Alliance HealthCare Services, Inc
Form 10-K
March 10, 2017
F1

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended: December 31, 2016

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: 1-16609

ALLIANCE HEALTHCARE SERVICES, INC.

(Exact name of registrant as specified in its charter)

DELAWARE	33-0239910
(State or other jurisdiction of incorporation or organization)	(IRS Employer Identification Number)

100 Bayview Circle, Suite 400, Newport Beach, California 92660

(Address of principal executive office)

Registrant’s telephone number, including area code: (949) 242-5300

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

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, Par Value $0.01	NASDAQ Stock Market, LLC

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

None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes 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 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 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” and “smaller reporting 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	

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant as of June 30, 2016, based upon the closing price of the Common Stock as reported by The NASDAQ Stock Market, LLC on such date, was $30.5 million.

The number of shares outstanding of Common Stock as of March 1, 2017 was 10,812,964 shares.

Documents Incorporated by Reference

The registrant's definitive proxy statement for the Annual Meeting of Stockholders, to be filed within 120 days of December 31, 2016 is incorporated by reference into Part III of this Annual Report on Form 10-K to the extent stated herein.

ALLIANCE HEALTHCARE SERVICES, INC.

ANNUAL REPORT ON FORM 10-K

FOR THE FISCAL YEAR ENDED DECEMBER 31, 2016

TABLE OF CONTENTS

PART I

Cautionary Statement Regarding Forward-looking Statements

This Annual Report on Form 10-K, including Item 1, “Business”; Item 1A, “Risk Factors”; and Item 7, “Management’s Discussion and Analysis of Financial Condition and Results of Operations,” particularly in the section entitled “Liquidity and Capital Resources,” and elsewhere in this Annual Report on Form 10-K, includes “forward-looking statements” within the meaning of the safe harbor provisions of the Private Securities Litigation Reform Act of 1995.

In some cases you can identify these statements by forward-looking words, such as “may,” “will,” “should,” “expect,” “plan,” “anticipate,” “believe,” “estimate,” “predict,” “seek,” “intend” and “continue” or similar words. Forward-looking statements m use different phrases. Forward-looking statements address, among other things, our future expectations, projections of our future results of operations or of our financial condition and other forward-looking information and include statements related to the Company’s improvement plan, including its efforts to grow the Radiology, Oncology, and Interventional Divisions, and expected annualized savings.

Statements regarding the following subjects, among others, are forward-looking by their nature:

(a) future legislation and other healthcare regulatory reform actions, and the effect of that legislation and other regulatory actions on our business;
(b) our expectations with respect to future radiology services, oncology and interventional volumes and revenues;
(c) the effect of seasonality on our business;
(d) expectations with respect to capital expenditures in 2017;
(e) the effect of recent accounting pronouncements on our results of operations and cash flows or financial position;
(f) our business and strategic plans, including the effect of growth and cost-cutting initiatives;
(g) our compliance with legal and regulatory requirements;
(h) compliance with our debt covenants;
(i) unrecognized tax benefits and the adequacy of our tax provisions; and
(j) our belief regarding the sufficiency of our cash and cash equivalents to meet our working capital, capital expenditure and other cash needs.

We believe it is important to communicate our expectations to our investors. There may be events in the future, however, that we are unable to predict accurately or that we do not fully control that cause actual results to differ materially from those expressed or implied by our forward-looking statements, including:

- our ability to service our debt;
- factors affecting our leverage, including interest rates;
- the risk that the counterparties to our interest rate swap agreements fail to satisfy their obligations under those agreements;
- our ability to obtain financing;
- the effect of operating and financial restrictions in our debt instruments;
- the accuracy of our estimates regarding our capital requirements;
- intense levels of competition in our industry;
- changes in the rates or methods of third-party reimbursements for radiology, oncology and interventional services;
- fluctuations or unpredictability of our revenues, including as a result of seasonality;
- changes in the healthcare regulatory environment;
- our ability to keep pace with technological developments within our industry;
- the growth or decline in the market for radiology, oncology or interventional and other services;
- the disruptive effect of natural disasters, including weather;

- adverse changes in general domestic and worldwide economic conditions and instability and disruption of credit and equity markets;
- our ability to successfully integrate acquisitions;
- our ability to maintain effective internal controls over financial reporting and disclosure controls and procedures;
- the nature, timing and amount of any restatement; and
- other factors discussed under “Risk Factors” in this Annual Report on Form 10-K and that are otherwise described or updated from time to time in our SEC reports.

This Annual Report on Form 10-K includes statistical data that we obtained from public industry publications. These publications generally indicate that they have obtained their information from sources believed to be reliable but they do not guarantee the accuracy and completeness of their information. Although we believe that the publications are reliable, we have not independently verified their data.

ITEM 1. BUSINESS

General

Alliance HealthCare Services, Inc. ("Alliance" and together with its direct and indirect subsidiaries, the "Company," "we," "our," or "us") is a leading national provider of outsourced medical services, including radiology, oncology and interventional. We provide a full continuum of services from mobile to comprehensive service line management and joint venture partnerships, which can include one or more of the following depending on the customer's needs: systems, technologists to operate the systems, sales and marketing, patient scheduling and pre-authorization, billing and payer management, equipment maintenance and upgrades, overall management of services and fixed-site operations including outpatient clinics and Ambulatory Surgical Centers ("ASC").

As of December 31, 2016, we operated 625 diagnostic imaging, radiation therapy, and interventional radiology systems. With a strategy of partnering with hospitals, health systems and physician practices through joint ventures and fee for service arrangements, we provide quality healthcare services for over 1,100 hospitals and healthcare partners in 46 states, where approximately 2,450 Alliance Team Members are committed to providing exceptional patient care and exceeding customer expectations.

In 2016, we reported results in three segments: Radiology, Oncology and Interventional. Prior to 2016, results were reported in two segments, Radiology and Oncology. The Interventional Division was formed in February of 2015 with the acquisition of The Pain Center of Arizona ("TPC"). In October of 2015 and in January of 2016, we acquired two pain practices in Florida, creating the current foundation of our Interventional Division. With the completion of our third acquisition, we began reporting Interventional as a separate segment.

Service Overview

- Radiology Division: We provide a full continuum of diagnostic imaging capabilities from mobile to fixed-site to service line management to hospitals and provider groups. In a mobile setting, we provide mobile imaging systems to hospitals and provider groups under outsourced services contracts that generally average 3 years in length. In a fixed-setting, our imaging systems and staff can be located in a single-modality, fixed-site facility or parked mobile facility either onsite or near a hospital, physician practice or clinic. In addition, we provide full-service, multi-modality radiology center management known as Alliance RAD360™. Through our RAD360™ offering, we provide comprehensive management of the radiology center operations including sales and marketing support, patient scheduling and pre-authorization, billing and payer management, systems, equipment maintenance and upgrades, clinical staffing, and overall management of day-to-day services of the center. Single-modality, fixed-site contracts typically average 5 years in length. RAD360™ sites are generally joint venture relationships which often average 10 to 20 years in length with evergreen renewal cycles.
- Oncology Division: We provide a wide range of oncology services and ancillary services for cancer patients, including: planning and preparation for treatment, simulation of treatment, delivery of radiation therapy, therapy management, and follow-up care. We offer various treatment options, including conventional beam therapy ("CBT") using linear accelerator ("Linac") as well as stereotactic radiosurgery ("SRS"). We partner directly with hospitals, physicians, and other healthcare providers to offer a full suite of services in cancer care including access to the latest oncology technologies, full management of our partners' cancer care programs including clinical staffing, access to our national network of physicists for training and development on new treatment protocols and technologies, market analysis, equipment and capital, pre-authorization and billing, marketing and sales, and operational management.
- Interventional Division: We provide comprehensive pain management services for a wide range of conditions and diseases through therapeutic, minimally invasive procedures to treat and ease pain, medication, laboratory testing, and other services. All of our pain management services are performed either at an outpatient clinic setting or at an ASC, as determined by the treating physician. Our services also include clinical management, pharmaceutical referrals, functional restoration and other treatments that assist with chronic and acute pain care.

The following table summarizes our revenues by segment as a percentage of total revenue.

	Year ended December 31,		
	2016	2015	2014
Segment revenue as a percentage of total revenue:			
Radiology	70 %	72 %	79 %
Oncology	21 %	21 %	21 %
Interventional	9 %	7 %	— %
Total	100 %	100 %	100 %

For additional information on reportable business segments, see Note 17 of “Notes to Consolidated Financial Statements” included in this Report beginning on page F-7.

Our clients and partners contract with us to provide radiology, oncology and interventional services to:

- take advantage of our extensive radiology, radiation oncology and interventional services' management experience;
- partner with a leader whose core competency is high quality, efficient and scalable services in the areas of radiology, oncology and interventional services.
- alleviate capital investment, financial risk and contracting for maintenance associated with the purchase of their own systems;
- provide access to radiology, oncology, interventional and other services for their patients when the demand for these services does not justify the purchase of dedicated, full-time systems;
- eliminate the need to recruit, train and manage qualified technologists and/or therapists;
- make use of our ancillary services; and,
- gain access to services under our regulatory and licensing approvals when they do not have these approvals.

Significant 2016 Corporate Events

On December 12, 2016, we announced we had received a letter describing a non-binding proposal from Tahoe Investment Group Co., Ltd. ("Tahoe"), formerly known as Fujian Thai Hot Investment Co., Ltd., to acquire all of our outstanding common shares that are not currently owned by Tahoe for a purchase price of $9.60 per share in cash (the "Expression of Interest"). Our board of directors authorized a special committee, comprised solely of directors not affiliated with Tahoe, to evaluate the Expression of Interest. The Expression of Interest indicated that any transaction with Tahoe would be subject to approval by the special committee and a non-waiveable condition requiring approval of a majority of our shares not owned by Tahoe or its affiliates. Tahoe also indicated that the proposed transaction would not be subject to a financing condition. The special committee of our board of directors has engaged outside advisors to review the Expression of Interest and assist the committee in responding appropriately on behalf of the minority shareholders. This process is currently ongoing.

Effective on November 1, 2016, we executed an agreement among our Oncology Division, the Healthcare Authority of the City of Huntsville, and the Center for Cancer Care to form a comprehensive cancer care partnership in northern Alabama. We expect the partnership to generate annualized revenue of approximately $22 million.

In a two-part transaction on April 22, 2016 and May 19, 2016, we acquired the mobile business practice of American Health Centers, Inc. ("AHC"), a provider of fixed and mobile radiology and nuclear medicine services in New Hampshire and Vermont. We acquired 8 AHC mobile radiology sites and 5 AHC mobile nuclear medicine sites through our Radiology Division. We expect AHC to generate annualized revenue of approximately $3.8 million.

Effective March 29, 2016, Tahoe purchased approximately 5,537,945 shares of our common stock from funds managed by Oaktree Capital Management, L.P. ("Oaktree"), MTS Health Investors, LLC ("MTS") and Larry C. Buckelew ("Buckelew" and together with Oaktree and MTS, the "Selling Stockholders") for approximately $102.5 million or $18.50 per share (the "Tahoe Transaction"). See details in Note 3 of "Notes to Consolidated Financial Statements" included in this Report beginning on page F-7. As a result of the Tahoe Transaction, Tahoe, through a wholly-owned subsidiary, owned an aggregate of approximately 52% of the outstanding shares of our common stock as of December 31, 2016.

Industry Overview

Radiology is a medical specialty that employs the use of medical imaging systems to visualize, diagnose or stage diseases and injuries within the human body and convert them to film or digital media. The images produced by the imaging systems are then interpreted by a licensed radiologist, with the resulting dictated report being provided to physicians who are delivering care to a patient.

Within the field of radiology, diagnostic imaging services, such as magnetic resonance imaging ("MRI"), positron emission tomography ("PET") and computed tomography ("CT") services are typically offered in either a hospital-based setting or free-standing setting. In the hospital setting, services are offered inpatient within the acute setting, or at

hospital-based fixed sites, hospital-based outpatient facilities or hospital-based mobile laboratories. These inpatient and outpatient centers are either owned and operated by the hospital or clinic, owned by a joint venture partnership between the hospital and provider such as Alliance, or by an outsourced provider such as Alliance. The radiologists are often part of a medical group (Professional Corporation), a partner in the joint venture or are employed by the hospital. The hospital or clinic bills third-party payers, such as managed care organizations, insurance companies, Medicare or Medicaid.

Freestanding outpatient diagnostic facilities range from single-modality to multi-modality and are generally not owned by hospitals or clinics. Hospitals may choose to enter into a joint venture partnership with an organization, such as Alliance, in order to operate and deliver services as a freestanding facility. These facilities compete against the hospital network and depend upon physician referrals for their patients. These facilities bill third-party payers, such as managed care organizations, insurance companies, Medicare and Medicaid.

Many hospitals in smaller markets provide diagnostic imaging services by contracting with providers of mobile imaging services such as Alliance. Using specially designed trailers, mobile imaging service providers transport imaging equipment and provide services to hospitals and clinics on a part-time or full-time basis, thus allowing small to mid-size hospitals and clinics that do not have the patient demand to justify fixed on-site systems access to advanced diagnostic imaging technology. Mobile diagnostic imaging providers contract directly with hospitals or clinics and are typically compensated directly by them.

Radiation oncology is the practice of delivering ionizing radiation therapy to treat malignant and benign disease processes under the direction of a radiation oncologist. Radiotherapy is primarily used to treat cancer patients to kill cancer cells and shrink tumors with the goal of delivering the highest possible dose of radiation in order to destroy the cancerous cells while minimizing exposure to healthy surrounding tissue.

Interventional services commonly consist of one or more of the following: interventional radiology, interventional pain management and interventional therapeutics.

Radiology Division

Focused on hospitals and providers, we deliver radiology service line and outpatient center management, as well as mobile radiology solutions such as MRI, PET/CT and CT modalities. Through Alliance RAD360™, part of services offered in the Alliance Radiology Division, we offer an end-to-end business/operational lifecycle solution. RAD360™ is an innovative and comprehensive set of services that provides the sales and marketing, clinical quality, and operational excellence to take a radiology service line to new levels. We also offer premier quality programs and services, including OnPoint, which is an automated cloud-based software that allows hospitals and imaging providers to manage every scanner in their facilities, automate the quality control measures required for accreditation by the American College of Radiology (“ACR”), and detect gradual degradation in image quality to identify problems and preventative maintenance before they impact clinical results. Alliance Radiology partners with hospitals and healthcare groups to deliver an outstanding patient experience, drive operational excellence and create competitive differentiation to ensure mutual success.

Our Radiology Division offers the following procedural options:

- MRI: Physicians use MRI to find diseases or abnormalities in the body without using X-rays. MRI uses a magnetic field and radio waves to create detailed images of the body. MRI is a non-invasive and painless procedure. Most MRI scans require fewer than sixty minutes to complete. We offer both traditional, “wide-open” (meaning, the bore of the MRI is larger than a traditional bore) and open MRI scanning options. The large opening of the wide-bore and open MRIs make them a good option for children, patients with mild anxiety or claustrophobia, large patients, or patients with shoulder injuries.

- PET and CT: A PET/CT scan combines PET and CT technologies. PET images show the function of cells in the body. CT images show details of body anatomy such as vessels, lymph nodes and organs. Alone, PET and CT are each effective for a wide variety of applications. When PET and CT scans are combined, the fused images help doctors accurately diagnose, stage and treat cancer. PET/CT scans may reduce the need for biopsy or surgery.

PET/CT can help determine:

- size and location of the growth;
- whether the cancer is spreading;
- the best form of treatment;
- whether therapy is working; and
- whether there has been a recurrence.

- CT: CT uses X-ray technology and computer processing to create images of bones, organs, and blood vessels. These detailed images help doctors diagnose conditions and determine treatment options. CT is often used to assess internal trauma, diagnose cancers, guide procedures and therapies, and diagnose fractures.

CT can generate very detailed three-dimensional images of certain parts of the body, such as soft tissues, blood vessels, lungs, brain, abdomen and bones. Pictures of the same area are taken from different angles and then digitally combined to produce the images. CT is painless and usually lasts only a few minutes. Some patients require an intravenous or oral contrast agent to improve the image quality of body tissues.

- Ultrasound: Ultrasound is a safe, radiation-free imaging method that shows a range of body tissues in real-time. Ultrasound systems use high-frequency sound waves to create medical images that help doctors evaluate tissues including blood vessels in the neck, abdomen and legs as well as monitor fetal development. During the ultrasound exam the technologist uses a warm gel to move a transducer (a wand-like instrument) across the patient's skin.
- Nuclear medicine: Nuclear medicine is a specialized area of radiology that uses very small amounts of radioactive substances to evaluate organs, bones, or tissues. Unlike X-rays, where external radiation is used, nuclear medicine scans involve the patient taking a dose of radiopharmaceuticals internally.

There are several types of nuclear medicine diagnostic techniques. Scintigraphy creates two-dimensional images to evaluate areas such as bone, myocardial perfusion and parathyroid. Single-photon emission computed tomography ("SPECT") is a three-dimensional technique that helps doctors evaluate functional processes of the body. There are also hybrid techniques that superimpose nuclear medicine scans onto CT images. Nuclear medicine differs from imaging such as CT and magnetic resonance ("MR") by revealing the physiological function of the system being evaluated, rather than showing traditional anatomical images.

- X-ray (digital): Classic X-ray technology is often used as a first-line test in radiologic diagnosis. X-ray radiation can be used to create two-dimensional images of almost every part of the body. Bone fractures and pneumonia, for example, are often diagnosed with this quick, low-cost and widely available imaging modality.
- Mammography: Mammography is an imaging technique that takes low-dose X-rays of the breasts for early detection of cancer. Images are taken of each breast from several angles. This procedure can identify abnormal growths that are too small or deep to be detected during a routine self-exam. Mammography is the most effective method to detect breast disease in women. The American Cancer Society recommends annual mammograms for women by age 45.
- Bone density screening: Bone density screening is the standard measure used in preventing and diagnosing osteoporosis. The bone density test helps predict the patient's risk of breaking bones and can monitor the effects of osteoporosis treatment. A bone density test uses X-rays to measure the amount of minerals in the patient's bones and determine the presence or extent of osteoporosis. The less dense the bones are, the more likely they are to break. We use dual-energy X-ray absorptiometry ("DEXA") or quantitative computed tomography ("QCT") to diagnose and monitor osteoporosis as well as the effects of osteoporosis treatment and other conditions that cause bone loss.

We typically provide radiology services in one of the following settings:

- Outsourced: Imaging systems, located in mobile trailers or in fixed facilities, are used to provide services to a hospital or physician practice on a shared-service or full-time basis. Generally, the hospital or clinic contracts with Alliance as the radiology service provider to perform scans of its patients, and that hospital or clinic, instead of a third-party payer, pays the radiology service provider directly.
- Hospitals and physician practices: Imaging and/or radiation oncology systems are located in a hospital, physician practice or clinic. These systems are primarily used to scan patients of the hospital or clinic, and the hospital or clinic bills patients and third-party payers, such as health insurers, including Medicare or Medicaid.
- Independent centers: Systems are located in permanent facilities not generally owned by hospitals or physician practices. These centers depend upon physician referrals for their patients and generally do not maintain dedicated, contractual relationships with hospitals or clinics. Typically these centers are in markets in which strategic hospital partners are not available but services are still needed. Like hospitals and clinics, these centers bill patients and third-party payers for their services.

Oncology Division

Our oncology services help build, manage and grow oncology service lines for sustained long-term value. All oncology services we provide are in a hospital setting or at an independent radiation oncology center. Radiation therapy is the medical practice of treating disease, especially cancer, using ionizing radiation and is under the direction of a radiation oncologist. In general, radiation therapy is delivered daily over a period that varies from one day (a single treatment) to many weeks (40 or more treatments). Ionizing radiation has enough energy to damage living cells at the molecular level by interacting with the molecules within the DNA structure. Many of the cancer cells are more sensitive to radiation than normal tissues and are more likely to be killed over time, whereas normal tissue/cells have an opportunity to repair and heal. This has been important for traditional radiation treatment (greater than 10 treatments). With the technology we have today, we are able to minimize the normal tissue being exposed to high doses of radiation and focus the high radiation dose to the tumor. With this technology, we are able to deliver the radiation treatment in less than 5 treatments in some cases.

We estimate that approximately 60% of all newly diagnosed cancer patients today will be treated with some form of radiation therapy within their life-time. Radiation therapy is often combined with other oncology care such as chemotherapy and surgery. A typical oncology department provides a wide range of services for cancer patients. These include: planning and preparation for treatment, simulation of treatment, delivery of radiation therapy, therapy management and follow-up care. Several different technologies are used to deliver radiation treatments, including: Linac, Gamma Knife®, CyberKnife®, and radioactive isotopes – teletherapy and brachytherapy.

Our Oncology Division offers the following treatment options:

- CBT: CBT is the least sophisticated but the most established form of radiation therapy delivered by a Linac. It is the simplest form to deliver, using two-dimensional planning, and is typically reserved for use in patients where high precision and conformality of the radiation therapy is not required or when a remission is not envisioned.
- Three-dimensional conformal radiation therapy (“3D-CRT”): 3D-CRT uses three-dimensional imaging data and three-dimensional treatment planning to more accurately and effectively plan and deliver Linac radiation treatments. It is the most common form of technology used in practices and may be supplanted by intensity modulated radiation therapy (“IMRT”) or in conjunction with image guided radiation therapy (“IGRT”) when the specific case requires a higher level of precision or conformality.
- IMRT: IMRT entails the use of multiple beams of radiation delivered by a Linac whose intensity is adjusted individually during the actual daily treatment delivery to allow the radiation that is delivered to conform as closely as possible to the three-dimensional volume of the tumor and simultaneously reduce the dose to neighboring normal healthy tissues. It requires extremely sophisticated and time-consuming treatment planning to determine what beam shapes and orientations should be used and what their intensities should be to provide the optimal patient treatment based on the patient’s anatomy of normal tissues and the targeted tumor volume. Extensive treatment quality assurance is required to ensure that all the beams are modulated and delivered correctly.
- IGRT: IGRT uses a number of different types of imaging technologies to localize precisely the patient and the tumor target volume at the time of each treatment delivery to ensure that the radiation is delivered to the correct location. IGRT is not a radiation treatment in and of itself; it is used in support of advanced forms of treatment delivery such as 3D-CRT, IMRT, stereotactic body radiotherapy (“SBRT”) and SRS.
- SRS and SBRT: SRS was originally developed for intracranial applications. The technology is now being used in a range of extracranial applications such as spine, lung, prostate and other disease sites in the form of SBRT. SRS and SBRT deliver a very high dose of radiation in 1 to 5 treatments as opposed to the 10 to 40 treatments used for 3D-CRT, IMRT and IGRT. Due to the extremely high doses used for SRS and SBRT, the need for precision in the planning and delivery of the treatment is critical. The doses are so high that normal and tumor cells are destroyed, a “surgical ablative” response to the treated volume. SRS/SBRT is delivered with a range of advanced technologies such as the CyberKnife®, Gamma Knife®, BrainLab,™ Novalis-Tx,™ TrueBeam STx,™ Trilogy,™ VERO, TomoTherapy®, Elekta Infinity™ and Axesse.™

- Low dose rate brachytherapy ("LDR"): LDR allows the radiation oncologist to treat cancer by delivering the dose of radiation from the "inside out." Radioactive isotopes encased in a metal jacket the size of a grain of rice ("seeds") are implanted directly in the tumor through needles, with the seeds permanently left in place, or left in place temporarily within catheters (thin hollow tubes) and removed with the catheters when treatment is completed. The radioactive isotopes decay over time (days to years) to an inert form and in the process gradually release ionizing radiation called gamma rays, which are generally of low energy and thus deposit their therapy over short distances, thereby treating the cancer over time (hours to days).
- High dose rate brachytherapy ("HDR"): Like LDR, HDR allows the radiation oncologist to treat cancer by delivering the dose of radiation from the "inside out." HDR utilizes temporary seeds, made of radioactive isotopes that deliver a much higher dose of radiation over a much shorter period of time. These seeds are inserted and removed several times, over several minutes, one to two times per day, for 1 to 10 treatments delivered over 1 to 45 days, through catheters that are left in place for the entire course of care and then removed when the treatment course is completed.

Interventional Division

We provide minimally invasive interventional radiology services and comprehensive pain management services for a wide range of conditions and diseases. Minimally invasive procedures often result in less trauma and pain with faster recovery and less cost to payers and patients. We use best-in-class treatment protocols and clinical excellence standards. For hospital systems and providers looking to improve their competitive position and expand their continuum of care, we provide comprehensive and scalable solutions to build, manage and optimize interventional services programs.

Our Interventional Division offers therapeutic minimally invasive pain management procedures and services, such as epidural steroid injections, discectomy, vertebroplasty, kyphoplasty, neuro stimulators, nerve blocks and other procedures that provide intermediary care. As part of the continuum of pain care, we also include clinical management, pharmaceutical referral, functional restoration and other treatments that assist chronic and acute pain care. All of our Interventional services are delivered in outpatient physician practices or at an ASC.

Based on 2012 Part B Medicare Revenue, industry trends are indicating highest value interventional radiology procedures are migrating from hospitals to ASCs. Persons over the age of 65 comprise one of the fastest growing segments of the population in the U.S. According to the U.S. Census Bureau, this group is expected to increase as much as 33% from 2010 to 2020. We believe the aging population will generate more demand for interventional radiology and pain management procedures.

Our Competitive Strengths

Industry leading provider and platforms

We are the leading national provider of advanced diagnostic mobile imaging services, an industry-leading operator of fixed-site radiology centers, and a leading provider of SRS, as well as additional services provided in our Radiology, Oncology and Interventional segments. As of December 31, 2016, we had 625 diagnostic imaging, radiation therapy, and interventional radiology systems in operation. With a strategy of partnering with hospitals, health systems and physician practices through joint venture and fee for service arrangements, we provide strategic business management as well as quality clinical services for over 1,100 hospitals and other healthcare partners in 46 states, where approximately 2,450 Alliance Team Members are committed to providing exceptional patient care and exceeding customer expectations. This scale allows us to achieve operating, sourcing and administrative efficiencies enabling us to improve utilization through deployment of mobile systems, replicate best practices as turnkey solutions for markets to increase hospital outpatient traffic, obtain equipment purchasing savings, and negotiate favorable service and maintenance contracts from equipment manufacturers.

Hospital-centric model aligns with favorable industry trends

We participate in some of the largest and most fragmented sectors of the healthcare industry with significant growth opportunities. Operating for over 30 years, we have developed deep, long-standing relationships with over 1,100 hospitals and healthcare providers in 46 states. We believe healthcare trends will foster hospital-centric models and allow us to expand our platform. Hospitals are increasingly looking to expand upon existing care networks and market share through maintaining the highest level of patient care in a cost efficient manner. We are uniquely positioned with a national footprint to offer outsourced services to healthcare service providers by providing in-depth industry expertise coupled with the ability to drive volume growth and market share for hospital partnerships.

Outsourced services and joint venture model

For the year ended December 31, 2016, approximately 73% of our revenues were generated through long-term contracts and joint ventures with hospitals and other healthcare providers. Outsourced contracts average 3 years for mobile radiology services and up to 5 years for fixed site. Joint ventures across all segments range from 10 to 20 years with evergreen renewal cycles. These long-term agreements provide high revenue visibility. Most outsourced radiology contracts require a fee for each scan performed which is fixed for the life of the contract or are billed on a fixed-fee basis regardless of the number of scans. With respect to our Oncology segment, contracts are billed to the hospital as either a fixed fee per case, per treatment, or as a percentage of cash collected.

Reduced reimbursement risk

With long-term contracts and joint ventures, payments are due to us under our contracts regardless of the customer's receipt of payment from patients or reimbursement from third-party payers (including commercial payers, Medicare and Medicaid). For the years ended December 31, 2016, 2015 and 2014, we generated approximately 73%, 77% and 80%, respectively, of our revenues by billing hospitals and other healthcare providers rather than billing patients or other third-party payers directly. Importantly, this contrasts with the vast majority of other diagnostic imaging and radiation therapy markets, which typically collect directly from patients and third-party payers and are, therefore, directly exposed to uncollectible bad debt as well as reimbursement volatility. Our wholesale model reduces our exposure to patient bad debt, as evidenced by our bad debt expense as a percentage of revenues of only 0.4%, 0.6% and 0.6% for the years ended December 31, 2016, 2015 and 2014, respectively. Further, our short-term exposure to Medicare reimbursement cuts is limited because we received only approximately 4% of our total Radiology and Oncology revenues directly from Medicare in each of the years ended December 31, 2016, 2015 and 2014.

Proven history of cash flow generation with track record of deleveraging

We have a strong track record of significant cash flow generation giving us optionality with regard to growth investments or deleveraging. Despite recent pricing pressure in our Radiology segment, cash flow generation has remained strong and we have invested significant capital to support our growth initiatives. Beginning in 2014, we embarked on a strategic re-pricing of certain contracts in our Radiology segment. We believe our strategic price reset in Radiology was largely completed at the end of 2016, allowing future margin expansion from continued same-store volume growth and acquisitions which had been previously offset by pricing pressures in 2015 and 2016. Historical cash flow generation has enabled us to reduce debt by approximately $155 million from 2010 through 2014, while still funding strategic investments. In 2015 and 2016, we invested more heavily in both maintenance and growth capital and acquisitions to improve performance.

Experienced and committed management team

Most members of our management team bring over 30 years of relevant operational and industry experience.

Our Strategy

We are committed to executing on these critical elements of our strategic growth plan in our key service areas including radiology, oncology and interventional services to drive our long-term growth and continued success:

- Leverage position as a market leader. Our goal is to continue to execute proven strategies that have generated strong cash flows and growth for our business while continuing to develop complementary and higher margin segments.
- Continued expansion of RAD360™ (fixed-site, multi-modality radiology footprint). We are a market leader for hospitals seeking strategic partnerships in the radiology service line. The implementation and adoption of RAD360™, through which we are able to provide comprehensive radiology service line management and fixed-site radiology center management, positions us for growth in our Radiology segment. RAD360™ utilizes a powerful

value proposition to provide hospitals and health systems with comprehensive radiology solutions.

- Drive same-store sales volume growth. Same-store-growth ("SSG"), which we calculate by comparing the cumulative scan, treatment or case volume at all locations in the current period to the same period in the prior year. The SSG for MRI and PET/CT has increased by 1.6% and 6.7%, respectively, for the year ended December 31, 2016. SSG is further supported by strong customer retention and net new contract performance in our radiology business during this period. In our Oncology segment, SSG for the year ended December 31, 2016 grew by 2.9% for Linac and 0.4% for SRS. With strong synergistic relationships across all three segments, we will continue to take advantage of cross-sell opportunities of additional services to existing customers. For example, existing patient flow within the interventional platform will drive volume to our diagnostic imaging business. We plan to continue to leverage hospital relationships across all divisions and partner alongside acute operations to drive performance while building more comprehensive joint venture opportunities to expand our growth strategy.

- Accelerate growth in Oncology and build Interventional platform. Our Oncology and Interventional segments both offer strong value propositions as we continue to grow and strengthen our segments in order to provide multiple service lines to our hospital partners.

Our continued focus on clinical excellence, patient service and quality, as well as demand generation through marketing and referring physician outreach programs, are expected to drive growth in our Oncology segment. Our strategy is to increase performance of existing centers through marketing strategies and payer management as well as emphasize technology upgrades opportunities, as 34% of U.S. healthcare facilities plan to upgrade oncology systems within the next three years. We believe that a strong value proposition to hospital partners, coupled with our substantial historical investments and acquisitions, will continue to drive expansion in the Oncology segment.

Our Interventional segment brings a rapidly growing and highly fragmented market opportunity with few sizeable competitors and attractive unit level economics. As we continue the integration of the entities we acquired to create our Interventional segment, we believe significant growth opportunities exist. The interventional platform is a natural complement to the diagnostic imaging business and aligns with our strategy of providing multiple service lines to single hospital customers. Diagnostic imaging is often used to determine the source of a patient's pain. Imaging is also used during interventional procedures.

- Future margin expansion with strategic pricing reset largely complete. In 2014, we began taking competitive pricing actions, specifically with respect to MRI and PET/CT renewals, in our core mobile Radiology operations. Additionally, we also terminated and spun off certain unprofitable mobile service and fixed-site contracts. We believe our strategic price reset in Radiology was largely completed at the end of 2016, allowing future margin expansion from continued same-store volume growth and acquisitions which had been previously offset by pricing pressures in 2015 and 2016.
- Pursue accretive and strategic acquisitions. We continue to seek opportunities to acquire businesses that expand our footprint and capabilities into higher growth markets and segments. We have developed a disciplined framework to support our acquisition efforts that focuses on well-run businesses with strong growth potential in fragmented markets. Illustrating this highly disciplined acquisition framework are the four strategic acquisitions completed in 2015, as well as the acquisition of AHC in April 2016 and the formation of a comprehensive cancer care partnership in northern Alabama in November 2016. Small tuck-in acquisitions such as the acquisition of AHC offer roughly equivalent economics to adding new de novo customers in the core radiology business and will remain highly attractive on a go-forward basis. In addition, we may explore asset-light, low capital investments overseas, utilizing the expertise of Tahoe, our majority owner.

Contracts and Payment

Our typical radiology contract is exclusive, averages approximately 3 years in length for mobile services and approximately 5 to 10 years in length for fixed-site imaging center arrangements, and often includes an automatic renewal provision. Most of our contracts require a fee for each scan we perform. With other contracts, we bill clients on a fixed-fee basis for a period of time, regardless of the number of scans performed. These fee levels are affected primarily by the type of imaging system provided, scan volume and the number of ancillary services provided. Our typical oncology contract is exclusive, averages approximately 10 to 20 years in length and often includes an automatic renewal provision. We leverage our national footprint and enter into payer contracts on behalf of our joint ventures, wholly-owned subsidiaries and interventional services' partners with the objective to gain favorable payer status and reimbursement.

Segments and Regional Structure

The strategic organization of our business is divided into three divisions: Radiology, Oncology and Interventional. For the years ended December 31, 2016, 2015 and 2014, there were no revenues derived from business outside the U.S. We will continue to focus on growth opportunities in the U.S., as well as explore international market prospects. We operate each of our Radiology, Oncology and Interventional divisions as separate profit centers responsible for their own revenues, expenses and overhead, and we manage them on a national basis. For the purposes of Financial

Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") 280, "Segment Reporting," we have three reportable segments (Radiology, Oncology, and Interventional) based on similar economic and other characteristics. See Note 17 of "Notes to Consolidated Financial Statements" included in this Report beginning on page F-7 for financial information about our segments. We have regional managers to oversee local markets throughout the U.S. We believe we will continue to benefit from our regional managers' local presence and knowledge of the markets we serve, which allows us to address the specific needs of each local operating environment. To complement and support this regional structure, we continue to have standardized contracts, operating policies and other procedures that we implement nationwide in an effort to ensure quality, consistency and efficiency across all regions.

Systems, Management and Maintenance

We purchase our radiology, oncology, and interventional radiology systems from major medical equipment manufacturers, primarily General Electric Medical Systems, Siemens Medical Systems, Philips Medical Systems, Varian Medical Systems, Elekta and Accuray, Inc. Generally, we contract with clients for new or expanded services before we order new systems. This practice reduces our system utilization risk. As one of the largest commercial purchasers of MRI, PET/CT and SRS systems in the U.S., we believe we receive relatively attractive pricing for equipment and service contracts from these equipment manufacturers.

For our mobile radiology systems, we actively manage deployment to increase their utilization while optimizing routes through coordinated transportation. Our current fleet includes 142 power units, which are large trucks that pull the trailers that house and transport our mobile systems. We examine client requirements, route patterns, travel times, fuel costs and system availability in our deployment process. We currently schedule our shared-service MRI and PET/CT systems for as little as one-half day and up to 7 days per week at any particular client, with an average usage of 1.5 days per week per client. Drivers typically move the systems at night and activate them upon arrival at each client location so that the systems are operational when our technologists arrive.

For our fixed site radiology, oncology and interventional systems, we actively manage the equipment, associated warranties and service contracts.

Timely and effective maintenance is essential for achieving high utilization rates of our systems. Typically, we contract with the original equipment manufacturers ("OEMs") for comprehensive maintenance programs on our systems to minimize the period of time the equipment is unavailable. System repair typically takes less than one day but could take longer, depending upon the nature of the repair. During the warranty period and maintenance contract term, we receive guarantees related to equipment operation and availability.

Information Technology

Our corporate headquarters and many of our facilities are interconnected through a state-of-the-art information technology system. This medical-grade system, which is compliant with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), is comprised of a number of integrated applications and provides a single operating platform for billing and collections, electronic medical records, practice management and image management. This technology also supports our strategy as an outsourced service provider, thereby creating additional value for the customer from each of our service lines.

Sales and Marketing

Our sales and marketing teams are positioned under national leadership within each division. As of December 31, 2016, our national sales, including business development and field marketing teams, consisted of 85 members who focus on the following:

- seeking new customers;
- managing current customers, growing and upselling within each account; consulting with new hospital clients; supporting our current customers to continue our current relationships and helping to identify new opportunities to expand their business with us; and
- improving SSG (referring physician sales) within current customer accounts with the goal of increasing the number of scans or healthcare services at that account.

Competition

We consider our primary competition to be outpatient radiology service providers, oncology service providers, and interventional radiology and comprehensive pain management service providers. The markets for these services are competitive and widespread throughout the U.S. We believe that the key competitive factors affecting our business include:

- the quality and reliability of service;
- the quality and type of equipment available;
- the availability of types of radiology, radiation oncology, interventional, and ancillary services;
- the availability of locations and flexibility of scheduling;
- pricing;
- the knowledge and service quality of technologists;
- the ability to obtain regulatory approvals;
- the ability to establish and maintain relationships with healthcare providers and referring physicians; and
- access to capital.

We are, and expect to continue to be, subject to competition in our targeted markets from businesses offering radiology, oncology and interventional services, including existing and developing technologies. Many companies are engaged in the shared-service and fixed-site imaging market, including two national competitors and many smaller regional competitors. These competitors in the radiology market include RadNet, Inc., Center for Diagnostic Imaging (purchased by InSight Health Services Corp.), Diagnostic Imaging Group, American Radiology Services and several smaller regional competitors, including Medquest, Inc., Shared Medical Services, Kings Medical Company Inc. and DMS Health Technologies (a subsidiary of Digirad Corporation). We also face competitors in the radiation oncology market, including Radiation Therapy Services, Inc., Vantage Oncology, Inc. (a subsidiary of McKesson Corporation), US Oncology, Inc. (a subsidiary of McKesson Corporation) and many other smaller regional competitors. Our competitors for interventional services are primarily smaller, regional-based physician-owned practices. Some of our competitors may now or in the future have access to greater resources than we do. In addition, some physician practices have established their own diagnostic imaging facilities within their group practices to compete with us.

In addition to direct competition from other radiology and oncology providers, independent imaging centers and referring physicians with diagnostic imaging systems in their own offices, we compete with OEMs that aggressively sell or lease imaging systems to healthcare providers for full-time installation. In recent years, we have seen an increase in direct sales by OEMs of systems to some of our clients. OEMs typically target our higher scan volume clients. These sales efforts by OEMs have resulted in an overcapacity of systems in the marketplace, especially for medical groups that add imaging capacity within their practice settings. This situation has caused an increase in the number of our higher scan volume clients declining renewal of their contracts. We typically replace these higher volume scan clients with lower volume clients.

In all of our businesses, we may also experience greater competition in states that currently have certificate-of-need (“CON”) laws if those laws are repealed, thereby reducing barriers to entry in those states.

Employees

As of December 31, 2016, we had approximately 2,450 employees, of whom 1,347 were trained diagnostic imaging technologists, therapists, medical doctors and assistants, nurses and nurse practitioners, patient coordinators and other clinical and technical support staff or drivers. In addition, we use independent contractor drivers for some long-haul and rural routes. We believe we have good relationships with our employees.

Seasonality

We experience seasonality in the revenues and margins generated for our services. First and fourth quarter revenues are typically lower than those from the second and third quarters. First quarter revenues are affected primarily by inclement weather, typically resulting in fewer patients being scanned or treated during the period. Fourth quarter revenues are affected by holiday and client and patient vacation schedules, resulting in fewer scans or treatments during the period.

Regulation

Our business is subject to extensive federal and state government regulation. This includes the federal Anti-Kickback Statute ("AKS") and similar state anti-kickback laws, the Stark Law and similar state laws affecting physician referrals, the federal civil False Claims Act ("FCA"), HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH Act"), and similar state laws addressing privacy and security, state unlawful practice of medicine and fee splitting laws, and state CON laws. Although we believe that our operations materially comply with the laws governing our industry, it is possible that non-compliance with existing laws or the adoption of new laws or interpretations of existing laws could adversely affect our financial performance.

Fraud and Abuse Laws; Physician Referral Prohibitions

The healthcare industry is subject to extensive federal and state regulation relating to licensure, conduct of operations, ownership of facilities, addition of facilities and services and payment for services.

In particular, the AKS prohibits persons from knowingly and willfully soliciting, receiving, offering or providing remuneration, directly or indirectly, to induce either the referral of an individual, or the furnishing, recommending, or arranging for a good or service, for which payment may be made under a federal healthcare program such as the Medicare and Medicaid programs. The definition of "remuneration" has been broadly interpreted to include anything of value, including for example, gifts, discounts, the furnishing of supplies or equipment, credit arrangements, payments of cash, waivers of payments, ownership interests, and providing anything at less than its fair market value. In addition, there is no one generally accepted definition of intent for purposes of finding a violation of the AKS. For instance, one court has stated that an arrangement will violate the AKS where any party has the intent to unlawfully induce referrals. In contrast, another court has opined that a party must engage in the proscribed conduct with the specific intent to disobey the law to be found in violation of the AKS. The lack of uniform interpretation of the AKS makes compliance with the law difficult. Moreover, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act (collectively, the "PPACA"), among other things, amended the intent requirement of the AKS and criminal healthcare fraud statutes; a person or entity no longer needs to have actual knowledge of these statutes or specific intent to violate them. In addition, the PPACA provided that the government may assert that a claim including items or services resulting from a violation of the AKS constitutes a false or fraudulent claim for purposes of the FCA. The penalties for violating the AKS can be severe. These sanctions include criminal penalties and civil sanctions, including fines, imprisonment and possible exclusion from the Medicare and Medicaid programs.

The AKS prohibition is broad, and it reaches many arrangements and practices that are lawful in businesses outside of the healthcare industry. Recognizing the breadth of the AKS and that it may technically prohibit many innocuous or beneficial arrangements within the healthcare industry, Congress granted the Secretary of the U.S. Department of Health and Human Services ("DHHS") the authority to issue regulations referred to as "safe harbors" that describe certain types of arrangements that will not be considered unlawful under the statute, provided that the safe harbor requirements are met in form and substance. The DHHS Office of Inspector General ("OIG") has been delegated the authority to promulgate safe harbors. Our arrangements with physicians, physician practice groups, hospitals and other persons or entities who are in a position to refer may not fully meet the stringent criteria specified in the various safe harbors. Although full compliance with these provisions is an affirmative defense to prosecution under the AKS, the failure of a transaction or arrangement to fit within a specific safe harbor does not necessarily mean that the transaction or arrangement is illegal or that prosecution under the AKS will be pursued. Instead, the OIG and other government enforcement agencies will consider the totality of the facts and circumstances of an arrangement and its impact on the federal health care programs and patient care. The OIG also issues Advisory Opinions, compliance guidance and special alerts and bulletins on topics considered to be suspect. In April 2003, the OIG issued a Special Advisory Bulletin on Contractual Joint Ventures (the "OIG Bulletin") that set out OIG's concerns regarding contractual joint ventures and identified characteristics of arrangements the OIG may consider problematic. The OIG Bulletin focused on arrangements in which a healthcare provider expands into a related service, through a contractual

arrangement with an existing supplier of the related service, to furnish the service to the healthcare provider's existing patient population. The OIG noted that such arrangements may be suspect when the provider contracts out all or nearly all aspects of the new venture, including the management, to the existing supplier, and provides only an existing patient base. The OIG asserted that the provider's return on its investment in such circumstances may be viewed as remuneration for the referral of the provider's federal healthcare program patients to the supplier and, therefore, could violate the AKS.

Although some of our arrangements may not fall within a safe harbor, we believe that such business arrangements comport with the AKS because we are careful to structure them to reflect fair market value and ensure that the reasons underlying our decision to enter into a business arrangement comport with reasonable interpretations of the AKS. Even though we continuously strive to comply with the requirements of the AKS, liability could arise because of the intentions or actions of the parties with whom we do business. In addition, we could be faced with AKS liability based on arrangements established by the entities we have acquired. While we conduct careful due diligence, determining the intentions or actions underlying those arrangements is difficult.

Many states have adopted laws similar to the AKS. Some of these state prohibitions apply to referral of patients for healthcare services reimbursed by any source, not only the Medicare and Medicaid programs. Although we believe that we comply with both federal and state anti-kickback laws, any finding of a violation of these laws could subject us to criminal and civil penalties or possible exclusion from federal or state healthcare programs. Such penalties would adversely affect our financial performance and our ability to operate our business.

The Ethics in Patient Referral Act of 1989, commonly referred to as the federal physician self-referral prohibition or Stark Law, prohibits physician referrals of Medicare and Medicaid patients for certain designated health services (including MRI and other diagnostic imaging services) ("DHS") to an entity if the physician or an immediate family member has any financial arrangement with the entity and no statutory or regulatory exception applies. The Stark Law also prohibits the entity from billing for any DHS arising from a prohibited referral. Initially, the Stark Law applied only to clinical laboratory services but in 1995, Congress expanded the prohibition to additional goods and services, including MRI and other imaging services. Since that time, the Centers for Medicare & Medicaid Services ("CMS") (formerly known as the Health Care Financing Administration) has promulgated a series of regulations/rules implementing the statute. In addition to recoupment of monies collected improperly, a violation of the Stark Law may result in FCA liability or civil monetary penalties.

Several states in which we operate have enacted or are considering legislation that prohibits physician self-referral arrangements or requires physicians to disclose any financial interest they may have with a healthcare provider to their patients when referring patients to that provider. Possible sanctions for violating these state law physician self-referral and disclosure requirements include loss of license and civil and criminal sanctions. State laws vary from jurisdiction to jurisdiction and have been interpreted by the courts or regulatory agencies infrequently.

We believe our operations comply with these federal and state physician self-referral prohibition laws. We intend for any financial relationships we have with physicians and their immediate family members to meet a Stark exception. In the event, we receive a prohibited referral, our submission of a bill for DHS could subject us to sanctions under the Stark Law and applicable state law. Any sanctions imposed on us under the Stark Law or any similar state laws could adversely affect our financial results and our ability to operate our business.

HIPAA created federal statutes to prevent healthcare fraud and false statements relating to healthcare matters. The healthcare fraud statute prohibits knowingly and willfully executing a scheme to defraud any healthcare benefit program, including private payers. A violation of this statute is a felony and may result in fines, imprisonment or exclusion from government sponsored programs such as the Medicare and Medicaid programs. The false statements statute prohibits knowingly and willfully falsifying, concealing or covering up a material fact or making any materially false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services. A violation of this statute is a felony and may result in fines or imprisonment or exclusion from government sponsored programs.

Both federal and state government agencies are continuing heightened and coordinated civil and criminal enforcement efforts. The extent to which future legislation or regulations, if any, relating to healthcare fraud abuse laws and/or enforcement, may be enacted or what effect such legislation or regulation would have on our business remains uncertain.

Section 6402(a) of the Affordable Care Act requires a person who has received an overpayment to report and return the overpayment to the Secretary, the state, an intermediary, a carrier, or a contractor, as appropriate, within the later of: (a) the date which is 60 days after the date on which the overpayment was identified; or (b) the date any corresponding cost report is due, if applicable. Any overpayment retained by a person after the deadline for reporting and returning an overpayment is an obligation under the FCA.

On February 12, 2016, CMS published a final rule, effective March 14, 2016, that adopts new regulations related to the 60-day reporting requirement. The regulations require Medicare providers and suppliers to exercise reasonable

diligence to determine whether an overpayment was received, and within 60 days of that determination, report and return any overpayments identified within 6 years of the date the overpayment was received. Failure to report and return such overpayments within 60 days may subject the provider or supplier to FCA liability. We strive to ensure that we meet applicable billing requirements. However, the costs of defending claims under the FCA, as well as sanctions imposed under the Act, could significantly affect our financial performance.

HIPAA

In addition to creating the new federal statutes discussed above, HIPAA, as amended by the HITECH Act and updated by the January 2013 Omnibus Rule, also establishes uniform standards governing the conduct of certain electronic healthcare transactions and protecting the security and privacy of individually identifiable health information maintained or transmitted by certain covered entities, including healthcare providers, health plans and healthcare clearinghouses. HITECH and the Omnibus Final Rule significantly expanded HIPAA's privacy and security requirements. Among other things, HITECH and the Omnibus Final Rule make HIPAA's privacy and security standards directly applicable to "business associates," which are independent contractors or agents of covered entities that create, receive, maintain, or transmit protected health information ("PHI") in connection with providing a service for or on behalf of a covered entity. As a covered entity, we must comply with the Standards for Privacy and Security promulgated under HIPAA and HITECH. We believe that we are in compliance with all of the applicable HIPAA and HITECH standards, rules and regulations. Failure to comply with these standards can lead to criminal penalties and civil sanctions.

Most states have also enacted privacy and security statutes or regulations that, in some cases, are more stringent than those issued under HIPAA, including the laws of the state of California. In those cases it may be necessary to modify our operations and procedures to comply with the more stringent state laws, which may entail significant and costly changes for us. We believe that we are in compliance with such state laws and regulations. However, if we fail to comply with applicable state laws and regulations, we could be subject to additional sanctions.

Unlawful Practice of Medicine and Fee Splitting

The marketing and operation of our business is subject to some state laws prohibiting the practice of medicine by non-physicians. We believe that our radiology operations do not involve the practice of medicine because all professional medical services relating to our radiology operations, including the interpretation of scans and related diagnoses, are separately provided by licensed physicians not employed by us. Some states also have laws that prohibit fee-splitting arrangements between a physician and a referring person or entity that would provide for remuneration paid to the referral source on the basis of revenues generated from referrals by the referral source. We believe that our operations are in compliance with these state laws.

CON Laws

In some states, a CON or similar regulatory approval is required before the acquisition of high-cost capital items, including diagnostic imaging or radiation oncology systems or provision of diagnostic imaging or radiation oncology services by us or our clients. CON regulations may limit or preclude us from providing diagnostic imaging or radiation oncology services or systems. Revenue from states with CON regulations represented a substantial portion of our total revenue for the years ended December 31, 2016, 2015 and 2014.

Should there be an increase in the number of states regulating our business through CON or similar programs, our growth could be adversely impacted. Conversely, repeal of existing CON regulations or defunding of CON programs in jurisdictions where we have obtained a CON, or CON exemption, also could adversely affect us by allowing competitors to enter our markets. CON laws are the subject of continuing legislative activity.

Reimbursement

We derive most of our revenues directly from healthcare providers, primarily from acute care hospitals, with which we contract to provide services to their patients ("wholesale"). Additionally, some of our revenues come from patients and their third-party payers, including government programs such as the Medicare and Medicaid programs that we bill directly ("retail"). Services for which we submit direct billings for Medicare and Medicaid patients are paid on a fee schedule basis, and patients are responsible for deductibles and coinsurance. The following table summarizes the

percentage of wholesale and retail revenues as a percentage of total revenues.

	Year ended December 31,					
	2016		2015		2014	
Wholesale	73	%	77	%	80	%
Retail	25	%	20	%	20	%
Other	2	%	3	%	—	%
Total	100	%	100	%	100	%

With respect to our retail business, for services for which we bill Medicare directly, we are paid under the Medicare Physician Fee Schedule (“PFS”), which is updated on an annual basis. Changes in the methodology used to calculate fees under the PFS may adversely impact our business.

In addition to annual updates to the PFS, as indicated above, CMS also publishes regulatory changes to the hospital outpatient prospective payment system ("HOPPS") on an annual basis. These payments are bundled amounts received by our hospital clients for hospital outpatient services related to MRI scans, PET scans, PET/CT scans and SRS treatments. In the 2016 HOPPS final rule, CMS finalized a 0.3% rate reduction, which, combined with other policy changes finalized under the rule, is expected to result in a 0.4% reduction in payments to hospitals under the HOPPS in 2016. Recent adjustments to the HOPPS payments have not had a material adverse effect on our revenue and earnings in 2016, 2015 or 2014.

Over the past few years, the growth rate of PET/CT and MRI industry-wide scan volumes has slowed in part due to weak hospital volumes as reported by several investor-owned hospital companies, additional patient-related cost-sharing programs and an increasing trend of third-party payers intensifying their utilization management efforts, for example, through benefit managers who require prior authorizations to control the growth rate of imaging services generally. We expect that these trends will continue.

The Protecting Access to Medicare Act of 2014 ("PAMA") required CMS, in conjunction with medical specialty societies, to adopt appropriate use criteria ("AUC") for certain advanced diagnostic imaging services by November 15, 2015. Beginning in 2017, PAMA requires CMS to establish a program that promotes the use of AUC by requiring physicians who order and furnish advanced diagnostic imaging services to consult and report compliance with the AUC. Advanced imaging services ordered by certain physicians who do not adhere to the AUC are expected to be subject to prior authorization for applicable imaging services provided to Medicare beneficiaries beginning in 2020. We cannot predict the full impact of this project.

Payments to us by third-party payers depend substantially upon each payer's coverage, coding and reimbursement policies. Third-party payers may impose limits on coverage or reimbursement for diagnostic imaging services, including denying reimbursement for tests that do not follow recommended diagnostic procedures. Because unfavorable coverage and reimbursement policies have and may continue to constrict the profit margins of the hospitals and clinics we bill directly, we have and may continue to need to lower our fees to retain existing clients and attract new ones. If coverage is limited or reimbursement rates are inadequate, a healthcare provider might find it financially unattractive to own diagnostic imaging or radiation oncology systems, yet beneficial to purchase our services. It is possible that third-party coverage and reimbursement policies will affect the need or prices for our services in the future, which could significantly affect our financial performance and our ability to conduct our business.

Environmental, Health and Safety Laws

We are subject to federal, state and local regulations governing the storage, use, transport and disposal of materials and waste products, including biohazardous and radioactive wastes. Our PET service and some of our other imaging services require the use of radioactive materials. While this material has a short half-life, meaning it quickly breaks down into inert, or non-radioactive substances, using such materials presents the risk of accidental environmental contamination and physical injury. Although we believe that our safety procedures for storing, handling, transporting and disposing of these hazardous materials comply with the standards prescribed by law and regulation, we cannot completely eliminate the risk of accidental contamination or injury from those hazardous materials. We maintain professional liability insurance that covers such matters with coverage that we believe is consistent with industry practice and appropriate in light of the risks attendant to our business. However, in the event of an accident, we could be held liable for any damages that result, and any liability could exceed the limits or fall outside the coverage of our insurance. We may not be able to maintain insurance on acceptable terms, or at all. We could incur significant costs and the diversion of our management's attention to comply with current or future environmental laws and regulations. We have not had material expenses related to environmental, health and safety laws or regulations to date.

How to Obtain Our SEC Filings

All reports we file with the SEC are available free of charge via EDGAR through the SEC website at www.sec.gov. We also provide copies of our current reports on Form 8-K, Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, proxy statements and amendments to those documents at no charge to investors upon request and make electronic copies of those reports available through our website at www.alliancehealthcareservices-us.com as soon as reasonably practicable after filing those materials with the SEC. The information found on, or otherwise accessible through, our website is not incorporated by reference into, nor does it form a part of, this Annual Report on Form 10-K or any other document that we file with the SEC.

Our Investor Relations Department can be contacted at Alliance HealthCare Services, Inc., 100 Bayview Circle, Suite 400, Newport Beach, California 92660, Attn: Investor Relations, tel: (949) 242-5300.

Executive Officers of the Registrant

Set forth below is information regarding our executive officers, including their principal occupations for the past five years and their ages as of March 1, 2017. There are no family relationships between any of our executive officers and any other executive officer or board member. Our board of directors elects our executive officers, who serve at the discretion of our board of directors.

Name	Age	Present Position
Percy C. Tomlinson	54	Chief Executive Officer
Rhonda A. Longmore-Grund	54	Executive Vice President and Chief Financial Officer
Richard W. Johns	59	Chief Operating Officer and Chief Legal Officer
Richard A. Jones	53	President, Alliance HealthCare Radiology
Gregory E. Spurlock	55	President, Alliance Oncology and Alliance HealthCare International
Steven M. Siwek, M.D.	52	President, Alliance Interventional

Percy C. Tomlinson became Chief Executive Officer in October 2013. Mr. Tomlinson has more than 25 years of diverse executive management and leadership experience, serving in a variety of roles, most recently as the Chief Executive Officer of Midwest Dental, from 2012 until joining us. Previously, he spent 10 years with the Center for Diagnostic Imaging, Inc. in several senior roles including Chief Executive Officer from 2011 to 2012, President and Chief Operating Officer from 2005 to 2011 and Senior Vice President and Chief Financial Officer from 2002 to 2005. Mr. Tomlinson holds an M.B.A. from Columbia University and a B.A. from the University of St. Thomas.

Rhonda A. Longmore-Grund became Executive Vice President and Chief Financial Officer in March 2016. Ms. Longmore-Grund most recently served as the Senior Vice President and Chief Financial Officer for Printronix, a privately-held global industrial technology design and manufacturing company from November 2009 to February 2016. Previously, Ms. Longmore-Grund held senior management positions at Ingram Micro, Inc., Exult, Inc., Velocium and Digital Equipment Corporation. Ms. Longmore-Grund received a B.A. from the University of Massachusetts at Amherst and an M.A.L.D. from the Fletcher School of Law and Diplomacy at Tufts University.

Richard W. Johns has served as our Chief Operating Officer and Chief Legal Officer since February 2016. Previously, Mr. Johns served as our Executive Vice President, General Counsel and Secretary since February 2012. Mr. Johns has had a legal career spanning over 30 years providing legal services to a variety of healthcare clients based in the U.S. and Europe. From 2010 to 2012, he was General Counsel at LaVie Care Centers, a national long-term care company with revenues in excess of $1 billion annually. From 2009 to 2010, Mr. Johns maintained his own law practice serving various healthcare clients in the U.S. and Europe, and from 1998 to 2008 served as a partner with the internationally recognized firm of Foley & Lardner, where he was instrumental in developing a national healthcare practice. Mr. Johns began his legal career working with various law firms in the Washington, D.C. area and holds a Juris Doctor degree from the University of Southern California.

Richard A. Jones was appointed President of Alliance HealthCare Radiology in June 2012. Previously, Mr. Jones served as Executive Vice President of the Radiology Division since August 2011. He has been with Alliance since 1996, originally serving as Regional Operations Manager, then Vice President of Business Development, then Vice President of Operations for the North zone, then Senior Vice President of the North zone, and then as Senior Vice President of Operations. Before joining Alliance, Mr. Jones held a number of leadership roles in hospitals and the commercial healthcare sector. Mr. Jones holds a Bachelor of Arts degree from Eastern Nazarene College.

Gregory E. Spurlock was appointed President of Alliance Oncology and Alliance HealthCare International in February 2016 and has served as President of Alliance Oncology since April 2013. He initially joined Alliance

Oncology as Chief Administrative Officer in April 2011, as part of the company's acquisition of US Radiosurgery and was later promoted to Senior Vice President of Business Development and Contract Operations in June of 2012. In his current role, Mr. Spurlock oversees all aspects of Alliance Oncology and leads the new International Division overseeing both Oncology and Radiology for operations outside of the U.S. Mr. Spurlock's career has been focused on ancillary services, physician relationships and facility development. Mr. Spurlock joined US Radiosurgery in 2004 and held various executive leadership positions with the company and its affiliates from 2004 until its acquisition by Alliance in 2011, including Chief Operating Officer of US Radiosurgery, Executive Vice President of NeoSpine, and Chief Executive Officer of Imaging One, LLC. Prior to 2004, Mr. Spurlock also held the role of Executive Director at Tennessee Orthopaedic Alliance and at the Kerlan-Jobe Orthopaedic Clinic in Los Angeles.

Steven M. Siwek, M.D. was appointed President of Alliance Interventional in April 2015. Dr. Siwek initially joined Alliance through the February 2015 acquisition of TPC —Arizona's center of excellence for the diagnosis and treatment of chronic pain disorders with 12 locations statewide. As founder and CEO of TPC, Dr. Siwek has focused the last 15 years of his medical career on building programs that set national standards for quality coordinated care in pain management. Dr. Siwek's multi-disciplinary and integrative approach to preventing, treating, and eliminating chronic pain is advancing the way in which interventional and pain management services are accessed and delivered nationwide. Dr. Siwek received his M.D. from the New York Medical College and completed his residency training at the Mayo Clinics in Rochester, Minneapolis, and Scottsdale, Arizona, and fellowship at the Mayo Clinic in Jacksonville, Florida. In addition, Dr. Siwek holds an M.B.A. from the Graziadio School of Business and Management at Pepperdine University.

ITEM 1A. RISK FACTORS

You should carefully consider the risks described below before investing in our publicly-traded securities. If any of these risks actually occurs, our business, financial condition or results of operations will likely suffer. In that event, the trading price of our common stock could decline, and you could lose all or part of your investment. Some of the statements in this Item 1A are "forward-looking statements" within the meaning of the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. See "Cautionary Statement Regarding Forward-looking Statements" on page 1.

We have described the risk factors in the following related groups:

- risks related to government regulation of our business;
- other risks related to our business;
- risks related to our governance and stock exchange listing; and
- risks related to our debt.

Risks Related to Government Regulation of Our Business

Changes in the rates or methods of third-party reimbursements for diagnostic imaging, radiation oncology and interventional services could result in reduced demand for our services or create downward pressure, which could cause our revenues to decline and harm our financial position.

We derived approximately 25%, 20% and 20% of our revenues in 2016, 2015 and 2014, respectively, from direct billings to patients and third-party payers such as Medicare, Medicaid or private health insurance companies. Changes in the rates or methods of reimbursement for the services we provide could have a significant negative effect on those revenues. Moreover, our healthcare provider clients on whom we depend for the majority of our revenues generally rely on reimbursement from third-party payers. If we or our clients receive decreased reimbursements as a result of various governmental efforts to reduce healthcare costs as described in detail in the "Regulation" and "Reimbursement" sections of Item 1, "Business," these decreases could result in a reduced demand for our services or downward pricing pressures, which could have a material adverse effect on our results of operations and financial position.

Complying with federal and state regulations is an expensive and time-consuming process, and any failure to comply could result in substantial penalties.

We are directly or indirectly through our clients subject to extensive regulation by both the federal government and the states in which we conduct our business, including the AKS and similar state anti-kickback laws, the Stark Law and similar state laws affecting physician referrals, the FCA, HIPAA, as amended by the HITECH Act, and similar state laws addressing privacy and security, state unlawful practice of medicine and fee splitting laws, state CON laws, the Medicare and Medicaid statutes and regulations, and requirements for handling biohazardous and radioactive materials and wastes.

Both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of healthcare companies, as well as their executives and managers. These investigations relate to a wide variety of matters, including referral and billing practices. The OIG and the DOJ have, from time to time, established national enforcement initiatives that focus on specific billing practices or other suspected areas of abuse. Some of our activities could become the subject of governmental investigations or inquiries.

If our operations are found to be in violation of any of the laws and regulations to which we or our clients are subject, we may be subject to the applicable penalty associated with the violation, including civil and criminal penalties, damages, fines and the curtailment of our operations. Any penalties, damages, fines or curtailment of our operations, individually or in the aggregate, could adversely affect our ability to operate our business and our financial results. Our risk of being found in violation of these laws and regulations is increased by the fact that many of them have not been fully interpreted by the regulatory authorities or the courts, and their provisions are open to a variety of

interpretations. Any action against us for violation of these laws or regulations, even if we successfully defend against it, could cause us to incur significant legal expenses and divert management's attention from the operation of our business. For a more detailed discussion of the various state and federal regulations to which we are subject, see the "Regulation," "Reimbursement" and "Environmental, Health and Safety Laws" sections in Item 1, "Business."

Federal and state anti-kickback and anti-self-referral laws may adversely affect our operations and income.

Various federal and state laws govern financial arrangements among healthcare providers. The AKS prohibits the knowing and willful offer, payment, solicitation or receipt of any form of remuneration in return for, or to induce, the referral of Medicare, Medicaid or other federal healthcare program patients, or in return for, or to induce, the purchase, lease or order of items or services that are covered by Medicare, Medicaid or other federal healthcare programs. Many state laws also prohibit the solicitation, payment or receipt of remuneration in return for, or to induce, the referral of patients in private as well as government programs. Violation of these laws may result in substantial civil or criminal penalties and/or exclusion from participation in federal or state healthcare programs. We believe that we are operating in compliance with applicable laws and believe that our arrangements with providers would not be found to violate the federal and state anti-kickback laws. However, these laws could be interpreted in a manner that could have an adverse effect on our operations.

The Stark Law prohibits a physician from referring Medicare or Medicaid patients to any entity for certain designated health services (including MRI and other diagnostic imaging services) if the physician has a prohibited financial relationship with that entity, unless an exception applies. Although we believe that our operations do not violate the Stark Law, our activities may be challenged. If a challenge to our activities is successful, it could have an adverse effect on our operations. In addition, legislation may be enacted in the future that further addresses Medicare and Medicaid fraud and abuse or that imposes additional requirements or burdens on us.

A number of states in which we operate have adopted a form of anti-kickback law and/or Stark Law. The scope of these laws and the interpretations of them vary from state to state and are enforced by state courts and regulatory authorities, each with broad discretion. A determination of liability under the laws described in this risk factor could result in fines and penalties and restrictions on our ability to operate in these jurisdictions.

Changes expected under the Trump Administration could adversely affect our operations or limit the prices we can charge for our services or decrease the number of individuals who have health insurance, which would reduce our revenues and harm our operating results.

In addition to extensive existing government healthcare regulation, there have been and continue to be numerous initiatives at the federal and state levels for reforms affecting the payment for and availability of healthcare services, including proposals that would significantly limit reimbursement under the Medicare and Medicaid programs. Limitations on reimbursement amounts and other cost containment pressures have in the past resulted in a decrease in the revenue we receive for each scan we perform, which would reduce our revenues and harm our operating results. For a more detailed discussion of the various state and federal legislation and regulations to which we are subject, see the “Regulation” and “Reimbursement” sections in Item 1, “Business.”

The application or repeal of state certificate of need regulations could harm our business and financial results.

Some states require a CON or similar regulatory approval prior to the acquisition of high-cost capital items, including diagnostic imaging and radiation oncology systems or provision of diagnostic imaging and radiation therapy services by us or our clients. A majority of the 46 states in which we operate require a CON, and more states may adopt similar licensure frameworks in the future. In many cases, a limited number of these certificates are available in a given state. If we are unable to obtain the applicable certificate or approval or additional certificates or approvals necessary to expand our operations, these regulations may limit or preclude our operations in the relevant jurisdictions.

Conversely, states in which we have obtained a CON may repeal existing CON regulations or liberalize exemptions from the regulations. The repeal of CON regulations or defunding of CON programs in states in which we have obtained a CON or CON exemption would lower barriers to entry for competition in those states and could adversely affect our business.

If we fail to comply with various licensure, certification and accreditation standards, we may be subject to loss of licensure, certification or accreditation, which would adversely affect our operations.

All of the states in which we operate require the imaging technologists and radiation therapists who operate systems to be licensed or certified. Also, each of our retail sites must continue to meet various requirements to receive payments from the Medicare program. In addition, we are currently accredited by The Joint Commission, an independent, non-profit organization that accredits various types of healthcare providers such as hospitals, nursing homes and providers of diagnostic imaging services. In the healthcare industry, various types of organizations are accredited to meet certain Medicare certification requirements, expedite third-party payments and fulfill state licensure requirements. Some managed care providers prefer to contract with accredited organizations. Any lapse in our licenses, certifications or accreditations or those of our technologists, or the failure of any of our retail sites to satisfy the necessary requirements under Medicare could adversely affect our operations and financial results.

We cannot predict the full extent of recent legislative changes or changes that may be enacted on our business, and their effects may harm our financial performance and our stockholder value.

Healthcare reform laws enacted since 2010, in particular the PPACA, substantially changed the way healthcare is financed by both governmental and private insurers. For example, certain provisions may negatively affect payment rates for some radiology and oncology services. The PPACA made a number of changes that expanded healthcare coverage and reformed insurance practices, including provisions that provide federal subsidies to help lower-income individuals obtain healthcare coverage through insurance Exchanges and provisions that give states enhanced federal funding to expand their Medicaid programs. A number of states have not expanded their Medicaid programs despite these PPACA incentives, but 31 states and the District of Columbia have expanded their Medicaid programs as of early 2017. Currently, however, President Trump and Republican congressional leaders have expressed an intention to enact new legislation that would repeal and replace PPACA's coverage expansion provisions in a way that curbs federal healthcare spending and increases states' authority to regulate insurance and design their Medicaid programs. How repeal and replacement legislation would be structured and whether it will be enacted are unknown. However, it is possible that such legislation would be enacted that resulted in fewer individuals having health insurance and/or in insured individuals having less generous coverage.

Other legislative changes have been proposed and adopted since the PPACA was enacted. On August 2, 2011, President Obama signed into law the BCA, which, among other things, created the Joint Select Committee on Deficit Reduction to recommend proposals in spending reductions to Congress. The Joint Select Committee did not achieve its targeted deficit reduction of at least $1.2 trillion for the years 2013 through 2021, triggering the legislation's automatic reduction to several government programs. These reductions include aggregate reductions to Medicare payments to providers of up to 2% per fiscal year. The enactment of the ATRA of 2012 on January 2, 2013, delayed the imposition of these automatic cuts until March 1, 2013. On March 1, 2013, the President signed an executive order implementing the automatic reductions. Pursuant to that order, payments to Medicare providers for services furnished on or after April 1, 2013 were reduced by 2%. The impact to our revenue related to this 2% reduction was approximately $0.2 million, $0.3 million and $0.4 million in 2016, 2015 and 2014, respectively. The 2013 Budget Act extended the 2% reduction in payments to Medicare providers by another two years (through 2023), and subsequent legislation extended the cuts through 2024. Unless Congress acts to repeal or revise the automatic budget cuts enacted by the BCA, this payment reduction will continue until 2024. The PAMA also included a new quality incentive payment policy that, beginning January 1, 2016, reduces Medicare payments for certain CT services paid under the PFS or HOPPS that are furnished using equipment that does not meet certain dose optimization and management standards. The full effect of the PPACA, BCA, ATRA and PAMA on our business is uncertain, and it is not clear whether other legislative changes will be adopted or how those changes would affect the demand for our services. It is also unknown whether or how any new regulatory policies related to demonstration projects being developed by the CMS Center for Innovation ("CMMI") or the implementation of PAMA or MACRA will affect demand for, and reimbursement of, our services.

Other Risks Related to Our Business

Our MRI and PET/CT scan volumes may decline in the future, leading to material adverse effects on the demand for our services and/or our future revenues.

The demand for our MRI and PET/CT scan services and volumes are directly linked to authorization rates by insurance companies, sustained unemployment rates, the number of under-insured or uninsured patients, the reported decline in physician office visits, hospitals adding imaging services directly to enhance hospital profitability and other conditions arising from the global economic conditions described below. We believe that demand for MRI and PET/CT scans from our shared-service operations could decline in future periods as a result of these factors. If we are unable to arrest and reverse these declines, our financial performance and condition will suffer.

We experience competition from other radiology and oncology companies and equipment manufacturers, and this competition, as well as overcapacity to meet demand for radiology and oncology services, could adversely affect our revenues and our business.

The market for radiology and oncology services and systems is competitive. In addition to direct competition from other radiology and oncology providers, we compete with independent imaging centers and referring physicians with diagnostic imaging systems in their own offices, as well as with OEMs that aggressively sell or lease imaging or radiation oncology systems to healthcare providers for full-time installation. Some of our competitors may now or in the future have access to greater resources than we do or may be less burdened with debt and contribute to overcapacity to meet the demand for our services. If we are unable to compete successfully with this diverse group of competitors, particularly if overall MRI usage declines, our client base will decline and our business and financial condition will suffer.

Our revenues may fluctuate or be unpredictable, which may adversely affect our financial results.

The amount and timing of revenues that we may derive from our business will fluctuate based on:

- the effects of governmental laws, regulations and reimbursement policies on payments to us and to third-party payers;
- variations in the rate at which our clients renew their contracts with us;
- the extent to which our mobile shared-service clients become full-time clients;
- competitive factors;
- trends in healthcare treatment and reimbursement by government and private insurance;
- overall revenue trends;
- changes in the number of days of service we can offer with respect to a given system due to equipment malfunctions or the seasonal factors discussed below;
- the mix of wholesale and retail billing for our services; and
- the overall U.S. economy and the economy in the particular areas where we provide our services.

In addition, we experience seasonality in the sale of our services. First and fourth quarter revenues are typically lower than those from the second and third quarters. First quarter revenues are affected primarily by inclement weather, typically resulting in fewer patients being scanned or treated during the period. Fourth quarter revenues are affected by holiday and client and patient vacation schedules, resulting in fewer scans or treatments during the period. Due to the fixed nature of our costs, the variability in margins is higher than the variability in revenues. As a result, our revenues may vary significantly from quarter to quarter, and our quarterly results have been and may in the future be below market expectations. We also experience fluctuations in revenues due to general economic conditions, including recession or economic slowdown. We may not be able to reduce our expenses, including our debt service obligations, quickly enough to respond to these declines in revenue, which would make our business difficult to operate and would harm our financial results.

We may be unable to renew or maintain our client contracts, which would harm our business and financial results.

When our clients' contracts with us expire, those clients may cease using our imaging services and purchase or lease their own imaging systems or use our competitors' imaging systems. If our clients do not renew or maintain their contracts as we expect, our business will suffer. It is not always possible to obtain replacement clients quickly. Historically, many replacement clients have been smaller facilities that have a lower number of scans and generate less revenue than the clients we lost. We also run the risk of being unable to renew or maintain our client contracts in our Oncology Division.

Pressure to control healthcare costs could have a negative effect on our results.

One of the principal objectives of managed care organizations, such as health maintenance organizations and preferred provider organizations, is to control the cost of healthcare services. Healthcare providers participating in managed care plans may be influenced to refer patients seeking radiology, oncology or interventional services to certain providers depending on the plan in which a covered patient is enrolled. The expansion of health maintenance organizations, preferred provider organizations and other managed care organizations within the geographic areas we cover could have a negative effect on the utilization and pricing of our services, because these organizations may exert greater control over patients' access to services of the type we offer, the selections of the provider of those services and reimbursement rates for those services.

We may be unable to maintain our imaging and radiation oncology systems effectively or generate revenue when our systems are not working.

Timely, effective service is essential to maintaining our reputation and high utilization rates on our imaging and radiation oncology systems. Repairs to one of our systems can take up to two weeks and result in a loss of revenue.

Our warranties and maintenance contracts do not fully compensate us for loss of revenue when our systems are not working. The principal components of our cost of revenues include: depreciation; amortization; compensation paid to technologists, therapists, drivers and other clinical staff; system maintenance costs; insurance; medical supplies; system transportation; technologists' travel costs; and professional costs related to the delivery of radiation therapy and professional radiology interpretation services. Because the majority of these expenses are fixed, a reduction in the number of scans or treatments performed due to out-of-service equipment will result in lower revenues and margins. Equipment manufacturers repair our equipment, and they may not be able to perform repairs or supply needed parts in a timely manner. Therefore, if we experience greater than anticipated system malfunctions or if we are unable to promptly obtain the service necessary to keep our systems functioning effectively, our revenues could decline and our ability to provide services would be harmed.

Harsh weather conditions may limit our ability to maximize the utilization of our diagnostic imaging and radiation oncology equipment, which may reduce our revenue.

Harsh weather conditions can adversely affect our operations and financial condition. To the extent severe weather patterns affect the regions in which we operate, potential patients may find it difficult to travel to our centers and we may have difficulty moving our mobile systems along their scheduled routes. As a result, we could experience a decrease in equipment utilization, scan volume and revenues during that period.

Natural disasters could adversely affect our business and operations.

Our corporate headquarters is located in California and we currently operate in various geographic regions across 46 states. Consequently, we are subject to varying risks for natural disaster, including drought, hurricanes, blizzards, floods, earthquakes and tornados. Depending on its severity, a natural disaster could damage our facilities and systems or prevent potential patients from traveling to our centers. Damage to our equipment or any interruption in our business would adversely affect our financial condition and could result in the loss of the capital invested in the damaged facilities or systems or anticipated future cash flows from those facilities or systems.

Adverse changes in general domestic and worldwide economic conditions and instability and disruption of credit markets could adversely affect our operating results, financial condition or liquidity.

We are subject to risks arising from adverse changes in general domestic and global economic conditions, including recession or economic slowdown and disruption of credit markets. In recent periods, investor concerns about the U.S. and global economic outlook, including concerns about the level of economic recovery in the U.S., combined with volatile oil prices, increased tax rates and governmental budget deficits and debt levels have contributed to high volatility levels in our business.

As a result of these and other market conditions, the cost and availability of credit have been adversely affected. A continued deterioration of credit markets may adversely affect our liquidity and financial condition and the liquidity and financial condition of our customers. If these market conditions continue or worsen, they may limit our ability to timely access the capital markets to meet liquidity needs, resulting in adverse effects on our financial condition and results of operations.

We may not receive payment from some of our healthcare provider clients because of their financial circumstances.

Some of our healthcare provider clients do not have significant financial resources, liquidity or access to capital. If these clients experience financial difficulties, they may be unable to pay us for the services that we provide. We have experienced, and expect to continue to experience, write-offs of accounts receivable from healthcare provider clients that become insolvent, file for bankruptcy or are otherwise unable to pay amounts owed to us. A significant deterioration in general or local economic conditions could have a material adverse effect on the financial health of some of our healthcare provider clients. As a result, we may have to increase the amounts of accounts receivable that we write-off, which would adversely affect our financial condition and results of operations.

Technological change in our industry could reduce the demand for our services and require us to incur significant costs to upgrade our equipment.

We operate in a competitive, capital intensive and high fixed-cost industry. The development of new technologies or refinements of existing ones might make our existing systems technologically or economically obsolete, or reduce the need or demand for our systems. Numerous companies currently manufacture medical imaging and radiation oncology systems. Competition among manufacturers for a greater share of imaging systems has resulted in and likely will continue to result in technological advances in the speed and imaging capacity of these new systems, including the new ultra-high field MRI systems and 256-slice CT systems. Consequently, the obsolescence of our systems may be

accelerated. In the future, to the extent we are unable to generate sufficient cash from our operations or obtain additional funds through bank financing or the issuance of equity or debt securities, we may be unable to maintain a competitive equipment base. In addition, advancing technology may enable hospitals, physicians or other service providers to perform procedures without the assistance of service providers such as ourselves. As a result, we may not be able to maintain our competitive position in our targeted regions or expand our business.

Because a high percentage of our operating expenses are fixed, a relatively small decrease in revenues could have a significant negative effect on our financial results.

A high percentage of our expenses are fixed, meaning they do not vary significantly with the increase or decrease in revenues. Those expenses include debt service and capital lease payments, rent payments, payroll, maintenance, insurance and vehicle operation costs. As a result, a relatively small reduction in the prices we charge for our services or in our procedure volumes could have a disproportionate negative effect on our financial results.

We may be subject to professional liability risks, which could be costly and could negatively affect our business and financial results.

We may be subject to professional liability claims. There is a risk of harm to a patient during a MRI if the patient has certain types of metal implants or cardiac pacemakers within his or her body. Although patients are screened to safeguard against this risk, screening may nevertheless fail to identify the hazard.

In response to press reports concerning the risk of significant, sometimes fatal, errors in radiation therapy, especially relating to linear radiation, accreditation of facilities and the establishment of a national error reporting database are under consideration. In addition, various trade organizations have called for quality improvement measures and the establishment of the nation's first central database for the reporting of errors involving linear particle accelerators and CT scanners. Federal legislation in these areas is under consideration and a Congressional hearing was held in February 2010. We are not aware of any actions taken after the hearing. In addition, on September 29, 2010, California enacted a law that requires hospitals and clinics to record radiation doses for CT scans, which became effective July 1, 2012, and to report any overdoses to patients, their doctors and the California Department of Public Health. Effective July 1, 2013, the new California law requires all facilities that furnish CT services to be accredited by an organization approved by CMS, the Medical Board of California or the California Department of Public Health. Other states have considered similar legislation and enacted regulations to implement additional record keeping, education, or oversight requirements relate to CT services. We cannot assure you that the cost of complying with any new regulations will not be substantial, that the negative publicity concerning these errors will not adversely affect our business, or that these types of errors will not occur with our services.

We maintain professional liability insurance with coverage that we believe is consistent with industry practice and appropriate in light of the risks attendant to our business. Nevertheless, any claim made against us could be costly to defend against, result in a substantial damage award against us and divert the attention of our management from our operations, which could have an adverse effect on our financial performance. It is also possible that our insurance coverage will not continue to be available at acceptable costs or on favorable terms.

Loss of key executives and failure to attract qualified managers and sales persons could limit our growth and negatively affect our operations.

Our senior management team has extensive experience in our industry. We believe that they are instrumental in guiding our business, instituting valuable performance and quality monitoring, and driving innovation. Accordingly, our future performance is substantially dependent upon the services of our senior management team and our ability to attract talented executives as and when needed. In particular, we depend upon Percy Tomlinson, our Chief Executive Officer, and Division Presidents, for their skills, experience, and knowledge of our company and industry contacts. We do not have key employee insurance policies covering any of our management team. The loss of Mr. Tomlinson and divisional leadership, or other members of our management team could have a material adverse effect on our business, results of operations or financial condition.

We require field managers and sales persons with experience in our industry to operate and sell our services for radiology and oncology. We cannot predict the availability of qualified field managers and sales persons or the compensation levels that will be required to hire and retain them. The loss of the services of any member of our senior management or our inability to hire qualified field managers and sales persons at compensation levels that are economically reasonable to us could adversely affect our ability to operate and grow our business.

Many of the states in which we operate do not enforce agreements that prohibit a former employee from competing with a former employer. As a result, many of our employees whose employment is terminated are free to compete with us, subject to prohibitions on the use of confidential information and, depending on the terms of the employee's employment agreement, on solicitation of existing employees and customers. A former executive, field or sales manager or other key employee who joins one of our competitors could use the relationships he or she established

while our employee and the industry knowledge he or she acquired during that tenure to enhance the new employer's ability to compete with us.

Loss of, and failure to attract, qualified employees, technologists and other clinical staff could limit our growth and negatively affect our operations.

Our future success depends on our continuing ability to identify, hire, develop, motivate and retain highly skilled personnel for all areas of our organization. Competition in our industry for qualified employees is intense. In particular, there is a very high demand for qualified technologists who are necessary to operate our systems, particularly PET/CT technologists. We may not be able to hire and retain a sufficient number of technologists, therapists, physicists and dosimetrists, and we expect that our costs for the salaries and benefits of these employees will continue to increase for the foreseeable future because of the industry's competitive demand for their services. Our continued ability to compete effectively depends on our ability to attract new employees and to retain and motivate our existing employees.

Our PET/CT services and some of our other imaging services require the use of radioactive materials, which could subject us to regulation-related costs and delays and potential liabilities for injuries or violations of environmental, health and safety laws and regulations.

Our PET/CT services and some of our other imaging services require radioactive materials. While these radioactive materials have a short half-life—meaning it quickly breaks down into inert or non-radioactive substances—storage, transportation, use and disposal of these materials present the risk of accidental environmental contamination and physical injury. We are subject to federal, state and local regulations governing storage, transportation, handling and disposal of these materials and waste products. In spite of our safety procedures for storing, transporting, handling and disposing of these hazardous materials, we cannot completely eliminate the risk of accidental contamination or injury from those hazardous materials. We maintain professional liability insurance with coverage that we believe is consistent with industry practice and appropriate in light of the risks attendant to our business. In the event of an accident, however, we could be held liable for any damages that result, and any liability could exceed the limits or fall outside the coverage of our insurance. We may not be able to maintain insurance on acceptable terms or at all. We could incur significant costs and the diversion of our management's attention to comply with current or future environmental, health and safety laws and regulations.

We may not be able to achieve the expected benefits from future acquisitions and investments, which would adversely affect our financial condition and results.

We have historically relied on acquisitions and joint venture investments as methods of expanding our business. In addition, we will consider future acquisitions and investments as opportunities arise and our financial performance permits. If we do not successfully integrate acquisitions, we may not realize anticipated operating advantages and cost savings. The integration of companies that have previously operated separately involves a number of risks, including:

- demands on management related to the increase in our size after an acquisition;
- the diversion of management's attention from the management of daily operations to the integration of operations;
- difficulties in the assimilation and retention of employees;
- potential adverse effects on operating results; and
- challenges in retaining clients.

We may not be able to maintain the levels of operating efficiency that acquired companies have achieved or might achieve separately. Successful integration of each of their operations will depend upon our ability to manage those operations and to eliminate redundant and excess costs. Because of difficulties in combining operations, we may not be able to achieve the cost savings and other size-related benefits that we hoped to achieve after these acquisitions. In addition, if we are not able to successfully manage our relationships with our joint venture partners, our future expansion and revenue growth may be adversely affected

Some acquisitions or joint ventures we undertake in the future may be in regions outside the U.S., such as Asia. In these transactions, we will face additional challenges, such as dealing with different languages and cultures, working with a local partner, and having to address the particular economic, currency, political, and regulatory risks associated with specific countries. If we are unable to obtain the anticipated benefits from acquisitions or joint venture investments, whether within or outside the U.S., our financial condition and operating results may be adversely impacted.

High fuel costs can harm our operations and financial performance.

Fuel costs constitute a significant portion of our mobile operating expenses through diesel fuel for our tractor fleet and mileage reimbursement for our team members. Historically, fuel costs have been subject to wide price fluctuations based on geopolitical issues and supply and demand. Fuel availability is also affected by demand for home heating oil, diesel, gasoline and other petroleum products, as well as overall economic conditions. Because of the effect of these events on the price and availability of fuel, we cannot predict the cost and future availability of fuel with any degree of

certainty. In the event of a fuel supply shortage or further increases in fuel prices, we might be forced to curtail our scheduled mobile services. Sustained high fuel costs will harm our financial condition and results of operations.

Insurance costs and claims expenses could adversely affect our earnings.

The transportation aspect of our business is exposed to costs for claims related to: property damage claims by others; personal injury; damage to our mobile systems resulting from accidents, vandalism or theft; and workers' compensation. We carry insurance to minimize these exposures. Insurance costs have varied over the past five years, reflecting the level of our operations, the insurance environment for our industry, our claim experience and our self-retained (deductible) level.

We are also responsible for claim expenses within our self-retained (deductible) levels for liability and workers' compensation claims. We maintain insurance to cover claims and expense in excess of our deductible levels with insurance companies that we consider financially sound. Although we believe our aggregate insurance limits are sufficient to cover reasonably expected claims, it is possible that one or more claims could exceed those limits and adversely affect our operating results. If the number or severity of claims within our deductible levels increases, or if we are required to accrue or pay additional amounts because the claims prove to be more severe than our original assessment, our operating results would be adversely affected.

Our transportation operations are regulated, and failure to comply or increased costs of compliance with existing or future regulations could have a material adverse effect on our business.

The transportation aspect of our business is subject to legislative and regulatory changes that can affect our operations and financial performance. Our trucking operations and those of the trucking companies and independent contractors with whom we engage are subject to regulation by the Department of Transportation ("DOT"), and various state, local and foreign governmental agencies, which govern such activities as authorization to engage in motor carrier operations, handling of hazardous materials, safety ratings, insurance requirements, vehicle weight and size, and emissions restrictions. We are also periodically audited by the DOT and other state and federal authorities to ensure that we comply with safety, required licenses, hours-of-service, clean truck regulations, and other rules and regulations.

New governmental laws and regulations, or changes to existing laws and regulations, could affect our transportation operations. Any additional measures that may be required by future laws and regulations or changes to existing laws and regulations may require us to make changes to our operating practices and may result in additional costs which, if we are unable to pass through to our clients, could have an adverse effect on our financial performance.

We are vulnerable to system failures, including those that may be related to cyber security attacks, which could harm our business.

We rely on our technology infrastructure to sell our services, interact with customers, and bill, collect, and make payments. Our systems are vulnerable to damage or interruption from natural disasters, power loss, telecommunication failures, terrorist or hacker attacks, computer viruses, and other events. When we upgrade or change systems, we may suffer interruptions in service, loss of data, or reduced functionality. Despite any precautions we may take, such problems could result in improper use of our systems or networks, unauthorized access, use, disclosure, modification or destruction of confidential or other information, fraudulent loss of assets, and interruptions in our services. A cyber-related attack, or other information technology system failure, could have a significant adverse impact on our financial condition or results of operations. A cyber-related attack could also result in other negative consequences, including damage to our reputation or competitiveness, remediation or increased protection costs, litigation or regulatory action.

Risks Related to Our Governance and Stock Exchange Listing

Tahoe beneficially owns the majority of our outstanding shares of common stock and is, therefore, able to exert significant influence over us, including with respect to change of control transactions.

On September 16, 2015, Tahoe agreed to purchase approximately 5,537,945 shares of our common stock from the Selling Stockholders (the "Share Purchase"). The Share Purchase closed on March 29, 2016.

As a result of the Share Purchase, Tahoe beneficially owned an aggregate of approximately 52% of the outstanding shares of our common stock as of December 31, 2016. In connection with the Share Purchase, Tahoe and the Company entered into a governance, voting and standstill agreement, which provides that Tahoe is prohibited, for a period of three years after execution of the agreement, from purchasing any shares of our equity securities without the

approval of the independent directors of our Company not affiliated with Tahoe, subject to a right of Tahoe to acquire additional shares to maintain its 52% ownership. During the three-year period and for so long as Tahoe owns at least 35% of our fully diluted equity securities, Tahoe will have the right to appoint to our board of directors the number of directors necessary to comprise a majority of the board of directors as well as two designees on certain board committees. In the event that Tahoe beneficially owns less than 35% but at least 25% of our outstanding common stock, Tahoe will have the right to nominate three members to our board of directors, and the number of its permitted committee designees will decrease to one. In the event Tahoe beneficially own less than 25% but at least 15% of our outstanding common stock, Tahoe will have the right to nominate one member to our board of directors, and it will lose its right to have any committee designees. Upon completion of the Share Purchase, Tahoe, therefore, has the ability to exert significant influence on our management and operations, and to control the outcome of matters requiring stockholder approval. This concentration of ownership and voting power may have the effect of delaying or preventing a merger, consolidation, sale of assets or other similar transaction that involves a third party. It is possible that the interests of Tahoe may in some circumstances (such as in connection with the Expression of Interest, described below) conflict with our interests or the interests of our other stockholders.

Because of the equity ownership of Tahoe, we are considered a "controlled company" for purposes of the National Association of Securities Dealers Automated Quotations: Global Market ("NASDAQ") listing requirements. As such, we are exempt from the requirement that the majority of our board of directors meet the standards of independence established by the NASDAQ and we are exempt from the requirement that we have a separate Compensation Committee comprised entirely of directors who meet those independence standards. We do not currently intend to rely upon the Compensation Committee exemption available for controlled companies, or, if the Tahoe designees meet the NASDAQ standards of independence, the exemption from having a majority of independent directors. However, we may choose to use the exemption at any time that we remain a controlled company.

If our discussions with our majority owner Tahoe terminate and Tahoe does not complete its proposed acquisition of all of the outstanding share capital of our Company that it does not currently own, our stock price may fall.

On December 12, 2016, we announced we had received a letter describing a non-binding proposal from Tahoe to acquire all of our outstanding common shares that are not currently owned by Tahoe for a purchase price of $9.60 per share in cash (the "Expression of Interest"). Our board of directors authorized a special committee, comprised solely of directors not affiliated with Tahoe, to evaluate the Expression of Interest. The Expression of Interest indicated that any transaction with Tahoe would be subject to approval by the special committee and a non-waiveable condition requiring approval of a majority of our shares not owned by Tahoe or its affiliates. Tahoe also indicated that the proposed transaction would not be subject to a financing condition. The special committee of our board of directors has engaged outside advisors to review the Expression of Interest and assist the committee in responding appropriately on behalf of the minority shareholders. This process is currently ongoing. There can be no assurance that any definitive agreement will be entered into or that the proposed transaction will be consummated. A failure to complete the proposed transaction, and the distraction to management during the process, may materially and adversely affect our stock price and our operating results.

Possible volatility in our stock price could negatively affect us and our stockholders.

The trading price of our common stock has fluctuated significantly in the past. During the period from January 1, 2014 through December 31, 2016, the trading price of our common stock fluctuated from a high of $34.15 per share to a low of $5.77 per share. The price of our common stock could also be subject to wide fluctuations in the future as a result of a number of other factors, including the following:

- changes in expectations as to future financial performance or buy/sell recommendations of securities analysts;
- our, or a competitor's, announcement of new products or services, or significant acquisitions, strategic partnerships, joint ventures or capital commitments;
- the operating and stock price performance of other comparable companies; and
- whether our discussions relating to the Expression of Interest result in a signed and completed deal with Tahoe or other third party.

In addition, the securities markets in the U.S. have experienced significant price and volume fluctuations. These fluctuations often have been unrelated to the operating performance of companies in these markets. Broad market and industry factors may lead to volatility in the price of our common stock, regardless of our operating performance. Moreover, our stock has limited trading volume, and this illiquidity may increase the volatility of our stock price.

In the past, following periods of volatility in the market price of an individual company's securities, securities class action litigation often has been instituted against that company. The institution of similar litigation against us could result in substantial costs and a diversion of management's attention and resources, which could negatively affect our business, results of operations or financial condition.

Provisions of the Delaware General Corporation Law and our organizational documents may discourage an acquisition of us.

Our organizational documents and the General Corporation Law of the State of Delaware both contain provisions that impede the removal of directors and may discourage another party from making a proposal to acquire us, even if such a proposal would be in the best interest of our stockholders. For example, the provisions:

- permit the board of directors to increase its own size and fill the resulting vacancies;
- provide for a board composed of three classes of directors with each class serving a staggered three-year term;
- authorize the issuance of additional shares of preferred stock in one or more series without a stockholder vote; and
- establish an advance notice procedure for stockholder proposals to be brought before an annual meeting of our stockholders, including proposed nominations of persons for election to the board of directors.

Moreover, these provisions can only be amended by the vote of two-thirds or more of our outstanding shares entitled to vote. Furthermore, we are subject to Section 203 of the Delaware General Corporation Law, which could have the effect of delaying or preventing a change in control.

Risks Related to Our Debt

Our substantial debt could restrict our operations and make us more vulnerable to adverse economic conditions.

As of December 31, 2016, we had $573.2 million of outstanding debt, excluding letters of credit, and approximately $24.1 million was available for borrowing under our revolving loan facility. Our substantial debt could have important consequences for our stockholders. For example, it requires us to dedicate a substantial portion of our cash flow from operations to payments on our debt, thereby reducing the availability of our cash flow to fund working capital, capital expenditures and acquisitions and for other general corporate purposes. In addition, our debt could:

- increase our vulnerability to economic downturns and competitive pressures in our industry;
- place us at a competitive disadvantage compared to our competitors that have less debt in relation to cash flow;
- limit our flexibility in planning for, or reacting to, changes in our business and our industry; and
- limit our ability to borrow additional funds on terms that are satisfactory to us or at all.

Our credit agreement contains restrictions on our ability to incur additional debt and engage in business activities and requirements that we maintain specified financial ratios. If we cannot comply with these covenants, we may be in default under these agreements.

Our credit agreement contains affirmative and negative covenants that restrict, among other things, our ability to:

- incur additional debt;
- sell assets;
- create liens or other encumbrances;
- make certain payments and dividends; or
- merge or consolidate.

In addition, the Credit Agreement also contains a leverage ratio covenant requiring the Company to maintain a maximum total debt to Consolidated Adjusted EBITDA expense that ranges from 4.95 to 1.00 to 4.30 to 1.00. For the period ended December 31, 2016, the Credit Agreement requires a maximum leverage ratio of not more than 4.55 to 1.00, decreasing to 4.30 to 1.00 beginning in the quarter ending March 31, 2017. As of December 31, 2016, our ratio of consolidated total debt to Consolidated Adjusted EBITDA calculated pursuant to the Credit Agreement was 4.03 to 1.00.

All of these restrictions could affect our ability to operate our business and may limit our ability to take advantage of potential business opportunities as they arise. A failure to comply with these covenants and restrictions would permit the relevant creditors to declare all amounts borrowed under the relevant borrowing, together with accrued interest and fees, to be immediately due and payable. If the debt under the credit facility is accelerated, we may not have sufficient assets to repay amounts due under the credit facility or on other debt then outstanding. If we are unable to refinance our debt, we could become subject to bankruptcy proceedings, and you may lose all or a portion of your investment because of the priority of the claims of certain of our creditors on our assets.

If there is a default under the agreements governing our material debt, the value of our assets may not be sufficient to repay our creditors.

Our property and equipment, which make up a significant portion of our tangible assets, had a net book value of $204.8 million and $177.2 million as of December 31, 2016 and 2015, respectively. The book value of these assets should not be relied on as a measure of realizable value for such assets. The realizable value may be lower than net book value. The value of our assets in the event of liquidation will depend upon market and economic conditions, the availability of buyers and similar factors. A sale of these assets in a bankruptcy or similar proceeding would likely be made under duress, which would reduce the amounts recovered. Furthermore, such a sale could occur when other companies in our industry also are distressed, which might increase the supply of similar assets and further reduce the amounts that could be recovered. Our goodwill and other intangible assets had a net book value of $318.1 million and $265.7 million as of December 31, 2016 and 2015, respectively. These assets primarily consist of the excess of the acquisition cost over the fair market value of the net assets acquired in purchase transactions, customer contracts and costs to obtain certificates of need. The value of goodwill and other intangible assets will continue to depend significantly upon the success of our business as a going concern and the growth in future cash flows. As a result, in the event of a default under the agreements governing our material debt or any bankruptcy or dissolution, the realizable value of these assets will likely be substantially lower and may be insufficient to satisfy the claims of our creditors.

The financial condition of our assets will likely deteriorate during any period of financial distress preceding a sale of our assets. In addition, much of our assets consist of illiquid assets that may have to be sold at a substantial discount in an insolvency situation. Accordingly, the proceeds of any such sale of our assets may not be sufficient to satisfy, and may be substantially less than, amounts due to our creditors.

Despite current debt levels, we and our subsidiaries may still be able to incur substantially more debt, which could increase the risks described above.

We and our subsidiaries may be able to incur substantial additional debt in the future. The terms of our credit agreement permit us or our subsidiaries to incur additional debt, subject to certain restrictions. In addition, as of December 31, 2016, our credit facility permitted additional borrowings of up to approximately $24.1 million under our revolving loan facility subject to the covenants contained in our credit facility. If we add new debt to our or our subsidiaries' current debt levels, the risks discussed above could intensify.

If we are unable to generate or borrow sufficient cash to make payments on our debt or to refinance our debt on acceptable terms when it matures, our financial condition would be materially harmed, our business could fail and you may lose all of your investment.

Our ability to make scheduled payments on or to refinance our obligations at maturity will depend on our financial and operating performance, which will be affected by economic, financial, competitive, business and other factors, some of which are beyond our control. As a result of global market and economic conditions, such as occurred during the recent global financial crisis, the cost and availability of credit and equity capital may be severely affected. We cannot assure you that our business will generate sufficient cash flow from operations or that future borrowings will be available to us in an amount sufficient to enable us to service our debt or to fund our other liquidity needs. If we are unable to meet our debt obligations or fund our other liquidity needs, we may need to restructure or refinance all or a portion of our debt on or before maturity or sell certain of our assets. We cannot assure you that we will be able to restructure or refinance any of our debt on commercially reasonable terms, if at all, which could cause us to default on our debt obligations and impair our liquidity. 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.

Increases in interest rates could adversely affect our financial condition.

An increase in prevailing interest rates would have an effect on the interest rates charged on our variable-rate debt, which rise and fall upon changes in interest rates. As of December 31, 2016, approximately $533.9 million of our debt was at variable interest rates. If prevailing interest rates or other factors result in higher interest rates, the increased interest expense would adversely affect our cash flow and our ability to service our debt. If interest rates are higher when our debt becomes due, we may be forced to borrow at the higher rates.

As a protection against rising interest rates, we may enter into agreements such as interest rate swaps, caps, floors and other interest rate exchange contracts. These agreements, however, carry the risks that the other parties to the agreements may not perform or that the agreements could be unenforceable.

ITEM 1B. UNRESOLVED STAFF COMMENTS

Not applicable.

ITEM 2. PROPERTIES

We lease approximately 40,596 square feet of space in Newport Beach, California for our executive and principal administrative offices. We lease 13,396 square feet of space in Nashville, Tennessee for our Alliance Oncology executive and administrative offices. We also lease 19,979 square feet of space in Canton, Ohio for our retail billing and scheduling operations. We lease 16,243 square feet of space for a large regional office in Andover, Massachusetts, in addition to other small regional offices we lease throughout the country. We also lease a 11,200 square foot operations warehouse in Fontana, California and a 9,000 square foot operations warehouse in Childs, Pennsylvania, which are used for the Radiology Division.

ITEM 3. LEGAL PROCEEDINGS

From time to time we are involved in routine litigation and regulatory matters incidental to the conduct of our business. We believe that resolution of such matters will not have a material adverse effect on our consolidated results of operations or financial position.

In November 2015, we were served with a lawsuit in the U.S. District Court for the Northern District of Ohio by Todd S. Elwert, DC, Inc. The Complaint alleges violations of the Junk Fax Prevention Act for allegedly sending an unsolicited advertisement to Plaintiff, which promoted commercial availability and/or quality of our services. The Plaintiff further alleges that it is part of a class of similarly situated chiropractors who received the blast fax, and as such, requested class certification. We filed our response on December 17, 2015 and are currently in the discovery phase of the lawsuit.

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

Our common stock is traded on the NASDAQ Global Market under the symbol "AIQ." The following table sets forth, for the periods indicated, the high and low sales prices of our common stock as reported on the NASDAQ Global Market.

	2016		2015	
	High	Low	High	Low
First quarter	$8.80	$6.51	$25.33	$19.76
Second quarter	$7.83	$5.90	$24.49	$17.83
Third quarter	$6.88	$5.77	$19.04	$9.00
Fourth quarter	$9.60	$6.94	$10.92	$6.73

Holders

As of March 1, 2017, there were 12 stockholders of record of our common stock.

We have never paid any cash dividends on our common stock and have no current plans to do so. We intend to retain available cash to operate our business, including capital expenditures, future acquisitions and debt repayment. Our credit agreement restricts the payment of cash dividends on our common stock. See the "Liquidity and Capital Resources" section in Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

SECURITIES AUTHORIZED FOR ISSUANCE UNDER EQUITY COMPENSATION PLANS

Our stockholders have previously approved all stock option plans under which our common stock is reserved for issuance. The following table provides summary information as of December 31, 2016 for all of our stock option plans:

	Number of shares of common stock to be issued upon exercise of outstanding options	Weighted average exercise price of outstanding options	Number of shares of common stock remaining available for future issuance (excluding shares reflected in column 1)
Stock option plans approved by shareholders	650,969	$ 18.51	947,886
Stock option plans not approved by shareholders	—	—	—
	650,969	$ 18.51	947,886

31

STOCK PERFORMANCE GRAPH

The following graph sets forth the cumulative return on our common stock from December 31, 2011 through December 31, 2016, as compared to the cumulative return of the S&P 500 Index and the cumulative return of the S&P Health Care Index. The graph assumes that $100 was invested on December 31, 2011 in each of (1) our common stock, (2) the S&P 500 Index and (3) the S&P Health Care Index and that all dividends (if applicable) were reinvested.

	12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015	12/31/2016
Alliance HealthCare Services, Inc.	$ 100.00	$ 101.27	$ 392.70	$ 333.17	$ 145.71	$ 152.38
S&P 500	$ 100.00	$ 116.00	$ 153.57	$ 174.60	$ 177.01	$ 198.18
S&P Health Care Index	$ 100.00	$ 117.89	$ 166.76	$ 209.02	$ 223.42	$ 217.41

This graph and the accompanying text are not “soliciting material,” are not deemed filed with the SEC and are not to be incorporated by reference in any filing by us under the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended, whether made before or after the date hereof and irrespective of any general incorporation language in any such filing.

ITEM 6. SELECTED FINANCIAL DATA

The selected consolidated financial data shown below has been taken or derived from the audited consolidated financial statements of the Company and should be read in conjunction with Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" and our consolidated financial statements and related notes included in this Annual Report on Form 10-K. We acquired various businesses in each of the years presented that affect the comparability of financial data presented. See details in Note 3 of "Notes to Consolidated Financial Statements" included in this Report beginning on page F-7.

	Year Ended December 31,				
(in thousands except per share data)	2016	2015	2014	2013	2012
Consolidated Statements of Operations Data:					
Revenues	$505,549	$473,054	$436,387	$448,831	$472,258
Costs and expenses:					
Cost of revenues, excluding depreciation and amortization	285,746	269,104	237,420	239,397	253,225
Selling, general and administrative expenses	96,663	88,471	79,903	80,215	76,022
Transaction costs	1,886	3,296	2,344	465	994
Shareholder transaction costs	4,219	1,853	—	—	—
Severance and related costs	3,910	1,347	2,517	1,658	2,226
Impairment charges	632	6,817	308	13,031	—
Loss on extinguishment of debt	—	—	—	26,018	—
Depreciation expense	54,972	48,595	54,971	66,319	79,333
Amortization expense	10,561	9,325	7,880	10,973	15,861
Interest expense, net	34,506	26,241	24,693	39,170	54,101
Other (income) expense, net	(6,586)	(12,255)	(1,823)	(1,945)	3,036
Total costs and expenses	486,509	442,794	408,213	475,301	484,798
Income (loss) before income taxes, earnings from unconsolidated investees and noncontrolling interest	19,040	30,260	28,174	(26,470)	(12,540)
Income tax expense (benefit)	2,852	6,536	7,327	(12,398)	(6,710)
Earnings from unconsolidated investees	(1,290)	(3,391)	(4,654)	(5,630)	(4,667)
Net income (loss)	17,478	27,115	25,501	(8,442)	(1,163)
Less: Net income attributable to noncontrolling interest	(16,985)	(20,373)	(14,883)	(13,041)	(10,775)
Net income (loss) attributable to Alliance HealthCare Services, Inc.	$493	$6,742	$10,618	$(21,483)	$(11,938)
Income (loss) per common share attributable to Alliance HealthCare Services, Inc.:					
Basic	$0.05	$0.63	$1.00	$(2.02)	$(1.12)
Diluted	$0.04	$0.62	$0.98	$(2.02)	$(1.12)
Weighted average number of shares of common stock and common stock equivalents:					
Basic	10,866	10,741	10,669	10,634	10,624
Diluted	10,959	10,849	10,836	10,634	10,624
Consolidated Balance Sheets Data (at end of period):					

Cash and cash equivalents	$22,241	$38,070	$33,033	$34,702	$39,977
Total assets[(1)]	659,864	603,660	457,795	439,988	508,143
Long-term debt, including current maturities[(1)]	548,745	571,091	499,170	519,801	542,138
Stockholders' deficit	(9,503)	(77,620)	(122,524)	(147,661)	(127,337)

(1) Total assets and long-term debt, including current maturities, have been retroactively adjusted to reflect the impact of accounting pronouncements adopted on January 1, 2016. See Note 2 in "Notes to Consolidated Financial Statements" included in this Report beginning on page F-7.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Overview

We are a leading national provider of outsourced and joint venture healthcare services to hospitals and providers. We also operate freestanding outpatient radiology, oncology and interventional clinics, and Ambulatory Surgical Centers ("ASC") that are not owned by hospitals or providers. Our diagnostic imaging services are delivered through our Radiology Division (Alliance Radiology), oncology services through our Oncology Division (Alliance Oncology), and interventional and pain management services through our Interventional Division (Alliance Interventional). We are the nation's largest provider of advanced diagnostic mobile imaging services, an industry-leading operator of fixed-site radiology centers, and a leading provider of stereotactic radiosurgery ("SRS") nationwide. As of December 31, 2016, we operated 625 diagnostic imaging and radiation therapy systems, including 113 fixed-site radiology centers across the country, and 33 radiation therapy centers and SRS facilities. With a strategy of partnering with hospitals, health systems and physician practices, we provide quality healthcare services for over 1,100 hospitals and healthcare partners in 46 states, where approximately 2,450 Alliance Team Members are committed to providing exceptional patient care and exceeding customer expectations. We were incorporated in the state of Delaware on May 27, 1987.

Service Overview

- Radiology Division: We provide a full continuum of diagnostic imaging capabilities through service line management to hospitals and provider groups in both fixed-site and mobile settings. In a mobile setting, we provide mobile imaging systems to hospitals and provider groups under outsourced services contracts that generally average 3 years in length. In a fixed-setting, our imaging systems and staff can be located in a single-modality, fixed-site facility or parked mobile facility either onsite or near a hospital, physician practice or clinic. In addition, we provide full-service, multi-modality radiology center management known as Alliance RAD360™. Through our RAD360™ offering, we provide comprehensive management of the radiology center operations including sales and marketing support, patient scheduling and pre-authorization, billing and payer management, systems, equipment maintenance and upgrades, clinical staffing, and overall management of day-to-day services of the center. Single-modality, fixed-site contracts typically average 5 years in length. RAD360™ sites are generally joint venture relationships which often average 10 to 20 years in length with evergreen renewal cycles.
- Oncology Division: We provide a wide range of radiation oncology services and ancillary services for cancer patients, including: planning and preparation for treatment, simulation of treatment, delivery of radiation therapy, therapy management, and follow-up care. We offer various treatment options, including conventional beam therapy using linear accelerator ("Linac") as well as SRS. We partner directly with hospitals, physicians, and other healthcare providers to offer a full suite of services in cancer care including access to the latest radiation oncology technologies, full management of our partner's cancer care programs including clinical staffing, access to our national network of physicists for training and development on new treatment protocols and technologies, market analysis, equipment and capital, pre-authorization and billing, marketing and sales, and operational management.
- Interventional Division: We provide comprehensive pain management services for a wide range of conditions and diseases through therapeutic, minimally invasive procedures to treat and ease pain, medication, laboratory testing, and other services. All of our pain management services are performed either at an outpatient clinic setting or at an ASC, as determined by the treating physician. Our services also include clinical management, pharmaceutical referrals, functional restoration and other treatments that assist with chronic and acute pain care.

We currently operate in three reportable business segments: Radiology, Oncology and Interventional. The following table summarizes our revenues by segment as a percentage of total revenue.

	Year ended December 31,		
	2016	2015	2014

Segment revenue as a percentage of total revenue:						
Radiology	70	%	72	%	79	%
Oncology	21	%	21	%	21	%
Interventional	9	%	7	%	—	%
Total	100	%	100	%	100	%

For additional information on reportable business segments, see Note 17 of “Notes to Consolidated Financial Statements” included in this Report beginning on page F-7.

Our clients and partners contract with us to provide radiology, oncology and interventional services to:

- take advantage of our extensive radiology, oncology and interventional service lines management experience;
- partner with a leader whose core competency is high quality, efficient and scalable services in the areas of radiology, interventional and oncology services;
- eliminate the need to recruit, train and manage qualified technologists or therapists;
- leverage our extensive physician marketing capabilities to grow market share;
- access our full suite of ancillary services, such as scheduling and call center management, pre-authorization and billing to manage the service line;
- mitigate capital investment, financial risk and contracting for maintenance associated with the purchase of their own systems;
- leverage our platform to gain access to radiology, oncology, interventional and other services for their patients when the demand for these services may not justify the purchase of dedicated, full-time systems and infrastructure; and
- gain access to services under our regulatory and licensing approvals when they do not have these approvals.

Factors Affecting Our Results of Operations

Pricing

Continued expansion of health maintenance organizations, preferred provider organizations and other managed care organizations have influence over the pricing of our services because these organizations can exert great control over patients' access to our services and reimbursement rates for accessing those services.

Cost of revenues

The principal components of our cost of revenues include: compensation paid to technologists, therapists, drivers and other clinical staff; system maintenance costs; insurance; medical supplies; system transportation; team members' travel costs; and professional costs related to the delivery of radiation therapy and professional radiology interpretation services. Because a majority of these expenses are fixed, increased revenues as a result of higher scan and treatment volumes per system significantly improves our margins while lower scan and treatment volumes result in lower margins.

Selling, general and administrative expenses

The principal components of selling, general and administrative expenses are sales and marketing costs, corporate overhead costs, provision for doubtful accounts and share-based payment.

Net income attributable to noncontrolling interest and Earnings from unconsolidated subsidiaries

We record net income attributable to noncontrolling interest and earnings from unconsolidated investees related to our consolidated and unconsolidated subsidiaries, respectively. These subsidiaries primarily provide shared-service and fixed-site diagnostic imaging, radiation therapy, and interventional services.

Third-party payer reimbursement rates and policies

We experience seasonality in the revenues and margins generated for our services. First and fourth quarter revenues are typically lower than those from the second and third quarters. First quarter revenue is affected primarily by fewer calendar days and inclement weather, typically resulting in fewer patients being scanned or treated during the period. Fourth quarter revenues are affected by holiday and client and patient vacation schedules, resulting in fewer scans or treatments during the period. The variability in margins is higher than the variability in revenues due to the fixed nature of our costs. We also experience fluctuations in our revenues and margins due to acquisition activity and general economic conditions, including recession or economic slowdown.

35

Results of Operations

The following table shows our consolidated statements of income for each of the years ended December 31:

	2016		2015		2014	
(dollars in thousands)	Amount	% of Revenue	Amount	% of Revenue	Amount	% of Revenue
Revenues	$505,549	100.0 %	$473,054	100.0 %	$436,387	100.0 %
Costs and expenses:						
Cost of revenues, excluding depreciation and amortization	285,746	56.5 %	269,104	56.9 %	237,420	54.4 %
Selling, general and administrative expenses	96,663	19.1 %	88,471	18.7 %	79,903	18.3 %
Transaction costs	1,886	0.4 %	3,296	0.7 %	2,344	0.5 %
Shareholder transaction costs	4,219	0.8 %	1,853	0.4 %	—	— %
Severance and related costs	3,910	0.8 %	1,347	0.3 %	2,517	0.6 %
Impairment charges	632	0.1 %	6,817	1.4 %	308	0.1 %
Depreciation expense	54,972	10.9 %	48,595	10.3 %	54,971	12.6 %
Amortization expense	10,561	2.1 %	9,325	2.0 %	7,880	1.8 %
Interest expense, net	34,506	6.8 %	26,241	5.5 %	24,693	5.7 %
Other income, net	(6,586)	(1.3)%	(12,255)	(2.6)%	(1,823)	(0.4)%
Total costs and expenses	486,509	96.2 %	442,794	93.6 %	408,213	93.5 %
Income before income taxes, earnings from unconsolidated investees, and noncontrolling interest	19,040	3.8 %	30,260	6.4 %	28,174	