as follows:

	June 30, 2017	June 30, 2016
Land and improvements	**$ 950,074**	$ 935,542
Buildings and equipment	**17,069,585**	16,505,068
	18,019,659	17,440,610
Less accumulated depreciation	**9,447,994**	8,981,575
	8,571,665	8,459,035
Construction in progress	**611,313**	560,970
Total property and equipment, net	**$ 9,182,978**	$ 9,020,005

Several capital projects have remaining construction and related equipment purchase commitments of approximately $545,000 as of June 30, 2017.

Intangible Assets

Intangible assets primarily consist of goodwill and capitalized computer software costs, including internally developed software. Costs incurred in the development and installation of internal use software are expensed or capitalized depending on whether they are incurred in the preliminary project stage, application development stage, or post-implementation stage, and the nature of the costs. Intangible assets are included in the Consolidated Balance Sheets as presented in the table that follows. Capitalized software costs in the table below include software in progress of $228,499 and $244,552 at June 30, 2017 and 2016, respectively:

2. Significant Accounting Policies (continued)

	June 30, 2017	June 30, 2016
Capitalized software costs	**$ 2,213,989**	$ 2,050,184
Less accumulated amortization	**1,333,170**	1,123,474
Capitalized software costs, net	**880,819**	926,710
Goodwill	**211,278**	210,320
Other, net	**27,781**	31,731
Intangible assets included in other assets	**239,059**	242,051
Total intangible assets, net	**$ 1,119,878**	$ 1,168,761

Intangible assets whose lives are indefinite, primarily goodwill, are not amortized and are evaluated for impairment at least annually or when circumstances indicate a possible impairment may exist, while intangible assets with definite lives, primarily capitalized computer software costs, are amortized over their expected useful lives. Amortization expense for these intangible assets in 2017 and 2016 was $232,144 and $206,860, respectively.

Estimated future amortization of intangible assets with definite lives, excluding software in progress, as of June 30, 2017 is as follows:

Year ending June 30:	
2018	$ 190,154
2019	151,630
2020	124,447
2021	98,228
2022	72,052
Thereafter	34,437
Total	$ 670,948

2. Significant Accounting Policies (continued)

The System is in the final phases of a significant multi-year, System-wide enterprise resource planning project, including information technology and process standardization (Symphony), which is expected to continue through fiscal year 2018. The project is facilitating a transition to a common software product for various finance, information technology, procurement, and human resources management processes, including standardization of those processes throughout the System. Capitalized costs of Symphony, net of amortization, were approximately $351,000 and $329,000 at June 30, 2017 and 2016, respectively, and are being amortized on a straight-line basis over the expected useful life of the software. Certain costs of this project were also expensed. Accumulated amortization of Symphony was approximately $160,000 and $120,000 at June 30, 2017 and 2016, respectively. See the Impairment, Restructuring, and Nonrecurring Losses discussion below for additional information about costs associated with Symphony.

Noncontrolling Interests

The consolidated financial statements include all assets, liabilities, revenues, and expenses of entities that are controlled by the System and therefore consolidated. Noncontrolling interests in the Consolidated Balance Sheets represent the portion of net assets owned by entities outside the System, for those entities in which the System's ownership interest is less than 100%.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those assets whose use by the System has been limited by donors to a specific time period or purpose. Permanently restricted net assets consist of gifts with corpus values that have been restricted by donors to be maintained in perpetuity, which include endowment funds. Temporarily restricted net assets and earnings on permanently restricted net assets, including earnings on endowment funds, are used in accordance with the donors' wishes, primarily to purchase equipment and to provide charity care and other health and educational services. Contributions with donor-imposed restrictions that are met in the same reporting period are reported as unrestricted.

Temporarily and permanently restricted net assets consist solely of controlling interests of the System.

2. Significant Accounting Policies (continued)

Performance Indicator

The performance indicator is the excess of revenues and gains over expenses and losses. Changes in unrestricted net assets that are excluded from the performance indicator primarily include pension and other postretirement liability adjustments, transfers to or from sponsors and other affiliates, net assets released from restrictions for property acquisitions, and change in unconsolidated entities' net assets.

Operating and Nonoperating Activities

The System's primary mission is to meet the healthcare needs in its market areas through a broad range of general and specialized healthcare services, including inpatient acute care, outpatient services, long-term care, and other healthcare services. Activities directly associated with the furtherance of this purpose are considered to be operating activities. Other activities that result in gains or losses peripheral to the System's primary mission are considered to be nonoperating.

Net Patient Service Revenue, Accounts Receivable, and Allowance for Doubtful Accounts

Net patient service revenue is reported at the estimated realizable amounts from patients, third-party payors, and others for services provided and includes estimated retroactive adjustments under reimbursement agreements with third-party payors. The System recognizes patient service revenue at the time services are rendered, even though the patient's ability to pay may not be completely assessed at that time. Revenue under certain third-party payor agreements is subject to audit, retroactive adjustments, and significant regulatory actions. Provisions for third-party payor settlements and adjustments are estimated in the period the related services are provided and adjusted in future periods as additional information becomes available and as final settlements are determined.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a possibility that recorded estimates will change by a material amount in the near term. Adjustments to revenue related to prior periods increased net patient service revenue by $128,100 and $102,217 for the years ended June 30, 2017 and 2016, respectively.

2. Significant Accounting Policies (continued)

The percentage of net patient service revenue, less provision for doubtful accounts earned by payor for the years ended June 30, 2017 and 2016, is as follows:

	Year Ended June 30,	
	2017	**2016**
Medicare - traditional and managed	**36 %**	35 %
Medicaid - traditional and managed	**13**	12
Commercial and other managed care	**46**	47
Self-Pay and other	**5**	6
	100 %	100 %

The System grants credit without collateral to its patients, who are primarily local residents and are insured under third-party payor arrangements. Significant concentrations of accounts receivable, less allowance for doubtful accounts, at June 30, 2017 and 2016, are as follows:

	June 30,	
	2017	**2016**
Medicare - traditional and managed	**27 %**	27 %
Medicaid - traditional and managed	**11**	9
Commercial and other managed care	**42**	42
Self-Pay and other	**20**	22
	100 %	100 %

2. Significant Accounting Policies (continued)

The provision for doubtful accounts is based upon management's assessment of expected net collections considering historical experience, economic conditions, trends in healthcare coverage, and other collection indicators. Periodically throughout the year, management assesses the adequacy of the allowance for doubtful accounts based upon historical write-off experience by payor category, including those amounts not covered by insurance. The results of this review are then used to make any modifications to the provision for doubtful accounts to establish an appropriate allowance for doubtful accounts. After satisfaction of amounts due from insurance and reasonable efforts to collect from the patient have been exhausted, the System follows established guidelines for placing certain past-due patient balances with collection agencies, subject to the terms of certain restrictions on collection efforts as determined by the System. Accounts receivable are written off after collection efforts have been followed in accordance with the System's policies. The methodology for determining the allowance for doubtful accounts and related write-offs on uninsured patient accounts has remained consistent with the prior year.

Other Operating Revenue

Other operating revenue includes net gains on sales of assets, clinical engineering services, retail pharmacy revenue, income from unconsolidated entities, premium revenue, net assets released from restrictions for operating purposes, and other nonpatient service revenue. Net gains on sales of assets were $258,631 and $201,330 for the years ended June 30, 2017 and 2016, respectively. Assets sold during the years ended June 30, 2017 and 2016 include certain hospital and nonhospital operating entities and patient care equipment.

Impairment, Restructuring, and Nonrecurring Losses

Long-lived assets are reviewed for impairment whenever events or business conditions indicate the carrying amount of such assets may not be fully recoverable. Initial assessments of recoverability are based on estimates of undiscounted future net cash flows associated with an asset or group of assets. Where impairment is indicated, the carrying amount of these long-lived assets is reduced to fair value based on future discounted net cash flows or other estimates of fair value.

2. Significant Accounting Policies (continued)

Nonrecurring expenses associated with Symphony primarily include deployment costs to implement Symphony in certain Health Ministries. Costs associated with product deployment are recorded as nonrecurring losses, and costs associated with product support are recorded as recurring operating expenses.

During the year ended June 30, 2017, the System recorded total impairment, restructuring, and nonrecurring losses, net of $230,407. This amount was comprised primarily of $110,390 of nonrecurring expenses associated with Symphony, one-time termination benefits and other restructuring expenses of $86,669, impairment expenses of $34,689, and other nonrecurring expenses of $38,659 partially offset by a pension curtailment gain of $40,000.

During the year ended June 30, 2016, the System recorded total impairment, restructuring, and nonrecurring losses, net of $227,832. This amount was comprised primarily of $129,494 of nonrecurring expenses associated with Symphony, one-time termination benefits and other restructuring expenses of $72,097, impairment expenses of $14,064, and other nonrecurring expenses of $12,177.

Amortization

Bond issuance costs, discounts, and premiums are amortized over the term of the bonds using a method approximating the effective interest method.

Capitalized software, including internally developed software, is amortized on a straight-line basis over the expected useful life of the software.

Income Taxes

The member healthcare entities of the System are primarily tax-exempt organizations under Internal Revenue Code Section 501(c)(3) or Section 501(c)(2), and their related income is exempt from federal income tax under Section 501(a). The System accounts for uncertainty in income tax positions by applying a recognition threshold and measurement attribute for financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. The System has determined that no material unrecognized tax benefits or liabilities exist as of June 30, 2017.

2. Significant Accounting Policies (continued)

The System had deferred tax assets of approximately $461,000 and $378,000 for federal and state income tax purposes primarily related to net operating loss carryforwards for the years ended June 30, 2017 and 2016, respectively, with expiration dates through 2037. A valuation allowance of approximately $459,000 and $377,000 was recorded due to the uncertainty regarding use of the deferred tax assets for the years ended June 30, 2017 and 2016, respectively.

Regulatory Compliance

Various federal and state agencies have initiated investigations regarding reimbursement claimed by certain members of the System. The investigations are in various stages of discovery, and the ultimate resolution of these matters, including the liabilities, if any, cannot be readily determined; however, in the opinion of management, the results of the investigations will not have a material adverse impact on the consolidated financial statements of the System.

Reclassifications

Certain reclassifications were made to the accompanying 2016 consolidated financial statements to conform to the 2017 presentation.

Recently Issued Accounting Standards

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)* (ASU 2014-09). In August 2015, the FASB amended the guidance to defer the effective date by one year. ASU 2014-09 affects any entity that either enters into contracts with customers to transfer goods or services or enters into contracts for the transfer of nonfinancial assets unless those contracts are within the scope of other standards. The guidance in ASU 2014-09 outlines a single comprehensive model for entities to use in accounting for revenue arising from contracts with customers and supersedes most current revenue recognition guidance, including industry-specific guidance, and requires significantly expanded disclosures about revenue recognition. The core principle of the revenue model is that an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services.

2. Significant Accounting Policies (continued)

The requirements of ASU 2014-09 will result in changes to the presentation and disclosure of revenue from services to patients. Currently, a significant portion of the System's provision for doubtful accounts relates to uninsured patients as well as deductibles and co-pays due from patients with insurance. Under ASU 2014-09, the uncollectible amounts due from patients will generally be reported as a direct reduction to net patient service revenue and will result in a significant reduction in the amounts presented separately as provision for doubtful accounts. Although the adoption of ASU 2014-09 will have a significant impact on the amounts presented in certain categories of the System's Consolidated Statements of Operations and Changes in Net Assets, it is not expected to materially impact the System's financial position, results of operations or cash flows. The System is currently evaluating the requirements of the new standard to ensure that the processes and systems are in place to implement the new standard and to collect the related information required. The new guidance will be effective for Ascension beginning July 1, 2018, and interim periods within that year. Early adoption is permitted, but the System does not plan to early adopt the new standard.

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842) (ASU 2016-02),* which affects any entity that enters into a lease (as that term is defined in ASU 2016-02), with some specified scope exceptions. The main difference between the guidance in ASU 2016-02 and current guidance is the recognition of lease assets and liabilities by lessees for those leases classified as operating leases under current guidance. Recognition of these assets and liabilities will have a significant impact on the System's Consolidated Balance Sheet upon adoption. This guidance will be effective for Ascension on July 1, 2019. Ascension is in the process of evaluating the potential impact on its consolidated financial statements.

Subsequent Events

The System evaluates the impact of subsequent events, which are events that occur after the Consolidated Balance Sheet date but before the consolidated financial statements are issued, for potential recognition or disclosure in the consolidated financial statements as of the Consolidated Balance Sheet date. For the year ended June 30, 2017, the System evaluated subsequent events through September 22, 2017, representing the date on which the accompanying audited consolidated financial statements were issued.

2. Significant Accounting Policies (continued)

Subsequent to June 30, 2017, certain debt obligations which had a total outstanding balance of $188,705 as of June 30, 2017 were defeased or redeemed. Specifically, the Series 2012 Oklahoma Development Finance Authority St. John Health System Revenue & Refunding Bonds were legally defeased, and a commercial bank loan was repaid in full.

3. Organizational Changes

Business Combinations

Crittenton Hospital Medical Center – Michigan

Effective October 1, 2015, Ascension Michigan became the sole corporate member of Crittenton Hospital Medical Center (Crittenton) under the terms of an agreement among Ascension Michigan, Crittenton and Ascension Health. The fair value of the unrestricted net assets totaling $137,912 was recognized in the Consolidated Statements of Operations and Changes in Net Assets for the year ended June 30, 2016 as a nonoperating contribution from business combination.

Wheaton Franciscan Healthcare – Southeast Wisconsin, Inc.

Effective March 1, 2016, Ascension Health became the sole corporate member of Wheaton Franciscan Healthcare – Southeast Wisconsin, Inc. (Wheaton) under the terms of an agreement between Ascension Health and Wheaton Franciscan Services, Inc. The fair value of the unrestricted net assets totaling $167,049 was recognized in the Consolidated Statements of Operations and Changes in Net Assets for the year ended June 30, 2016 as a nonoperating contribution from business combination.

The fair values of Crittenton and Wheaton's net assets, by major type, that were recognized by the System during the year ended June 30, 2016 were as follows. The valuations of these net assets were substantially complete as of June 30, 2016.

3. Organizational Changes (continued)

	Crittenton	Wheaton	Total
Net working capital	$ 80,335	$ 312,129	$ 392,464
Long-term investments	102,890	27,511	130,401
Property and equipment	193,174	645,299	838,473
Investments in unconsolidated entities	4,491	58,174	62,665
Intangible assets, including capitalized software costs	-	48,820	48,820
Other long-term assets	795	2,567	3,362
Long-term debt	(161,205)	(641,936)	(803,141)
Other long-term liabilites assumed	(79,177)	(270,452)	(349,629)
Fair value of total net assets	$ 141,303	$ 182,112	$ 323,415

The fair value of net assets of $323,415 in the preceding table was recognized in the Consolidated Statement of Operations and Changes in Net Assets for the year ended June 30, 2016, as a nonoperating contribution from business combinations of $304,961, and contributions of temporarily and permanently restricted net assets of $16,091 and $2,363, respectively.

During the year ended June 30, 2016, Ascension recognized revenues of Crittenton and Wheaton combined totaling $611,100, and an excess of revenues and gains over expenses and losses totaling $15,560, of which all was attributable to controlling interest. Ascension recognized a decrease in unrestricted net assets – controlling interests, excluding the excess of revenues and gains over expenses and losses of $15,560 above, of $10,003 and a decrease in temporarily restricted net assets of Crittenton and Wheaton of $618 for the year ended June 30, 2016.

The following unaudited pro forma financial information presents the combined results of operations of Ascension, Crittenton and Wheaton for the year ended June 30, 2016 as though the business combination transactions had occurred on July 1, 2015. This pro forma financial information is not necessarily indicative of the results of operations that would occur if these entities were consolidated into the System during that period, nor is it necessarily indicative of future operating results.

3. Organizational Changes (continued)

	Year Ended June 30, 2016
Total operating revenue	$ 22,838,814
Deficit of revenues and gains over expenses and losses attributable to controlling interest	118,977
Decrease in unrestricted net assets - controlling interest	(532,879)
Decrease in unrestricted net assets - noncontrolling interests	(143,164)
Decrease in temporarily restricted net assets	36,226
Decrease in permanently restricted net assets	2,636

Divestitures

Discontinued Operations

During the years ended June 30, 2017 and 2016, Ascension, including certain of its wholly owned subsidiaries, closed on the sale of, or undertook actions to sell or transfer ownership of, certain assets and liabilities, as follows:

- On July 1, 2015, Catholic Health, Inc. (Catholic Health) became the sole corporate member of Mount St. Mary's Hospital in Lewiston, New York under the terms of an affiliation agreement between Ascension Health and Catholic Health.

- On September 1, 2015, Carondelet Health Network, a subsidiary of Ascension Health, sold certain assets, liabilities and related operations, excluding certain non-acute entities, in Tucson, Arizona to CHN Holdings, LLC, a joint venture in which Ascension holds a noncontrolling interest.

3. Organizational Changes (continued)

- On September 28, 2016, St. Joseph Regional Medical Center, Inc. in Lewiston, Idaho (St. Joseph Regional), a wholly owned subsidiary of Ascension Healthcare, and RCCH entered into an asset purchase agreement, whereby RCCH purchased substantially all assets and assumed certain liabilities associated with the operations of St. Joseph Regional. Assets and liabilities of St. Joseph Regional's foundation remain with Ascension Healthcare. The sale was completed on May 1, 2017.

- On September 28, 2016, Our Lady of Lourdes Hospital at Pasco in Pasco, Washington, d/b/a Lourdes Health Network (Lourdes Health), a wholly owned subsidiary of Ascension Healthcare, and Capella Healthcare, Inc. (a predecessor corporation of RCCH HealthCare Partners) (RCCH) entered into an asset purchase agreement, whereby RCCH will purchase substantially all assets and assume certain liabilities associated with the operations of Lourdes Health. Assets and liabilities of Lourdes Health's foundation will remain with Ascension Healthcare. The sale is expected to close in fiscal year 2018, after obtaining all necessary regulatory approvals.

Assets and liabilities associated with the aforementioned transactions were held for sale and qualified for discontinued operations as of June 30, 2017 and 2016, and are included in other current assets and other current liabilities, respectively, in the System's Consolidated Balance Sheets. Assets held for sale were $44,935 and $144,490 at June 30, 2017 and 2016, respectively, while liabilities held for sale were $22,531 and $30,552 at June 30, 2017 and 2016, respectively. Net losses of the entities, which include excess of revenues over expenses of St. Joseph Regional through the May 1, 2017 sale date and a deficit of revenues over expenses of Carondelet Health Network through the September 1, 2015 sale date and a $14,520 loss on sale, are included in the loss from discontinued operations in the Consolidated Statements of Operations and Changes in Net Assets and were $1,292 and $15,790 for the years ended June 30, 2017 and 2016, respectively. Total operating revenues of the entities were $260,219 and $355,516 for the years ended June 30, 2017 and 2016, respectively, which includes total operating revenues of St. Joseph Regional and Carondelet Health through the sale dates.

3. Organizational Changes (continued)

Assets Held for Sale

On March 31, 2017, St. Joseph's Hospital of Marshfield, Inc. in Marshfield, Wisconsin (SJHM), a subsidiary of Ministry Health Care (Ministry), entered into an asset sale agreement with MCHS Hospitals Inc. (Marshfield Clinic) whereby Marshfield Clinic purchased substantially all the assets and assumed certain liabilities associated with SJHM. Ministry is a subsidiary of Ascension Healthcare. The sale was completed on June 30, 2017.

Assets and liabilities associated with the aforementioned transaction were designated as assets and liabilities held for sale, and included in other current assets and other current liabilities, respectively, in the System's Consolidated Balance Sheets at June 30, 2016. Assets and liabilities held for sale were $161,058 and $11,760 at June 30, 2016, respectively. Net income of SJHM is included in the excess of revenues and gains over expenses and losses in the Consolidated Statements of Operations and Changes in Net Assets and is $32,766 and $35,499 for the years ended June 30, 2017 and 2016, respectively. Revenues of SJHM total $300,364 and $319,959 for the years ended June 30, 2017 and 2016, respectively.

Other

In May 2016, Ascension sold primarily all of the assets, liabilities and operations of its Medxcel, Inc. business to TMX Holdings, LLLP (TMX), a partnership in which Ascension maintains a 50% interest. As a result of the transaction, Ascension recognized a gain, which is included in other operating revenue in the Consolidated Statements of Operations and Changes in Net Assets for the year ended June 30, 2016, and the interest in TMX was recorded at its initial fair value. Subsequent to the transaction, Ascension is accounting for its interest in TMX under the equity method of accounting.

4. Pooled Investment Fund

At June 30, 2017 and 2016, a significant portion of the System's investments consists of the System's interest in the Alpha Fund, a limited liability company organized in the state of Delaware. Certain System investments, including some held by the Health Ministries and their consolidated foundations, are managed outside of the Alpha Fund.

The Alpha Fund includes the investment interests of the System and other Alpha Fund members. AIM, a wholly owned subsidiary of the System, serves as the manager and primary investment advisor of the Alpha Fund, overseeing the investment strategies offered to the Alpha Fund's members. AIM provides expertise in the areas of asset allocation, selection and monitoring of outside investment managers, and risk management. The Alpha Fund is consolidated in the System's financial statements. The portion of the Alpha Fund's net assets representing interests held by entities other than the System are reflected in noncontrolling interests in the Consolidated Balance Sheets, which amount to $1,598,399 and $1,256,666 at June 30, 2017 and 2016, respectively.

The Alpha Fund invests in a diversified portfolio of investments including alternative investments, such as real asset funds, hedge funds, private equity funds, commodity funds, and private credit funds. Collectively, these funds have liquidity terms ranging from daily to annual with notice periods ranging from 1 to 120 days. Due to redemption restrictions, investments in certain of these funds, whose fair value was approximately $2,528,129 at June 30, 2017, cannot currently be redeemed for periods ranging from one to twelve years. However, the potential for the Alpha Fund to sell its interest in these funds in a secondary market prior to the end of the fund term does exist.

The Alpha Fund's investments in certain alternative investment funds also include contractual commitments to provide capital contributions during the investment period, which is typically five years and can extend to the end of the fund term. During these contractual periods, investment managers may require the Alpha Fund to invest in accordance with the terms of the agreement. Commitments not funded during the investment period will expire and remain unfunded. As of June 30, 2017, contractual agreements of the Alpha Fund expire between August 2017 and February 2023. The remaining unfunded capital commitments of the Alpha Fund total approximately $1,863,000 for 169 individual funds as of June 30, 2017. Due to the uncertainty surrounding whether the contractual commitments will require funding during the contractual period, future minimum payments to meet these commitments cannot be reasonably estimated. These committed amounts are expected to be primarily satisfied by the liquidation of existing investments in the Alpha Fund.

4. Pooled Investment Fund (continued)

In the normal course of operations and within established Alpha Fund guidelines, the Alpha Fund may enter into various exchange-traded and over-the-counter derivative contracts for trading purposes, including futures, options, and forward contracts as well as warrants and swaps. These instruments are used primarily to adjust the portfolio duration, restructure term structure exposure, change sector exposure, and arbitrage market inefficiencies. See the Fair Value Measurements note for a discussion of how fair value for the Alpha Fund's derivatives is determined.

At June 30, 2017 and 2016, the notional value of Alpha Fund derivatives outstanding was approximately $5,533,000 and $4,540,000, respectively. The fair value of Alpha Fund derivatives in an asset position was $30,032 and $34,713 at June 30, 2017 and 2016, respectively, while the fair value of Alpha Fund derivatives in a liability position was $28,809 and $31,677 at June 30, 2017 and 2016, respectively. These derivatives are included in long-term investments in the Consolidated Balance Sheets at June 30, 2017 and 2016.

Due from brokers and due to brokers on the Consolidated Balance Sheets at June 30, 2017 and 2016, represent the Alpha Fund's positions and amounts due from or to various brokers, primarily for security transactions not yet settled, and cash held by brokers for securities sold, not yet purchased.

5. Cash and Investments

The System's cash and investments are reported in the Consolidated Balance Sheets as presented in the table that follows. Total cash and investments, net, includes both the System's membership interest in the Alpha Fund and the noncontrolling interests held by other Alpha Fund members. System unrestricted cash and investments, net, represent the System's cash and investments excluding the noncontrolling interests held by other Alpha Fund members and assets limited as to use.

	June 30, 2017	June 30, 2016
Cash and cash equivalents	**$ 857,605**	$ 696,237
Short-term investments	**103,857**	122,545
Long-term investments	**16,999,371**	15,069,123
Subtotal	**17,960,833**	15,887,905
Other Alpha Fund assets and liabilities:		
In other current assets	**34,314**	27,768
In other long-term assets	**2,174**	2,335
In accounts payable and other accrued liabilities	**(14,698)**	(9,312)
In other current liabilities	**(330)**	-
In other noncurrent liabilities	**(2,342)**	(4,569)
Due from brokers, net	**81,412**	208,057
Total cash and investments, net	**18,061,363**	16,112,184
Less noncontrolling interests of Alpha Fund	**1,598,399**	1,256,666
System cash and investments, including assets limited as to use	**16,462,964**	14,855,518
Less assets limited as to use:		
Under bond indenture agreement	**19,504**	20,002
Self-insurance trust funds	**689,197**	676,375
Temporarily or permanently restricted	**649,891**	595,761
Total assets limited as to use	**1,358,592**	1,292,138
System unrestricted cash and investments, net	**$ 15,104,372**	$ 13,563,380

5. Cash and Investments (continued)

At June 30, 2017 and 2016, the composition of cash and cash equivalents, short-term investments and long-term investments, which include certain assets limited as to use, is summarized as follows.

	June 30, 2017	June 30, 2016
Cash and cash equivalents and short-term investments	$ 1,200,191	$ 935,026
Pooled short-term investment funds	515,516	471,099
U.S. government, state, municipal and agency obligations	2,534,968	3,064,411
Corporate and foreign fixed income securities	2,501,060	1,728,149
Asset-backed securities	1,190,364	771,971
Equity securities	4,282,517	2,996,662
Alternative investments and other investments:		
Private equity and real estate funds	2,002,292	1,648,545
Hedge funds	2,068,742	2,677,275
Commodities funds and other investments	1,665,183	1,594,767
Total alternative investments and other investments	5,736,217	5,920,587
Total cash and cash equivalents, short-term investments, and long-term investments	$ 17,960,833	$ 15,887,905

As of June 30, 2017 and 2016, the System's membership interest in the Alpha Fund totaled $13,634,600 and $11,861,266, respectively. As of June 30, 2017 and 2016, the noncontrolling interest (see Note 4) in the Alpha Fund, representing interests held by entities other than the System, totaled $1,598,399 and $1,256,666, respectively.

Investment return recognized by the System for the years ended June 30, 2017 and 2016, is summarized in the following table. Total investment return includes the System's return on certain investments held and managed outside the Alpha Fund and the investment return of the Alpha Fund. System investment return represents the System's total investment return, net of the investment return earned by the noncontrolling interests of other Alpha Fund members.

5. Cash and Investments (continued)

	Year Ended June 30, 2017	Year Ended June 30, 2016
Interest and dividends	$ **256,949**	$ 234,677
Net gains (losses) on investments reported at fair value	**1,206,832**	(609,308)
Restricted investment return and unrealized gains (losses), net	**36,673**	(6,349)
Total investment return	**1,500,454**	(380,980)
Less return earned by noncontrolling interests of Alpha Fund	**140,511**	(42,756)
System investment return	$ **1,359,943**	$ (338,224)

6. Fair Value Measurements

The System measures the fair value of assets and liabilities in accordance with FASB ASC 820, *Fair Value Measurement*. Under ASC 820, fair value is defined as the price that would be received to sell an asset or paid to transfer a liability at the measurement date. Assets and liabilities reported at fair value are classified and disclosed in one of the following four categories:

Level 1 – Quoted prices (unadjusted) that are readily available in active markets/exchanges for identical assets or liabilities.

Level 2 – Pricing inputs other than quoted prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. Level 2 pricing inputs include prices quoted for similar assets and liabilities in active markets/exchanges or prices quoted for identical or similar assets and liabilities in markets that are not active. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 – Significant pricing inputs that are unobservable for the asset or liability, including assets or liabilities for which there is little, if any, market activity for such asset or liability. Inputs to determine the fair value of Level 3 assets and liabilities require management judgment and estimation.

6. Fair Value Measurements (continued)

Net Asset Value – Values are based on the calculated net asset value. The calculated net asset values for underlying investments are fair value estimates determined by an external fund manager based on quoted market prices, operating results, balance sheet stability, growth, and other business and market sector factors.

The System categorizes, for disclosure purposes, assets and liabilities measured at fair value in the consolidated financial statements based upon whether the inputs used to determine their fair values are observable or unobservable. Observable inputs are inputs that are based on market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the reporting entity's own assumptions about pricing the asset or liability based on the best information available in the circumstances.

In certain cases, the inputs used to measure fair value may fall into different levels of the fair value hierarchy. In such cases, an asset's or liability's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement of the asset or liability. The System's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment and considers factors specific to the asset or liability.

There were no significant transfers between Levels 1 and 2 during the years ended June 30, 2017 and 2016.

As of June 30, 2017 and 2016, the assets and liabilities listed in the fair value hierarchy tables below use the following valuation techniques and inputs:

Cash and Cash Equivalents and Short-Term Investments

Cash and cash equivalents and certain short-term investments include certificates of deposit, whose fair value is based on cost plus accrued interest. Significant observable inputs include security cost, maturity, and relevant short-term interest rates. Other short-term investments designated as Level 2 investments primarily consist of commercial paper, whose fair value is based on the income approach. Significant observable inputs include security cost, maturity, credit rating, interest rate, and par value.

6. Fair Value Measurements (continued)

Pooled Short-term Investment Fund

The pooled short-term investment fund is a short term exchange traded money market fund primarily invested in treasury securities.

U S. Government, State, Municipal, and Agency Obligations

The fair value of investments in U.S. government, state, municipal, and agency obligations is primarily determined using techniques consistent with the income approach. Significant observable inputs include benchmark yields, reported trades, observable broker/dealer quotes, and issuer spreads.

Corporate and Foreign Fixed Income Securities

The fair value of investments in U.S. and international corporate bonds and foreign government bonds is primarily determined using techniques that are consistent with the market approach. Significant observable inputs include benchmark yields, reported trades, observable broker/dealer quotes, issuer spreads, and security-specific characteristics (e.g., such as early redemption options).

Asset-backed Securities

The fair value of U.S. agency, mortgage, and other asset-backed securities is primarily determined using techniques that are consistent with the income approach. Significant observable inputs include prepayment speeds and spreads, benchmark yield curves, volatility measures, and observable broker/dealer quotes.

Equity Securities

The fair value of investments in U.S. and international equity securities is primarily determined using techniques that are consistent with the market and income approaches. The values for underlying investments are fair value estimates determined by an external fund manager based on quoted market prices, operating results, balance sheet stability, growth, dividend, dividend yield, and other business and market sector fundamentals.

6. Fair Value Measurements (continued)

Alternative Investments and Other Investments

Alternative investments consist of private equity, hedge funds, private equity funds, commodity funds, and real estate partnerships. The fair value of private equity is primarily determined using techniques consistent with both the market and income approaches, based on the System's estimates and assumptions in the absence of observable market data. The market approach considers comparable company, comparable transaction, and company-specific information, including but not limited to restrictions on disposition, subsequent purchases of the same or similar securities by other investors, pending mergers or acquisitions, and current financial position and operating results. The income approach considers the projected operating performance of the portfolio company.

The fair value of hedge funds, private equity funds, commodity funds, and real estate partnerships is primarily determined using net asset values, which approximate fair value, as determined by an external fund manager based on quoted market prices, operating results, balance sheet stability, growth, and other business and market sector fundamentals.

Other investments include derivative assets and derivative liabilities of the Alpha Fund, whose fair value is primarily determined using techniques consistent with the market approach. Significant observable inputs to valuation models include interest rates, Treasury yields, volatilities, credit spreads, maturity, and recovery rates.

Benefit Plan Assets

The fair value of benefit plan assets is based on original investment into a guaranteed pooled fund, plus guaranteed, annuity contract-based interest rates. Significant unobservable inputs to the guaranteed rate include the fair value and average duration of the portfolio of investments underlying annuity contract, the contract value, and the annualized weighted-average yield to maturity of the underlying investment portfolio.

6. Fair Value Measurements (continued)

Interest Rate Swap Assets and Liabilities

The fair value of interest rate swaps is primarily determined using techniques consistent with the market approach. Significant observable inputs to valuation models include interest rates, Treasury yields, volatilities, credit spreads, maturity, and recovery rates.

Investments Sold, Not Yet Purchased

The fair value of investments sold, not yet purchased is primarily determined using techniques consistent with the income approach. Significant observable inputs to the income approach include data points for benchmark, constant maturity curves, and spreads.

6. Fair Value Measurements (continued)

The following table summarizes fair value measurements, by level, at June 30, 2017, for all financial assets and liabilities measured at fair value on a recurring basis in the System's consolidated financial statements:

	Level 1	Level 2	Level 3	Total
June 30, 2017				
Cash equivalents	$ 61,317	$ 579	$ -	$ 61,896
Short-term investments	109,387	103,344	345	213,076
Pooled short-term investment funds	515,516	-	-	515,516
U.S. government, state, municipal and agency obligations	-	2,534,968	-	2,534,968
Corporate and foreign fixed income securities	-	2,371,296	28,119	2,399,415
Asset-backed securities	-	997,153	193,211	1,190,364
Equity securities	3,775,634	224,584	4,738	4,004,956
Alternative investments and other investments:				
Private equity and real estate funds	1,873	2,400	241,420	245,693
Commodities funds and other investments	12,537	5,339	7,493	25,369
Assets at net asset value:				
Corporate and foreign fixed income securities				101,645
Equity securities				277,561
Private equity and real estate funds				1,756,599
Hedge funds				2,068,742
Commodities funds and other investments				1,553,370
Cash and other investments not at fair value				1,011,663
Cash and investments				$ 17,960,833
Benefit plan assets, in other noncurrent assets	$ 312,120	$ 47,163	$ 54,698	$ 413,981
Interest rate swaps, in other noncurrent assets	-	1,648	-	1,648
Investments sold, not yet purchased, in other noncurrent liabilities	-	2,342	-	2,342
Interest rate swaps, included in other noncurrent liabilities	-	157,518	-	157,518

6. Fair Value Measurements (continued)

For the year ended June 30, 2017, the changes in the fair value of the assets and liabilities measured using significant unobservable inputs (Level 3) consisted of the following.

	Short-term investments	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities	Private Equity and Real Estate Funds	Commodities Funds and Other Investments	Benefit Plan Assets
Year Ended June 30, 2017							
Beginning balance	$ 287	$ 29,545	$ 142,831	$ 3,759	$ 197,886	$ 4,464	$ 56,070
Total realized and unrealized gains (losses):							
Included in nonoperating gains (losses)	58	3,428	14,434	663	28,731	19	-
Included in changes in net assets	-	-	-	-	-	(35)	-
Purchases	-	6,357	154,039	1,158	57,900	2,880	127,432
Sales	-	(5,033)	(84,813)	(584)	(43,141)	-	(127,097)
Transfers into Level 3	-	2,379	-	121	44	320	54,003
Transfers out of Level 3	-	(8,557)	(33,280)	(379)	-	(155)	(55,710)
Ending balance	$ 345	$ 28,119	$ 193,211	$ 4,738	$ 241,420	$ 7,493	$ 54,698
The amount of total gains or losses for the period included in nonoperating gains (losses) attributable to the changes in unrealized gains or losses relating to assets still held at June 30, 2017	$ -	$ 3,377	$ 8,404	$ 705	$ 800	$ 3,339	$ -

The basis for recognizing and valuing transfers into or out of Level 3, in the Level 3 rollforward, is as of the beginning of the period in which the transfers occur.

6. Fair Value Measurements (continued)

The following table summarizes fair value measurements, by level, at June 30, 2016, for all financial assets and liabilities measured at fair value on a recurring basis in the System's consolidated financial statements:

	Level 1	Level 2	Level 3	Total
June 30, 2016				
Cash equivalents	$ 497,847	$ 12,173	$ -	$ 510,020
Short-term investments	46,750	20,291	287	67,328
Pooled short-term investment funds	471,099	-	-	471,099
U.S. government, state, municipal and agency obligations	-	3,064,411	-	3,064,411
Corporate and foreign fixed income securities	-	1,604,725	29,545	1,634,270
Asset-backed securities	-	629,140	142,831	771,971
Equity securities	2,671,500	130,930	3,759	2,806,189
Alternative investments and other investments:				
Private equity and real estate funds	1,409	2,400	197,886	201,695
Commodities funds and other investments	13,420	5,183	4,464	23,067
Assets at net asset value:				
Corporate and foreign fixed income securities				93,879
Equity securities				190,473
Private equity and real estate funds				1,446,850
Hedge funds				2,677,275
Commodities funds and other investments				1,454,136
Cash and other investments not at fair value				475,242
Cash and investments				$ 15,887,905
Benefit plan assets, in other noncurrent assets	$ 300,726	$ 33,055	$ 56,070	$ 389,851
Interest rate swaps, in other noncurrent assets	-	10,713	-	10,713
Investments sold, not yet purchased, in other noncurrent liabilities	-	4,569	-	4,569
Interest rate swaps, included in other noncurrent liabilities	-	236,702	-	236,702

6. Fair Value Measurements (continued)

For the year ended June 30, 2016, the changes in the fair value of the assets and liabilities measured using significant unobservable inputs (Level 3) consisted of the following.

	Short-term investments	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities	Private Equity and Real Estate Funds	Commodities Funds and Other Investments	Benefit Plan Assets
Year Ended June 30, 2016							
Beginning balance	$ 301	$ 26,599	$ 89,364	$ 2,198	$ 187,338	$ (4,245)	$ 35,256
Total realized and unrealized gains (losses):							
Included in nonoperating gains (losses)	(14)	(2,661)	(3,472)	(61)	17,014	(6,445)	(3)
Included in changes in net assets	-	-	-	-	-	(47)	-
Purchases	-	19,410	82,958	611	50,400	8,701	31,245
Sales	-	(10,790)	(40,064)	(2,222)	(55,697)	-	(19,892)
Transfers into Level 3	-	3,512	16,075	3,233	1	6,500	25,508
Transfers out of Level 3	-	(6,525)	(2,030)	-	(1,170)	-	(16,044)
Ending balance	$ 287	$ 29,545	$ 142,831	$ 3,759	$ 197,886	$ 4,464	$ 56,070
The amount of total gains or losses for the period included in nonoperating gains (losses) attributable to the changes in unrealized gains or losses relating to assets still held at June 30, 2016	$ -	$ (1,625)	$ (5,621)	$ 494	$ 4,153	$ -	$ -

The basis for recognizing and valuing transfers into or out of Level 3, in the Level 3 rollforward, is as of the beginning of the period in which the transfers occur.

7. Long-Term Debt

Long-term debt at June 30, 2017 and 2016 is comprised of the following and is presented in accordance with the specific master trust indenture to which the debt relates. As further discussed below, certain portions of long-term debt are secured under the Alexian Brothers Health System Master Trust Indenture; the Mercy Regional Health Center, Inc. Master Trust Indenture; and the St. John Health System Master Trust Indenture.

	June 30, 2017	June 30, 2016
Tax-exempt hospital revenue bonds – secured under Ascension Health Alliance Senior Credit Group Master Trust Indenture:		
Variable rate demand bonds, subject to a put provision that provides for a cumulative 7-month notice and remarketing period, payable through November 2047; interest (0.68% at June 30, 2016) tied to a market index plus a spread	$ -	$ 350,890
Variable rate demand bonds, subject to a 7-day put provision, payable through November 2047; interest (0.87% to 0.92% at June 30, 2017) set at prevailing market rates	**533,935**	553,820
Indexed put bonds subject to weekly rate resets based on a taxable index, payable through November 2046; interest (1.264% at June 30, 2016)	-	153,800
Fixed rate put bonds (converted from an indexed put bond mode based on a taxable index in May 2009) payable through November 2046; interest (4.10% at June 30, 2016)	-	153,690
Fixed rate serial, term and mode bonds fixed to maturity payable in installments through November 2051; interest at 3.00% to 5.00%	**2,723,220**	2,392,360
Fixed rate serial mode bonds payable through 2047 with purchase dates ranging from February 2018 through March 2023; interest at 0.95% to 5.00% through the purchase dates	**1,386,245**	1,120,680
Tax-exempt hospital revenue bonds – unsecured under Ascension Health Alliance Subordinate Master Trust Indenture:		
Variable rate demand bonds, subject to a 7-day put provision, payable through November 2025; interest (0.90% at June 30, 2017) set at prevailing market rates	**39,085**	42,985
Fixed rate serial mode bonds payable through 2027 with purchase dates through May 2020; interest at 1.15% to 4.00%	**387,260**	419,055

7. Long-Term Debt (continued)

	June 30, 2017	June 30, 2016
Taxable bonds – secured under Ascension Health Alliance Senior Credit Group Master Trust Indenture:		
Taxable fixed rate term bonds payable in installments through November 2053; interest at 4.847%	$ **425,000**	$ 425,000
Taxable fixed rate term bonds payable as of November 2046; interest at 3.945%	**925,000**	700,000
Total hospital revenue bonds under Senior Master Trust Indenture and Subordinate Master Trust Indenture	**6,419,745**	6,312,280
Tax-exempt hospital revenue bonds – secured under Alexian Brothers Health System Master Trust Indenture:		
Fixed rate serial and term bonds payable in installments through February 2038; interest at 4.25% to 5.50%	**49,090**	61,935
Total hospital revenue bonds under the Alexian Brothers Health System Master Trust Indenture	**49,090**	61,935
Tax-exempt hospital revenue bonds – secured under Mercy Regional Health Center, Inc. Master Trust Indenture:		
Fixed rate serial and term bonds payable in installments through November 2029; interest at 4.00% to 5.00%	**20,790**	21,915
Total hospital revenue bonds under the Mercy Regional Health Center, Inc. Master Trust Indenture	**20,790**	21,915
Tax-exempt hospital revenue bonds – secured under St. John Health System Master Trust Indenture:		
Fixed rate serial and term bonds payable in installments through February 2042; interest at 4.00% to 5.00%	**165,110**	385,240
Total hospital revenue bonds under the St. John Health System Master Trust Indenture	**165,110**	385,240
Total hospital revenue bonds – all Master Trust Indentures	**6,654,735**	6,781,370

7. Long-Term Debt (continued)

	June 30, 2017	June 30, 2016
Other debt:		
Obligations under capital leases	**22,134**	24,987
Other	**84,783**	111,923
	6,761,652	6,918,280
Unamortized premium, net	**274,438**	271,774
Less debt issuance cost, net	**(38,595)**	(35,708)
Less current portion	**(298,270)**	(96,193)
Less long-term debt subject to short-term remarketing arrangements	**(999,785)**	(1,666,245)
Long-term debt, less current portion and long-term debt subject to short-term remarketing arrangements	**$ 5,699,440**	$ 5,391,908

	June 30, 2017	June 30, 2016
Ascension Health Alliance Senior Master Trust Indenture long-term debt obligations, including unamortized premium and cost of issuance, net	**$ 5,332,260**	$ 4,477,894
Ascension Health Alliance Subordinate Master Trust Indenture long-term debt obligations, including unamortized premium and cost of issuance, net	**239,406**	309,316
Alexian Brothers Health System Master Trust Indenture long-term debt obligations, including unamortized premium, net	**34,498**	50,296
Mercy Regional Health Center, Inc. Master Trust Indenture long-term debt obligations, including unamortized premium, net	**21,158**	22,627
St. John Health System Master Trust Indenture long-term debt obligations, including unamortized premium, net	**-**	403,132
Other	**72,118**	128,643
Long-term debt, less current portion, and long-term debt subject to short-term remarketing arrangements	**$ 5,699,440**	$ 5,391,908

7. Long-Term Debt (continued)

Scheduled principal repayments of long-term debt, considering obligations subject to short-term remarketing as due according to their long-term amortization schedule, as of June 30, 2017, are as follows:

	Ascension Health Alliance MTIs	Alexian Brothers Health System MTI	Mercy Regional Health Center, Inc. MTI	St. John Health System MTI	Other Debt	Total
Year Ending June 30:						
2018	$ 68,530	$ 15,355	$ 1,175	$ 165,110	$ 48,100	$ 298,270
2019	88,780	2,080	1,230	-	7,000	99,090
2020	91,880	2,495	1,285	-	19,355	115,015
2021	95,345	1,700	1,350	-	7,022	105,417
2022	101,685	2,260	1,420	-	6,525	111,890
Thereafter	5,973,525	25,200	14,330	-	18,915	6,031,970
Total	$ 6,419,745	$ 49,090	$ 20,790	$ 165,110	$ 106,917	$ 6,761,652

Refer to subsequent events disclosure in Note 2 regarding defeasance, or redemption, of certain debt obligations.

The carrying values of fixed rate bonds were $6,081,715 and $5,679,875 at June 30, 2017 and 2016, respectively. The fair values of these fixed rate bonds were $6,446,481 and $6,350,071 at June 30, 2017 and 2016, respectively, representing Level 2 measurements obtained from an independent third party valuation service. The carrying amounts of variable rate bonds and other notes payable approximate fair value.

During the years ended June 30, 2017 and 2016, interest paid was approximately $236,000 and $203,000, respectively. Capitalized interest was approximately $5,700 and $3,700 for the years ended June 30, 2017 and 2016, respectively.

7. Long-Term Debt (continued)

Certain members of the System formed the Ascension Health Alliance Credit Group (Senior Credit Group). Each Senior Credit Group member is identified as either a senior obligated group member, a senior designated affiliate, or a senior limited designated affiliate. Senior obligated group members are jointly and severally liable under a Senior Master Trust Indenture (Senior MTI) to make all payments required with respect to obligations under the Senior MTI and may be entities not controlled directly or indirectly by the System.

Senior designated affiliates and senior limited designated affiliates are not obligated to make debt service payments on the obligations under the Senior MTI. The System may cause each senior designated affiliate to transfer such amounts as are necessary to enable the obligated group to comply with the terms of the Senior MTI, including payment of the outstanding obligations. Additionally, each senior limited designated affiliate has an independent limited designated affiliate agreement and promissory note with the System with stipulated repayment terms and conditions, each subject to the governing law of the senior limited designated affiliate's state of incorporation.

Pursuant to a Supplemental Master Indenture dated February 1, 2005, senior obligated group members, which are operating entities, have pledged and assigned to the Master Trustee a security interest in all of their rights, title, and interest in their pledged revenues and proceeds thereof.

A Subordinate Credit Group, which is comprised of subordinate obligated group members, subordinate designated affiliates, and subordinate limited designated affiliates, was created under the Subordinate Master Trust Indenture (Subordinate MTI). The subordinate obligated group members are jointly and severally liable under the Subordinate MTI to make all payments required with respect to obligations under the Subordinate MTI and may be entities not controlled directly or indirectly by the System. Subordinate designated affiliates and subordinate limited designated affiliates are not obligated to make debt service payments on the obligations under the Subordinate MTI.

The System may cause each subordinate designated affiliate to transfer such amounts as are necessary to enable the obligated group members to comply with the terms of the Subordinate MTI, including payment of the outstanding obligations. Additionally, each subordinate limited designated affiliate has an independent subordinate limited designated affiliate agreement and promissory note with the System, with stipulated repayment terms and conditions, each subject to the governing law of the subordinate limited designated affiliate's state of incorporation.

7. Long-Term Debt (continued)

The unsecured variable rate demand bonds of both the Senior and Subordinate Credit Groups, while subject to long-term amortization periods, may be put to the System at the option of the bondholders in connection with certain remarketing dates. To the extent that bondholders may, under the terms of the debt, put their bonds within 12 months after June 30, 2017, the principal amount of such bonds has been classified as a current liability in the accompanying Consolidated Balance Sheets. Management believes the likelihood of a material amount of bonds being put to the System to be remote. However, to address this possibility, management has taken steps to provide various sources of liquidity in the event any bonds would be put, including the line of credit, commercial paper program, and maintaining unrestricted assets as a source of self-liquidity.

On January 1, 2012, Alexian Brothers became part of the System. Subsequently, the System redeemed or refinanced a portion of Alexian Brothers' debt; however, a portion of the bonds previously issued for the benefit of Alexian Brothers remains outstanding (the Alexian Brothers' Bonds). The Alexian Brothers' Bonds continue to be secured by the Alexian Brothers Health System Master Trust Indenture (As Amended and Restated), dated October 1, 1992, between the Members of the Alexian Brothers Health System Obligated Group established under this document and the Alexian Brothers Health System Master Trustee.

On April 1, 2013, Marian Health System joined Ascension Health. Subsequently, the System redeemed or refinanced a portion of the debt of the Marian Systems; however, a portion of the bonds previously issued for the benefit of the Marian Systems remains outstanding. These bonds continue to be secured by the respective Master Trust Indentures, including the Amended and Restated Master Trust Indenture dated October 1, 1999, by and between St. John Health System and the St. John Health Master Trustee; and the Master Trust Indenture dated January 15, 2013, between Mercy Regional Health Center, Inc. and the Mercy Regional Health Center, Inc. Master Trustee.

In order to terminate the respective Master Trust Indentures of Crittenton and Wheaton, and the redemption or defeasance of all associated outstanding debt, Ascension issued and redeemed taxable commercial paper of approximately $161,000 and $637,000, respectively, during the year ended June 30, 2016. Following the discharge of these Master Trust Indentures, certain Crittenton and Wheaton entities were added to the Senior and Subordinate Credit Groups.

7. Long-Term Debt (continued)

In May 2016, Ascension issued $2,046,250 of debt, consisting of $1,346,250 tax-exempt bonds through issuing authorities in Wisconsin, Alabama and Michigan, and $700,000 taxable bonds. The debt was issued to refund certain Ascension 2006 fixed rate bonds payable through 2039, to refund the commercial paper associated with the Crittenton and Wheaton transactions, to refund the remaining debt of Ministry Health Care, Inc. and Howard Young Health Care, Inc. and to reimburse the System for previous capital expenditures. Subsequent to the closing, both the Ministry Health Care Master Trust Indenture and The Howard Young Medical Center, Inc. Master Trust Indenture were terminated and certain Ministry Health Care, Inc. and Howard Young Health Care, Inc. entities were added to the Senior and Subordinate Credit Groups.

In June 2017, Ascension issued $225 million of taxable bonds through a reopening of the Series 2016A taxable bond offering, a Senior Credit Group Obligation. The debt was issued primarily to refund certain Series 2007 St. John Health System bonds. The St. John Health System has not joined the Senior or Subordinate Credit Groups.

Due to aggregate financing activity during the fiscal years ended June 30, 2017 and 2016, gains (losses) on extinguishment of debt of $10,907 and ($13,594), respectively, were recorded, which are included in nonoperating gains (losses) in the accompanying Consolidated Statements of Operations and Changes in Net Assets.

As of June 30, 2017, the Senior Credit Group has two lines of credit totaling $1,000,000. The first line of credit totals $500,000 which may be used as a source of funding for unremarketed variable debt (including commercial paper) or for general corporate purposes. The second line of credit totals $500,000 which may be used for general corporate purposes. Both lines are committed to November 3, 2017 and as of June 30, 2017 and 2016, there were no borrowings under either line of credit.

As of June 30, 2017, the Senior Credit Group has a $100,000 revolving line of credit related to its letters of credit program toward which a bank commitment of $100,000 extends to November 22, 2017. The revolving line of credit may be accessed solely in the form of Letters of Credit issued by the bank for the benefit of the members of the Credit Groups. Of this $100,000 revolving line of credit, letters of credit totaling $85,925 have been issued as of June 30, 2017. No borrowings were outstanding under the letters of credit as of June 30, 2017 and 2016.

8. Derivative Instruments

The System uses interest rate swap agreements to manage interest rate risk associated with its outstanding debt. Interest rate swaps with varying characteristics are outstanding under the Master Trust Indentures of the System and St. John Health. These swaps have historically been used to effectively convert interest rates on variable rate bonds to fixed rates and rates on fixed rate bonds to variable rates. At June 30, 2017 and 2016, the notional values of outstanding interest rate swaps were as follows:

	June 30,	
	2017	**2016**
Ascension Health Alliance MTI	**$ 1,146,600**	$ 2,146,107
St. John Health System MTI	**100,000**	100,000
Total	**$ 1,246,600**	$ 2,246,107

The System recognizes the fair value of its interest rate swaps in the Consolidated Balance Sheets as assets, recorded in other noncurrent assets, or liabilities, recorded in other noncurrent liabilities, as appropriate. The respective fair values of interest rate swaps in an asset and liability position for the System and St. John Health were as follows:

	June 30, 2017		June 30, 2016	
	Asset	**Liability**	**Asset**	**Liability**
Ascension Health Alliance MTI	**$ 1,648**	**$ 157,394**	$ 10,713	$ 236,367
St. John Health System MTI	**-**	**124**	-	335
Total	**$ 1,648**	**$ 157,518**	$ 10,713	$ 236,702

8. Derivative Instruments (continued)

The System's interest rate swap agreements include collateral requirements for each counterparty under such agreements, based upon specific contractual criteria, subject to master netting arrangements. Collateral requirements are separately calculated for the System and St. John Health based on the credit ratings of each. In the case of the System, the applicable credit rating is the Senior Credit Group long-term debt credit ratings (Senior Debt Credit Ratings), as obtained from each of two major credit rating agencies. Credit rating and the net liability position of total interest rate swap agreements outstanding with each counterparty determine the amount of collateral to be posted. No collateral was posted at June 30, 2017 and 2016.

The System does not account for any of its interest rate swaps as hedges, and accordingly, all changes in the fair value of interest rate swaps are recognized in nonoperating gains (losses) in the accompanying Consolidated Statements of Operations and Changes in Net Assets. The System does not offset fair value amounts recognized for derivative instruments.

9. Retirement Plans

Defined-Benefit Plans

Certain System entities participate in defined-benefit pension plans (the System Plans), which are noncontributory, defined-benefit pension plans. Benefits are based on each participant's years of service and compensation. All of the System Plans' assets are invested in Trusts, which include the Master Pension Trust (the Trust) and other trusts (the Other Trusts). The System Plans' assets primarily consist of short-term investments, equity, fixed income, and alternative investments, consisting of various hedge funds, real estate funds, private equity funds, commodity funds, private credit funds, and certain other private funds. Contributions to the System Plans are based on actuarially determined amounts sufficient to meet the benefits to be paid to participants.

Most System defined benefit plans were frozen effective December 31, 2012. Four of the System Plans remain ongoing with $28,174 of service cost recognized during the year ended June 30, 2017. During the year ended June 30, 2017, the System froze a defined benefit plan which resulted in the recognition of a curtailment gain of $40,000 which was recognized in total impairment, restructuring, and nonrecurring losses as discussed in Note 2.

9. Retirement Plans (continued)

The assets of the System Plans are available to pay the benefits of eligible employees and retirees of all participating entities. In the event entities participating in the System Plans are unable to fulfill their financial obligations under the System Plans, the other participating entities are obligated to do so.

The following table sets forth the combined benefit obligations and assets of the System Plans at June 30, 2017 and 2016, components of net periodic benefit costs for the years then ended, and a reconciliation of the amounts recognized in the accompanying consolidated financial statements.

	Year Ended June 30,	
	2017	**2016**
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	**$ 9,435,964**	$ 7,786,840
Service cost	**28,174**	25,467
Interest cost	**341,998**	352,212
Actuarial (gain) loss	**(18,943)**	624,503
Acquisitions	**-**	1,069,401
Curtailment	**(58,351)**	(12,206)
Benefits paid	**(555,192)**	(410,253)
Projected benefit obligation at end of year	**9,173,650**	9,435,964
Change in plan assets:		
Fair value of plan assets at beginning of year	**8,199,379**	7,305,030
Actual return on plan assets	**269,419**	482,083
Employer contributions	**6,161**	24,381
Acquisitions	**-**	798,138
Benefits paid	**(555,192)**	(410,253)
Fair value of plan assets at end of year	**7,919,767**	8,199,379
Net amount recognized at end of year and funded status	**$ (1,253,883)**	$ (1,236,585)
Accumulated benefit obligation at end of year	**$ 9,169,399**	$ 9,386,710

9. Retirement Plans (continued)

The System Plans' funded status as a percentage of the projected benefit obligation at June 30, 2017 and 2016, was 86.3% and 86.9%, respectively. The System Plans' funded status as a percentage of the accumulated benefit obligation at June 30, 2017 and 2016, was 86.4% and 87.4%, respectively.

Included in unrestricted net assets at June 30, 2017 and 2016, are the following amounts that have not yet been recognized in net periodic pension cost for the System Plans:

	2017	2016
Unrecognized prior service credit	$ **(5,285)**	$ (8,293)
Unrecognized actuarial loss	**1,857,547**	1,546,707
	$ **1,852,262**	$ 1,538,414

Changes in plan assets and benefit obligations recognized in unrestricted net assets for System Plans during 2017 and 2016 include:

	2017	2016
Current year actuarial gain	$ **334,981**	$ 749,175
Amortization of actuarial loss	**(24,141)**	(35,534)
Amortization of prior service credit	**3,008**	3,778
	$ **313,848**	$ 717,419

9. Retirement Plans (continued)

	2017	2016
Components of net periodic benefit cost		
Service cost	$ **28,174**	$ 25,467
Interest cost	**341,998**	352,212
Expected return on plan assets	**(681,695)**	(618,961)
Amortization of prior service credit	**(2,842)**	(3,140)
Amortization of actuarial loss	**60,827**	34,985
Curtailment gain	**(40,000)**	(638)
Settlement loss	**3,148**	549
Net periodic benefit	$ **(290,390)**	$ (209,526)

The prior service credit and actuarial loss included in unrestricted net assets and expected to be recognized in net periodic pension cost during the year ending June 30, 2018, are $2,700 and $72,435, respectively.

The assumptions used to determine the benefit obligation and net periodic benefit cost for the System Plans are set forth below:

	June 30,	
	2017	2016
To determine benefit obligations:		
Weighted-average discount rate	**3.87%**	3.80%
To determine net periodic benefit cost:		
Weighted-average discount rate	**3.80%**	4.48%
Weighted-average expected long-term rate of return on plan assets	**8.50%**	8.36%

9. Retirement Plans (continued)

The expected long-term rate of return on the System Plans' assets is based on historical and projected rates of return for current and planned asset categories in the investment portfolio. Assumed projected rates of return for each asset category were selected after analyzing historical experience and future expectations of the returns and volatility for assets of that category using benchmark rates. Based on the target asset allocation among the asset categories, the overall expected rate of return for the portfolio was developed and adjusted for historical and expected experience of active portfolio management results compared to benchmark returns and for the effect of expenses paid from plan assets.

The System Plans' assets invested in the Trust are invested in a portfolio designed to protect principal and obtain competitive investment returns and long-term investment growth, consistent with actuarial assumptions, with a reasonable and prudent level of risk. Diversification is achieved by allocating to funds and managers that correlate to one of three economic strategies: growth, deflation, and inflation. Growth strategies include U.S. equity, emerging market equity, global equity, international equity, directional hedge funds, private equity, high yield, and private credit. Deflation strategies include core fixed income, absolute return hedge funds, and cash. Inflation strategies include inflation-linked bonds, commodity-related investments, and real assets. The System Plans use multiple investment managers with complementary styles, philosophies, and approaches. In accordance with the System Plans' objectives, derivatives may also be used to gain market exposure in an efficient and timely manner.

In accordance with the System Plans' asset diversification targets, as presented in the table that follows, the Trust holds certain alternative investments, consisting of various hedge funds, real asset funds, private equity funds, commodity funds, private credit funds, and certain other private funds. These investments do not have observable market values. As such, each of these investments is valued at net asset value (NAV) as determined by each fund's investment manager, which approximates fair value. Management elected to use the NAV per share, or equivalent, for fair value. Collectively, these funds have liquidity terms ranging from daily to annual with notice periods ranging from 1 to 120 days. Due to redemption restrictions, investments of certain private funds, whose fair value was approximately $893,000 at June 30, 2017, cannot currently be redeemed. However, the potential for the System Plans to sell their interest in real asset funds and private equity funds in a secondary market prior to the end of the fund term does exist.

9. Retirement Plans (continued)

The investments in these alternative investment funds may also include contractual commitments to provide capital contributions during the investment period, which is typically five years, and may extend to the end of the fund term. During these contractual periods, investment managers may require the System Plans to invest in accordance with the terms of the agreement. Commitments not funded during the investment period will expire and remain unfunded. As of June 30, 2017, investment periods expire between January 2018 and February 2023. The remaining unfunded capital commitments of the Trust total approximately $587,000 for 86 individual contracts as of June 30, 2017.

The weighted-average asset allocation for the System Plans in the Trust at the end of fiscal 2017 and 2016 and the target allocation for fiscal 2018, by asset category, are as follows:

	Target Allocation	Percentage of Plan Assets At Year-End	
Asset Category	**2018**	**2017**	**2016**
Growth	57 %	**57 %**	46 %
Deflation	28	**27**	38
Inflation	15	**16**	16
Total	100 %	**100 %**	100 %

9. Retirement Plans (continued)

The following tables summarize fair value measurements at June 30, 2017 and 2016, by asset class and by level, for the System Plans' assets and liabilities. As also discussed in the Fair Value Measurements note, the System follows the three-level fair value hierarchy to categorize plan assets and liabilities recognized at fair value, which prioritizes the inputs used to measure such fair values. The inputs and valuation techniques discussed in the Fair Value Measurements note also apply to the System Plans' assets and liabilities as presented in the following tables.

	Level 1	Level 2	Level 3	Total
June 30, 2017				
Short-term investments	$459,619	$21,466	$ -	$481,085
Derivatives receivable	73	21,900	19,144	41,117
U.S. government, state, municipal and agency obligations	-	1,389,683	-	1,389,683
Corporate and foreign fixed income securities	-	876,984	931	877,915
Asset-backed securities	-	467,600	4,523	472,123
Equity securities	2,092,749	323	12,481	2,105,553
Assets at net asset value:				
Corporate and foreign fixed income securities				10,723
Equity securities				259,556
Private equity and real estate funds				965,209
Hedge funds				1,033,739
Commodities funds and other investments				303,244
Other receivables				229,757
Total				8,169,704
Derivatives payable	1,267	187,443	19,347	208,057
Other payables				41,880
Total				249,937
Fair value of plan assets				$ 7,919,767

9. Retirement Plans (continued)

	Level 1	Level 2	Level 3	Total
June 30, 2016				
Short-term investments	$ 1,235,230	$ -	$ -	$ 1,235,230
Derivatives receivable	31,674	280,634	55,187	367,495
U.S. government, state, municipal and agency obligations	1,840	1,567,670	-	1,569,510
Corporate and foreign fixed income securities	-	617,395	7,870	625,265
Asset-backed securities	-	154,113	41,220	195,333
Equity securities	1,555,564	12,226	12,321	1,580,111
Assets at net asset value:				
Corporate and foreign fixed income securities				8,929
Equity securities				97,760
Private equity and real estate funds				908,403
Hedge funds				1,406,679
Commodities funds and other investments				349,516
Other receivables				241,603
Total				8,585,834
Derivatives payable	30,917	11,291	4,819	47,027
Other payables				339,428
Total				386,455
Fair value of plan assets				$ 8,199,379

9. Retirement Plans (continued)

For the years ended June 30, 2017 and 2016, the changes in the fair value of the System Plans' assets measured using significant unobservable inputs (Level 3) consisted of the following:

	Net Derivatives	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities
June 30, 2017				
Beginning balance	**$ 50,368**	**$ 7,870**	**$ 41,220**	**$ 12,321**
Total actual return on assets	**-**	**1,282**	**3,013**	**(1,758)**
Purchases (sales), net	**(203)**	**(9,319)**	**(33,183)**	**(1,529)**
Transfers (out of) into Level 3	**(50,368)**	**1,098**	**(6,527)**	**3,447**
Ending balance	**$ (203)**	**$ 931**	**$ 4,523**	**$ 12,481**
Actual return on plan assets relating to plan assets still held at June 30, 2017	**$ -**	**$ 450**	**$ 177**	**$ (33)**

	Net Derivatives	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities
June 30, 2016				
Beginning balance	$ (8,737)	$ 3,372	$ 19,610	$ 1,345
Total actual return on assets	(3,649)	(1,200)	(73)	10,198
Purchases (sales), net	62,754	6,184	26,325	738
Transfers (out of) into Level 3	-	(486)	(4,642)	40
Ending balance	$ 50,368	$ 7,870	$ 41,220	$ 12,321
Actual return on plan assets relating to plan assets still held at June 30, 2016	$ 50,368	$ (1,642)	$ (446)	$ (58)

9. Retirement Plans (continued)

The Trust has entered into a series of swap agreements with a net notional amount of approximately $1,927,000. The combined targeted duration of these swaps and the Trust's fixed income investments approximates the duration of the liabilities of the Trust. Currently, 50% of the dollar duration of the liability is subject to this economic hedge. The purpose of this strategy is to economically hedge the change in the net funded status for a significant portion of the liability that can occur due to changes in interest rates.

Information about the expected cash flows for the System Plans follows:

Expected employer contributions 2018	$ 5,970
Expected benefit payments:	
2018	617,125
2019	598,955
2020	610,970
2021	608,655
2022	608,820
2023-2027	2,854,281

The contribution amount above includes expected amounts paid to Trusts. The benefit payment amounts above reflect the total benefits expected to be paid from Trusts.

Other Postretirement Benefit Plans

In addition to the retirement plan described above, certain Health Ministries sponsor postretirement benefit plans that provide healthcare benefits to qualified retirees who meet certain eligibility requirements. The total benefit obligation of these plans at June 30, 2017 and 2016 is $28,987 and $36,044, respectively. The net asset included in pension and other postretirement liabilities in the accompanying Consolidated Balance Sheets at June 30, 2017 and 2016 is $17,972 and $7,954, respectively. The change in the plans' assets and benefit obligations recognized in unrestricted net assets during the year ended June 30, 2017 and 2016, was an increase (decrease) of $4,468 and $(3,731), respectively.

9. Retirement Plans (continued)

Defined-Contribution Plans

System entities participate in contributory and noncontributory defined-contribution plans covering all eligible associates. There are three primary types of contributions to these plans: employer automatic contributions, employee contributions, and employer matching contributions. Benefits for employer automatic contributions are determined as a percentage of a participant's salary and, for certain entities, increases over specified periods of employee service. These benefits are funded annually, and participants become fully vested over a period of time. Benefits for employer matching contributions are determined as a percentage of an eligible participant's contributions each payroll period. These benefits are funded each payroll period, and participants become fully vested in these employer contributions immediately. Expenses for the defined-contribution plans were $349,514 and $326,881 during 2017 and 2016, respectively, and are included in employee benefits in the Consolidated Statements of Operations and Changes in Net Assets.

10. Self-Insurance Programs

Certain System hospitals and other entities participate in pooled risk programs to insure professional and general liability risks and workers' compensation risks to the extent of certain self-insured limits. In addition, various insurance policies have been purchased to provide coverage in excess of the self-insured limits. The System provides its self-insurance through various trust funds and captive insurance companies. Actuarially determined amounts, discounted at 5.5%, are contributed to the trust funds and the captive insurance companies to provide for the estimated cost of claims. The loss reserves recorded for estimated self-insured professional, general liability, and workers' compensation claims include estimates of the ultimate costs for both reported claims and claims incurred but not reported, which were discounted at 5.5% and 6.0% in 2017 and 2016, respectively. Those entities not participating in the self-insured programs are insured under separate policies.

Professional and General Liability Programs

Professional and general liability coverage is provided on a claims-made or occurrence basis through a wholly owned onshore trust and through Ascension Health Insurance, Ltd. (AHIL), a direct subsidiary of Ascension Risk Services.

10. Self-Insurance Programs (continued)

The wholly owned onshore revocable trust has a self-insured retention up to $10,000 per occurrence with no aggregate. Excess coverage is provided through AHIL with limits up to $225,000. AHIL retains $5,000 per incident and in the aggregate for professional liability. The excess coverage is reinsured by commercial carriers.

Employed physicians and certain entities in the states of Indiana, Kansas, Pennsylvania, and Wisconsin are provided coverage by ProAssurance on a fronted basis and are reinsured through AHIL. These entities and physicians are provided professional liability coverage with limits in compliance with participation in the Patient Compensation Funds. The Patient Compensation Funds apply to claims in excess of the primary self-insured limit, except the Fund in Kansas, which only covers claims up to the first $1,000 and then the trust and AHIL cover amounts above $1,000.

Sunflower Assurance, Ltd. (Sunflower) was acquired when Via Christi Health joined the System. As of October 1, 2013, Via Christi Health's primary and excess medical professional and general liability and employed physician programs were integrated into the System trust and AHIL. After January 1, 2014, the employer stop loss and employee life insurance coverage provided by Sunflower to Via Christi Health were not renewed and are in run off.

Effective July 1, 2014, the reinsurance of Ascension's independent physician professional liability program with ProAssurance Corporation (ProAssurance), the System's partner insurance company, was transferred from AHIL to Sunflower.

Beginning July 1, 2014, Sunflower offered physician professional liability coverage through insurance or reinsurance arrangements to nonemployed physicians practicing at the System's various facilities, primarily in Michigan, Indiana, Texas, Florida, Illinois and Alabama. Coverage is offered to physicians with limits ranging from $100 per claim to $1,000 per claim with various aggregate limits. Beginning July 1, 2014, AHIL offered similar coverage to employed physicians in the states of Indiana, Kansas, Pennsylvania and Wisconsin.

10. Self-Insurance Programs (continued)

Included in operating expenses in the accompanying Consolidated Statements of Operations and Changes in Net Assets is professional and general liability expense of $167,393 and $139,778 for the years ended June 30, 2017 and 2016, respectively. Included in current and long-term self-insurance liabilities on the accompanying Consolidated Balance Sheets are professional and general liability loss reserves of $541,177 and $552,656 at June 30, 2017 and 2016, respectively.

Workers' Compensation

Workers' compensation coverage is provided on an occurrence basis through a grantor trust. The self-insured trust provides coverage up to $1,500 per occurrence with no aggregate. The trust provides a mechanism for funding the workers' compensation obligations of its members. Prior to October 1, 2013, workers' compensation coverage for Via Christi Health, Ministry, and St. John Health System, a subsidiary of Ascension Health, (collectively the former Marian Health System) was self-insured or commercially insured up to various limits and excess insurance against catastrophic loss was obtained through commercial insurers.

Included in employee benefits in the accompanying Consolidated Statements of Operations and Changes in Net Assets is workers' compensation expense of $49,767 and $41,777 for the years ended June 30, 2017 and 2016, respectively. Included in current and long-term self-insurance liabilities on the accompanying Consolidated Balance Sheets are workers' compensation loss reserves of $131,566 and $138,221 at June 30, 2017 and 2016, respectively.

11. Lease Commitments

Certain System entities are lessees under operating lease agreements for the use of space in buildings owned by third parties, including medical office buildings (MOBs) and medical and information technology equipment. In addition, certain System entities have subleased space within buildings where the entity has a current operating lease commitment. Certain System entities are also lessors under operating lease agreements, primarily ground leases related to third-party-owned MOBs on land owned by the System entity.

11. Lease Commitments (continued)

The System's future minimum noncancelable payments associated with operating leases with terms of one year or more where a System entity is the lessee, as well as future minimum noncancelable receipts associated with operating leases where a System entity is the sublessor or lessor, are presented in the table that follows. Future minimum payments and receipts relate to noncancelable leases with terms of one year or more.

	Future Payments Where the System is Lessee	Future Receipts Where the System is Sublessor/ Lessor	Net Future Payments
Year ending June 30:			
2018	$167,069	$ 35,541	$ 131,528
2019	153,590	30,175	123,415
2020	119,148	23,006	96,142
2021	89,713	19,053	70,660
2022	70,859	18,133	52,726
Thereafter	274,815	274,733	82
Total	$875,194	$ 400,641	$ 474,553

Rental expense under operating leases amounted to $396,656 and $391,054 in 2017 and 2016, respectively.

12. Related Parties

The System has agreements with related parties for revenue cycle management services and clinical engineering services. The System expensed approximately $585,000 for these services during the year ended June 30, 2017.

13. Contingencies and Commitments

The System is involved in litigation and regulatory investigations arising in the ordinary course of business. Regulatory investigations also occur from time to time. In the opinion of management, after consultation with legal counsel, these matters are expected to be resolved without material adverse effect on the System's Consolidated Balance Sheet.

The System enters into agreements with non-employed physicians that include minimum revenue guarantees. The terms of the guarantees vary. The carrying amounts of the liability for the System's obligation under these guarantees were $16,686 and $21,152 at June 30, 2017 and 2016, respectively, and are included in other current and noncurrent liabilities in the accompanying Consolidated Balance Sheets. The maximum amount of future payments that the System could be required to make under these guarantees is approximately $44,300.

The System entered into Master Service Agreements for information technology services provided by third parties. The maximum amount of future payments that the System could be required to make under these agreements is approximately $148,600.

Guarantees and other commitments represent contingent commitments issued by Ascension Health Alliance Senior and Subordinate Credit Groups, generally to guarantee the performance of an affiliate to a third party in borrowing arrangements such as commercial paper issuances, bond financing, and other transactions. The terms of guarantees are equal to the terms of the related debt, which can be as long as 25 years. The following represents the remaining guarantees and other commitments of the Senior and Subordinate Credit Groups at June 30, 2017:

Hospital de la Concepción 2017 Series A debt guarantee	$	25,700
St. Vincent de Paul Series 2000 A debt guarantee		28,300
Other guarantees and commitments		22,700

Supplementary Information

Ascension

Schedule of Expenditures of Federal Awards

June 30, 2017

Federal Grantor / Federal Program Title	Federal CFDA Number	Pass-through Grantor	Federal / Pass-through Grantor's Identifying Number	Health Ministry	Hospital	Research and Development Cluster Expenditures	Other Federal Expenditures	Total Federal Expenditures	Expenditures to Subrecipients
U.S. Department of Agriculture									
Special Supplemental Nutrition Program for Women, Infants, and Children	10.557	Indiana State Department of Health	A70-5-070661	Indiana	St. Vincent Health, Inc	$ -	$ 214,006	$ 214,006	$ -
Child and Adult Care Food Program	10.558	Kansas State Department of Education	2091501	Wichita	Via Christi Hospital Wichita, Inc	-	18,341	18,341	-
Child Nutrition Cluster:									
Summer Food Service Program for Children	10.559	Wisconsin Department of Public Instruction	40-9410	Wisconsin	Agape Community Center	-	3,563	3,563	-
Food Distribution Cluster:									
Commodity Supplemental Food Program	10.565	Hunger Task Force	200000	Wisconsin	Agape Community Center	-	2,214	2,214	-
Emergency Food Assistance Program (Food Commodities)	10.569	Hunger Task Force	200000	Wisconsin	Agape Community Center	-	30,985	30,985	-
Total Food Distribution Cluster						-	33,199	33,199	-
Total U.S. Department of Agriculture						-	269,109	269,109	-
U.S. Department of Defense									
Military Medical Research and Development	12.420	University of Colorado Denver	FY16 79-1 006, and #1	Austin	Seton Family of Hospitals	105,352	-	105,352	-
Total U.S. Department of Defense						105,352	-	105,352	-
U.S. Department of Justice									
Crime Victim Assistance	16.575	Indiana Criminal Justice Institute	15VA4364	Indiana	St. Vincent Health, Inc.	-	16,900	16,900	-
Crime Victim Assistance	16.575	Indiana Criminal Justice Institute	5414	Indiana	St. Vincent Health, Inc.	-	21,571	21,571	-
Crime Victim Assistance	16.575	Michigan Department of Health and Human Services	20160014-00	Detroit	St. John Community Health Investment Corporation	-	99,946	99,946	-
Crime Victim Assistance	16.575	Michigan Department of Health and Human Services	201723-41-00	Detroit	St. John Community Health Investment Corporation	-	251,294	251,294	-
Total Crime Victim Assistance						-	389,711	389,711	-
Edward Byrne Memorial Justice Assistance Grant Program	16.738	Kansas Criminal Justice Coordinating Council	2015-MU-BX-0395	Wichita	Via Christi Hospital Wichita, Inc.	-	36,749	36,749	-
Edward Byrne Memorial Justice Assistance Grant Program	16.738	Kansas Criminal Justice Coordinating Council	2016-MU-BX-0342	Wichita	Via Christi Hospital Wichita, Inc.	-	121,997	121,997	-
Total Edward Byrne Memorial Justice Assistance Grant Program						-	158,746	158,746	-
Total U.S. Department of Justice						-	548,457	548,457	-
U.S. Department of Transportation									
Transit Services Programs Cluster:									
Enhanced Mobility of Seniors and Individuals with Disabilities	20.513	None	None	Saginaw	St. Mary's Medical Center Foundation	-	62,722	62,722	-
Enhanced Mobility of Seniors and Individuals with Disabilities	20.513	Kansas Department of Transportation	PT-0079-18-012179150	Wichita	Via Christi Hospital Pittsburg, Inc	-	45,098	45,098	-
Total Transit Services Programs Cluster						-	107,820	107,820	-
Highway Safety Cluster:									
National Priority Safety Programs	20.616	Wisconsin Department of Transportation Bureau of Transportation Safety	2016-20-06-OP	Wisconsin	Ministry Medical Group	-	3,890	3,890	-
Total U.S. Department of Transportation						-	111,710	111,710	-
U.S. Department of Education									
Special Education – Grants for Infants and Families	84.181	Florida Department of Health	COQUC	Gulf Coast	Sacred Heart Health System	-	692,335	692,335	-
Total U.S. Department of Education						-	692,335	692,335	-

Ascension

Schedule of Expenditures of Federal Awards (continued)

June 30, 2017

Federal Grantor / Federal Program Title	Federal CFDA Number	Pass-through Grantor	Federal / Pass-through Grantor's Identifying Number	Health Ministry	Hospital	Research and Development Cluster Expenditures	Other Federal Expenditures	Total Federal Expenditures	Expenditures to Subrecipients
U.S. Department of Health and Human Services:									
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	Indiana State Department of Health	Various	Indiana	St. Vincent Health, Inc	$ -	$ 82,273	$ 82,273	$ -
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	Maryland Department of Health and Mental Hygiene Office of Preparedness and Response and Maryland Hospital Association	None	Baltimore	St. Agnes Hospital	-	3,536	3,536	-
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	Kansas Department of Health & Environment	U90TP000523-05-00	Wichita	Via Christi Hospital Pittsburg, Inc	-	5,355	5,355	-
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	Kansas Department of Health & Environment	U90TP000523-05-00	Wichita	Via Christi Hospital Manhattan	-	3,808	3,808	-
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	Kansas Department of Health & Environment	U90TP000523-05-00	Wichita	Via Christi Hospital Pittsburg, Inc	-	97,028	97,028	-
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	Fox Valley Area Healthcare Coalition	5 NU90TP000561-04	Wisconsin	Calumet Medical Center	-	1,011	1,011	-
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	Fox Valley Area Healthcare Coalition	5 NU90TP000561-05-00	Wisconsin	Calumet Medical Center	-	3,944	3,944	-
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	Fox Valley Area Healthcare Coalition	5 NU90TP000561-05-00	Wisconsin	St. Elizabeth's Hospital	-	3,960	3,960	-
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	Fox Valley Area Healthcare Coalition	5 NU90TP000561-05-00	Wisconsin	Mercy Medical Center	-	3,951	3,951	-
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	North Central Wisconsin Healthcare Emergency Readiness Coalition (NCW HERC)	5 NU90TP000561-05-00	Wisconsin	St. Joseph's Hospital	-	4,213	4,213	-
Total Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements						-	209,099	209,099	-
Prevention of Disease, Disability, and Death through Immunization and Control of Respiratory and Related Diseases	93.083	Vanderbilt University Medical Center	VUMC57039	Nashville	St. Thomas West Hospital	32,341	-	32,341	-
Affordable Care Act (ACA) Abstinence Education Program	93.235	Michigan Department of Health and Human Services	20160203-001	Detroit	St. John Community Health Investment Corporation	-	11,676	11,676	-
Affordable Care Act (ACA) Abstinence Education Program	93.235	Michigan Department of Health and Human Services	20172410-00	Detroit	St. John Community Health Investment Corporation	-	88,872	88,872	-
Total Affordable Care Act (ACA) Abstinence Education Program						-	100,548	100,548	-
Mental Health Research Grants	93.242	University of Texas Austin	UTA14-001033, Amd #3	Austin	Seton Healthcare Family	77,405	-	77,405	-
Substance Abuse and Mental Health Services: Projects of Regional and National Significance	93.243	None	None	Indiana	St. Vincent Health, Inc	-	76,580	76,580	-
Substance Abuse and Mental Health Services: Projects of Regional and National Significance	93.243	None	1H79T102a548-01	Detroit	St. John Providence	-	217,732	217,732	-
Total Substance Abuse and Mental Health Services: Projects of Regional and National Significance						-	294,312	294,312	-
Small Rural Hospital Improvement Grant Program	93.301	Alabama Hospital Association	None	Birmingham	St. Vincent's St. Clair	-	7,900	7,900	-
Small Rural Hospital Improvement Grant Program	93.301	Alabama Hospital Association	None	Birmingham	St. Vincent's Blount	-	7,900	7,900	-
Small Rural Hospital Improvement Grant Program	93.301	Indiana State Department of Health	Various	Indiana	St. Vincent Health, Inc	-	51,703	51,703	-
Small Rural Hospital Improvement Grant Program	93.301	Kansas Department of Health & Environment	H3HR100019	Wichita	Wamego Health Center	-	8,112	8,112	-
Small Rural Hospital Improvement Grant Program	93.301	Wisconsin Office of Rural Health	687K186	Wisconsin	Good Samaritan Hospital	-	8,576	8,576	-
Small Rural Hospital Improvement Grant Program	93.301	Wisconsin Office of Rural Health	687K190	Wisconsin	Our Lady of Victory	-	8,576	8,576	-
Small Rural Hospital Improvement Grant Program	93.301	Wisconsin Office of Rural Health	None	Wisconsin	Sacred Heart Hospital	-	8,576	8,576	-
Small Rural Hospital Improvement Grant Program	93.301	Wisconsin Office of Rural Health	None	Wisconsin	Eagle River Memorial Hospital	-	8,576	8,576	-
Small Rural Hospital Improvement Grant Program	93.301	Wisconsin Office of Rural Health	None	Wisconsin	Calumet Medical Center	-	8,576	8,576	-
Total Small Rural Hospital Improvement Grant Program						-	118,495	118,495	-

Ascension

Schedule of Expenditures of Federal Awards (continued)

June 30, 2017

Federal Grantor / Federal Program Title	Federal CFDA Number	Pass-through Grantor	Federal / Pass-through Grantor's Identifying Number	Health Ministry	Hospital	Research and Development Cluster Expenditures	Other Federal Expenditures	Total Federal Expenditures	Expenditures to Subrecipients
U.S. Department of Health and Human Services (continued)									
Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Marketplaces	93.332	None	None	Gulf Coast	Sacred Heart Health System	$ -	$ 1,325,957	$ 1,325,957	$ 354,090
Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Marketplaces	93.332	None	None	System Office	Advocacy External Relations (Via Christi)	-	158,842	158,842	-
Total Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Marketplaces						-	1,484,799	1,484,799	354,090
Cancer Treatment Research	93.395	St. Joseph Mercy Health System	M013	Saginaw	St. Mary's of Michigan Saginaw	77,540	-	77,540	-
Cancer Treatment Research	93.395	The Children's Hospital of Philadelphia	U10 CA180886	Indiana	St. Vincent Health, Inc	50,850	-	50,850	-
Cancer Treatment Research	93.395	NRG Oncology Foundation	None	Wisconsin	Columbia St. Mary's, Inc.	4,500	-	4,500	-
Cancer Treatment Research	93.395	ECOG ACRIN Cancer Research Group	None	Wisconsin	Wheaton Franciscan Medical Group, Inc	12,800	-	12,800	-
Cancer Treatment Research	93.395	None	5UG1CA189808-03	Wichita	Via Christi Hospital Wichita, Inc	1,684,632	-	1,684,632	-
Cancer Treatment Research	93.395	Oregon Health & Science University	5U10CA180888-03	Wichita	Via Christi Hospital Wichita, Inc	9,612	-	9,612	-
Cancer Treatment Research	93.395	Oregon Health & Science University	5U10CA180888-04	Wichita	Via Christi Hospital Wichita, Inc	4,290	-	4,290	-
Cancer Treatment Research	93.395	NRG Oncology Foundation	TFED41S2EXT-753	Austin	Seton Family of Hospitals d/b/a University Medical Center at Brackenridge	38,932	-	38,932	-
Cancer Treatment Research	93.395	University of Texas Health Science Center at San Antonio	158615 158481	Austin	Dell Children Medical Center of Central Texas	15,989	-	15,989	-
Cancer Treatment Research	93.395	University of Texas Health Science Center at San Antonio	160679 160586	Austin	Dell Children Medical Center of Central Texas	91,819	-	91,819	-
Cancer Treatment Research	93.395	University of Texas Health Science Center at San Antonio	158616 158481	Austin	Dell Children Medical Center of Central Texas	1,720	-	1,720	-
Cancer Treatment Research	93.395	University of Texas Health Science Center at San Antonio	160680 160586	Austin	Dell Children Medical Center of Central Texas	19,383	-	19,383	-
Total Cancer Treatment Research						2,012,067	-	2,012,067	-
Cancer Control	93.399	None	3UG1CA189808-03S1	Wichita	Via Christi Hospital Wichita, Inc	38,500	-	38,500	-
Strong Start for Mothers and Newborns	93.611	None	1D1CMS331147-02-03	Detroit	St. John Community Health Investment Corporation	-	46,664	46,664	-
ACA-Transforming Clinical Practice Initiative: Practice Transformation Networks (PTNs)	93.638	Vanderbilt University Medical Center	VUMC57486	Nashville	St. Thomas Health Foundation	49,225	-	49,225	49,225
ARRA – Beacon Communities - Community Health Peer Learning Program	93.727	AcademyHealth	375.90CL.00L.And 1	Austin	Seton Healthcare d/b/a Dell's Children Medical Center of Central Texas	-	129,969	129,969	-
PPHF: Chronic Disease Innovation Grants - financed solely by Public Prevention Health Funds	93.739	None	984155	Gulf Coast	Providence Hospital	-	8,000	8,000	-
Cancer Prevention and Control Programs for State, Territorial and Tribal Organizations financed in part by Prevention and Public Health Funds	93.752	Kansas Department of Health & Environment	5 NU58DP003889-04-00	Wichita	Via Christi Hospital Wichita, Inc	-	6,000	6,000	-
Preventive Health and Health Services Block Grant funded solely with Prevention and Public Health Funds (PPHF)	93.758	Michigan Department of Health and Human Services	E201722655-00	Detroit	St. John Hospital & Medical Center	-	1,112	1,112	-
Preventive Health and Health Services Block Grant funded solely with Prevention and Public Health Funds (PPHF)	93.758	Kansas Department of Health & Environment	3B01OT009021-14S1	Wichita	Via Christi Hospital Wichita, Inc.	-	4,731	4,731	-
Total Preventive Health and Health Services Block Grant funded solely with Prevention and Public Health Funds (PPHF)						-	5,843	5,843	-

Ascension

Schedule of Expenditures of Federal Awards (continued)

June 30, 2017

Federal Grantor / Federal Program Title	Federal CFDA Number	Pass-through Grantor	Federal / Pass-through Grantor's Identifying Number	Health Ministry	Hospital	Research and Development Cluster Expenditures	Other Federal Expenditures	Total Federal Expenditures	Expenditures to Subrecipients
U.S. Department of Health and Human Services (continued)									
Medicaid Cluster:									
Medical Assistance Program	93.778	Oneida County Department of Social Services	Various	Wisconsin	Dr. Kate Newcomb Convalescent Center	$ -	$ 159,058	$ 159,058	$ -
Increasing the Implementation of Evidence-Based Cancer Survivorship Interventions to Increase Quality and Duration of Life Among Cancer Patients	93.808	Indiana State Department of Health	[illegible]	Indiana	St. Vincent Health, Inc	-	65,946	65,946	-
Hospital Preparedness Program (HPP) Ebola Preparedness and Response Activities	93.817	Kansas Department of Health & Environment	U3REP150487-01-00	Wichita	Via Christi Hospital Wichita, Inc	-	6,075	6,075	-
Cardiovascular Diseases Research	93.837	University of Rochester	415575-G	Wisconsin	Wheaton Franciscan, Inc.	3,564	-	3,564	-
Cardiovascular Diseases Research	93.837	New York University School of Medicine	135562309	Detroit	Providence Hospital & Medical Centers	15,987	-	15,987	-
Cardiovascular Diseases Research	93.837	Yale University	606-46973	Detroit	St. John Hospital and Medical Center	3,000	-	3,000	-
Cardiovascular Diseases Research	93.837	University of Texas Austin	UTA15-000471, Amd 1	Austin	Seton Healthcare Family	18,552	-	18,552	-
Cardiovascular Diseases Research	93.837	University of Texas Austin	UTA15-000471, Amd 2	Austin	Seton Healthcare Family	3,856	-	3,856	-
Cardiovascular Diseases Research	93.837	Yale University	1R01HL115295-01	Waco	Providence Healthcare Network	1,800	-	1,800	-
Cardiovascular Diseases Research	93.837	Brigham and Women's Hospital, Inc.	30811269	Wisconsin	Columbia St. Mary's, Inc.	1,000	-	1,000	-
Total Cardiovascular Diseases Research						47,759	-	47,759	-
Lung Diseases Research	93.838	Seattle Children's Hospital	110185[illegible]B	Austin	Seton Healthcare Clinical Enterprise ACCA	7,115	-	7,115	-
Blood Diseases and Resources Research	93.839	None	1K23HL127227-01A1	Austin	Seton Healthcare	114,296	-	114,296	-
Blood Diseases and Resources Research	93.839	All Children's Research Institute, Inc	ACR136-001, amd 1	Austin	Seton Family of Hospitals	1,025	-	1,025	-
Total Blood Diseases and Resources Research						115,321	-	115,321	-
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853	University of California San Francisco	1U01NS026835-01A1	Arlington	Alexian Brothers Hospital Network	4,050	-	4,050	-
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853	Rutgers University	5R01NS038384-08	Arlington	Alexian Brothers Hospital Network	1,200	-	1,200	-
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853	Mayo Clinic	5U01NS080168-03	Arlington	Alexian Brothers Hospital Network	2,000	-	2,000	-
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853	Medical College of Wisconsin	3001413101-PNT	Wisconsin	Columbia St. Mary's, Inc	2,858	-	2,858	-
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853	Rutgers The State University of New Jersey	22-6001086	Detroit	Providence Hospital & Medical Centers	3,900	-	3,900	-
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853	University of Texas Health Science Center at Houston	6007865C, Amd 4	Austin	Seton Healthcare Family	10,883	-	10,883	-
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853	University of California San Francisco	7896sc, amd 3	Austin	Seton Family of Hospitals	3,176	-	3,176	-
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853	University of California San Francisco	7896sc, amd 5	Austin	Seton Family of Hospitals	10,368	-	10,368	-
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853	Mayo Clinic Jacksonville	5U01NS080168-04	Austin	Seton Healthcare Family	11,655	-	11,655	-
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853	University of Texas Austin	UTA16-000513	Austin	Seton Family of Hospitals	23,480	-	23,480	-
Total Extramural Research Programs in the Neurosciences and Neurological Disorders						73,570	-	73,570	-

Ascension

Schedule of Expenditures of Federal Awards (continued)

June 30, 2017

Federal Grantor / Federal Program Title	Federal CFDA Number	Pass-through Grantor	Federal / Pass-through Grantor's Identifying Number	Health Ministry	Hospital	Research and Development Cluster Expenditures	Other Federal Expenditures	Total Federal Expenditures	Expenditures to Subrecipients
U.S. Department of Health and Human Services (continued)									
Allergy, Immunology and Transplantation Research	93.855	The General Hospital Corp. d/b/a Massachusetts General Hospital	225488, and 2	Austin	Seton Family of Hospitals d/b/a Dell Children's Medical Center of Central Texas	$ 6,916	$ –	$ 6,916	$ –
Aging Research	93.866	University of Pennsylvania	10045513	System Office	Ascension Information Services	218,333	–	218,333	–
National Bioterrorism Hospital Preparedness Program	93.889	Texas Department of Health Services - Capital Area Trauma Regional Advisory Council	TSA-O Tx Hosp Preparedness Program	Austin	Seton Healthcare Family	–	16,721	16,721	–
HIV Emergency Relief Project Grants	93.914	Southeastern Michigan Health Association and Detroit Eligible Metro Area	H89HA00021	Detroit	St. John Community Health Investment Corporation	–	160,463	160,463	–
HIV Care Formula Grants	93.917	Lutheran Services of Northwest Florida	IPX003	Gulf Coast	Sacred Heart Health System	–	107,451	107,451	–
Cooperative Agreements for State-Based Comprehensive Breast and Cervical Cancer Early Detection Programs	93.919	None	None	Lewiston	St. Joseph Regional Medical Center	–	10,020	10,020	–
Assistance Programs for Chronic Disease Prevention and Control	93.945	Florida Department of Health	None	Gulf Coast	Sacred Heart Health System	–	7,000	7,000	–
Block Grants for Prevention and Treatment of Substance Abuse	93.959	Indiana State Department of Health	Various	Indiana	St. Vincent Health, Inc	–	82,719	82,719	–
Block Grants for Prevention and Treatment of Substance Abuse	93.959	State of Wisconsin Department of Health Services	Various	Wisconsin	St. Michaels Hospital Ministry Behavioral Health	–	96,896	96,896	–
Block Grants for Prevention and Treatment of Substance Abuse	93.959	State of Wisconsin Department of Health Services	435 547	Wisconsin	St Mary's Hospital	–	279,243	279,243	–
Block Grants for Prevention and Treatment of Substance Abuse	93.959	Detroit Wayne Mental Health Authority	None	Detroit	Eastwood Clinics	–	16,307	16,307	–
Block Grants for Prevention and Treatment of Substance Abuse	93.959	Macomb County Community Mental Health Services Board	16385400	Detroit	Eastwood Clinics	–	152,725	152,725	–
Block Grants for Prevention and Treatment of Substance Abuse	93.959	Oakland Community Mental Health Authority	830617986	Detroit	Eastwood Clinics	–	95,234	95,234	–
Total Block Grants for Prevention and Treatment of Substance Abuse						–	723,124	723,124	–
Maternal and Child Health Services Block Grant to the States	93.994	Indiana State Department of Health	Various	Indiana	St. Vincent Health, Inc	–	95,041	95,041	–
Total U.S. Department of Health and Human Services						2,678,552	3,754,628	6,433,180	403,315
U.S. Department of Homeland Security									
Disaster Grants – Public Assistance (Presidentially Declared Disasters)	97.036	Maryland Emergency Management Agency	None	Baltimore	St. Agnes Hospital	–	145,139	145,139	–
Disaster Grants – Public Assistance (Presidentially Declared Disasters)	97.036	State of Michigan - Department of State Police	125-HWGSA-00	Detroit	St. John Macomb-Oakland Hospital	–	375,000	375,000	–
Total Disaster Grants – Public Assistance (Presidentially Declared Disasters)						–	520,139	520,139	–
Homeland Security Grant Program	97.067	State of Michigan Department of State Police Emergency Management Division County of Macomb Oakland County	EMW-2016-SS-00016-S01	Detroit	Providence Hospital and Medical Center	–	583	583	–
Homeland Security Grant Program	97.067	North Central Regional Planning Commission	EMW-2014-SS-00027-S01	Wichita	Via Christi Hospital Wichita, Inc	–	14,727	14,727	–
Total Homeland Security Grant Program						–	15,310	15,310	–
Total U.S. Department of Homeland Security						–	535,449	535,449	–
Total Expenditures of Federal Awards						$ 2,783,904	$ 5,931,688	$ 8,715,592	$ 403,315

See accompanying notes to the schedule of expenditures of federal and state of Wisconsin awards.

Ascension

Schedule of Expenditures of State of Wisconsin Awards

June 30, 2017

State Program Title	State ID Number	State Grantor	Pass-Through Grantor	Health Ministry	Hospital	State of Wisconsin Expenditures
Low Income Dental Clinics	435,170000	Wisconsin Department of Health Services	CAP Services, Inc.	Ministry	St. Michael's Hospital/Dental Center	$ 90,131
Community Options Program-W Waiver	435,338	Wisconsin Department of Health Services	Oneida County Department of Social Services	Ministry	Dr. Kate Newcomb Convalescent Center	73,944
Community Integration Program II Non Federal	435,348	Wisconsin Department of Health Services	Oneida County Department of Social Services	Ministry	Dr. Kate Newcomb Convalescent Center	38,845
Urban/Rural Women County	435,547	Wisconsin Department of Health Services	The Human Service Center	Ministry	St. Mary's Hospital	19,189
Basic County Allocation	435,561	Wisconsin Department of Health Services	Portage County	Ministry	St. Michael's Hospital/Ministry Behavioral Health	99,028
Basic County Allocation	435,561	Wisconsin Department of Health Services	Outgamie County	Ministry	St. Michael's Hospital/Ministry Behavioral Health	118,364
Basic County Allocation	435,561	Wisconsin Department of Health Services	Winnebago County	Ministry	St. Michael's Hospital/Ministry Behavioral Health	50,006
Basic County Allocation	435,561	Wisconsin Department of Health Services	Waushara County	Ministry	St. Michael's Hospital/Ministry Behavioral Health	5,088
Basic County Allocation	435,561	Wisconsin Department of Health Services	Waupaca County	Ministry	St. Michael's Hospital/Ministry Behavioral Health	5,310
Basic County Allocation	435,561	Wisconsin Department of Health Services	Wood County	Ministry	St. Michael's Hospital/Ministry Behavioral Health	5,796
Total Basic County Allocation						283,592
Treatment Alternative Program	435,576	Wisconsin Department of Health Services	Portage County	Ministry	St. Michael's Hospital/Ministry Behavioral Health	4,291
Wisconsin Fast Forward Worker Training Grant	445,109	Wisconsin Department of Workforce Development	Office of Skills Development	Ministry	St. Elizabeth's Hospital	19,532
Telemedicine Grant	196,218-283546	Public Service Commission of Wisconsin	None	Ministry	Ministry Medical Group – Merrill	38,899
Telemedicine Grant	196,218-283971	Public Service Commission of Wisconsin	None	Ministry	St. Michael's Hospital	38,899
Telemedicine Grant	196,218-283545	Public Service Commission of Wisconsin	None	Ministry	Sacred Heart	38,899
Telemedicine Grant	196,218-283548	Public Service Commission of Wisconsin	None	Ministry	Calumet Medical Center	38,899
Total Telemedicine Grant						155,596
						$ 685,120

See accompanying notes to the schedule of expenditures of federal and state of Wisconsin awards.

Ascension

Notes to Schedule of Expenditures of Federal and State of Wisconsin Awards

June 30, 2017

1. Basis of Presentation

The accompanying schedule of expenditures of federal and state of Wisconsin awards (collectively, the Schedule) includes the federal and state grant activity of Ascension Health Alliance d/b/a Ascension (Ascension) and is presented on the accrual basis of accounting. The information in the Schedule is presented in accordance with the requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* and the *State of Wisconsin Single Audit Guidelines*. Therefore, some amounts presented in the Schedule may differ from amounts presented in or used in the preparation of the financial statements.

2. Reporting Entity

Ascension's reporting entity is defined in Note 1 to Ascension's consolidated financial statements. However, for the year ended June 30, 2017, federal and state of Wisconsin expenditures related to four health ministries and six other entities are not included in Ascension's total federal and state of Wisconsin expenditures reported in the Schedule. These four health ministries and six other entities have a separate financial statement audit, and, as such, these expenditures are subject to the requirements of the Uniform Guidance at that reporting level. The following health ministries and other entities not included in the Schedule are as follows:

- Alexian Brothers Bonaventure House, Inc. (Arlington Heights, Illinois)
- Alexian Brothers Bettendorf Place (Arlington Heights, Illinois)
- Alexian Brothers Center for Mental Health (Arlington Heights, Illinois)
- Alexian Brothers Housing and Health Alliance (Arlington Heights, Illinois)
- St. Vincent's Medical Center, including St. Vincent's College of Nursing (Bridgeport, Connecticut)
- Providence Health Foundation, Inc. (Washington, DC)
- Columbia College of Nursing, Inc. (Milwaukee, Wisconsin)
- St. Mary's Healthcare (Amsterdam, New York)
- Our Lady of Lourdes Memorial Hospital, Inc. and Affiliates (Binghamton, New York)
- Our Lady of Lourdes Hospital at Pasco (Pasco, Washington)

3. Indirect Costs

Indirect cost rates for certain Ascension health ministries were based on applicable U.S. Department of Health and Human Services (HHS) negotiated rates or sponsor-specified rates. For Ascension health ministries that do not have a negotiated indirect cost rate with HHS, the 10% de minimis indirect cost rate allowed by the Uniform Guidance was used, as applicable.

4. Disaster Grant

Expenditures under CFDA No. 97.036, *Disaster Grants – Public Assistance (Presidentially Declared Disasters)*, from the U.S. Department of Homeland Security are recorded on the Schedule when the funds are approved (i.e., federal amount obligated through the approval of the project worksheets) and eligible expenditures have been incurred. Disaster grant expenditures included in the Schedule for the year ended June 30, 2017, that related to prior fiscal years were $520,139.

Internal Control and Compliance Reports and Schedule

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Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

The Board of Directors, Chief Executive Officer, and
Chief Financial Officer
Ascension Health Alliance d/b/a Ascension

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, the financial statements of Ascension Health Alliance d/b/a Ascension (Ascension), which comprise the consolidated balance sheet as of June 30, 2017, and the related consolidated statements of operations and changes in net assets and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated September 22, 2017.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered Ascension's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Ascension's internal control. Accordingly, we do not express an opinion on the effectiveness of Ascension's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies, and therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified. We did identify a

deficiency in internal control, described in the accompanying schedule of findings and questioned costs as Finding 2017-001 that we consider to be a significant deficiency.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Ascension's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards.*

Ascension's Response to Finding

Ascension's response to the finding identified in our audit is described in the accompanying schedule of findings and questioned costs. Ascension's response was not subjected to the auditing procedures applied in the audit of the financial statements, and accordingly, we express no opinion on it.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the result of that testing, and not to provide an opinion on the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Ernst + Young LLP

September 22, 2017

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Report of Independent Auditors on Compliance for Each Major Federal and State of Wisconsin Program and Report on Internal Control Over Compliance Required by the Uniform Guidance and the *State of Wisconsin Single Audit Guidelines*

The Board of Directors, Chief Executive Officer, and
Chief Financial Officer
Ascension Health Alliance d/b/a Ascension

Report on Compliance for Each Major Federal and State of Wisconsin Program

We have audited Ascension Health Alliance d/b/a Ascension's (Ascension) compliance with the types of compliance requirements described in the U.S. Office of Management and Budget (OMB) *Compliance Supplement* and the *State of Wisconsin Single Audit Guidelines* that could have a direct and material effect on each of Ascension's major federal and state of Wisconsin programs for the year ended June 30, 2017. Ascension's major federal and state of Wisconsin programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Ascension's consolidated financial statements include the operations of Alexian Brothers Bonaventure House, Inc. (Arlington Heights, Illinois); Alexian Brothers Bettendorf Place (Arlington Heights, Illinois); Alexian Brothers Center for Mental Health (Arlington Heights, Illinois); Alexian Brothers Housing and Health Alliance (Arlington Heights, Illinois); St. Vincent's Medical Center, including St. Vincent's College of Nursing (Bridgeport, Connecticut); Providence Health Foundation, Inc. (Washington, DC); Columbia College of Nursing, Inc. (Milwaukee, Wisconsin); St. Mary's Healthcare (Amsterdam, New York); Our Lady of Lourdes Memorial Hospital, Inc. and Affiliates (Binghamton, New York); and Our Lady of Lourdes Hospital at Pasco (Pasco, Washington) (collectively, the Health Ministries and other entities), which received federal awards that are not included in the schedule of expenditures of federal and state of Wisconsin awards during the year ended June 30, 2017. Our audit, described below, did not include the operations of these Health Ministries and other entities because these Health Ministries and other entities had separate financial statement, and where applicable, compliance audits performed in accordance with the Uniform Guidance.

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Management's Responsibility

Management is responsible for compliance with federal statutes, regulations and the terms and conditions of its federal and state of Wisconsin awards applicable to its federal and state of Wisconsin programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for each of Ascension's major federal and state of Wisconsin programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Costs Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), and the *State of Wisconsin Single Audit Guidelines*. Those standards, the Uniform Guidance, and the *State of Wisconsin Single Audit Guidelines* require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal or state of Wisconsin program occurred. An audit includes examining, on a test basis, evidence about Ascension's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal and state of Wisconsin program. However, our audit does not provide a legal determination of Ascension's compliance.

Opinion on Each of the Other Major Federal and State of Wisconsin Programs

In our opinion, Ascension complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal and state of Wisconsin programs for the year ended June 30, 2017.

Other Matters

The results of our auditing procedures disclosed an instance of noncompliance which is required to be reported in accordance with the Uniform Guidance and the *State of Wisconsin Single Audit Guidelines*, and which is described in the accompanying schedule of findings and questioned costs as follows:

Finding No.	CFDA No.	Program (or Cluster) Name	Compliance Requirement
2017-003	93.638	Research & Development Cluster	M. Subrecipient Monitoring

Our opinion on each major federal and state of Wisconsin program is not modified with respect to this matter.

Ascension's response to the noncompliance finding identified in our audit is described in the accompanying schedule of findings and questioned costs and corrective action plan. Ascension's response was not subjected to the auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the response.

Report on Internal Control Over Compliance

Management of Ascension is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered Ascension's internal control over compliance with the requirements that could have a direct and material effect on each major federal or state of Wisconsin program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major program and to test and report on internal control over compliance in accordance with the Uniform Guidance and the *State of Wisconsin Single Audit Guidelines*, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of Ascension's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal or state of Wisconsin program on a timely basis. *A material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal or state of Wisconsin program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal or state of Wisconsin

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program that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, we identified the following deficiencies in internal control over compliance, as described in the accompanying schedule of findings and questioned costs that we consider to be significant deficiencies.

Finding No.	CFDA No.	Program (or Cluster) Name	Compliance Requirement
2017-002	93.332	Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Marketplaces	I. Procurement, Suspension, and Debarment
2017-003	93.638	Research & Development Cluster	M. Subrecipient Monitoring

Ascension's responses to the internal control over compliance findings identified in our audit are described in the accompanying schedule of findings and questioned costs and corrective action plan. Ascension's responses were not subjected to the auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the responses.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance and the *State of Wisconsin Single Audit Guidelines*. Accordingly, this report is not suitable for any other purpose.

Ernst & Young LLP

November 27, 2017

Ascension

Schedule of Findings and Questioned Costs

Year Ended June 30, 2017

Section I – Summary of Auditor's Results

Financial Statements

Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP (*unmodified, qualified, adverse or disclaimer*):	Unmodified			
Internal control over financial reporting:				
Material weakness(es) identified?		Yes	X	No
Significant deficiency(ies) identified?	X	Yes		None reported
Noncompliance material to financial statements noted?		Yes	X	No

Federal and State of Wisconsin Awards

Internal control over major federal programs and state of Wisconsin program:				
Material weakness(es) identified?		Yes	X	No
Significant deficiency(ies) identified?	X	Yes		None reported
Type of auditor's report issued on compliance for major federal programs and state of Wisconsin program *(unmodified, qualified, adverse or disclaimer)*:	Research & Development Cluster – Unmodified CFDA 93.332 – Unmodified State ID 435.561 – Unmodified			
Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)?	X	Yes		No
Any audit findings disclosed that are required to be reported in accordance with the State of Wisconsin Single Audit Guidelines?		Yes	X	No

Ascension

Schedule of Findings and Questioned Costs (continued)

Section I – Summary of Auditor's Results (continued)

Federal and State of Wisconsin Awards (continued)

Identification of major federal programs and State of Wisconsin program:

CFDA Number(s)	Name of Federal Program or Cluster
Various	Research & Development Cluster
93.332	Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Marketplaces

State of Wisconsin Identification Number	Name of State of Wisconsin Program
435.561	Basic County Allocation

Dollar threshold used to distinguish between Type A and Type B programs for federal programs:	$750,000			
Dollar threshold used to distinguish between Type A and Type B state of Wisconsin programs:	$250,000			
Auditee qualified as low-risk auditee for federal programs?		Yes	X	No
Auditee qualified as low-risk auditee for state of Wisconsin programs?	X	Yes		No

Section II – Financial Statement Findings

This section should identify the significant deficiencies, material weaknesses, fraud, noncompliance with provisions of laws, regulations, contracts and grant agreements, and abuse related to the financial statements for which *Government Auditing Standards* requires reporting.

Finding 2017-001

During the June 30, 2017 consolidated financial statement audit of Ascension, one significant deficiency was noted relating to a single health ministry within Ascension that did not follow Ascension's financial integrity program and internal controls. This health ministry did not receive any Federal grants or awards during the period under audit. At this single location, capitation receivables, and certain other account balances which lacked sufficient supporting documentation to validate an appropriate business purpose, were recorded in error misstating revenue by approximately 0.5%. Management should ensure that accounting entries are appropriately recorded and reviewed in accordance with Ascension's financial integrity program and internal controls and Accounting and Reporting Manual.

View of responsible officials and planned corrective actions:

Ascension agrees with the comment. See attached corrective action plan.

Section III – Federal and State of Wisconsin Award Findings and Questioned Costs

This section should identify the audit findings required to be reported by 2 CFR 200.516(a) or the State of Wisconsin *Single Audit Guidelines* (for example, significant deficiencies, material weaknesses, material instances of noncompliance, including questioned costs, and material abuse).

Finding 2017-002 (Procurement, Suspension, and Debarment)

Information on the federal program

Federal Grantor: United States Department of Health and Human Services
Pass-Through Grantor: N/A
CFDA No.: 93.332, Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Marketplaces
Ascension Entity: System Office
Award Numbers: NAVCA150243-01-00 and NAVCA150243-02-00
Award Periods: 9/2/15–9/1/16 and 9/2/16–9/1/17

Criteria or specific requirement (including statutory, regulatory or other citation)

The Uniform Guidance 2 CFR section 200.303 states, "The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO)."

Condition

System Office did not follow its procurement policy and controls from July 2016 through February 2017. We tested five procurement transactions totaling $11,440 in federal expenditures from a population of 26 procurement transactions totaling $13,735. We noted at the time of purchase for one selection, System Office did not document a procurement checklist in accordance with its procurement policy.

Section III – Federal and State of Wisconsin Award Findings and Questioned Costs (continued)

Questioned costs

$5,105

Context

System Office did not comply with its procurement policy or controls. Procurement-related expenditures at System Office totaled $13,735 for the year ended June 30, 2017, representing 9% of System Office's program expenditures of $158,842 and 1% of the major program's federal expenditures of $1,484,799.

Cause

System Office did not follow its federal procurement policy and controls as the grant was new in the prior year and compliance with the Uniform Guidance procurement requirements was not timely.

Effect

The best cost or price may not have been achieved.

Identification as a repeat finding

Finding 2017-002 is included on the Summary Schedule of Prior Audit Findings prepared by Ascension as Finding 2016-001.

Recommendation

All procurement and/or vendor files should be reviewed to ensure the required documentation is in place at the time of procurement for all federal procurements in accordance with the governing requirements of the federal award and in accordance with Ascension's procurement policy.

Views of responsible officials and planned corrective actions

Management agrees with the finding. Purchases were supported by vendor invoices. Refer to the corrective action plan prepared by Ascension.

Section III – Federal and State of Wisconsin Award Findings and Questioned Costs (continued)

Finding 2017-003 (Subrecipient Monitoring)

Information on the federal program

Federal Grantor: United States Department of Health and Human Services
Major Program: Research & Development Cluster
CFDA No.: 93.638, ACA-Transforming Clinical Practices Initiative: Practice Transformation Networks (PTNs)
Pass-Through Grantor: Vanderbilt University
Ascension Location: St. Thomas Health Foundations (Nashville)
Award Number: VUMC 57486
Award Period: 9/29/15–9/28/16

Criteria or specific requirement (including statutory, regulatory or other citation)

The Uniform Guidance Section 200.331 states, "All pass-through entities must:

(a) Ensure that every subaward is clearly identified to the subrecipient as a subaward and includes the following information at the time of the subaward and if any of these data elements change, include the changes in subsequent subaward modification. When some of this information is not available, the pass-through entity must provide the best information available to describe the Federal award and subaward.

(b) Evaluate each subrecipient's risk of noncompliance with Federal statutes, regulations, and the terms and conditions of the subaward for purposes of determining the appropriate subrecipient monitoring described in paragraphs (d) and (e) of this section.

(c) . . . (d) Monitor the activities of the subrecipient as necessary to ensure that the subaward is used for authorized purposes, in compliance with Federal statutes, regulations, and the terms and conditions of the subaward; and that subaward performance goals are achieved."

Section III – Federal and State of Wisconsin Award Findings and Questioned Costs (continued)

The Uniform Guidance 2 CFR section 200.303 states, "The non-Federal entity must:

(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO)."

Condition

Nashville did not have a subrecipient contract, did not perform subrecipient risk assessments, and did not perform subrecipient monitoring activities in the year based on the requirements per the Uniform Guidance.

Questioned costs

$49,225

Context

Expenditures subject to subrecipient monitoring at Nashville totaled $49,225 for the year ended June 30, 2017, representing 61% of Nashville's program expenditures of $81,566 and 1.8% of the Research & Development Cluster's federal expenditures of $2,783,904.

Cause

Nashville did not properly apply all of the principles of the Uniform Guidance Section 200.331 related to subrecipient monitoring as it did not identify the grant as being a subrecipient grant.

Section III – Federal and State of Wisconsin Award Findings and Questioned Costs (continued)

Effect

Funds may not have been properly spent by the subrecipient.

Identification as a repeat finding

This is not a repeat finding.

Recommendation

Nashville should assess its grants and identify any grants that are passed through to subrecipients. For any subrecipient grants, Nashville should have a subrecipient subaward in place, perform annual risk assessments, and perform required subrecipient monitoring activities as required by the Uniform Guidance Section 200.331.

Views of responsible officials and planned corrective actions

Management agrees with the finding. Refer to the corrective action plan prepared by Ascension.

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Summary Schedule of Prior Audit Findings

June 30, 2017

Financial Statement Findings – For the Years Ended June 30, 2016 and 2015

None identified.

Federal Award Findings and Questioned Costs – For the Year Ended June 30, 2016

Finding 2016-001 (Procurement)

Federal program information:

Federal Grantor: United States Department of Health and Human Services
Pass-Through Grantor: N/A
CFDA No.: 93.332, Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Marketplaces
Ascension Entity: System Office
Award Number: NAVCA140140-01-00 and NAVCA150243-01-00
Award Period: 9/16/14–9/15/15 and 9/2/15–9/1/16

Summary of finding:

System Office – Purchases of goods and services under CFDA No. 93.332 were subject to the procurement process. As such, eight procurement transactions were tested totaling $5,268 in federal expenditures from a population of 44 procurement invoices totaling $66,408 in federal expenditures and the following was noted:

- For the eight procurement transactions tested it was noted at the time of purchase for all eight selections, Ascension System Office did not document a cost or price analysis in accordance with OMB Circular A-110, Section .45. Purchases were supported by vendor invoices.

Prior year views of responsible officials and planned corrective actions:

System Office will use the "Procurement – Purchasing Goods and Services with Federal Funds Checklist" with each purchase involving federal funds as a means of documenting the cost or price at the time of purchase. The Grant Manager will complete the form and submit it with supporting documents to System Office. While preparing the quarterly Schedule of Expenditures of Federal Awards (SEFA) template, System Office will ensure that all purchases that require a cost or price analysis are supported by the checklist prior to submitting the SEFA.

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Summary Schedule of Prior Audit Findings (continued)

Current year status:

The corrective action plan was not completed until February 28, 2017, and therefore, the finding is a repeat finding for the year ended June 30, 2017. See Finding 2017-002.

Finding 2016-002 (Procurement)

Federal program information:

Federal Grantor: United States Department of Health and Human Services
Pass-Through Grantor: N/A
CFDA No.: 93.074, Hospital Preparedness Program & Public Health Emergency Preparedness Aligned Cooperative Agreements
Ascension Hospital: St. Agnes Hospital, Baltimore, Maryland (Baltimore)
Award Number: BP4
Award Period: 7/1/15–6/30/16

Summary of finding:

Baltimore – Purchases of goods and services under CFDA No. 93.332 were subject to the procurement process. As such, one procurement transaction was tested totaling $22,542 in federal expenditures from a population of five procurement invoices totaling $26,464 in federal expenditures and the following was noted:

- Baltimore did not document a cost or price analysis in accordance with OMB Circular A-110, Section .45. Purchase was supported by a vendor invoice.

Prior year views of responsible officials and planned corrective actions:

Baltimore will use the "Procurement – Purchasing Goods and Services with Federal Funds Checklist" with each purchase involving federal funds as a means of documenting the cost or price at the time of purchase. The Grant Manager will complete the form and submit it with supporting documents to the Finance Department. While preparing the quarterly SEFA template, the Finance Department will ensure that all purchases that require a cost or price analysis are supported by the checklist prior to submitting the SEFA.

Current year status:

Corrective action was completed during fiscal year 2017.

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Summary Schedule of Prior Audit Findings (continued)

Federal Award Findings and Questioned Costs – For the Year Ended June 30, 2015

Finding 2015-001 (Procurement)

Federal program information:

Federal Grantor: United States Department of Health and Human Services
CFDA No.: 93.074, Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements

Ascension Hospitals (Health Ministry)	Pass-Through Grantor	Pass-Through Award Numbers	Pass-Through Award Periods
St. Agnes Healthcare – Baltimore, Maryland (Baltimore)	Maryland Department of Health and Mental Hygiene Office of Preparedness and Response and Maryland Hospital Association	None	7/1/13–6/30/14; 7/1/14–6/30/15
St. Elizabeth Hospital, Mercy Medical Center, Calumet Medical Center, St. Clare's Hospital, St. Joseph's Hospital of Marshfield – Milwaukee, Wisconsin (Wisconsin)	State of Wisconsin Department of Health Services	Flexible Funding – 1UT90TPO561-01; St. Joseph's Hospital of Marshfield Hospital Preparedness Program – 264879	Flexible Funding – 11/6/14–4/1/15 and 9/1/14–4/1/15; St. Joseph's Hospital of Marshfield – 7/1/14–6/30/15

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Summary Schedule of Prior Audit Findings (continued)

Summary of finding:

Wisconsin – Purchases of goods and services under CFDA No. 93.074 were subject to the procurement process. As such, we tested five procurements (covering five vendors and totaling $124,750 in federal expenditures) from a population of 27 procurements (covering 27 vendors and totaling $253,225 in federal expenditures). For the five procurements tested, two of the five procurements (totaling $118,860 in federal expenditures) included purchases in excess of the small-purchase threshold of $25,000, and therefore, competitive bidding was required by federal regulation. Wisconsin did not formally document the rationale for vendor selection or the lack of competitive bids for one of the two procurements (totaling $29,825 in federal expenditures) in accordance with OMB Circular A-110, Sections .45 and .46, at the time of purchase. The other three procurements (totaling $5,889 in federal expenditures) did not include purchases in excess of the small-purchase threshold, and therefore, only a cost or price analysis was required by federal regulation. Wisconsin did not formally document a cost or price analysis or lack thereof in accordance with OMB Circular A-110, Section .45, at the time of purchase.

Baltimore – Purchases of goods and services under CFDA 93.074 were subject to the procurement process. We tested five procurements (covering four vendors and totaling $29,252 in federal expenditures) from a population of 28 procurements (covering 6 vendors and totaling $49,054 in federal expenditures) and noted the following: For the five procurements tested, none included purchases in excess of the small-purchase threshold, and therefore, a cost or price analysis was required by federal regulation. Baltimore did not formally document a cost or price analysis or lack thereof in accordance with OMB Circular A-110, Section .45, at the time of purchase for these five procurements.

Prior year views of responsible officials and planned corrective actions:

Baltimore and Wisconsin will begin using the "Procurement – Purchasing Goods and Services with Federal Funds Checklist" with each purchase involving federal funds as a means of documenting the cost or price analysis at the time of purchase. The grant manager will complete the form and submit it with supporting documents to the Finance department. While preparing the quarterly SEFA template, Finance will ensure that all purchases are supported by a completed checklist prior to submitting the SEFA. This procedure will be implemented by January 31, 2016.

Current year status:

Wisconsin – Corrective action plan was completed during fiscal year 2016.

Baltimore – Finding is a repeat finding for the year ended June 30, 2016. See finding 2016-002.

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Summary Schedule of Prior Audit Findings (continued)

Finding 2015-002 (Allowable Costs/Cost Principles and Eligibility)

Federal program information:

Federal Grantor: United States Department of Health and Human Services
CFDA No.: 93.959, Block Grants for Prevention and Treatment of Substance Abuse

Ascension Hospitals (Health Ministry)	Pass-Through Grantor	Pass-Through Award Numbers	Pass-Through Award Periods
Eastwood Clinics – Detroit, Michigan (Detroit)	Oakland County Community Mental Health Authority (Oakland); Detroit Wayne Mental Health Authority (DWMHA); and Southeast Michigan Community Alliance (SEMCA)	830617986 (Oakland); None (DWMHA and SEMCA)	10/1/14–9/30/15 (Oakland, DWMHA and SEMCA)

Summary of finding:

Three patient files could not be located and, therefore, testing of the Detroit Health Ministry's controls over and compliance with the B. Allowable Costs/Cost Principles and E. Eligibility compliance requirements could not be performed.

Prior year views of responsible officials and planned corrective actions:

Two of the three missing charts were related to the Warren Residential program. While proper policy and procedures were in place, the cause was related to the physical site move in June 2015, and lack of leadership oversight. Leadership was transitioned in July 2015 and processes have been implemented to verify proper medical record procedures. Safety and Risk consultants have inspected the site to verify proper medical procedures.

The third chart noted was not secured at the St. Clair Shores site. Upon review, it was identified that the chart was not filed properly by a clinician who is no longer employed. Safety and Risk consultants will be performing a review of proper medical record procedures with office staff no later than January 31, 2016.

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Summary Schedule of Prior Audit Findings (continued)

Current year status:

Corrective action plan was completed during fiscal year 2016.

Finding 2015-003 (Cash Management)

Federal program information:

Federal Grantor: United States Department of Health and Human Services
CFDA No.: 93.074, Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements

Ascension Hospitals (Health Ministry)	Pass-Through Grantor	Pass-Through Award Numbers	Pass-Through Award Periods
St. Clare's Hospital, St. Joseph's Hospital of Marshfield – Milwaukee, Wisconsin (Wisconsin)	State of Wisconsin Department of Health Services	Flexible Funding – 1UT90TPO561-01; St. Joseph's Hospital of Marshfield Hospital Preparedness Program – 264879	Flexible Funding – 11/6/14–4/1/15; St. Joseph Hospital of Marshfield – 7/1/14–6/30/15

Summary of finding:

Wisconsin's CFDA No. 93.074 grants are funded on a reimbursement basis. However, based on testing performed, the program costs were not always paid for by entity funds before reimbursement was requested from the pass-through entity.

Prior year views of responsible officials and planned corrective actions:

Wisconsin's grant committee is the in process of developing a grant process checklist which will include tasks that will require the grant accountant or coordinator to verify the expense was incurred and paid prior to a reimbursement request being submitted. Verification will include documenting the disbursement check number on the reimbursement request in addition to the reviewer initialing and dating the request. Implementation of the grant process checklist will be completed by January 31, 2016.

Current year status:

Corrective action plan was completed during fiscal year 2016.

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Summary Schedule of Prior Audit Findings (continued)

Finding 2015-004 (Reporting)

Federal program information:

Federal Grantor: United States Department of Health and Human Services
Research and Development Cluster

CFDA No.	Ascension Hospital (Health Ministry)	Pass-Through Grantor	Pass-Through Award Number	Pass-Through Award Period
93.866, Aging Research	Ascension Information Services	University of Pennsylvania	565335	9/30/14–6/30/15

Summary of finding:

Ascension did not provide a complete listing of all federal awards and expenditures in the schedule of expenditures of federal awards.

Prior year views of responsible officials and planned corrective actions:

Management will strengthen existing controls and procedures over the preparation and review of the SEFA. Ascension will continue to utilize Internal Audit to perform agreed-upon procedures on the SEFA template, including completeness and accuracy of the grants reported. All direct subsidiaries will be required to submit a quarterly SEFA template in addition to all Health Ministries as part of our quarterly financial integrity program. Quarterly SEFA templates will continue to be reviewed by Ascension Finance for missing or unusual items on a quarterly basis and appropriate follow up with preparers and reviewers to address findings will be performed prior to the next quarter. Communications will be made during monthly System Financial Reporting calls in order to provide education and enhance awareness of federal fund compliance and audit requirements. In addition, management will investigate adding a question to the standard contract approval form inquiring as to whether the contract involves federal awards subject to audit requirements and reportable on the SEFA. The corrective action plan will be completed by July 31, 2016.

Current year status:

Corrective action plan was completed in July 2016.

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Summary Schedule of Prior Audit Findings (continued)

Finding 2015-005 (Reporting)

State of Wisconsin program information:

State of Wisconsin Grantor: Wisconsin Department of Health Services
State of Wisconsin Identification Number: 435.170000, Low Income Dental Clinics

Ascension Hospital (Health Ministry)	Pass-Through Grantor	Award Numbers	Award Periods
Door County Medical Center Dental Clinic (Wisconsin)	Not applicable	26383	7/1/14–6/30/15
St. Michael's Hospital (Wisconsin)	CAP Services, Inc.	Not applicable	1/1/14-12/31/14 1/1/15-12/31/15

Summary of finding:

Ascension did not provide a complete listing of all state awards and expenditures in the schedule of expenditures of state awards.

Prior year views of responsible officials and planned corrective actions:

Management will strengthen existing controls and procedures over the preparation and review of the Schedule of Expenditures of State Awards (SESA). Wisconsin will be required to submit a quarterly SESA template as part of our quarterly financial integrity program. The quarterly SESA template will be reviewed by Ascension Finance for missing or unusual items on a quarterly basis and appropriate follow up with preparers and reviewers to address findings will be performed prior to the next quarter. The corrective action plan will be completed by March 31, 2017.

Current year status:

Corrective action plan was completed during fiscal year 2017.

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Current Year Audit Findings Corrective Action Plans

June 30, 2017

Financial Statement Findings – For the Year Ended June 30, 2017

Finding 2017-001

Views of responsible officials and planned corrective actions:

Ascension is in the process of centralizing the accounting for these risk-based contracts and the accounting function in general.

Federal Award Findings and Questioned Costs – For the Year Ended June 30, 2017

Finding 2017-002 (Procurement)

Federal program information:

Federal Grantor: United States Department of Health and Human Services
Pass-Through Grantor: N/A
CFDA No.: 93.332, Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Marketplaces
Ascension Entity: System Office
Award Number: NAVCA150243-01-00 and NAVCA150243-02-00
Award Period: 9/2/15–9/1/16 and 9/2/16–9/1/17

Views of responsible officials and planned corrective actions:

System Office will use the "Procurement – Purchasing Goods and Services with Federal Funds Checklist" with each purchase involving federal funds as a means of documenting the cost or price at the time of purchase. The Grant Manager will complete the form and submit it with supporting documents to System Office. While preparing the quarterly Schedule of Expenditures of Federal Awards (SEFA) template, System Office will ensure that all purchases that require a cost or price analysis are supported by the checklist prior to submitting the SEFA.

Responsible Official: System Office

Anticipated completion date: Corrective action was completed as of February 28, 2017.

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Current Audit Findings Corrective Action Plans (continued)

Finding 2017-003 (Subrecipient Monitoring)

Federal program information:

Federal Grantor: United States Department of Health and Human Services
Major Program: Research & Development Cluster
CFDA No.: 93.638, ACA-Transforming Clinical Practices Initiative: Practice Transformation Networks (PTNs)
Pass-Through Entity: Vanderbilt University
Ascension Hospital: St. Thomas Health Foundations (Nashville)
Award Number: VUMC 57486
Award Period: 9/29/15–9/28/16

Views of responsible officials and planned corrective actions:

Nashville will put in place subaward agreements for all grants passed through to subrecipients. In addition, annual risk assessments will be completed and monitoring activities will be instituted on all grants passed through to subrecipients.

Responsible Official: Nashville Grants Manager

Anticipated completion date: December 31, 2017

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Saint Thomas Health | ASCENSION

May 10, 2018

Melanie Hill, Executive Director
Health Services and Development Agency
State of Tennessee
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Dear Mrs. Hill:

Saint Thomas West currently operates a twenty-four (24) bed inpatient geriatric psychiatric bed unit. We support the Certificate of Need application being filed by Cumberland Behavioral Health, LLC, which is a joint venture between Saint Thomas Health and Acadia Nashville JV Holdings, LLC for a new seventy-six (76) bed psychiatric hospital (the "Project"). It is proposed that this new hospital will fill an increasing need for geriatric and adult psychiatric services in the area.

Therefore, when the Project is both approved and licensed, Saint Thomas West will voluntarily surrender our twenty-four (24) beds, thereby resulting in a net increase of only 52 new hospital beds in Davidson County.

Sincerely,

Fahad Tahir
CEO, Saint Thomas West Hospital