Acadia Healthcare Company, Inc.
Form 424B5
June 10, 2014
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The information in this preliminary prospectus supplement is not complete and may be changed. This preliminary prospectus supplement and the accompanying prospectus are not an offer to sell, and we are not soliciting an offer to buy, these securities in any state where the offer or sale is not permitted.

Filed Pursuant to Rule 424 (b) (5) and 424 (b) (7)
Registration No. 333-196611

Subject to Completion

Preliminary Prospectus Supplement dated June 9, 2014

PROSPECTUS SUPPLEMENT

(To prospectus dated June 9, 2014)

$340,000,000

Acadia Healthcare Company, Inc.

Common Stock

We are selling $340,000,000 of our common stock.

Our shares trade on The NASDAQ Global Market under the symbol ACHC. On June 6, 2014, the last reported sale price of our common stock on The NASDAQ Global Market was $46.29 per share.

Investing in shares of our common stock involves substantial risks that are described in the Risk Factors sections beginning on page S-12 of this prospectus supplement and in our Annual Report on Form 10-K for the year ended December 31, 2013, which we have filed with the Securities and Exchange Commission and which is incorporated by reference in this prospectus supplement and the accompanying prospectus.

	Per Share	Total
Public offering price	$	$
Underwriting discount	$	$
Proceeds, before expenses, to us	$	$

The underwriters may also exercise their option to purchase up to an additional $51,000,000 of our common stock at the public offering price, less the underwriting discount, for 30 days after the date of this prospectus supplement. The option to purchase these additional shares may be granted by the selling stockholders. We will not receive any of the proceeds from the sale of shares of our common stock by the selling stockholders. See Selling Stockholders beginning on page S-58 of this prospectus supplement. To the extent any of the selling stockholders elect not to grant the underwriters an option to purchase some or all of these additional shares, the Company will grant the underwriters an option to purchase such additional shares.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or determined if this prospectus supplement or the accompanying prospectus is truthful or complete. Any representation to the contrary is a criminal offense.

The shares will be ready for delivery on or about , 2014.

Joint Book-Running Managers

BofA Merrill Lynch **Jefferies** **Citigroup**

Co-Managers

Raymond James **RBC Capital Markets**

Avondale Partners **Baird** **BMO Capital Markets**

The date of this prospectus supplement is , 2014.

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ABOUT THIS PROSPECTUS SUPPLEMENT

This prospectus supplement is a supplement to the accompanying prospectus. This prospectus supplement and the accompanying prospectus are part of a registration statement that we filed with the Securities and Exchange Commission, or SEC, utilizing a shelf registration process. Under this shelf registration process, we and selling stockholders may sell from time to time the securities described in the accompanying prospectus in one or more offerings such as this offering. This prospectus supplement provides you with specific information about our common stock that we and the selling stockholders are selling in this offering. Both this prospectus supplement and the accompanying prospectus include important information about us, the selling stockholders and other information you should know before investing. This prospectus supplement also adds to, updates and changes information contained in the accompanying prospectus. To the extent the information in this prospectus supplement is different from that in the accompanying prospectus, you should rely on the information in this prospectus supplement. You should read both this prospectus supplement and the accompanying prospectus, together with the additional information described in the sections entitled Where You Can Find More Information and Incorporation of Certain Documents by Reference of this prospectus supplement, before investing in our common stock.

We have not, and the selling stockholders and the underwriters have not, authorized any person to provide you with any information other than that contained in or incorporated by reference into this prospectus supplement and the accompanying prospectus or that is contained in any free writing prospectus issued by or on behalf of us or to which we have referred you. Neither we nor the selling stockholders nor the underwriters take any responsibility for, and can provide no assurances as to the reliability of, any other information that others may give to you. This prospectus supplement, the accompanying prospectus and any applicable free writing prospectus is not an offer to sell, nor is it seeking an offer to buy, these securities in any state where the offer or sale is not permitted. The information in this prospectus supplement and the accompanying prospectus is complete and accurate as of the date on the front cover of this prospectus supplement, but the information and our business, cash flows, condition (financial and otherwise), liquidity, prospects and results of operations may have changed since that date.

You should not consider any information in this prospectus supplement or the accompanying prospectus to be investment, legal or tax advice. You should consult your own counsel, accountants and other advisers for legal, tax, business, financial and related advice regarding the purchase of shares of our common stock.

SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS

This prospectus supplement and the accompanying prospectus contain and incorporate by reference forward-looking statements. Forward-looking statements include any statements that address future results or occurrences. In some cases you can identify forward-looking statements by terminology such as may, might, will, would, should, could or the negative thereof. Generally, the words anticipate, be continue, expect, intend, estimate, project, plan and similar expressions identify forward-looking statements. In particular, statements abo expectations, beliefs, plans, objectives, assumptions or future events or performance contain forward-looking statements.

We have based these forward-looking statements on our current expectations, assumptions, estimates and projections. While we believe these expectations, assumptions, estimates and projections are reasonable, such forward-looking statements are only predictions and involve known and unknown risks, uncertainties and other factors, many of which are outside of our control, which could cause our actual results, performance or achievements to differ materially from any results, performance or achievements expressed or implied by such forward-looking statements. These risks, uncertainties and other factors include, but are not limited to:

- our ability to close our planned acquisition of Partnerships in Care in a timely manner or at all;
- our ability to obtain the necessary financing for the Partnerships in Care acquisition on anticipated terms or at all;

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our ability to amend our existing senior secured credit facility on time, on currently anticipated terms, or at all;

our significant indebtedness, our ability to meet our debt obligations, and our ability to incur substantially more debt;

difficulties in successfully integrating the operations of acquired facilities, including those acquired in the Partnerships in Care acquisition, or realizing the potential benefits and synergies of these acquisitions;

our ability to implement our business strategies in the United Kingdom and adapt to the regulatory and business environment in the United Kingdom;

the impact of payments received from the government and third-party payors on our revenues and results of operations, including the significant dependence of the Partnerships in Care facilities on payments received from the National Health Service in the United Kingdom, or NHS;

negative media coverage relating to patient incidents, which could adversely affect the price of our securities and result in incremental regulatory burdens and governmental investigations;

our future cash flow and earnings;

our restrictive covenants, which may restrict our business and financing activities;

our ability to make payments on our financing arrangements;

the impact of the economic and employment conditions in the United States and the United Kingdom on our business and future results of operations;

compliance with laws and government regulations;

the impact of claims brought against our facilities;

the impact of governmental investigations, regulatory actions and whistleblower lawsuits;

the impact of healthcare reform in the United States and abroad;

the impact of our highly competitive industry on patient volumes;

our ability to recruit and retain quality psychiatrists and other physicians;

the impact of competition for staffing on our labor costs and profitability;

our dependence on key management personnel, key executives and local facility management personnel;

our acquisition strategy, which exposes us to a variety of operational and financial risks, as well as legal and regulatory risks (e.g., exposure to the new regulatory regimes such as the United Kingdom for Partnerships in Care);

the impact of state efforts to regulate the construction or expansion of healthcare facilities (including those from Partnerships in Care) on our ability to operate and expand our operations;

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our potential inability to extend leases at expiration;

the impact of controls designed to reduce inpatient services on our revenues;

the impact of different interpretations of accounting principles on our results of operations or financial condition;

the impact of environmental, health and safety laws and regulations, especially in states where we have concentrated operations;

the impact of an increase in uninsured and underinsured patients or the deterioration in the collectability of the accounts of such patients on our results of operations;

the risk of a cyber-security incident and any resulting violation of laws and regulations regarding information privacy or other negative impact;

the impact of laws and regulations relating to privacy and security of patient health information and standards for electronic transactions;

the impact of a change in the mix of our earnings, and changes in tax rates and laws generally;

failure to maintain effective internal control over financial reporting;

the impact of fluctuations in our operating results, quarter to quarter earnings and other factors on the price of our securities;

the impact of our sponsor s rights over certain company matters;

the impact of the trend for insurance companies and managed care organizations to enter into sole source contracts on our ability to obtain patients; and

the other risks described under the heading Risk Factors in this prospectus supplement and the accompanying prospectus and in similarly titled sections in our other reports that we file with the SEC that are incorporated by reference into this prospectus supplement and the accompanying prospectus.

This list of risks and uncertainties, however, is only a summary of some of the most important factors and is not intended to be exhaustive. Given these risks and uncertainties, you are cautioned not to place undue reliance on such forward-looking statements. These risks and uncertainties may cause our actual future results to be materially different than those expressed in our forward-looking statements. These forward-looking statements are made only as of the date of this prospectus supplement. Except as otherwise required by applicable law, we do not undertake and expressly disclaim any obligation to update any such statements or to publicly announce the results of any revisions to any such statements to reflect future events or developments. All subsequent written and oral forward-looking statements attributable to us, or to persons acting on our behalf, are expressly qualified in their entirety by these cautionary statements.

CAUTIONARY NOTE REGARDING FINANCIAL INFORMATION

The audited consolidated financial statements as of and for the financial years ended December 31, 2013, 2012 and 2011 relating to Partnerships in Care that are included in, or incorporated by reference into, this prospectus supplement have been prepared in accordance with United Kingdom Accounting Standards, or U.K. GAAP. U.K. GAAP differs in certain respects from generally accepted accounting principles in the United States, or U.S. GAAP. Partnerships in Care has not prepared and does not currently intend to prepare its financial

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statements in U.S. GAAP. A reconciliation to U.S. GAAP is included in the Partnerships in Care financial statements.

This prospectus supplement contains and incorporates by reference certain unaudited information, including revenue and operating statistics based on revenue, that is presented on a pro forma basis assuming that the Partnerships in Care acquisition, and acquisitions occurred as of January 1, 2013. The unaudited pro forma financial information has been prepared using the acquisition method of accounting for business combinations under GAAP. The unaudited pro forma financial information is for illustrative purposes only and does not purport to represent what our financial condition or results of operations actually would have been had the events in fact occurred on the assumed date or to project our financial condition or results of operations for any future date or future period. The unaudited pro forma financial information should be read in conjunction with the consolidated financial statements and notes thereto elsewhere in this prospectus supplement and the financial statements of Acadia in other reports that we have filed with the SEC.

MARKET AND INDUSTRY DATA

We obtained the market and competitive position data used throughout this prospectus supplement and in the documents incorporated by reference herein from our own research, surveys or studies conducted by third parties and industry or general publications. Such surveys, studies and publications generally state that they have obtained information from sources believed to be reliable, but do not guarantee the accuracy and completeness of such information. While we believe that each of these studies and publications is reliable, we have not independently verified the information, and we have not ascertained the underlying economic assumptions relied upon therein, and we do not make any representation as to the accuracy of such information. Similarly, we believe our internal research is reliable, but it has not been verified by any independent sources. Our estimates involve risks and uncertainties, and are subject to change based on various factors, including those discussed under the heading Risk Factors in this prospectus supplement and in similarly titled sections in our other reports that we file with the SEC.

TRADEMARKS AND TRADE NAMES

This prospectus supplement includes our trademarks, which are protected under applicable intellectual property laws and are the property of Acadia Healthcare Company, Inc. or its subsidiaries. This prospectus supplement also contains trademarks, service marks, trade names and copyrights of other companies, which are the property of their respective owners. Solely for convenience, trademarks and trade names referred to in this prospectus supplement may appear without the ® or TM symbols, but such references are not intended to indicate, in any way, that we will not assert, to the fullest extent under applicable law, our rights or the right of the applicable licensor to these trademarks and trade names.

NON-GAAP FINANCIAL MEASURES

We have included certain financial measures in this prospectus supplement, including pro forma EBITDA and pro forma adjusted EBITDA, which are non-GAAP financial measures as defined under the rules and regulations promulgated by the SEC. We define pro forma EBITDA as pro forma net income (loss) adjusted for loss (income) from discontinued operations, net interest expense, income tax provision (benefit) and depreciation and amortization. We define pro forma adjusted EBITDA as pro forma EBITDA adjusted for equity-based compensation expense, cost savings / synergies, rate increases, integration and closing costs, rent elimination, other and debt extinguishment costs. For a reconciliation of pro forma net income (loss) to pro forma adjusted EBITDA, see Prospectus Supplement Summary Summary Historical Condensed Consolidated Financial Data and Unaudited Pro Forma Condensed Combined Financial Data Summary Unaudited Pro Forma Condensed Combined Financial Data.

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Pro forma EBITDA and pro forma adjusted EBITDA, as presented in this prospectus supplement, are supplemental measures of our performance and are not required by, or presented in accordance with, GAAP. Pro forma EBITDA and pro forma adjusted EBITDA are not measures of our financial performance under GAAP and should not be considered as alternatives to net income or any other performance measures derived in accordance with GAAP or as an alternative to cash flow from operating activities as measures of our liquidity. Our measurements of pro forma EBITDA and pro forma adjusted EBITDA may not be calculated similarly to, and therefore may not be comparable to, similarly titled measures of other companies and are not measures of performance calculated in accordance with GAAP. We have included information concerning pro forma EBITDA and pro forma adjusted EBITDA in this prospectus supplement because we believe that such information is used by certain investors as measures of a company s historical performance and by securities analysts, investors and other interested parties in the evaluation of issuers of equity securities, many of which present EBITDA and adjusted EBITDA when reporting their results. Our presentation of pro forma EBITDA and pro forma adjusted EBITDA should not be construed as an inference that our future results will be unaffected by unusual or non-recurring items.

CURRENCY EXCHANGE RATE

This prospectus supplement contains translations amounts denominated in British Pounds Sterling into U.S. dollars at specific rates solely for the convenience of the potential investor. Unless otherwise noted, all translations from British pounds to U.S. dollars and from U.S. dollars to British pounds in this prospectus supplement were made at a rate of (£0.5972) British Pound Sterling for one ($1.00) U.S. Dollar or U.S. $1.6744 for one (£1) British Pound Sterling, the exchange rate set forth in the Federal Reserve Statistical Release, Foreign Exchange Rates on June 3, 2014. Certain financial information for Partnerships in Care presented herein are translated to U.S. dollars based on the historical exchange rates set forth in the financial statements of Partnerships in Care appearing in this Prospectus Supplement. We make no representation that any amounts denominated in either British Pounds Sterling or U.S. dollars could have been, or could be, converted into either British Pounds Sterling or U.S. dollars, as applicable, at any particular rate, at the rates stated above, or at all.

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PROSPECTUS SUPPLEMENT SUMMARY

The information below is a summary of the more detailed information included elsewhere or incorporated by reference in this prospectus supplement and the accompanying prospectus. You should read carefully the following summary together with the more detailed information contained in this prospectus supplement, the accompanying prospectus and the information incorporated by reference into those documents, including the Risk Factors section beginning on page S-12 of this prospectus supplement and the Risk Factors section in the accompanying prospectus, in our Annual Report on Form 10-K for the year ended December 31, 2013 and in our other reports that we file with the SEC. This summary is not complete and does not contain all of the information you should consider when making your investment decision.

In this prospectus supplement, unless the context requires otherwise, references to Acadia, the Company, we, us or our refer to Acadia Healthcare Company, Inc., together with its consolidated subsidiaries. When we refer to our operations or results on a pro forma basis, we mean the statement is made as if the Partnerships in Care acquisition had been completed as of the date stated or as of the beginning of the period referenced.

Our Company

We are the leading publicly-traded pure-play provider of inpatient behavioral health care services in the United States based upon number of licensed beds. Upon completion of the planned acquisition described in this prospectus supplement, we expect we will operate 75 behavioral health care inpatient and outpatient facilities with over 5,500 licensed beds in 24 states, Puerto Rico and the United Kingdom. We believe that our primary focus on the provision of behavioral health care services allows us to operate more efficiently and provide higher quality care than our competitors. On a pro forma basis for the three months ended March 31, 2014 and the year ended December 31, 2013, giving effect to the acquisition of Partnerships in Care, we would have generated pro forma revenue of approximately $270.9 million and approximately $1.0 billion, respectively, pro forma net income of approximately $19.6 million and $73.8 million, respectively, and pro forma adjusted EBITDA of $55.5 million and $219.1 million, respectively. A reconciliation of pro forma adjusted EBITDA to pro forma net income appears on page S-11 of this prospectus supplement.

Our inpatient facilities offer a wide range of inpatient behavioral healthcare services for children, adolescents and adults. We offer these services through a combination of acute inpatient psychiatric and specialty facilities and residential treatment centers, or RTCs. Our acute inpatient psychiatric and specialty facilities provide the most intensive level of care, including 24-hour skilled nursing observation and care, daily interventions and oversight by a psychiatrist and intensive, highly-coordinated treatment by a physician-led team of mental health professionals. Our RTCs offer longer-term treatment programs primarily for children and adolescents with long-standing chronic behavioral health problems. Our RTCs provide physician-led, multi-disciplinary treatments that address the overall medical, psychiatric, social and academic needs of the patient. During the year ended December 31, 2013, we acquired seven facilities with an aggregate of 694 licensed beds, including a 75-bed facility under construction which opened on October 1, 2013. In addition, we added 325 new beds during the year ended December 31, 2013, including by opening two newly-developed facilities with a combined 102 licensed beds. We expect to add over 300 total beds during 2014 (exclusive of acquisitions).

Our outpatient community-based services provide therapeutic treatment to children and adolescents who have a clinically defined emotional, psychiatric or chemical dependency disorder while enabling patients to remain at home and within their community. Many patients who participate in community-based programs have transitioned out of a residential facility or have a disorder that does not require placement in a facility that provides 24-hour care.

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Acquisition of Partnerships in Care

We are conducting this offering of common stock in connection with the acquisition of Partnerships in Care, which we refer to in this prospectus supplement as the Acquisition.

Overview. On June 3, 2014, a subsidiary of Acadia agreed to acquire the entire issued share capital of Partnerships in Care Investments 1 Limited, a company incorporated in England and Wales, and the issued and outstanding A ordinary shares in the capital of Partnerships in Care Property 1 Limited, a company incorporated in England and Wales, pursuant to a share purchase agreement by and among Acadia, Piper Holdco 2, Ltd., a subsidiary of Acadia, Partnerships in Care Holdings Limited and The Royal Bank of Scotland plc, or RBS. Acadia joined the Agreement for the purpose of guarantying the purchaser s obligations arising under the share purchase agreement. Under the terms of the share purchase agreement, Acadia will pay an amount to discharge the outstanding debt facilities of the target companies, and cash consideration for the equity to be acquired, which in the aggregate shall be equal to £395.0 million (approximately $660.0 million), subject to adjustment in relation to cash, debt and working capital balances of the target companies. A portion of the Partnerships in Care pre-acquisition debt owed to RBS is being equitized in connection with the acquisition. See The Acquisition and Financing Transactions.

The entities to be acquired by Acadia own and operate 23 inpatient behavioral health facilities with over 1,200 beds. The facilities are located in England, Wales and Scotland. For the year ended December 31, 2013 and the three months ended March 31, 2014, Partnerships in Care generated revenue of $267.0 million and $69.5 million, respectively, primarily through the operation and management of inpatient behavioral health facilities. See Partnerships in Care elsewhere in this prospectus supplement.

The share purchase agreement provides that the Acquisition will close on July 1, 2014. Consummation of this offering is not conditioned upon the closing of the Acquisition. We cannot assure you that the Acquisition will close as expected or at all. See Risk Factors We may be unable to complete our planned acquisition of Partnerships in Care on currently anticipated terms, or at all.

Strategic Rationale. We expect to realize significant benefits from the acquisition of Partnerships in Care. Our rationale for the acquisition includes the following:

Expand our geographic presence into a new, attractive market. The mental health market in the United Kingdom was roughly £14.4 billion in 2013. The independent mental health market accounted for roughly £1.1 billion of that amount, or approximately 8% market share. As a result of government budget constraints and an increased focus on quality, the independent mental health market has witnessed significant expansion in the last decade, making it one of the fastest growing sectors in United Kingdom healthcare industry.

Acquire a leading platform in the market. Partnerships in Care is the second largest independent provider of inpatient behavioral healthcare services in the United Kingdom, operating 23 inpatient behavioral health facilities with over 1,200 beds. The company holds an approximately 16% market share of the independent behavioral health market. In addition, Partnerships in Care is one of only two independent providers in the United Kingdom offering the full spectrum of mental health services. Partnerships in Care also has an experienced management team with market knowledge and relationships within the industry and governmental bodies.

Financially attractive and accretive acquisition. Assuming the Acquisition is completed as planned on July 1, 2014, we expect the combined benefits of increased adjusted EBITDA and a reduced income tax rate will produce earnings accretion (not including the impact of any future acquisitions beyond the purchase of Partnerships in Care or any transaction-related expenses).

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Opportunities for future growth. Demand for independent behavioral health services has grown significantly in the United Kingdom as a result of the National Health Service, or NHS, reducing bed capacity and increased hospitalization rates. Outsourcing demand is expected to increase in light of additional bed closures and reduction in community capacity by NHS. The independent market in the United Kingdom is highly fragmented with the largest four players accounting for 58% market share. These factors present opportunities for growth by well capitalized, experienced operators. In addition, Acadia management sees meaningful opportunities to produce organic growth in Partnerships in Care s existing facilities through the addition of new beds and service line expansions to meet areas of unmet need. Management also expects to pursue additional select acquisitions in the United Kingdom.

Financing of the Acquisition. We intend to fund the planned acquisition of Partnerships in Care in part through this offering and in part through a fifth amendment to our existing amended and restated senior credit agreement, or the Amended and Restated Senior Credit Facility. Such amendment is referred to herein as the Proposed Amended and Restated Senior Credit Facility. We anticipate that the Proposed Amended and Restated Senior Credit Facility will continue to provide for an existing $300.0 million revolver and $296.3 million in existing Term A Loans, and will provide for $300.0 million in new Term B Loans (subject to receipt of requisite consents in the consent solicitation mentioned below), which we will use partially to fund the Acquisition. At the same time, we are pursuing a consent solicitation (scheduled to expire June 17, 2014) under our indenture for the 12.875% Senior Notes due 2018, or the 2018 Indenture, in order to facilitate our incurring additional permitted liens securing indebtedness so long as our secured leverage ratio is under 3.5x. In the event that the amount of the new Term B Loans available under the Proposed Amended and Restated Senior Credit Facility is less than anticipated or the consent solicitation is unsuccessful, we intend to borrow additional amounts under our revolver, issue additional senior unsecured notes, or borrow under our committed bridge facility to fund the Acquisition. We expect that the Proposed Amended and Restated Senior Credit Facility will become effective commensurate with the closing of the Acquisition on July 1, 2014. We cannot assure you that this amendment will be executed as anticipated or at all. See Risk Factors We may be unable to complete our planned acquisition of Partnerships in Care on currently anticipated terms, or at all.

We refer in this prospectus supplement to this offering of common stock and the Proposed Amended and Restated Senior Credit Facility as the Financing Transactions. We refer to the Acquisition and the Financing Transactions collectively as the Transactions.

Our Competitive Strengths

Management believes the following strengths differentiate us from other providers of behavioral healthcare services:

Premier operational management team with track record of success. Our management team has approximately 170 combined years of experience in acquiring, integrating and operating a variety of behavioral health facilities. Following the sale of Psychiatric Solutions, Inc., or PSI, to Universal Health Services, Inc., or UHS, in November 2010, certain of PSI s key former executive officers joined Acadia in February 2011. The extensive national experience and operational expertise of our management team give us what management believes to be the premier leadership team in the behavioral healthcare industry. Our management team strives to use its years of experience operating behavioral health facilities to generate strong cash flow and grow a profitable business.

Favorable industry and legislative trends. According to the National Institute of Mental Health, approximately 6% of people in the United States suffer from a seriously debilitating mental illness and over 20% of children, either currently or at some point during their life, have had a seriously debilitating mental disorder. Management believes the market for behavioral services will continue to grow due to increased awareness of mental health and substance abuse conditions and treatment options. According to a 2008 report by the Substance

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Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services, national expenditures on mental health and substance abuse treatment are expected to reach $239 billion in 2014, up from $121 billion in 2003, representing a compound annual growth rate of approximately 6.4%.

While the growing awareness of mental health and substance abuse conditions is expected to accelerate demand for services, recent healthcare reform in the United States is expected to increase access to industry services as more people obtain insurance coverage. A key aspect of reform legislation is the extension of mental health parity protections established into law by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, or the MHPAEA. The MHPAEA provides for equal coverage between psychiatric or mental health services and conventional medical health services and forbids employers and insurers from placing stricter limits on mental healthcare compared to other health conditions.

As described above, the mental health market in the United Kingdom was roughly £14.4 billion in 2013. As a result of government budget constraints and an increased focus on quality, the independent mental health market has witnessed significant expansion in the last decade, making it one of the fastest growing sectors in United Kingdom healthcare industry. Demand for independent acute care services has grown significantly as a result of NHS reducing bed capacity and increased hospitalization rates. Outsourcing demand is expected to increase in light of additional bed closures and reduction in community capacity by NHS.

Leading platform in attractive healthcare niche. We are a leading behavioral healthcare platform in an industry that is undergoing consolidation in an effort to reduce costs and expand programs to better serve the growing need for inpatient behavioral healthcare services. In addition, the behavioral healthcare industry has significant barriers to entry, including (i) significant initial capital outlays required to open new facilities, (ii) expertise required to deliver highly specialized services safely and effectively and (iii) high regulatory hurdles that require market entrants to be knowledgeable of state and federal laws and facilities to be licensed with local agencies.

Diversified revenue and payor bases. As of December 31, 2013, we operated 51 facilities in 23 states and Puerto Rico. Our payor, patient/client and geographic diversity mitigates the potential risk associated with any single facility. For the year ended December 31, 2013, we received 48% of our revenue from Medicaid, 25% from commercial payors, 22% from Medicare and 5% from self-pay and other payors. On a pro forma basis for the 12 months ended March 31, 2014, giving effect to the Partnerships in Care acquisition, we would have received 35% of our revenue from Medicaid, 25% from NHS, 19% from commercial payors, 16% from Medicare and 5% from other payors. As we receive Medicaid payments from 30 states, the District of Columbia and Puerto Rico, management does not believe that we are significantly affected by changes in reimbursement policies in any one state or territory. Substantially all of our Medicaid payments relate to the care of children and adolescents. Management believes that children and adolescents are a patient class that is less susceptible to reductions in reimbursement rates. No facility accounted for more than 6% of revenue for the year ended December 31, 2013. On a pro forma basis, giving effect to the Partnerships in Care acquisition, no facility accounts for more than 5% of total revenue for the 12 months ended March 31, 2014. No state or territory accounted for more than 17% of revenue for the year ended December 31, 2013. Additionally, on a pro forma basis, no U.S. state or territory would have accounted for more than 12% of total revenue for the 12 months ended March 31, 2014. We believe that our increased geographic diversity will mitigate the impact of any financial or budgetary pressure that may arise in a particular state or market where we operate.

Strong cash flow generation and low capital requirements. We generate strong free cash flow by profitably operating our business and by actively managing our working capital. Moreover, as the behavioral healthcare business does not typically require the procurement and replacement of expensive medical equipment, our maintenance capital expenditure requirements are generally less than that of other facility-based healthcare

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providers. For the year ended December 31, 2013, our maintenance capital expenditures amounted to 2.3% of our revenue. In addition, our accounts receivable management is less complex than medical/surgical hospital providers because behavioral healthcare facilities have fewer billing codes and generally are paid on a per diem basis.

Our Business Strategy

We are committed to providing the communities we serve with high quality, cost-effective behavioral health services, while growing our business, increasing profitability and creating long-term value for our stockholders. To achieve these objectives, we have aligned our activities around the following growth strategies:

Increase margins by enhancing programs and improving performance at existing facilities. Management believes we can improve efficiencies and increase operating margins by utilizing our management s expertise and experience within existing programs and their expertise in improving performance at underperforming facilities. Management believes the efficiencies can be realized by investing in growth in strong markets, addressing capital-constrained facilities that have underperformed and improving management systems. Furthermore, our recent acquisitions of additional facilities give us an opportunity to develop a marketing strategy in many markets which should help us increase the geographic footprint from which our existing facilities attract patients and referrals.

Opportunistically pursue acquisitions. We have established a national platform for becoming the leading dedicated provider of high quality behavioral healthcare services in the U.S. With the Partnerships in Care acquisition, we intend to establish our company as a leading independent provider of mental health services in the United Kingdom. The behavioral healthcare industry in the United States and the independent behavioral healthcare industry in the United Kingdom are highly fragmented, and we selectively seek opportunities to expand and diversify our base of operations by acquiring additional facilities.

Acadia management believes there are a number of acquisition candidates available at attractive valuations, and we have a number of potential acquisitions in various stages of development and consideration in the United States. In addition, management sees meaningful opportunities to pursue additional select acquisitions in the United Kingdom.

Management believes our focus on inpatient behavioral healthcare and history of completing acquisitions provides us with a strategic advantage in sourcing, evaluating and closing acquisitions. We leverage our management team s expertise to identify and integrate acquisitions based on a disciplined acquisition strategy that focuses on quality of service, return on investment and strategic benefits. We also have a comprehensive post-acquisition strategic plan to facilitate the integration of acquired facilities that includes improving facility operations, retaining and recruiting psychiatrists and other healthcare professionals and expanding the breadth of services offered by the facilities.

Drive organic growth of existing facilities. We seek to increase revenue at our facilities by providing a broader range of services to new and existing patients and clients. In addition, management intends to increase licensed bed counts in our existing facilities, with a focus on increasing the number of acute psychiatric beds. During the year ended December 31, 2013, we acquired seven facilities with an aggregate of 694 licensed beds including a 75-bed facility under construction, which opened on October 1, 2013. In addition, we added 325 new beds during the year ended December 31, 2013, including opening two newly-developed facilities with a combined 102 licensed beds. We expect to add over 300 total beds during 2014 (exclusive of acquisitions). Furthermore, management believes that opportunities exist to leverage out-of-state referrals to increase volume and minimize payor concentration in the United States, especially with respect to our youth and adolescent focused services and our substance abuse services.

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Equity Sponsor

As of May 31, 2014, Waud Capital Partners, L.L.C. and its affiliates, or Waud Capital Partners, owned approximately 23% of our common stock. Affiliates of Waud Capital Partners are selling stockholders in this offering. Founded in 1993, Waud Capital Partners is a leading middle-market private equity firm that partners with management teams to create, acquire and grow companies that address significant, inefficient, highly-fragmented and underserved industry segments. Waud Capital Partners invests primarily through control-oriented growth equity investments, industry consolidations, buyouts or recapitalizations and seeks companies that generate strong cash flow and can be grown both organically and through add-on acquisitions. Waud Capital Partners current and exited portfolio is composed of companies in the healthcare, business/consumer, logistics/specialty distribution and value-added industrial business segments.

So long as Waud Capital Partners owns at least 17.5% of our outstanding common stock, it is entitled to designate the pro rata number of our directors that is proportional (but rounded up to the nearest whole number) to its percentage ownership of our outstanding common stock, subject to the NASDAQ rules regarding director independence, and has consent rights to many corporate actions, such as issuing equity or debt securities, paying dividends, acquiring any interest in another company and materially changing our business activities. It is possible that the interests of Waud Capital Partners may in some circumstances conflict with our interests and the interests of our other stockholders. It is expected that Waud Capital Partners will own approximately 18.4% of our outstanding common stock after completion of this offering assuming that the underwriters exercise their option to purchase additional shares of our common stock in full, or 20.3% of our outstanding common stock after completion of this offering assuming that the underwriters do not exercise their option to purchase additional shares of our common stock. See Risk Factors We are party to a stockholders agreement with Waud Capital Partners which provides it with certain rights over Company matters.

Company Information

Acadia Healthcare Company, Inc. is a Delaware corporation. On May 13, 2011, we converted from a Delaware limited liability company (Acadia Healthcare Company, LLC) to a Delaware corporation (Acadia Healthcare Company, Inc.) in accordance with Delaware law. Our principal executive offices are located at 830 Crescent Centre Drive, Suite 610, Franklin, Tennessee 37067. Our telephone number is (615) 861-6000. Our website is *www.acadiahealthcare.com*. The information contained on our website is not part of this prospectus supplement or the accompanying prospectus and is not incorporated in this prospectus supplement, the accompanying prospectus or any other document that we file with the SEC by reference.

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The Offering

Common stock offered by us	shares
Underwriters option to purchase additional shares from the selling stockholders or, if the selling stockholders elect not to grant such option, from the Company	shares
Common stock outstanding after this offering	shares
Use of proceeds	We estimate that the net proceeds to us from this offering, after deducting underwriting discounts and commissions and estimated offering expenses payable by us, will be approximately $325 million. We plan to use the proceeds from this offering to fund our acquisition strategy, particularly a portion of the purchase price for the planned acquisition of Partnerships in Care and fees and expenses related to the Transactions, and otherwise for general corporate purposes, which may include the repayment of debt under the Amended and Restated Senior Credit Facility. We will not receive any proceeds from the sale of our shares of our common stock by the selling stockholders. See Use of Proceeds and Selling Stockholders elsewhere in this prospectus supplement.
Risk factors	You should carefully consider the risk factors set forth in the section entitled Risk Factors beginning on page S-12 of this prospectus supplement, in the accompanying prospectus, in our Annual Report on Form 10-K for the fiscal year ended December 31, 2013 and in our other reports that we file with the SEC, which are incorporated by reference in this prospectus supplement, before making any decision to invest in our common stock.
Symbol for trading on The NASDAQ Global Market	ACHC

Unless otherwise indicated, all information in this prospectus supplement relating to the number of shares of our common stock outstanding immediately after the closing of this offering is based on 50,833,152 shares outstanding as of May 31, 2014, and:

gives effect to the issuance of shares of our common stock to be sold by us in this offering;

assumes that the underwriters do not exercise their option to purchase additional shares of common stock; and

excludes:

- 770,570 shares issuable upon exercise of stock options outstanding as of May 31**,** 2014 at a weighted average exercise price of $27.93 per share;

- 669,506 shares issuable upon the vesting of restricted units outstanding as of May 31, 2014; and

- an aggregate of 2,733,153 shares reserved for future grants under our Incentive Compensation Plan as of May 31, 2014.

Unless otherwise indicated, references to shares outstanding or percentages that assume exercise of the underwriters option to purchase additional shares of common stock, assume that the selling stockholders, rather than the Company, grant the underwriters the option to purchase all additional shares of common stock. For additional information regarding our common stock, see Description of Common Stock in the accompanying prospectus.

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Summary Historical Condensed Consolidated Financial Data and Unaudited Pro Forma Condensed Combined Financial Data

The table below sets forth:

- our summary historical condensed consolidated financial data for the periods ended and at the dates indicated; and
- the unaudited pro forma condensed combined financial data for Acadia giving effect to Acadia s planned acquisition of Partnerships in Care on July 1, 2014, the offering of common stock described in this prospectus supplement and Acadia s planned debt financing transactions.

We have derived the historical condensed consolidated financial data for each of the three years in the period ended December 31, 2013 from our audited consolidated financial statements incorporated by reference in this prospectus supplement from our Annual Report on Form 10-K for the year ended December 31, 2013. We have derived the summary condensed consolidated financial data as of and for the three months ended March 31, 2014 from our unaudited interim condensed consolidated financial statements incorporated by reference in this prospectus supplement from our Quarterly Report on Form 10-Q for the three months ended March 31, 2014. The unaudited financial statements were prepared on a basis consistent with our audited financial statements and include, in the opinion of management, all adjustments, consisting only of normal recurring adjustments, necessary for the fair statement of the financial information in those statements. The results for the three months ended March 31, 2014 are not necessarily indicative of the results that may be expected for the entire fiscal year.

The summary unaudited pro forma condensed combined financial information below as of and for the year ended December 31, 2013 and as of and for the three months ended March 31, 2014 gives pro forma effect, in each case as if they occurred on January 1, 2013, to Acadia s planned acquisition of Partnerships in Care, the offering of common stock described in this prospectus supplement and the planned debt financing transactions. With respect to this offering, the unaudited pro forma condensed combined financial data is based on the assumption that we are offering 7,344,998 shares of common stock at an assumed public offering price of $46.29 per share, which was the closing price of our common stock on June 6, 2014, as reported on the NASDAQ Global Market.

The summary historical condensed consolidated financial data below should be read in conjunction with Unaudited Pro Forma Condensed Combined Financial Information in this prospectus supplement and the consolidated financial statements and the notes thereto of Acadia and Partnerships in Care included in, or incorporated by reference into, this prospectus supplement.

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On May 13, 2011, we converted from a Delaware limited liability company (Acadia Healthcare Company, LLC) to a Delaware corporation (Acadia Healthcare Company, Inc.) in accordance with Delaware law.

	Year Ended December 31,			Pro Forma Year Ended	Three Months Ended	Three Months Ended	Pro Forma Three Months Ended
	2011	2012	2013	December 31, 2013	March 31, 2013	March 31, 2014 (Unaudited)	March 31, 2014
				(In thousands)			
Income Statement Data:							
Revenue before provision for doubtful accounts	$ 219,704	$ 413,850	$ 735,109	$ 1,025,251	$ 165,705	$ 206,119	$ 275,569
Provision for doubtful accounts	(3,206)	(6,389)	(21,701)	(22,645)	(4,492)	(4,701)	(4,701)
Revenue	216,498	407,461	713,408	1,002,606	161,213	201,418	270,868
Salaries, wages and benefits(1)	152,609	239,639	407,962	571,767	94,351	117,575	158,372
Professional fees	8,896	19,019	37,171	50,032	9,014	10,382	13,498
Other operating expenses	37,096	70,111	128,190	168,629	27,908	35,943	45,640
Depreciation and amortization	4,278	7,982	17,090	32,807	3,622	5,436	9,240
Interest expense, net	9,191	29,769	37,250	55,869	8,762	9,707	13,711
Sponsor management fees	1,347						
Debt extinguishment costs			9,350	9,350	9,350		
Transaction-related expenses	41,547	8,112	7,150	5,563	1,474	1,579	1,570
Income (loss) from continuing operations, before income taxes	(38,466)	32,829	69,245	108,589	6,732	20,796	28,837
Income tax (benefit) provisions	5,272	12,325	25,975	34,748	2,678	7,775	9,228
Income (loss) from continuing operations	(33,194)	20,504	43,270	73,841	4,054	13,021	19,609
Income (loss) from discontinued operations, net of income taxes	(1,698)	(101)	(691)		(316)	37	
Net income (loss)	$ (34,892)	$ 20,403	$ 42,579	$ 73,841	$ 3,738	$ 13,058	$ 19,609
Other Financial Data:							
Pro forma EBITDA(2)				197,265			51,788
Pro forma adjusted EBITDA(3)				219,079			55,562

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	As of March 31, 2014	
	Actual	As Adjusted(4)
	(Unaudited)	
	(In thousands)	
Unaudited As Adjusted Condensed Combined Balance Sheet Data		
Cash and cash equivalents	$ 7,243	$ 7,362
Total assets	1,282,945	2,002,419
Total debt	663,196	1,019,196
Total stockholders equity	$ 496,150	$ 813,350

(1) Salaries, wages and benefits include equity-based compensation expense of $17.3 million, $2.3 million, $5.2 million and $1.8 million for the years ended December 31, 2011, 2012 and 2013 and the three months ended March 31, 2014, respectively.

(2) Pro forma EBITDA and pro forma adjusted EBITDA are reconciled to pro forma net income (loss) in the table below. Pro forma EBITDA and pro forma adjusted EBITDA are financial measures not recognized under GAAP. When presenting non-GAAP financial measures, we are required to reconcile the non-GAAP financial measures with the most directly comparable GAAP financial measure or measures. We define pro forma EBITDA as pro forma net income (loss) adjusted for loss (income) from discontinued operations, net interest expense, income tax provision (benefit) and depreciation and amortization. We define pro forma adjusted EBITDA as pro forma EBITDA adjusted for equity-based compensation expense, debt extinguishment costs, transaction-related expenses and other non-recurring costs. See the table and related footnotes below for additional information.

(3) We present pro forma adjusted EBITDA because it is a measure management uses to assess financial performance. We believe that companies in our industry use measures of pro forma EBITDA as common performance measurements. We also believe that securities analysts, investors and other interested parties frequently use measures of pro forma EBITDA as financial performance measures and as indicators of ability to service debt obligations. While providing useful information, measures of pro forma EBITDA, including pro forma adjusted EBITDA, should not be considered in isolation or as a substitute for consolidated statement of operations and cash flows data prepared in accordance with GAAP and should not be construed as an indication of a company s operating performance or as a measure of liquidity. Pro forma adjusted EBITDA may have material limitations as a performance measure because it excludes items that are necessary elements of our costs and operations. In addition, EBITDA, Adjusted EBITDA or similar measures presented by other companies may not be comparable to our presentation, because each company may define these terms differently. See Non-GAAP Financial Measures.

(4) Adjusted to give effect to the Transactions (assuming the issuance and sale of common stock as set forth on the cover of this prospectus supplement), after deducting the underwriting discount and estimated offering expenses payable by us, assuming that the Transactions closed on March 31, 2014. A $1.00 increase in our share price would decrease the number of shares that we issue by 155,317, and a $1.00 decrease in our share price would increase the number of shares that we issue by 162,177, assuming in either case that we raise the gross proceeds as set forth on the cover of this prospectus supplement.

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	Pro Forma Year Ended December 31, 2013	Pro Forma Three Months Ended March 31, 2014
		(Unaudited) (In thousands)
Reconciliation of Pro Forma Net Income (Loss) to Pro Forma Adjusted EBITDA:		
Net Income (loss)	$ 73,841	$ 19,609
Interest expense, net	55,869	13,711
Income tax provision	34,748	9,228
Depreciation and amortization	32,807	9,240
Pro forma EBITDA	$ 197,265	$ 51,788
Adjustments:		
Equity-based compensation expense(a)	$ 5,249	$ 1,764
Transaction costs(b)	5,563	1,570
Debt extinguishment costs(c)	9,350	
Other(d)	1,652	440
Pro forma adjusted EBITDA	$ 219,079	$ 55,562

(a) Represents the equity-based compensation expense of Acadia for the respective periods.
(b) Represents transaction costs incurred by Acadia primarily related to acquisitions.
(c) Represents costs incurred in connection with the redemption of $52.5 million of our 12.875% Senior Notes in March 2013.
(d) Represents costs incurred by Partnerships in Care related to non-recurring legal and other costs.

We may not be able to achieve all of the expected benefits from the synergies and cost savings described in the table above. This information is inherently uncertain and is not intended to represent what our financial position or results of operations might be for any future period. See Risk Factors Our acquisition strategy exposes us to a variety of operational and financial risks Benefits may not materialize.

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RISK FACTORS

Investing in our common stock involves risks. Before making an investment in our common stock, you should carefully consider, among other factors, the risks described below and elsewhere in this prospectus supplement, the accompanying prospectus and the documents incorporated by reference in this prospectus supplement. Please see Special Note Regarding Forward-Looking Statements on page S-ii of this prospectus supplement. Please also see Risk Factors and Special Note Regarding Forward-Looking Statements beginning on page 3 of the accompanying prospectus and the risks described in the documents incorporated by reference in this prospectus supplement, including those identified under Risk Factors in our Annual Report on Form 10-K for the fiscal year ended December 31, 2013 and in our other filings that we make with the Securities and Exchange Commission. The risks described in this prospectus supplement, the accompanying prospectus and the documents incorporated by reference in this prospectus supplement are not the only ones we face. Additional risks not presently known or that we currently deem immaterial could also materially and adversely affect our financial condition, results of operations, business and prospects. You should consult your own financial and legal advisors as to the risks entailed by an investment in these shares and the suitability of investing in such shares in light of your particular circumstances. Our business, financial condition and results of operations could be materially adversely affected by the materialization of any of these risks. The trading price of our common stock could decline due to the materialization of any of these risks, and you may lose all or part of your investment.

Risks Relating to the Acquisition

We may be unable to complete our planned acquisition of Partnerships in Care on currently anticipated terms, or at all.

On June 3, 2014, we entered into binding purchase agreement to acquire the specified equity interests of Partnerships in Care. The agreement provides that the Acquisition will close on July 1, 2014. The total consideration for the acquisition is equal to £395 million (approximately $660 million), subject to adjustment in relation to cash, debt and working capital balances of the target companies. We plan to finance the acquisitions in part through this offering and in part through an amendment to, or an amendment and restatement of, our Amended and Restated Senior Credit Facility, as we do not currently have sufficient capacity under our Amended and Restated Senior Credit Facility. We are currently negotiating a Proposed Amended and Restated Senior Credit Facility to provide for additional debt of approximately $300 million (or, if we cannot obtain the consent from holders of our existing notes, $250 million (or such lesser amount necessary for our secured leverage ratio to remain under 3.0x)) and expect the amendment to be effective commensurate with the closing of the Acquisition. If we do not get the requisite consents, we will only be able to borrow $250 million of term debt and then will issue additional unsecured debt to finance the Acquisition. If we are not able to complete the amendment to our Amended and Restated Senior Credit Facility on currently anticipated terms or at all or we otherwise are not able to close the anticipated financing transactions mentioned above, we may be unable to successfully complete the Acquisition on time, or at all, which could have a material adverse effect on our results of operations, financial condition and the trading price of our common stock.

If we are unable to integrate successfully Partnerships in Care into our business following the Acquisition, our business, financial condition and results of operations may be negatively impacted.

Upon the closing of the Acquisition, we will integrate Partnerships in Care s business into our current business. Successful integration will depend on our ability to effect any required changes in operations or personnel which may entail unforeseen liabilities. The integration of Partnerships in Care may expose us to certain risks, including the following: difficulty in integrating Partnerships in Care in a cost-effective manner, including the establishment of effective management information and financial control systems; unforeseen legal, regulatory, contractual, employment or other issues arising out of the combination; combining corporate cultures; maintaining employee morale and retaining key employees; potential disruptions to our on-going business caused

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by its senior management s focus on integrating Partnerships in Care; and performance of the combined assets not meeting our expectations or plans. A failure to properly integrate Partnerships in Care could have a corresponding material adverse effect on our business, results of operations, financial condition or prospects.

Expanding our operations internationally poses additional risks to our business.

We are currently engaged in business activities in the United States and Puerto Rico. The acquisition of Partnerships in Care marks our first entry into a foreign market. Our business or financial performance may be adversely affected due to the risks of operating internationally, including but not limited to the following: economic and political instability, failure to comply with foreign laws and regulations and adverse changes in the health care policy of the United Kingdom (including decreases in funding for the services provided by Partnerships in Care), adverse changes in law and regulations affecting the operations of Partnerships in Care, difficulties and costs of staffing and managing our new operations in the United Kingdom. If any of these events were to materialize, they could lead to disruption of our business, significant expenditures and/or damages to our reputation, which could have a material adverse effect on our results of operations, financial condition or prospects.

As a company based outside of the United Kingdom, we will need to take certain actions to be more easily accepted in the United Kingdom. For example, we may need to engage in a public relations campaign to emphasize service quality and company philosophy, preserve local management continuity and business practices and be transparent in our dealings with local governments and taxing authorities. Such efforts will require significant time and effort on the part of our management team. Our results of operation could suffer if these efforts are not successful.

Our acquisition of the capital shares of the Partnerships in Care entities may expose us to unknown or contingent liabilities for which we will not be indemnified.

We are acquiring the capital shares of Partnerships in Care entities. Such entities and/or the facilities that we will own upon completion of the Acquisition may have unknown or contingent liabilities, including, but not limited to, liabilities for uncertain tax positions, for failure to comply with healthcare laws and regulations and for unresolved litigation or regulatory reviews. Although we typically attempt to exclude significant liabilities from our acquisition transactions and seek indemnification from the sellers of such facilities, the purchase agreement with Partnerships in Care contains minimal representations and warranties about the entities and business that we are acquiring. In addition, we have no indemnification rights against the sellers under the purchase agreement and all of the purchase price consideration will be paid at closing of the Acquisition. Therefore, we may incur material liabilities for the past activities of acquired entities and facilities. Such liabilities and related legal or other costs and/or resulting damage to a facility s reputation could negatively impact our business, financial condition or results of operations.

Partnerships in Care relies on publicly funded entities in the United Kingdom for approximately 97% of its revenue, and the loss or reduction of such funding or changes to procurement methods could negatively impact Partnerships in Care s occupancy rates which could have a corresponding material adverse effect on Partnerships in Care s business, results of operations, financial condition or prospects.

Referrals to Partnerships in Care s services by NHS accounted for approximately 97% of its revenue for the year ended December 31, 2013. There is a risk that budget constraints, public spending cuts (such as the cuts announced by the United Kingdom government in the 2010 Comprehensive Spending Review and implemented in the 2011 and 2012 government budgets) or other financial pressures could cause NHS to reduce funding for the types of services that Partnerships in Care provides. For example, in 2010, NHS announced a period of austerity and reduced spending and outsourcing of medical health treatment, which adversely affected our results from 2010 to 2012 until such austerity was relaxed. In addition, policy changes in the United Kingdom could lead to fewer of such services being purchased by publicly funded entities or material changes being made to

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their procurement practices, or the in-sourcing of mental health services, any of which could materially reduce Partnerships in Care s revenue.

As part of the Acquisition, we will assume Partnerships in Care s existing pension plans and a defined contribution plan and will be responsible for an underfunded pension liability. In addition, we may be required to increase funding of the pension plans and/or be subject to restrictions on the use of excess cash.

Partnerships in Care is the sponsor of a defined benefit pension plan (the Partnerships in Care Limited Pension and Life Assurance Plan) that, as of December 31, 2013, covered approximately 187 members in the United Kingdom, most of whom are inactive and retired former employees. As of May 1, 2005, this plan was closed to new participants but then-current participants continue to accrue benefits. As of December 31, 2013, the net deficit recognized under UK GAAP in respect of this scheme was £4.9 million. Although this underfunded position was considered in determining the purchase price for Partnerships in Care, it may adversely affect the combined company as follows:

- Laws and regulations normally require a new funding plan to be agreed upon every three years, with the next new funding plan to be agreed upon with the plan trustees by March 2015. Changes in actuarial assumptions, including future discount, inflation and interest rates, investment returns and mortality rates, may increase the underfunded position of the pension plan and cause the combined company to increase its contributions to the pension plan to cover underfunded liabilities.

- The pension plan is regulated in the United Kingdom, and trustees represent the interests of covered workers. Laws and regulations could create an immediate funding obligation to the pension plan which could be significantly greater than the £5 million assumed for accounting purposes as of December 31, 2013, and could impact the ability to use Partnerships in Care s existing cash or the combined company s future excess cash to grow the business or finance other obligations. The use of Partnerships in Care s cash and future cash flows beyond the operation of Partnerships in Care s business or the satisfaction of Partnerships in Care s obligations would require negotiations with the trustees and regulators.

We also are assuming an additional pension plan (the Federated Pension Plan), of which fewer than five Partnerships in Care employees are participants, and a defined contribution plan (the Partnerships in Care Limited New Generation Personal Pension) under which participants receive contributions as a proportion of earnings. Maintenance of these plans following the Acquisition may result in additional expenses to the combined company. Termination of these plans could have an adverse impact on employee relations and a material adverse effect on our financial results.

Partnerships in Care may not achieve fee rate increases or may suffer fee rate decreases, which could have an adverse impact on Partnerships in Care s business, results of operations, financial condition or prospects.

The majority of fee rates that Partnerships in Care decides to set for its services are subject to annual adjustments. NHS has been under budgetary pressure since the announcement by the United Kingdom Government of the Comprehensive Spending Review in 2010 imposing cuts on government spending and have, as such, reduced its spending. This resulted in Partnerships in Care being unable to implement material price increases during the last several years (which has adversely affected its results), and there can be no assurance that Partnerships in Care will be able to implement price increases in the future. Furthermore, should the effect of any increase in Partnerships in Care s annual wages or other operating costs of the business exceed the effect of any increase in Partnerships in Care s weekly fee rates (which are the basis of Partnerships in Care s revenue), we would have to absorb such costs and this could have a material adverse effect on our business, results of operations, financial condition or prospects.

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With NHS as the principal provider of secure mental healthcare services and the preferred provider in the United Kingdom, and other independent operators, we face significant competition in the United Kingdom.

NHS is the principal provider of secure mental healthcare services in the United Kingdom, with approximately 70% of the totals beds in the United Kingdom. As the preferred provider, there is a bias toward referrals to NHS, and therefore NHS facilities have maintained a high occupancy rates. As a result of budget constraints, independent operators have emerged to satisfy the demand for mental health services not supplied by NHS. Partnerships in Care may not be able to compete effectively with NHS or other independent operators.

Partnerships in Care relies upon maintaining strong relationships with commissioners employed by publicly funded entities and any reorganization of such publicly funded entities may result in the loss of those relationships.

The relationships that Partnerships in Care s sales and marketing function holds with commissioners is a key driver of Partnerships in Care s referrals. Should there be a major reorganization of publicly funded entities, such as the NHS reorganization announced in 2010 and implemented between 2012 and 2013, Partnerships in Care may need to rebuild such relationships which could result in a decrease in the number of referrals made to Partnerships in Care s facilities, which could have a corresponding material adverse effect on our business, results of operations, financial condition or prospects.

Partnerships in Care operates in a highly regulated business environment, which is subject to political and regulatory scrutiny. Failure to comply with regulations or the introduction of new regulations or standards with which Partnerships in Care does not comply could lead to substantial penalties, including the loss of registration on one or more of Partnerships in Care s facilities.

Partnerships in Care s business is subject to a high level of regulation and oversight, in particular from: the Care Quality Commission (CQC), the independent regulator for health and adult social care in England; Healthcare Improvement Scotland (HIS), the independent regulator for healthcare services in Scotland; Healthcare Inspectorate Wales (HIW), the independent regulator of for all healthcare services in Wales; and Monitor, the non-departmental public body of the United Kingdom government that serves as the sector regulator for health services in England. The regulatory requirements relevant to Partnerships in Care s business span the range of Partnerships in Care s operations from the establishment of new facilities, which are subject to registration requirements, to the recruitment and appointment of staff, occupational health and safety, duty of care to the people Partnerships in Care supports, administration of controlled drugs, clinical standards, conduct of Partnerships in Care s professional and care staff and other requirements.

Inspections by regulators can be carried out on both an announced and, in most cases, unannounced basis, depending on the specific regulatory provisions relating to the different services Partnerships in Care provides. A failure to comply with regulations in the future, the receipt of poor ratings or lower ratings, the receipt of a negative report that leads to a determination of regulatory noncompliance, or Partnerships in Care s failure to cure any defect noted in an inspection report could result in reputational damage to Partnerships in Care, fines, or the revocation or suspension of the registration or closure of any care facility or service. Additionally, as placing authorities monitor performance, negative changes in regulatory compliance may affect the number of referrals made to Partnerships in Care. In addition, frequent changes are made to regulatory assessment methods.

We cannot guarantee that current laws, regulations and regulatory assessment methodologies will not be modified or replaced in the future. Such future developments and amendments may negatively impact Partnerships in Care s operations which could have a material adverse effect on Partnerships in Care s business, results of operations, financial condition or prospects.

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Foreign currency exchange rate fluctuations could materially impact our consolidated financial position and results of operations.

The acquisition of Partnerships in Care expands our operations to the United Kingdom. Accordingly, a portion of our net revenues will be derived from operations in the United Kingdom, and we intend to translate sales and other results denominated in foreign currency into U.S. dollars for our consolidated financial statements. During periods of a strengthening U.S. dollar, our reported international sales and net earnings could be reduced because foreign currencies may translate into fewer U.S. dollars.

In all jurisdictions in which we operate, we are also subject to laws and regulations that govern foreign investment, foreign trade and currency exchange transactions. These laws and regulations may limit our ability to repatriate cash as dividends or otherwise to the United States and may limit our ability to convert foreign currency cash flows into U.S. dollars.

We will incur significant transaction and acquisition-related costs in connection with the Acquisition.

We will incur substantial costs in connection with the Acquisition, including approximately $19.0 million in transaction-related expenses. In addition, we may incur additional costs to maintain employee morale and to retain key employees, and we will incur substantial fees and costs related to formulating and executing integration plans. Although we expect that the elimination of duplicative costs, as well as the realization of other efficiencies related to the integration of the businesses, should allow us to more than offset incremental transaction and acquisition-related costs over time, this net benefit may not be achieved in the near term, or at all.

The pro forma financial statements are presented for illustrative purposes only and may not be an indication of the combined company s financial condition or results of operations following the Acquisition.

The pro forma financial statements contained in this prospectus supplement are presented for illustrative purposes only and may not be an indication of the combined company s financial condition or results of operations following the Acquisition for several reasons. For example, the pro forma financial statements have been derived from our historical financial statements and Partnerships in Care s historical financial statements, and certain adjustments and assumptions have been made regarding the combined company after giving effect to the Acquisition. The information upon which these adjustments and assumptions have been made is preliminary, and these kinds of adjustments and assumptions are difficult to make with accuracy. Moreover, the actual financial condition and results of operations of the combined company following the Acquisition may not be consistent with, or evident from, these pro forma financial statements.

In addition, the assumptions used in preparing the pro forma financial data may not prove to be accurate, and other factors may affect the combined company s financial condition or results of operations following the Acquisition. Any potential decline in the combined company s financial condition or results of operations may cause significant variations in the stock price of the combined company. See the section entitled Unaudited Pro Forma Condensed Combined Financial Information.

We have made certain assumptions relating to the Acquisition in our forecasts that may prove to be materially inaccurate.

We have made certain assumptions relating to the forecast level of cost savings, synergies and associated costs of the Acquisition. Our assumptions relating to the forecast level of cost savings, synergies and associated costs of the Acquisition may be inaccurate based on the information available to us, including as the result of the failure to realize the expected benefits of the Acquisition, higher than expected transaction and integration costs and unknown liabilities as well as general economic and business conditions that may adversely affect the combined company following the completion of the Acquisition. In addition, Partnerships in Care was

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operating at a net loss for the year ended December 31, 2013 and for the three months ended March 31, 2014, which may impact our ability to achieve synergies and profitability from the Acquisition in the near term.

Risks of the Combined Company Upon Completion of the Acquisition

Our substantial debt could adversely affect our financial health and prevent us from fulfilling our obligations under our financing arrangements.

As of March 31, 2014, we had $663.2 million of total debt, which included $392.1 million of debt under our Amended and Restated Senior Credit Facility, $96.3 million (net of a discount of $1.2 million) of debt under our 12.875% Senior Notes due 2018, or the 12.875% Senior Notes, $150.0 million of debt under our 6.125% Senior Notes due 2021, or together with the 12.875% Senior Notes, the Senior Notes, and $24.8 million (including a premium of $2.0 million) of Lee County (Florida) Industrial Development Authority Healthcare Facilities Revenue Bonds, Series 2010 with stated interest rates of 9.0% and 9.5%. In connection with the planned acquisition of Partnerships in Care, we anticipate amending, or amending and restating, our Amended and Restated Senior Credit Facility to provide for additional debt of approximately $300.0 million (or, if we cannot obtain the consent from holders of our existing notes, $250.0 million (or such lesser amount necessary for our secured leverage ratio to remain under 3.0x)) and incurring additional debt. Our substantial debt could have important consequences to our business. For example, it could:

- increase our vulnerability to general adverse economic and industry conditions;
- make it more difficult for us to satisfy our other financial obligations;
- restrict us from making strategic acquisitions or cause us to make non-strategic divestitures;
- require us to dedicate a substantial portion of our cash flow from operations to payments on our debt (including scheduled repayments on our outstanding term loan borrowings under the Amended and Restated Senior Credit Facility), thereby reducing the availability of our cash flow to fund working capital, capital expenditures and other general corporate purposes;
- expose us to interest rate fluctuations because the interest on the Amended and Restated Senior Credit Facility is imposed at variable rates;
- make it more difficult for us to satisfy our obligations to our lenders, resulting in possible defaults on and acceleration of such debt;
- limit our flexibility in planning for, or reacting to, changes in our business and the industry in which we operate;
- place us at a competitive disadvantage compared to our competitors that have less debt;
- limit our ability to borrow additional funds; and
- limit our ability to pay dividends, redeem stock or make other distributions.

In addition, the terms of our financing arrangements contain restrictive covenants that limit our ability to engage in activities that may be in our long-term best interests. Our failure to comply with those covenants could result in an event of default which, if not cured or waived, could result in the acceleration of all of our debts, including the Amended and Restated Senior Credit Facility and Senior Notes.

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Despite our debt level, we may incur significant additional amounts of debt, which could further exacerbate the risks associated with our substantial debt.

We may incur substantial additional debt, including additional notes and other secured debt, in the future. Although the indentures governing our outstanding Senior Notes and our Amended and Restated Senior Credit Facility contain restrictions on the incurrence of additional debt, these restrictions are subject to a number of significant qualifications and exceptions, and under certain circumstances, the amount of debt that could be incurred in compliance with these restrictions could be substantial. If new debt is added to our existing debt levels, the related risks that we now face would intensify and we may not be able to meet all our debt obligations.

Servicing our debt will require a significant amount of cash. Our ability to generate sufficient cash to service our debt depends on many factors beyond our control.

Our ability to make payments on and to refinance our debt, to fund planned capital expenditures and to maintain sufficient working capital will depend on our ability to generate cash in the future. This, to a certain extent, is subject to general economic, financial, competitive, legislative, regulatory and other factors that are beyond our control.

We cannot assure you that our business will generate sufficient cash flow from operations or that future borrowings will be available to us under the Amended and Restated Senior Credit Facility, as it may be amended, or from other sources in an amount sufficient to enable us to service our debt or to fund our other liquidity needs. If our cash flow and capital resources are insufficient to allow us to make scheduled payments on our debt, we may need to reduce or delay capital expenditures, sell assets, seek additional capital or restructure or refinance all or a portion of our debt on or before the maturity thereof, any of which could have a material adverse effect on our business, financial condition or results of operations. We cannot assure you that we will be able to refinance any of our debt on commercially reasonable terms or at all, or that the terms of that debt will allow any of the above alternative measures or that these measures would satisfy our scheduled debt service obligations. If we are unable to generate sufficient cash flow to repay or refinance our debt on favorable terms, it could significantly adversely affect our financial condition and the value of our outstanding debt. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations.

We will be subject to taxation in certain foreign jurisdictions after the acquisition of Partnerships in Care. Any adverse development in the tax laws of such jurisdictions or any disagreement with our tax positions could have a material adverse effect on our business, financial condition or results of operations. In addition, our effective tax rate could change materially as a result of certain changes in our mix of United States and foreign earnings and other factors, including changes in tax laws.

We will be subject to taxation in, and to the tax laws and regulations of, certain foreign jurisdictions as a result of our operations and our corporate and financing structure after the acquisition of Partnerships in Care. Adverse developments in these tax laws or regulations, or any change in position regarding the application, administration or interpretation thereof, in any applicable jurisdiction, could have a material adverse effect on our business, financial condition or results of operations. In addition, the tax authorities in any applicable jurisdiction may disagree with the tax treatment or characterization of any of our transactions, which, if successfully challenged by such tax authorities, could have a material adverse effect on our business, financial condition or results of operations. Certain changes in the mix of our earnings between jurisdictions and assumptions used in the calculation of income taxes, among other factors, could have a material adverse effect on our overall effective tax rate. In addition, legislative proposals to change the United States taxation of foreign earnings could also increase our effective tax rate.

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Our acquisition strategy exposes us to a variety of operational and financial risks.

A principal element of our business strategy is to grow by acquiring other companies and assets in the behavioral healthcare industry. Growth, especially rapid growth, through acquisitions exposes us to a variety of operational and financial risks. We summarize the most significant of these risks below. For specific risks related to the acquisition of Partnerships in Care, see Risks Relating to the Acquisition above.

Integration risks

We must integrate our acquisitions with our existing operations. This process includes the integration of the various components of our business and of the businesses we have acquired or may do so in the future, including the following:

- additional psychiatrists, other physicians and employees who are not familiar with our operations;
- patients who may elect to switch to another behavioral healthcare provider;
- regulatory compliance programs; and
- disparate operating, information and record keeping systems and technology platforms.

Integrating a new facility could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow and distract management and other key personnel from day-to-day operations.

We may not be able to combine successfully the operations of recently acquired facilities with our operations, and even if such integration is accomplished, we may never realize the potential benefits of the acquisition. The integration of acquisitions with our operations requires significant attention from management, may impose substantial demands on our operations or other projects and may impose challenges on the combined business including, but not limited to, consistencies in business standards, procedures, policies, business cultures and internal controls and compliance. Certain acquisitions involve a capital outlay, and the return that we achieved on any capital invested may be less than the return that we would achieve on our other projects or investments. If we fail to complete the integration of recently acquired facilities, we may never fully realize the potential benefits of the related acquisitions.

Benefits may not materialize

When evaluating potential acquisition targets, we identify potential synergies and cost savings that we expect to realize upon the successful completion of the acquisition and the integration of the related operations. We may, however, be unable to achieve or may otherwise never realize the expected benefits. Our ability to realize the expected benefits from potential cost savings and revenue improvement opportunities is subject to significant business, economic and competitive uncertainties and contingencies, many of which are beyond our control, such as changes to government regulation governing or otherwise impacting the behavioral healthcare industry, reductions in reimbursement rates from third-party payors, reductions in service levels under our contracts, operating difficulties, client preferences, changes in competition and general economic or industry conditions. If we are unsuccessful in implementing these improvements or if we do not achieve our expected results, it may adversely impact our business, financial condition or results of operations.

Assumptions of unknown liabilities

Facilities that we acquire may have unknown or contingent liabilities, including, but not limited to, liabilities for failure to comply with healthcare laws and regulations. Although we typically attempt to exclude

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significant liabilities from our acquisition transactions and seek indemnification from the sellers of such facilities for at least a portion of these matters, we do not have indemnification rights against the sellers under the Partnerships in Care acquisition. Even in those acquisitions in which we have such rights, we may experience difficulty enforcing the sellers obligations, or we may incur material liabilities for the past activities of acquired facilities. Such liabilities and related legal or other costs and/or resulting damage to a facility s reputation could negatively impact our business, financial condition or results of operations.

Competing for acquisitions

We face competition for acquisition candidates primarily from other for-profit healthcare companies, as well as from not-for-profit entities. Some of our competitors may have greater resources than we do. As a result, we may pay more to acquire a target business or may agree to less favorable deal terms than we would have otherwise. Our principal competitors for acquisitions have included UHS, Aurora Behavioral Health Care and private equity firms. Also, suitable acquisitions may not be accomplished due to unfavorable terms.

Further, the cost of an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for an acquired facility, the acquired facility s results of operations, the fair value of assets acquired and liabilities assumed, effects of subsequent legislation and limits on rate increases. In addition, we may have to pay cash, incur debt, or issue equity securities to pay for any such acquisition, which could adversely affect our financial results, result in dilution to our stockholders, result in increased fixed obligations or impede our ability to manage our operations.

Managing growth

Some of the facilities we have acquired or may acquire in the future may have had significantly lower operating margins prior to the time of our acquisition or may have had operating losses prior to such acquisition. If we fail to improve the operating margins of the facilities we acquire, operate such facilities profitably or effectively integrate the operations of the acquired facilities, our results of operations could be negatively impacted.

Failure to comply with the international and U.S. laws and regulations applicable to our international operations could subject us to penalties and other adverse consequences.

We face several risks inherent in conducting business internationally, including compliance with international and U.S. laws and regulations that apply to our international operations. These laws and regulations include U.S. laws such as the Foreign Corrupt Practices Act and other U.S. federal laws and regulations established by the Office of Foreign Asset Control, local laws such as the United Kingdom Bribery Act 2010 or other local laws which prohibit corrupt payments to governmental officials or certain payments or remunerations to customers. Given the high level of complexity of these laws, however, there is a risk that some provisions may be inadvertently breached by us, for example through fraudulent or negligent behavior of individual employees, our failure to comply with certain formal documentation requirements, or otherwise. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or our employees, implementation of compliance programs, and prohibitions on the conduct of our business. Any such violations could include prohibitions on our ability to conduct business in the United Kingdom and could materially damage our reputation, our brand, our international expansion efforts, our ability to attract and retain employees, our business and our operating results. Our success depends, in part, on our ability to anticipate these risks and manage these challenges.

If you purchase our common stock in this offering, you will incur immediate and substantial dilution in the book value of your shares.

The public offering price of our common stock is substantially higher than the net tangible book value per share of our outstanding common stock immediately after this offering. As a result, you will suffer immediate

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and substantial dilution in the net tangible book value of the common stock you purchase in this offering. If the underwriters exercise their option to purchase additional shares, you will experience additional dilution.

Future sales of common stock by our existing stockholders may cause our stock price to fall.

The market price of our common stock could decline as a result of sales by our existing stockholders in the market, or the perception that these sales could occur. These sales might also make it more difficult for us to sell equity securities at a time and price that we deem appropriate.

Waud Capital Partners, along with certain members of our management, have certain demand and piggyback registration rights with respect to shares of our common stock beneficially owned by them. The presence of additional shares of our common stock trading in the public market, as a result of the exercise of such registration rights, may have an adverse effect on the market price of our securities.

If securities or industry analysts do not publish research or reports about our business, if they were to change their recommendations regarding our stock adversely or if our operating results do not meet their expectations, our stock price and trading volume could decline.

The trading market for our common stock will be influenced by the research and reports that industry or securities analysts publish about us. If one or more of these analysts cease coverage of us or fail to publish regular reports on us, we could lose visibility in the financial markets, which in turn could cause our stock price or trading volume to decline. Moreover, if one or more of the analysts who cover us downgrade our stock or if our operating results do not meet their expectations, our stock price could decline.

We are party to a stockholders agreement with Waud Capital Partners which provides it with certain rights over Company matters.

Prior to this offering, Waud Capital Partners owned approximately 23% of our outstanding common stock. In accordance with the terms of the stockholders agreement among Waud Capital Partners, Acadia and certain current and former members of our management, for so long as Waud Capital Partners owns at least 17.5% of our outstanding common stock, it is entitled to designate the pro rata number of our directors that is proportional (but rounded up to the nearest whole number) to its percentage ownership of our outstanding common stock, subject to the NASDAQ rules regarding director independence, and has consent rights to many corporate actions, such as issuing equity or debt securities, paying dividends, acquiring any interest in another company and materially changing our business activities. It is possible that the interests of Waud Capital Partners may in some circumstances conflict with our interests and the interests of our other stockholders. Waud Capital Partners is selling shares of our common stock in this offering and is expected to own approximately 18.4% of our outstanding common stock after completion of the offering assuming that the underwriters exercise their option to purchase additional shares in full.

Fluctuations in our operating results, quarter to quarter earnings and other factors, including incidents involving our patients and negative media coverage, may result in significant decreases in the price of our common stock.

The stock markets experience volatility that is often unrelated to operating performance. These broad market fluctuations may adversely affect the trading price of our common stock and, as a result, there may be significant volatility in the market price of our common stock. If we are unable to operate our facilities as profitably as we have in the past or as our stockholders expect us to in the future, the market price of our common stock will likely decline as stockholders could sell shares of our common stock when it becomes apparent that the market expectations may not be realized. In addition to our operating results, many economic and seasonal factors outside of our control could have an adverse effect on the price of our common stock and increase fluctuations in our quarterly earnings. These factors include certain of the risks discussed herein, demographic changes, operating results of other healthcare companies, changes in our financial estimates or

recommendations of securities analysts, speculation in the press or investment community, the possible effects of war, terrorist and other hostilities, adverse weather conditions, the level of seasonal illnesses, managed care contract negotiations and terminations, changes in general conditions in the economy or the financial markets or other developments affecting the healthcare industry. An incident involving one or more of our patients could result in negative media coverage and adversely affect the trading price of our common stock.

We have been and could become the subject of negative media coverage as a result of incidents involving one or more of our patients. If we were to receive such negative publicity or unfavorable media attention, whether warranted or unwarranted, the trading price of our common stock and reputation could be significantly, adversely affected. In addition, we may become subject to increased regulatory burdens, governmental investigations and may be required to pay large judgments or fines.

Our revenues and results of operations are significantly affected by payments received from the government and third-party payors.

A significant portion of the combined companies revenues (after giving effect to the Acquisition) will be from government healthcare programs, principally Medicare, Medicaid and NHS. For the year ended December 31, 2013, Acadia derived approximately 70% of its revenues from the Medicare and Medicaid programs, and Partnerships in Care derived approximately 97% of its revenue from NHS.

Changes in these government programs in recent years have resulted in limitations on reimbursement and, in some cases, reduced levels of reimbursement for healthcare services. Payments from federal, state and UK government healthcare programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations, requirements for utilization review, and governmental funding restrictions, all of which could materially increase or decrease program payments, as well as affect the cost of providing service to patients and the timing of payments to facilities. We are unable to predict the effect of recent and future policy changes on our operations. In addition, since most states operate with balanced budgets, and since the Medicaid program is often a state s largest program, some states can be expected to enact or consider enacting legislation formulated to reduce their Medicaid expenditures. Furthermore, the recent economic downturn has increased the budgetary pressures on the federal government and many state governments, which may negatively affect the availability of taxpayer funds for Medicare and Medicaid programs.

If the rates paid or the scope of services covered by government payors are reduced, there could be a material adverse effect on our business, financial condition and results of operations.

In addition to changes in government reimbursement programs, our ability to negotiate favorable contracts with private payors, including managed care providers, significantly affects the financial condition and operating results of our facilities in the United States. Management expects third-party payors to aggressively manage reimbursement levels and cost controls. Reductions in reimbursement amounts received from third-party payors could have a material adverse effect on our business, financial condition and results of operations.

We are subject to a number of restrictive covenants, which may restrict our business and financing activities.

Our financing arrangements impose, and the terms of any future debt may impose, operating and other restrictions on us. Such restrictions affect, and in many respects limit or prohibit, among other things, our and our subsidiaries ability to:

- incur or guarantee additional debt and issue certain preferred stock;
- pay dividends on our common stock or redeem, repurchase or retire our equity interests or subordinated debt;

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transfer or sell our assets:

make certain payments or investments;

make capital expenditures;

create certain liens on assets;

create restrictions on the ability of our subsidiaries to pay dividends or make other payments to us;

engage in certain transactions with our affiliates; and

merge or consolidate with other companies.

The Amended and Restated Senior Credit Facility also requires us to meet certain financial ratios, including a fixed charge coverage ratio and a consolidated leverage ratio.

The restrictions may prevent us from taking actions that management believes would be in the best interests of our business and may make it difficult for us to successfully execute our business strategy or effectively compete with companies that are not similarly restricted. We also may incur future debt obligations that might subject us to additional restrictive covenants that could affect our financial and operational flexibility. Our ability to comply with these covenants in future periods will largely depend on the pricing of our products and services, our success at implementing cost reduction initiatives and our ability to successfully implement our overall business strategy. We cannot assure you that we will be granted waivers or amendments to our financing arrangements if for any reason we are unable to comply with our financial covenants. The breach of any of these covenants and restrictions could result in a default under the indentures governing the Senior Notes or under the Amended and Restated Senior Credit Facility, which could result in an acceleration of our debt.

If we default on our obligations to pay our debt, we may not be able to make payments on our financing arrangements.

Any default under the agreements governing our debt, including a default under the Amended and Restated Senior Credit Facility, and the remedies sought by the holders of such debt, could adversely affect our ability to pay the principal, premium, if any, and interest on the Senior Notes and substantially decrease the market value of the Senior Notes. If we are unable to generate sufficient cash flows and are otherwise unable to obtain funds necessary to meet required payments of principal, premium, if any, and interest on our debt, or if we otherwise fail to comply with the various covenants, including financial and operating covenants, in the instruments governing our debt (including the Amended and Restated Senior Credit Facility and the indentures governing the Senior Notes), we would be in default under the terms of the agreements governing such debt. In the event of such default, the holders of such debt could elect to declare all the funds borrowed thereunder to be due and payable, the lenders under the Amended and Restated Senior Credit Facility could elect to terminate their commitments or cease making further loans and institute foreclosure proceedings against our assets, or we could be forced to apply all available cash flows to repay such debt, and, in any such case, we could ultimately be forced into bankruptcy or liquidation. Because the indentures governing the Senior Notes and the agreement governing the Amended and Restated Senior Credit Facility have customary cross-default provisions, if the debt under the Senior Notes or under the Amended and Restated Senior Credit Facility is accelerated, we may be unable to repay or refinance the amounts due.

A worsening of the economic and employment conditions in the geographies in which we operate could materially affect our business and future results of operations.

During periods of high unemployment, governmental entities often experience budget deficits as a result of increased costs and lower than expected tax collections. These budget deficits at the federal, state and local

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levels have decreased, and may continue to decrease, spending for health and human service programs, including Medicare and Medicaid in the United States, which are significant payor sources for our facilities. In periods of high unemployment, we also face the risk of potential declines in the population covered under private insurance, patient decisions to postpone or decide against receiving behavioral healthcare services, potential increases in the uninsured and underinsured populations we serve and further difficulties in collecting patient co-payment and deductible receivables.

Furthermore, the availability of liquidity and capital resources to fund the continuation and expansion of many business operations worldwide has been limited in recent years. Our ability to access the capital markets on acceptable terms may be severely restricted at a time when we would like, or need, access to those markets, which could have a negative impact on our growth plans, our flexibility to react to changing economic and business conditions and our ability to refinance existing debt (including debt under our Amended and Restated Senior Credit Facility and the Senior Notes). The recent economic downturn or other economic conditions could also adversely affect the counterparties to our agreements, including the lenders under the Amended and Restated Senior Credit Facility, causing them to fail to meet their obligations to us.

If we fail to comply with extensive laws and government regulations, we could suffer penalties or be required to make significant changes to our operations.

Companies operating in the behavioral healthcare industry in the United States are required to comply with extensive and complex laws and regulations at the federal, state and local government levels relating to, among other things: billing practices and prices for services; relationships with physicians and other referral sources; necessity and quality of medical care; condition and adequacy of facilities; qualifications of medical and support personnel; confidentiality, maintenance and security issues associated with health-related information and patient health information, or PHI; the screening, stabilization and/or transfer of patients who have emergency medical conditions; certification, licensure and accreditation of our facilities; operating policies and procedures; activities regarding competitors; and addition or expansion of facilities and services.

Among these laws are the anti-kickback provision of the Social Security Act, or the Anti-Kickback Statute, the federal physician self-referral, or the Stark Law, the federal False Claims Act, or the False Claims Act, and similar state laws. These laws, and particularly the Anti-Kickback Statute and the Stark Law, impact the relationships that we may have with physicians and other potential referral sources. We have a variety of financial relationships with physicians and other professionals who refer patients to our facilities, including employment contracts, leases and professional service agreements. The Office of the Inspector General of the Department of Health and Human Services has issued certain exceptions and safe harbor regulations that outline practices that are deemed acceptable under the Stark Law and Anti-Kickback Statute. While we endeavor to comply with applicable exceptions and safe harbors, certain of our current arrangements with physicians and other potential referral sources may not qualify for safe harbor protection. Failure to meet a safe harbor does not mean that the arrangement necessarily violates the Anti-Kickback Statute, but may subject the arrangements to greater scrutiny. We cannot offer assurances that practices that are outside of a safe harbor will not be found to violate the Anti-Kickback Statute. Allegations of violations of the Stark Law and Anti-Kickback Statute may be brought under the federal Civil Monetary Penalty Law, which requires a lower burden of proof than other fraud and abuse laws.

These laws and regulations are extremely complex, and, in many cases, we do not have the benefit of regulatory or judicial interpretation. In the future, it is possible that different interpretations of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our arrangements for facilities, equipment, personnel, services, capital expenditure programs and operating expenses. A determination that we have violated one or more of these laws could subject us to liabilities, including civil penalties, exclusion of one or more facilities from participation in the government healthcare programs and, for violations of certain laws and regulations, criminal penalties. Even the public announcement that we are being investigated for possible violations of these laws could cause our reputation to suffer and have a material adverse effect on our business, financial condition or results of operations. In addition,

we cannot predict whether other legislation or regulations at the federal or state level will be adopted, what form such legislation or regulations may take or what their impact on us may be.

The construction and operation of healthcare facilities in the United States are subject to extensive federal, state and local regulation relating to, among other things, the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting, compliance with building codes and environmental protection. Additionally, such facilities are subject to periodic inspection by government authorities to assure their continued compliance with these various standards. If we fail to adhere to these standards, we could be subject to monetary and operational penalties.

Many of our U.S. facilities are also accredited by third-party accreditation agencies such as The Joint Commission. If any of our existing healthcare facilities lose their accreditation or any of our new facilities fail to receive accreditation, such facilities could become ineligible to receive reimbursement under Medicare or Medicaid.

Similarly, providers of behavioral healthcare services in the United Kingdom are also subject to a highly regulated business environment. Failure to comply with regulations, lapses in the standards of care, the receipt of poor ratings or lower ratings, the receipt of a negative report that leads to a determination of regulatory non-compliance, or the failure to cure any defect noted in an inspection report could lead to substantial penalties, including the loss of registration or closure of one or more facilities as well as damage to reputation.

We may be required to spend substantial amounts to comply with statutes and regulations relating to privacy and security of patient health information.

There are currently numerous legislative and regulatory initiatives in both the U.S. and the United Kingdom addressing patient privacy and information security concerns. In particular, federal regulations issued under HIPAA require our U.S. facilities to comply with standards to protect the privacy, security and integrity of PHI. These regulations have imposed extensive administrative requirements, technical and physical information security requirements, restrictions on the use and disclosure of PHI and related financial information and have provided patients with additional rights with respect to their health information. Compliance with these regulations requires substantial expenditures, which could negatively impact our business, financial condition or results of operations. In addition, our management has spent, and may spend in the future, substantial time and effort on compliance measures.

Violations of the privacy and security regulations could subject our operations to substantial civil monetary penalties and substantial other costs and penalties associated with a breach of data security, including criminal penalties.

We may be subject to liabilities from claims brought against our facilities.

We are subject to medical malpractice lawsuits and other legal actions in the ordinary course of business. Some of these actions may involve large claims, as well as significant defense costs. We cannot predict the outcome of these lawsuits or the effect that findings in such lawsuits may have on us. All professional and general liability insurance we purchase is subject to policy limitations. Management believes that, based on our past experience and actuarial estimates, our insurance coverage is adequate considering the claims arising from the operations of our facilities. While we continuously monitor our coverage, our ultimate liability for professional and general liability claims could change materially from our current estimates. If such policy limitations should be partially or fully exhausted in the future, or payments of claims exceed our estimates or are not covered by our insurance, it could have a material adverse effect on our business, financial condition or results of operations.

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We have been and could become the subject of governmental investigations, regulatory actions and whistleblower lawsuits.

Healthcare companies in both the United States and the United Kingdom are subject to numerous investigations by various governmental agencies. Certain of our facilities have received, and other facilities may receive, government inquiries from, and may be subject to investigation by, governmental agencies. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material adverse effect on our business, financial condition and results of operations.

Further, under the federal False Claims Act, private parties are permitted to bring qui tam or whistleblower lawsuits against companies that submit false claims for payments to, or improperly retain overpayments from, the government. Because qui tam lawsuits are filed under seal, we could be named in one or more such lawsuits of which we are not aware.

We are subject to uncertainties regarding recent health reform and budget legislation.

The expansion of health insurance coverage in the United States under the Patient Protection and Affordable Care Act and the Reconciliation Act, or, collectively, the Health Reform Legislation, may increase the number of patients using our facilities who have either private or public program coverage. In addition, a disproportionately large percentage of new Medicaid coverage is likely to be in states that currently have relatively low income eligibility requirements and may include states where we have facilities. Furthermore, as a result of the Health Reform Legislation, there may be a reduction in uninsured patients, which should reduce our expense from uncollectible accounts receivable.

Notwithstanding the foregoing, the Health Reform Legislation makes a number of other changes to Medicare and Medicaid which management believes may have an adverse impact on us. The various provisions in the Health Reform Legislation that directly or indirectly affect reimbursement are scheduled to take effect over a number of years. Health Reform Legislation provisions are likely to be affected by the incomplete nature of implementing regulations or expected forthcoming interpretive guidance, gradual implementation or future legislation. Further, Health Reform Legislation provisions, such as those creating the Medicare Shared Savings Program and the Independent Payment Advisory Board, create certain flexibilities in how healthcare may be reimbursed by federal programs in the future. Thus, we cannot predict the impact of the Health Reform Legislation on our future reimbursement at this time.

The Health Reform Legislation also contains provisions aimed at reducing fraud and abuse in healthcare. The Health Reform Legislation amends several existing laws, including the federal Anti-Kickback Statute and the False Claims Act, making it easier for government agencies and private plaintiffs to prevail in lawsuits brought against healthcare providers. Congress revised the intent requirement of the Anti-Kickback Statute to provide that a person is not required to have actual knowledge or specific intent to commit a violation of the Anti-Kickback Statute in order to be found guilty of violating such law. The Health Reform Legislation also provides that any claims for items or services that violate the Anti-Kickback Statute are also considered false claims for purposes of the federal civil False Claims Act. The Health Reform Legislation provides that a healthcare provider that knowingly retains an overpayment in excess of 60 days is subject to the federal civil False Claims Act.

The impact of the Health Reform Legislation on each of our facilities may vary. We cannot predict the impact the Health Reform Legislation may have on our business, results of operations, cash flow, capital resources and liquidity, or whether we will be able to adapt successfully to the changes required by the Health Reform Legislation.

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We are similarly unable to guarantee that current United Kingdom laws, regulations and regulatory assessment methodologies will not be modified or replaced in the future. Additionally, there is a risk that budget constraints, public spending cuts (such as the cuts announced by the United Kingdom government in the 2010 Comprehensive Spending Review and implemented in the 2011 and 2012 government budgets) or other financial pressures could cause NHS to reduce funding for the types of services that Partnerships in Care provides. Such policy changes in the United Kingdom could lead to fewer services being purchased by publicly funded entities or material changes being made to their procurement practices, any of which could materially reduce Partnerships in Care s revenue. These and other future developments and amendments may negatively impact our operations, which could have a material adverse effect on our business, financial condition or results of operations. See Expanding our operations internationally poses additional risks to our business in this prospectus supplement.

We operate in a highly competitive industry, and competition may lead to declines in patient volumes.

The healthcare industry is highly competitive, and competition among healthcare providers (including hospitals) for patients, physicians and other healthcare professionals has intensified in recent years. There are other healthcare facilities that provide behavioral and other mental health services comparable to at least some of those offered by our facilities in each of the geographical areas in which we operate. Some of our competitors are owned by tax-supported governmental agencies or by nonprofit corporations and may have certain financial advantages not available to us, including endowments, charitable contributions, tax-exempt financing and exemptions from sales, property and income taxes.

If our competitors are better able to attract patients, recruit and retain physicians and other healthcare professionals, expand services or obtain favorable managed care contracts at their facilities, we may experience a decline in patient volume and our results of operations may be adversely affected.

We will similarly face competition in the United Kingdom from other independent sector providers and publicly funded entities for individuals requiring care and for appropriate sites on which to develop or expand facilities in the United Kingdom. Should we fail to compete effectively with our peers and competitors in the industry, or if the competitive environment intensifies, individuals may be referred elsewhere for services that we provide, negatively impacting our ability to secure referrals and limiting the expansion of our business.

The trend by insurance companies and managed care organizations to enter into sole-source contracts may limit our ability to obtain patients.

Insurance companies and managed care organizations in the United States are entering into sole-source contracts with healthcare providers, which could limit our ability to obtain patients since we do not offer the range of services required for these contracts. Moreover, private insurers, managed care organizations and, to a lesser extent, Medicaid and Medicare, are beginning to carve-out specific services, including mental health and substance abuse services, and establish small, specialized networks of providers for such services at fixed reimbursement rates. Continued growth in the use of carve-out arrangements could materially adversely affect our business to the extent we are not selected to participate in such networks or if the reimbursement rate is not adequate to cover the cost of providing the service.

Our performance depends on our ability to recruit and retain quality psychiatrists and other physicians.

The success and competitive advantage of our facilities depends, in part, on the number and quality of the psychiatrists and other physicians on the medical staffs of our facilities and our maintenance of good relations with those medical professionals. Although we employ psychiatrists and other physicians at many of our facilities, psychiatrists and other physicians generally are not employees of our facilities, and, in a number of our markets, they have admitting privileges at competing hospitals providing acute or inpatient behavioral health services. Such physicians (including psychiatrists) may terminate their affiliation with us at any time or admit

their patients to competing healthcare facilities or hospitals. If we are unable to attract and retain sufficient numbers of quality psychiatrists and other physicians by providing adequate support personnel and facilities that meet the needs of those psychiatrists and other physicians, they may stop referring patients to our facilities and our results of operations may decline.

It may become difficult for us to attract and retain an adequate number of psychiatrists and other physicians to practice in certain of the communities in which our facilities are located. Our failure to recruit psychiatrists and other physicians to these communities or the loss of such medical professionals in these communities could make it more difficult to attract patients to our facilities and thereby may have a material adverse effect on our business, financial condition or results of operations. Additionally, our ability to recruit psychiatrists and other physicians is closely regulated. The form, amount and duration of assistance we can provide to recruited psychiatrists and other physicians is limited by the Stark Law, the Anti-Kickback Statute, state anti-kickback statutes, and related regulations. For example, the Stark Law requires, among other things, that recruitment assistance can be provided only to psychiatrists and other physicians who meet certain geographic and practice relocation requirements, that the amount of assistance cannot be changed during the term of the recruitment agreement, and that the recruitment payments cannot generally benefit psychiatrists and other physicians currently in practice in the community beyond recruitment costs actually incurred by them.

Our facilities face competition for staffing that may increase our labor costs and reduce our profitability.

Our operations depend on the efforts, abilities, and experience of our management and medical support personnel, including our therapists, nurses, pharmacists and mental health technicians, as well as our psychiatrists and other professionals. We compete with other healthcare providers in recruiting and retaining qualified management, physicians (including psychiatrists) and support personnel responsible for the daily operations of our business, financial condition or results of operations.

The nationwide shortage of nurses and other medical support personnel in the United States has been a significant operating issue facing us and other healthcare providers. This shortage may require us to enhance wages and benefits to recruit and retain nurses and other medical support personnel or require us to hire more expensive temporary or contract personnel. In addition, certain of our facilities are required to maintain specified staffing levels. To the extent we cannot meet those levels, we may be required to limit the services provided by these facilities, which would have a corresponding adverse effect on our net operating revenues.

Increased labor union activity is another factor that could adversely affect our labor costs. As of May 31, 2014, labor unions represented employees at only three of our facilities and three of our outpatient clinics. Upon closing of the Acquisition, the Royal College of Nursing will represent nursing employees at all of our facilities in the United Kingdom. To the extent that a greater portion of our employee base unionizes, it is possible that our labor costs could increase materially.

We cannot predict the degree to which we will be affected by the future availability or cost of attracting and retaining talented medical support staff. If our general labor and related expenses increase, we may not be able to raise our rates correspondingly. Our failure either to recruit and retain qualified management, psychiatrists, therapists, nurses and other medical support personnel or control our labor costs could have a material adverse effect on our results of operations.

We depend heavily on key management personnel, and the departure of one or more of our key executives or a significant portion of our local facility management personnel could harm our business.

The expertise and efforts of our senior executives and the chief executive officer, chief financial officer, medical director, physicians and other key members of our facility management personnel are critical to the success of our business. The loss of the services of one or more of our senior executives or of a significant portion of our facility management personnel could significantly undermine our management expertise and our ability to provide efficient, quality healthcare services at our facilities, which could harm our business.

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The Partnerships in Care senior management team is important to our acquisition of Partnerships in Care. The loss of members of the Partnerships in Care management team could impact our ability to successfully integrate and operate the Partnerships in Care facilities and business.

We could face risks associated with, or arising out of, environmental, health and safety laws and regulations.

We are subject to various federal, state and local laws and regulations that:

- regulate certain activities and operations that may have environmental or health and safety effects, such as the generation, handling and disposal of medical wastes;
- impose liability for costs of cleaning up, and damages to natural resources from, past spills, waste disposals on and off-site, or other releases of hazardous materials or regulated substances; and
- regulate workplace safety.

Compliance with these laws and regulations could increase our costs of operation. Violation of these laws may subject us to significant fines, penalties or disposal costs, which could negatively impact our results of operations, financial condition or cash flows. We could be responsible for the investigation and remediation of environmental conditions at currently or formerly operated or leased sites, as well as for associated liabilities, including liabilities for natural resource damages, third party property damage or personal injury resulting from lawsuits that could be brought by the government or private litigants, relating to our operations, the operations of facilities or the land on which our facilities are located. We may be subject to these liabilities regardless of whether we lease or own the facility, and regardless of whether such environmental conditions were created by us or by a prior owner or tenant, or by a third party or a neighboring facility whose operations may have affected such facility or land. That is because liability for contamination under certain environmental laws can be imposed on current or past owners or operators of a site without regard to fault. We cannot assure you that environmental conditions relating to our prior, existing or future sites or those of predecessor companies whose liabilities we may have assumed or acquired will not have a material adverse effect on our business, financial condition or results of operations.

State efforts to regulate the construction or expansion of healthcare facilities in the United States could impair our ability to operate and expand our operations.

A majority of the states in which we operate facilities in the United States have enacted certificate of need, or CON, laws that regulate the construction or expansion of healthcare facilities, certain capital expenditures or changes in services or bed capacity. In giving approval for these actions, these states consider the need for additional or expanded healthcare facilities or services. Our failure to obtain necessary state approval could (i) result in our inability to acquire a targeted facility, complete a desired expansion or make a desired replacement, (ii) make a facility ineligible to receive reimbursement under the Medicare or Medicaid programs or (iii) result in the revocation of a facility s license or impose civil or criminal penalties on us, any of which could harm our business.

In addition, significant CON reforms have been proposed in a number of states that would increase the capital spending thresholds and provide exemptions of various services from review requirements. In the past, we have not experienced any material adverse effects from such requirements, but we cannot predict the impact of these changes upon our operations.

We may be unable to extend leases at expiration, which could harm our business, financial condition or results of operations.

We lease the real property on which a number of our facilities are located. Our lease agreements generally give us the right to renew or extend the term of the leases and, in certain cases, purchase the real

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property. These renewal and purchase rights generally are based upon either prescribed formulas or fair market value. Management expects to renew, extend or exercise purchase options with respect to our leases in the normal course of business; however, there can be no assurance that these rights will be exercised in the future or that we will be able to satisfy the conditions precedent to exercising any such renewal, extension or purchase options. Furthermore, the terms of any such options that are based on fair market value are inherently uncertain and could be unacceptable or unfavorable to us depending on the circumstances at the time of exercise. If we are not able to renew or extend our existing leases, or purchase the real property subject to such leases, at or prior to the end of the existing lease terms, or if the terms of such options are unfavorable or unacceptable to us, our business, financial condition or results of operations could be adversely affected.

Controls designed to reduce inpatient services may reduce our revenues.

Controls imposed by Medicare, Medicaid and commercial third-party payors designed to reduce admissions and lengths of stay, commonly referred to as utilization review, have affected and are expected to continue to affect our facilities. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payor-required preadmission authorization and utilization review and by payor pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. For example, the Health Reform Legislation potentially expands the use of prepayment review by Medicare contractors by eliminating statutory restrictions on its use. Utilization review is also a requirement of most non-governmental managed-care organizations and other third-party payors. Although we are unable to predict the effect these controls and changes will have on our operations, significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material adverse effect on our financial condition and results of operations.

Additionally, the outsourcing of behavioral health care to the private sector is a relatively recent development in the United Kingdom. There has been some opposition to outsourcing. While we anticipate that NHS will continue to rely increasingly upon outsourcing, we cannot assure you that the outsourcing trend will continue. The absence of future growth in the outsourcing of behavioral healthcare services could have a material adverse impact on our business, financial condition and results of operations.

Although we have facilities in 24 states and Puerto Rico (prior to giving effect to the Acquisition), we have substantial operations in each of Arkansas, Michigan, Mississippi, Tennessee and Texas, which makes us especially sensitive to regulatory, economic, environmental and competitive conditions and changes in those states.

At December 31, 2013, we operated 51 facilities, 16 of which are located in Arkansas, Michigan, Mississippi, Tennessee and Texas. Our revenues in those states represented approximately 45% of our revenue for the year ended December 31, 2013. This concentration makes us particularly sensitive to legislative, regulatory, economic, environmental and competition changes in those states. Any material change in the current payment programs or regulatory, economic, environmental or competitive conditions in these states could have a disproportionate effect on our overall business results.

In addition, some of our facilities are located in hurricane-prone areas. In the past, hurricanes have had a disruptive effect on the operations of facilities and the patient populations in hurricane-prone areas. Our business activities could be significantly disrupted by a particularly active hurricane season or even a single storm, and our property insurance may not be adequate to cover losses from such storms or other natural disasters.

We are required to treat patients with emergency medical conditions regardless of ability to pay.

In accordance with our internal policies and procedures, as well as the Emergency Medical Treatment and Active Labor Act, or EMTALA, we provide a medical screening examination to any individual who comes to one of our hospitals while in active labor and/or seeking medical treatment (whether or not such individual is eligible for insurance benefits and regardless of ability to pay) to determine if such individual has an emergency

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medical condition. If it is determined that such person has an emergency medical condition, we provide such further medical examination and treatment as is required to stabilize the patient s medical condition, within the facility s capability, or arrange for transfer of such individual to another medical facility in accordance with applicable law and the treating hospital s written procedures. Our obligations under EMTALA may increase substantially; Centers for Medicare and Medicaid Services has recently sought stakeholder comments concerning the potential applicability of EMTALA to hospital inpatients and the responsibilities of hospitals with specialized capabilities, such as ours, to accept the transfer of such patients. If the number of indigent and charity care patients with emergency medical conditions we treat increases significantly, or if regulations expanding our obligations to inpatients under EMTALA are proposed and adopted, our results of operations may be harmed.

An increase in uninsured or underinsured patients or the deterioration in the collectability of the accounts of such patients could harm our results of operations.

Collection of receivables from third-party payors and patients is critical to our operating performance. Our primary collection risks relate to uninsured patients and the portion of the bill that is the patient s responsibility, which primarily includes co-payments and deductibles. We estimate our provisions for doubtful accounts based on general factors such as payor source, the agings of the receivables and historical collection experience. At December 31, 2013, our allowance for doubtful accounts represented approximately 19% of our accounts receivable balance as of such date. We routinely review accounts receivable balances in conjunction with these factors and other economic conditions that might ultimately affect the collectability of the patient accounts and make adjustments to our allowances as warranted. Significant changes in business office operations, payor mix, economic conditions or trends in federal and state governmental health coverage (including implementation of the Health Reform Legislation) could affect our collection of accounts receivable, cash flow and results of operations. If we experience unexpected increases in the growth of uninsured and underinsured patients or in bad debt expenses, our results of operations will be harmed.

A cyber security incident could cause a violation of HIPAA and other privacy laws and regulations or result in a loss of confidential data.

A cyber-attack that bypasses our information technology, or IT, security systems causing an IT security breach, loss of PHI or other data subject to privacy laws, loss of proprietary business information, or a material disruption of our IT business systems, could have a material adverse impact on our business, financial condition or results of operations. In addition, our future results of operations, as well as our reputation, could be adversely impacted by theft, destruction, loss, or misappropriation of PHI, other confidential data or proprietary business information.

Failure to maintain effective internal control over financial reporting in accordance with Section 404 of Sarbanes-Oxley, could have a material adverse effect on our business.

We are required to maintain internal control over financial reporting under Section 404 of Sarbanes-Oxley. If we are unable to maintain adequate internal control over financial reporting, we may be unable to report our financial information on a timely basis, may suffer adverse regulatory consequences or violations of NASDAQ listing rules and may breach the covenants under our financing arrangements. There could also be a negative reaction in the financial markets due to a loss of investor confidence in us and the reliability of our financial statements. Confidence in our financial statements is also likely to suffer if we or our independent registered public accounting firm report a material weakness in our internal control over financial reporting.

We incur substantial costs as a result of being a public company.

As a public company, we incur significant legal, accounting, insurance and other expenses, including costs associated with public company reporting requirements. We incur costs associated with complying with the requirements of the Sarbanes-Oxley Act of 2002, or Sarbanes-Oxley, the Dodd-Frank Wall Street Reform and

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Consumer Protection Act, or the Dodd-Frank Act, and related rules implemented by the SEC and NASDAQ. Enacted in July 2010, the Dodd-Frank Act contains significant corporate governance and executive compensation-related provisions, some of which the SEC has recently implemented by adopting additional rules and regulations in areas such as executive compensation. The expenses incurred by public companies generally for reporting and corporate governance purposes have been increasing. Management expects these laws and regulations to increase our legal and financial compliance costs and to make some activities more time-consuming and costly, although management is currently unable to estimate these costs with any degree of certainty. These laws and regulations could make it more difficult or costly for us to obtain certain types of insurance, including director and officer liability insurance, and we may be forced to accept reduced policy limits and coverage or incur substantially higher costs to obtain the same or similar coverage. These laws and regulations could also make it more difficult for us to attract and retain qualified persons to serve on our board of directors, our board committees or as our executive officers. Furthermore, if we are unable to satisfy our obligations as a public company, we could be subject to delisting of our common stock, fines, sanctions and other regulatory action and potentially civil litigation.

Provisions of our charter documents or Delaware law could delay or prevent an acquisition of us, even if the acquisition would be beneficial to our stockholders, and could make it more difficult for stockholders to change management.

Provisions of our amended and restated certificate of incorporation and amended and restated bylaws may discourage, delay or prevent a merger, acquisition or other change in control that stockholders may consider favorable, including transactions in which stockholders might otherwise receive a premium for their shares. This is because these provisions may prevent or frustrate attempts by stockholders to replace or remove our management. These provisions include:

a classified board of directors;

a prohibition on stockholder action through written consent;

a requirement that special meetings of stockholders be called only upon a resolution approved by a majority of our directors then in office;

advance notice requirements for stockholder proposals and nominations; and

the authority of the board of directors to issue preferred stock with such terms as the board of directors may determine.

Section 203 of the Delaware General Corporation Law, as amended, or DGCL, prohibits a publicly-held Delaware corporation from engaging in a business combination with an interested stockholder, generally a person that together with its affiliates owns or within the last three years has owned 15% of voting stock, for a period of three years after the date of the transaction in which the person became an interested stockholder, unless the business combination is approved in a prescribed manner. Although we have elected not to be subject to Section 203 of the DGCL, our amended and restated certificate of incorporation contains provisions that have the same effect as Section 203, except that they provide that Waud Capital Partners, its affiliates and any investment fund managed by Waud Capital Partners and any persons to whom Waud Capital Partners sells at least five percent (5%) of our outstanding voting stock will be deemed to have been approved by our board of directors, and thereby not subject to the restrictions set forth in our amended and restated certificate of incorporation that have the same effect as Section 203 of the DGCL. Accordingly, the provision in our amended and restated certificate of incorporation that adopts a modified version of Section 203 of the DGCL may discourage, delay or prevent a change in control of us.

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As a result of these provisions in our charter documents and Delaware law, the price investors may be willing to pay in the future for shares of our common stock may be limited.

We do not anticipate paying any cash dividends in the foreseeable future.

We intend to retain our future earnings, if any, for use in our business or for other corporate purposes and do not anticipate that cash dividends with respect to common stock will be paid in the foreseeable future. Any decision as to the future payment of dividends will depend on our results of operations, financial position and such other factors as our board of directors, in its discretion, deems relevant. In addition, the terms of our debt substantially limit our ability to pay dividends. As a result, capital appreciation, if any, of our common stock will be a stockholder s sole source of gain for the foreseeable future.

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THE ACQUISITION AND FINANCING TRANSACTIONS

Acquisition of Partnerships in Care

On June 3, 2014, a subsidiary of Acadia agreed to acquire the entire issued share capital of Partnerships in Care Investments 1 Limited, a company incorporated in England and Wales, and the issued and outstanding A ordinary shares in the capital of Partnerships in Care Property 1 Limited, a company incorporated in England and Wales, pursuant to a share purchase agreement by and among Acadia, Piper Holdco 2, Ltd., a subsidiary of Acadia, Partnerships in Care Holdings, Ltd. and The Royal Bank of Scotland plc, or RBS. Acadia joined the Agreement for the purpose of guarantying the Purchaser s obligations arising under the Agreement. Under the terms of the share purchase agreement, Acadia will pay an amount to discharge the outstanding debt facilities of the target companies, and cash consideration for the equity to be acquired, which in the aggregate will be equal to £395.0 million (approximately $660.0 million), subject to adjustment in relation to cash, debt and working capital balances of the target companies. A portion of the Partnerships in Care pre-acquisition debt owed to RBS is being equitized in connection with the acquisition.

The entities to be acquired by Acadia in the Acquisition own and operate 23 inpatient behavioral health facilities with over 1,200 beds. The facilities are located in England, Wales and Scotland. For the year ended December 31, 2013 and the three months ended March 31, 2014, Partnerships in Care generated revenue of $267.0 million and $69.5 million, respectively, primarily through the operation and management of inpatient behavioral health facilities.

The share purchase agreement contains certain warranties by the sellers of the Partnerships in Care equity interests, including warranties about the authorization of such entities to enter into the share purchase agreement and ownership of the shares to be sold, as well as warranties about the target companies business. The agreement does not provide either party with indemnification rights relating to warranties and there are no conditions to closing of the Acquisition.

In the share purchase agreement, the seller of the interests of Partnerships in Care Investments 1 Limited agreed among other things that, prior to the closing, it shall (i) use its reasonable endeavors to procure that (a) no target company undertake any conduct outside of the ordinary course of business without the prior written consent of Acadia, (b) each target company maintain in force all insurance policies and (c) no target company shall take certain identified actions without the prior written consent of Acadia; (ii) assist Acadia with the preparation of customary offering documents and information memoranda and similar documents in connection with the financing of the Transaction, deliver (or cause its accountants to deliver) accountants comfort letters and consents of accountants for use of their reports in any required filings, provide customary authorization letters for Acadia s financing transactions and cooperate with Acadia s marketing efforts; and (iii) procure that Acadia representatives and advisers be given reasonable access to the senior personnel, books, records, correspondence and databases of each target company. Acadia agreed not to change, amend or otherwise modify the financing commitment in a manner that would materially prejudice Acadia s ability to pay the purchase price or terminate any of the financing commitment and has agreed to take all reasonable endeavors to satisfy its obligations under the financing commitment agreements. The share purchase agreement provides that no party to the agreement has the right to rescind or otherwise terminate the agreement.

We expect to close the Acquisition on July 1, 2014. Consummation of this offering is not conditioned upon the closing of the Acquisition. We cannot assure you that the Acquisition will close as expected or at all. See Risk Factors We may be unable to complete our planned acquisition of Partnerships in Care on currently anticipated terms, or at all.

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Strategic Rationale

We expect to realize significant benefits from the acquisition of Partnerships in Care. Our rationale for the Acquisition includes the following:

Expand our geographic presence into a new, attractive market. The mental health market in the United Kingdom was roughly £14.4 billion in 2013. The independent mental health market accounted for roughly £1.1 billion of that amount, or approximately 8% market share. As a result of government budget constraints and an increased focus on quality, the independent mental health market has witnessed significant expansion in the last decade, making it one of the fastest growing sectors in United Kingdom healthcare industry.

Acquire a leading platform in the market. Partnerships in Care is the second largest independent provider of inpatient behavioral healthcare services in the United Kingdom, operating 23 inpatient behavioral health facilities with over 1,200 beds. The company holds an approximately 16% market share of the independent behavioral health market. In addition, Partnerships in Care is one of only two independent providers in the United Kingdom offering the full spectrum of mental health services. Partnerships in Care also has an experienced management team with market knowledge and relationships within the industry and governmental bodies.

Financially attractive and accretive acquisition. Assuming the Acquisition is completed as planned on July 1, 2014, we expect the combined benefits of increased adjusted EBITDA and a reduced income tax rate will produce earnings accretion (not including the impact of any future acquisitions beyond the purchase of Partnerships in Care or any transaction-related expenses).

Opportunities for future growth. Demand for independent behavioral health services has grown significantly in the United Kingdom as a result of NHS reducing bed capacity and increased hospitalization rates. Outsourcing demand is expected to increase in light of additional bed closures and reduction in community capacity by NHS. The independent market in the United Kingdom is highly fragmented with the largest four players accounting for 58% market share. These factors present opportunities for growth by well capitalized, experienced operators. In addition, Acadia management sees meaningful opportunities to produce organic growth in Partnerships in Care s existing facilities through the addition of new beds and service line expansions to meet areas of unmet need. Management also expects to pursue additional select acquisitions in the United Kingdom.

Financing Transactions

We intend to fund the planned acquisition of Partnerships in Care in part through this offering and in part through a fifth amendment to our existing Amended and Restated Senior Credit Facility (as amended, the Proposed Amended and Restated Senior Credit Facility). We anticipate that the Proposed Amended and Restated Senior Credit Facility will continue to provide for an existing $300.0 million revolver and $296.3 million in existing Term A Loans, and will provide for up to $300.0 million in new Term B Loans, which we will use partially to fund the Acquisition. At the same time, we are pursuing a consent solicitation (scheduled to expire on June 17, 2014) under our 2018 Indenture (subject to receipt of requisite consents in the consent solicitation) in order to facilitate our incurring additional permitted liens securing indebtedness so long as our secured leverage ratio is under 3.5x. This is an increase from the current secured leverage ratio of 3.0x. In the event that the amount of the new Term B Loans available under the Proposed Amended and Restated Senior Credit Facility is less than anticipated or the consent solicitation is unsuccessful, we intend to borrow additional amounts under our revolver, issue additional senior unsecured notes, or borrow under our committed bridge facility to fund the Acquisition. We expect that the Proposed Amended and Restated Senior Credit Facility will become effective commensurate with the closing of the Acquisition on July 1, 2014. We cannot assure you that this amendment to our existing Amended and Restated Senior Credit Facility will be executed as anticipated or at all. See Risk Factors We may be unable to complete our planned acquisition of Partnerships in Care on currently anticipated terms, or at all.

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We anticipate that the new Term B Loans will mature on July 1, 2021, and will be subject to quarterly amortization of principal equal to 0.25% of the original aggregate principal amount of the Term B Loans with the balance payable at maturity. The Term A Loans will continue to amortize in accordance with their current terms. Borrowings under the Proposed Amended and Restated Senior Credit Facility will be guaranteed by each of our wholly-owned domestic subsidiaries (other than certain excluded subsidiaries) and are secured by a lien on substantially all of the personal property of Acadia and our wholly-owned domestic subsidiaries (other than certain excluded subsidiaries), as well as mortgages on individual parcels of real property owned by us or such domestic subsidiaries with a fair market value of more than $3.0 million. We may elect for the loans to be LIBOR Rate Loans or Base Rate Loans. LIBOR Rate Loans bear interest at the Applicable Margin plus LIBOR (as approved by the Administrative Agent and published in a commercially available source prior to commencement of the interest rate period). Meanwhile, Base Rate Loans bear interest at the Applicable Margin plus the highest of (i) the federal funds rate plus 1/2 of 1.0%, (ii) the prime rate and (iii) the one month LIBOR Rate plus 1.0%. In addition, we will be required to pay a commitment fee on undrawn amounts under the revolver.

The Applicable Margin under the revolver and Term A Loans depends on our consolidated total net leverage ratio (defined as consolidated funded debt to consolidated EBITDA, in each case as defined in the Proposed Amended and Restated Senior Credit Facility). The Applicable Margin and the unused line fee on unused commitments for the Term A Loans and the revolver will be based upon the following pricing tiers:

Pricing Tier	Consolidated Total Net Leverage Ratio	LIBOR Rate Loans	Base Rate Loans	Unused Line Fee
1	<3.5:1.0	2.25%	1.25%	0.30%
2	³3.5:1.0 but <4.0:1.0	2.50%	1.50%	0.35%
3	³4.0:1.0 but <4.5:1.0	2.75%	1.75%	0.40%
4	³4.50:1.0 but <5.25:1.0	3.00%	2.00%	0.45%
5	³5.25:1.0	3.25%	2.25%	0.50%

We anticipate that the Applicable Margin for the Term B Loans will be 3.25% for LIBOR Rate Loans and 2.25% for Base Rate Loans. For the Term B Loans only, LIBOR will be deemed to be not less than 1.00% per annum, and Base Rate will be deemed to be not less than 2.00% per annum.

The Proposed Amended and Restated Senior Credit Facility will require us and our subsidiaries to comply with customary affirmative, negative and financial covenants, all of which will be subject to customary exceptions, materiality thresholds and qualifications. A breach of any of the restrictions or covenants in our debt agreements could cause a cross-default under other debt agreements. We may be required to pay all of our indebtedness immediately if we default on any of the numerous financial or other restrictive covenants contained in any of our material debt agreements. With respect to the revolver and Term A Loans only, we will be required to maintain a maximum consolidated total net leverage ratio, a maximum senior secured net leverage ratio and a minimum fixed charge coverage ratio with amounts to be agreed. We anticipate that the Term B Loans will not be subject to the financial covenants.

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In the event that we are unable to obtain the required lender consent to the amendment to our existing Amended and Restated Senior Credit Facility on the terms discussed above, Bank of America, N.A., and any parties that join the commitment papers, along with their respective affiliates, has committed separately to provide us a $300.0 million revolving credit facility, or the Backstop Revolver, and a $296.3 million senior secured term A facility, or the Backstop Term A Facility and, together with the Backstop Revolver, the Backstop Facilities, as well as the Term B Loans. The Backstop Facilities would be on substantially similar terms to the existing Amended and Restated Senior Credit Facility, except that the Backstop Term A Facility will amortize in the following amounts (expressed as a percentage of the initial principal amount thereof) in each year following the closing of the Acquisition, in each case in equal quarterly installments:

Year	% of Initial Principal Amount
1	2.50%
2	5.00%
3	7.50%
4	10.00%
5	12.50%

In the event that we are unable to consummate this equity offering, Bank of America, N.A., and any parties that join the commitment papers, along with their respective affiliates, has also committed to provide us with senior unsecured increasing rate bridge loans in an amount up to $325.0 million, which will be used to fund the Acquisition.

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PARTNERSHIPS IN CARE

Overview

Partnerships in Care is the second largest independent provider of inpatient behavioral healthcare services in the United Kingdom, operating 23 inpatient behavioral health facilities with over 1,200 beds. The facilities are located in England, Wales and Scotland. For the year ended December 31, 2013 and the three months ended March 31, 2014, Partnerships in Care generated revenue of $267.0 million and $69.5 million, respectively, primarily through the operation and management of inpatient behavioral health facilities. The company has over 27 years of experience in caring for men and women with complex mental health needs, including mental illness, learning disability, personality disorder, autistic spectrum disorder and brain injury rehabilitation, including stroke and respite services. All services are provided by on-site multi-disciplinary teams who work with the company s newly re-launched Care Programme Approach (CPA) and follow a recovery model designed to empower patients. Partnerships in Care provides a range of mental health services across all security levels, including:

- Providing medium secure, low secure, inpatient and community rehabilitation;
- Supporting the safe and positive re-integration of patients into the community;
- Tailoring individual, evidence-based treatment programs with clearly specified goals and timetables;
- Utilizing forensic specialization with a focus on risk reduction, relapse prevention and independent living; and
- Offering acute care for patients requiring short periods of stabilization.

United Kingdom Mental Health Industry

NHS is the publically funded healthcare system for the United Kingdom, with an annual budget of £106 billion, making it the largest single payer healthcare system in the world. The mental health market in the United Kingdom accounted for approximately £14.4 billion in 2013, with NHS acting as the primary provider of mental health services in the United Kingdom with approximately 70% of the total mental health hospital beds. The independent mental health market is comprised of approximately 41% medium and low secure facilities, 13.2% acute services, 38.8% rehabilitation and other services, and 6.7% acquired brain injury services, with approximately 87% of the funding for mental health services in the United Kingdom provided by NHS. While NHS is the preferred provider of mental health services in the United Kingdom and a bias towards referrals to NHS has maintained high NHS occupancy rates, NHS capacity is not optimized and NHS lacks the capital to address specific local demand patterns through capacity expansion or reconfiguration. As a result, mismatches between local demand and NHS supply exist that allows for independent mental health providers, such as Partnerships in Care, to address these specific patient demands.

Mental health services in the United Kingdom are provided through three separate commissioning entities, each with their own separate budget and defined service responsibilities. The three entities are as follows: (i) Local Area Teams, which commission specialist mental health services (e.g., secure facilities and some acute facilities), (ii) Clinical Commissioning Groups, which commission all acute, rehab and most community based services, and (iii) Local Authorities, which commission the remaining community mental health services (which focus primarily on learning disability services). In recent years, NHS has placed increasing emphasis on implementing integrated care pathways in its mental health commissioning strategy, and the three commissioning entities are currently working to implement an integrated care pathways strategy through which all the services within the secure pathway are commissioned from the same provider (or provider

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consortium). Integrated care pathways provide patients with highly coordinated and personalized care overseen by a single provider that can monitor patient progression through each stage of the care pathway. Additionally, commissioning trends toward moving patients more quickly down care pathways, out of secure settings and into community focused care teams have increased the demand for community and rehabilitation services in the independent mental health market. The United Kingdom Department of Health recently identified priorities for essential change in mental health that include, among other things, funding providers based on the quality of their service rather than volume of patients, allocating funds to support specialized housing for people with mental health problems and adopting a new rating system and inspection process to improve the quality of care.

Increasing political focus on the provision of mental health services in the United Kingdom and increasing support for the rights of mental health patients are expected to lead to further increases in the size of the mental health market in the United Kingdom. In addition, rising demand for mental health services in the United Kingdom coupled with a constrained mental healthcare funding environment are increasing pressure to improve operational efficiency and refer patients to single provider programs with care pathways that more appropriately reflect each patient s specific mental health needs. As a result of these pressures and an increased focus on quality, the independent mental health market has witnessed significant expansion in the last decade, making it one of the fastest growing sectors in the United Kingdom healthcare industry.

Description of Facilities

Partnerships in Care provides inpatient services through mental health hospitals and care homes and works continuously to expand its national network of care pathways to offer choice to each patient in its care. In addition to care pathway services, Partnerships in Care also operates a division that leverages on its clinical knowledge to provide Employee Assistance Programs (EAP) to organizations.

Mental Health Hospitals

Mental health hospitals provide psychiatric treatment and nursing for sufferers of mental disorders, specifically for patients detained under a section of the United Kingdom s Mental Health Act of 1983, and whose risk of harm to others and risk of escape from hospitals cannot be managed safely within other mental health settings. In order to manage the risks involved with treating patients, the facility is managed through the application of a range of security measures depending on the level of dependency and risk exhibited by the patient. The levels of dependency and risk stemming from the wide range of disorders treated at these hospitals determine the level of security and care provided, which are comprised of:

Medium Secure Facilities. Medium secure facilities treat patients who may present a serious danger to others and themselves but do not need the physical security arrangements of a high security hospital. The purpose of medium secure services is to provide effective care and treatment to reduce risk, promote recovery and support patients moving through the care pathway to lower levels of security or to reestablishing themselves successfully in the community. Partnerships in Care currently has 448 medium secure beds, which accounts for 36.0% of Partnerships in Care s total inpatient beds, with patients typically remaining in treatment for an average of 15 months.

Low Secure Facilities. Low secure facilities provide treatment for patients whom, because of the level of risk or challenge they present, cannot be treated in open mental health settings. Low secure services deliver intensive, comprehensive and multidisciplinary treatment to patients demonstrating disturbed behavior in the context of a serious mental disorder and require the provision of security but pose a lesser risk of harm to themselves and to others. Partnerships in Care currently has 410 low secure beds, which accounts for 33.0% of Partnerships in Care s total inpatient beds, with patients typically remaining in treatment for an average of 27 months.

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Rehabilitation Services. Both locked and open mental health rehabilitation services provide a bridge between secure hospital facilities and community living by providing relapse prevention and social integration services as well as vocational opportunities. Partnerships in Care currently has 230 locked rehabilitation beds and 33 open rehabilitation beds, which accounts for 18.5% and 2.7%, respectively, of Partnerships in Care s total inpatient beds, with patients typically remaining in treatment for an average of 14 months in locked rehabilitation and of 78 months in open rehabilitation.

Acute Services. Acute services provide treatment relating to emergency admissions for patients at risk to themselves or others, as well as crisis intervention and treatment of behavioral emergencies. Partnerships in Care currently has 61 acute care beds, which accounts for 4.9% of Partnerships in Care s total inpatient beds.

Care Homes

Care homes provide long-term, non-acute care for adults suffering from a mental illness or addiction, or who have a learning disability or brain injury and are unable to cope unsupported in the community. Patients utilizing care home services do not require conditions of either low or medium security. Partnerships in Care currently has 62 beds registered as care homes.

Care First

In addition to the care pathway services described above, Partnerships in Care also operates a division that leverages on its clinical knowledge to provide Employee Assistance Programs (EAP) to organizations. These support services are designed to help employees manage difficult issues in their professional or personal lives with services that include:

A call center for telephone counseling available 24-hours a day, seven days a week;

A national network of counselors available for live, face-to-face support;

Interactive health and wellness programs;

Debt management advice services; and

Management training.

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Facilities

The following table summarizes the services provided by, and information regarding, Partnerships in Care facilities as of May 31, 2014:

Facility	Type of Facility or Key Service(1)	Location	# of Licensed Beds
Abbey House	RH	Malvern Wells, Worcestershire, England	22
Aderyn	RH	Penperlleni, Pontypool, Monmouthshire, Wales	19
Annesley House	LS & RH	Annesley, Nottinghamshire, England	29
Arbury Court	MS & LS	Winwick, Warrington, Cheshire, England	74
The Ayr Clinic	LS	Ayrshire, Scotland	34
Brain Injury Services Essex	BI	Ardleigh, Colchester, Essex, England	24
Brain Injury Services Northampton	BI	Grafton Regis, Northamptonshire, England	27
Burston House	LS	Burston, Norfolk, England	31
Calverton Hill	MS & LS	Arnold, Nottinghamshire, England	64
The Dene	MS, LS & AA	Hassocks, West Sussex, England	84
Hazelwood House	LS	Chesterfield, Derbyshire, England	14
Kemple View	LS & RH	Langho, Lancashire, England	90
Kneesworth House	MS, LS, RH & AA	Royston, Hertfordshire, England	155
Learning Disability Services Community Rehab	RH	Norfolk, England	16
Llanarth Court	MS, LS & RH	Abergavenny, Monmouthshire, Wales	114
North London Clinic	MS, LS & RH	Edmonton, London, England	61
Oaktree Manor	LS, RH	Tendring & Rainham, Essex, England	57
Pelham Woods	RH	Dorking, Surrey, England	21
The Spinney	MS, LS, RH & AA	Atherton, Manchester, England	92
St. John s House	MS & LS	Palgrave, Norfolk, England	74
Stockton Hall	MS	Stockton-on-the-Forest, York, England	112
Suttons Manor	LS	Romford, Essex, England	24
The Willows	RH	Newark, Nottinghamshire, England	6

(1) The following definitions apply to the services listed in this column: MS means medium secure; LS means low secure; RH means rehab services; BI means brain injury and AA means acute services.

Sources of Revenue

Approximately 97% of Partnerships in Care s revenue is paid by NHS. Partnerships in Care receives funding for the provision of services primarily through the following types of arrangements with publicly funded entities:

Framework Agreements. Framework agreements are typically awarded to providers on a non-exclusive basis pursuant to a public tender. These agreements outline various service and reporting obligations as well as pricing terms. Framework agreements can be set up for any period of time, although a typical framework agreement is at least two years in length. The framework agreement establishes a basis for publicly funded entities to consider a provider s services, but it does not guarantee any minimum purchasing obligations or placements in its services. In addition, service users may be removed or placed elsewhere at short notice. The actual care package to be provided to an individual in a provider s care and the pricing for such services is agreed on a case by case basis at the time an assessment of their individual needs is made.

Spot Agreements. Regardless of whether a provider s relationship with a particular publicly funded entity is governed by a framework agreement, most admissions and referrals remain based on

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spot contracts, which are individual placement agreements. Spot contracts generally have a four week notice period to terminate the contract and typically do not have a minimum term. Spot contracts provide greater operational flexibility and are appropriate for bespoke care packages to meet the high severity support needs of the individuals in a provider s care. Fees are typically negotiated on a case-by-case basis.

Partnerships in Care provides services to various NHS commissioners via the NHS standard contract, which operates as the framework agreement for the services provided at Partnerships in Care s facilities across the United Kingdom. The majority of terms in the standard contract are mandatory service and general conditions setting forth such terms as (i) the services to be provided, (ii) performance and quality standards, (iii) price and payment terms and (iv) liability and risk, each with a limited scope for negotiability. The change of control provisions in the standard contract will require Partnerships in Care to notify each relevant NHS commissioner of our acquisition of Partnerships in Care following completion of the Acquisition. Failure to provide such notification is considered an event of default that permits the relevant NHS commissioner to terminate the agreement.

Partnerships in Care is reimbursed on a per diem rate based on the level of care provided. In addition to daily bed fees, the company can earn incentive revenue based on various metrics set by NHS under the Commissioning for Quality and Innovation (CQUIN) scheme. Under CQUIN, the company may earn up to an additional 2.5% of revenue, subject to achieving specified performance targets, for relevant patients.

Legal Proceedings

Partnerships in Care is, from time to time, subject to various claims and legal actions that arise in the ordinary course of its business, including claims for damages for personal injuries, medical malpractice, breach of contract, tort and employment related claims. In these actions, plaintiffs request a variety of damages, including, in some instances, punitive and other types of damages that may not be covered by insurance. In the opinion of Partnership s in Care s management, it is not currently a party to any proceeding that would have a material adverse impact on its business, financial condition or results of operations, and we do not believe any such proceedings would have a material adverse impact on our business, financial condition or results of operations upon completion of the Acquisition.

Regulatory Overview

Laws and Regulations

The regulatory environment applicable to facilities in the United Kingdom is complex and multifaceted. The regulatory regime is made up of multiple statutes, regulations and minimum standards that are subject to continuous change. The laws and regulations applicable to the United Kingdom facilities include, without limitation, the Mental Capacity Act of 2005, Safeguarding Vulnerable Groups Act of 2006, Mental Health Act of 2007, Health and Social Care Act of 2008 and Corporate Manslaughter and Corporate Homicide Act of 2008. These laws and regulations are predominantly protective in nature and share the same general underlying purpose to protect vulnerable persons from exploitation or harm.

Mental Capacity Act of 2005. The Mental Capacity Act of 2005 establishes the process for determining whether a person lacks mental capacity at a particular time and also sets out who can take decisions in those circumstances and how they should go about this. The Act sets out when liability may arise for actions in connection with the care or treatment of persons who lack capacity to consent to such actions.

Safeguarding Vulnerable Groups Act of 2006. The Safeguarding Vulnerable Groups Act of 2006 created the Independent Safeguarding Authority (ISA). In December 2012, the ISA merged with the Criminal Records Bureau to form the Discharge and Barring Service (DBS) and is required to establish and maintain lists of

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persons barred from working with children and adults. It is a criminal offense for a barred person to seek to work, or work in, activities from which they are barred. It is also generally a criminal offence for an employer to allow a barred person, or person who is not appropriately registered, to work in any regulated activity.

The Mental Health Act of 2007. The Mental Health Act of 2007 regulates the manner in which an individual can be committed or detained against his or her will. The main purpose of the legislation is to ensure that people with serious mental disorders which threaten their health or safety or the safety of the public can be treated irrespective of their consent where it is necessary to prevent them from harming themselves or others. The Act places the burden on the entity detaining a person to prove that the entity has the right to hold the detainee. This places a substantial regulatory burden on service providers to ensure compliance with the law.

The Health and Social Care Act of 2008. The Health and Social Care Act of 2008 (HSCA) established the Care Quality Commission (CQC) as the registration and regulatory body for health and adult social care in England. Under the HSCA, service providers carrying out regulated activities must be registered with the CQC for each separate regulated activity provided. Where the service provider is a company, each regulated activity/location must also have an individual registered as the registered manager. Registration depends both on an assessment of the fitness of the registered provider and also the individual registered manager. Regulated activities include the provision of residential accommodation together with nursing or personal care and the provision of treatment for a disease, disorder or injury by or under the supervision of a social worker or a multi-disciplinary team which includes a social worker where the treatment is for a mental disorder.

The regulated activities regulations and the registration regulations issued pursuant to the HSCA place legally binding obligations on health and social care providers. Breach of certain provisions of the HSCA or the regulations is a criminal offense. In addition, a breach may lead to the CQC taking action to suspend, cancel or vary the conditions of registration of a service provider or impose a substantial fine.

Inspections by regulators in the United Kingdom can, as a matter of regulation, be carried out on both an announced and an unannounced basis depending on the specific regulatory provisions relating to the different services provided and also depending upon whether the inspection is routine or as a result of specific information regarding the service that has been provided to the regulator. Generally, however, a majority of inspections tend to be unannounced. A failure to comply with laws and regulations, the receipt of a poor inspection report rating or a lower rating, or the receipt of a negative report that leads to a determination of regulatory non-compliance or a failure to cure any defect noted in an inspection report may result in reputational damage, fines, the revocation or suspension of the registration of any facility or a decrease in, or cessation of, the services provided at any given location.

Corporate Manslaughter and Corporate Homicide Act of 2007. The Corporate Manslaughter and Corporate Homicide Act of 2007 provides liability if the way in which a provider s activities are managed or organized causes a person s death and amounts to a gross breach of a relevant duty of care owed to the deceased person.

Regulatory and Enforcement Bodies

The primary healthcare regulatory enforcement bodies in the United Kingdom are Monitor, the CQC, HIW and HIS. These enforcement bodies control and administer the registration, inspection and complaints procedures set out under the applicable laws and regulations. The enforcement bodies have the power to terminate a facility s registration, refuse to register a facility, impose admissions holds, or impose significant fines if a service provider fails to meet the key minimum standards and requirements prescribed under the various laws and regulations. See Risk Factors Partnerships in Care operates in a highly regulated business environment, which is subject to political and regulatory scrutiny. Failure to comply with regulations or the introduction of new regulations or standards with which Partnerships in Care does not comply could lead to substantial penalties, including the loss of registration on one or more of Partnerships in Care s facilities.

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Monitor. Monitor is the sector regulator for healthcare, tasked with regulating all providers of non-exempt NHS funded services in England. Monitor is the general economic regulator and competition regulator. It fulfils this role through licensing health care providers and, together with NHS England, setting the national price tariff for NHS services. Monitor s role includes regulating clinical commissioning groups, community services and secondary care services, protecting and promoting patients interests, tackling abuses and dealing with unjustifiable restrictions on competition. Monitor must exercise its functions with a view to preventing anti-competitive behavior in the provision of health care services.

The CQC. The CQC is the independent regulator for health and adult social care in England. The CQC is distinct from Monitor in that it focuses on quality and to ensure the maintenance of standards in health and social care practices. The CQC licenses NHS and adult social care service providers to enable it to keep a check on safety and quality levels. Inspections will also be carried out by the CQC.

HIW. HIW is the independent inspectorate and regulator of all health care in Wales. Certain independent healthcare services are required to register with HIW. HIW also inspects NHS and independent healthcare organizations in Wales to ensure compliance with its and NHS standards, policies, guidance and regulations. As related to the mental health industry, the HIW Review Service for Mental Health monitors the use of the Mental Health Act 1983 to ensure that it is being used properly on behalf of Welsh Ministers.

HIS. HIS is the independent regulator for healthcare services in Scotland. HIS inspects healthcare providers in Scotland to ensure compliance with its standards, policies, guidance and regulations.

Competition

The mental health services sector in the United Kingdom comprises hospitals or establishments that provide psychiatric treatment for illness or mental disorder at all security and treatment levels. Currently, NHS accounts for 70% of the total mental health hospital beds providing care in the United Kingdom, with independent providers such as Partnerships in Care accounting for the remaining 30% of beds.

Mental Health Market

There are approximately 9,900 independent sector beds in the mental health sector, which includes secure, acute, step-down and acquire brain injury rehabilitation facilities. The independent mental health market is dominated by five key players in an otherwise fragmented market. In 2011, following a business combination, Priory became the market leader in the sector with a 20% market share. Partnerships in Care was the second largest provider of mental health services, representing 16% of the independent mental health hospital sector. St. Andrew s Healthcare, the largest not-for-profit provider of mental health care, captured 15% of the market, with Cygnet Health Care and Four Seasons Health Care each holding approximately 7% market share. Partnerships in Care s position reflects significantly lower penetration of the rehabilitation and acute care sectors.

Secure Mental Health Market

In 2013, Partnerships in Care was the independent sector market leader in secure treatment with 25% of the market. Partnerships in Care maintains 1,008 beds in 16 mental health hospitals with a medium or low secure primary patient type. Since 2005, Partnerships in Care has focused on expanding into the low secure sector, with capacity for low secure beds increasing from 84 beds in 2005 to 410 beds in May 2014 and capacity for medium secure beds decreasing from 544 beds to 448 beds during the same timeframe. St. Andrew s Healthcare and Priory Group are the second and third-largest providers, respectively, of secure mental health services with 863 beds and 404 beds, respectively.

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Management Team

Partnerships in Care has an experienced management team with demonstrated ability to improve financial performance, optimize operations, enhance patient care and deliver value to patients and their families. The company s Chief Executive Officer, Joy Chamberlain, joined the company in 1998 and, after holding several management positions, was promoted to Chief Executive Officer in 2012. Dr. Quazi Haque, Partnerships in Care s Group Medical Officer, joined the company in 2012 following a fellowship with the Royal College of Psychiatrists and holding senior clinical, operational and leadership roles for the NHS and in the independent behavioral health sector. Steven Woolgar has been Partnerships in Care s Director of Policy and Regulation since 2006, with 27 years of experience in the company s hospitals, and oversees policy and regulatory developments to ensure Partnerships in Care manages and delivers best practices in patient care. The Partnerships in Care management team is expected to remain with the company following the Acquisition.

Employees

As of May 31, 2014, Partnerships in Care had approximately 4,213 employees. Of these employees, 839 are registered on-call supply staff, 922 are non-clinical managerial, clerical or administrative staff and 2,452 are clinical staff.

Approximately 726 of the Partnerships in Care employees are represented by labor unions. The Royal College of Nursing is the trade union for all full and part-time nurses, nursing cadets and healthcare assistants employed by Partnerships in Care. Our relationships with unions will be important to future employee relations and the success of our business.

Pension Plans and Benefit Plans

Partnerships in Care is the sponsor of a defined benefit pension plan that, as of December 31, 2013, covered approximately 187 members in the United Kingdom, most of whom are inactive and retired former employees. As of December 31, 2013, the net deficit recognized under UK GAAP in respect of this scheme was £4.9 million. As part of the Acquisition, we will assume Partnerships in Care s existing pension plans and a defined contribution plan and will be responsible for the relevant pension liabilities. Maintenance of these plans following the Acquisition may result in additional expenses to the combined company. Termination of these plans could have an adverse impact on employee relations.

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USE OF PROCEEDS

Based on the assumed public offering price of $46.29 per share, which was the closing price of our common stock on June 6, 2014, as reported on the NASDAQ Global Market, we estimate that our net proceeds from the issuance and sale of 7,344,998 shares of common stock in this offering, after deducting the underwriting discount and estimated offering expenses payable by us, will be approximately $325.0 million. The underwriters may also exercise their option to purchase up to additional shares of our common stock. The option to purchase these additional shares may be granted by the selling stockholders. We will not receive any proceeds from the sale of shares of our common stock by the selling stockholders. To the extent any of the selling stockholders elect not to grant the underwriters an option to purchase some or all of these additional shares, the Company will grant the underwriters an option to purchase such additional shares and will use such additional proceeds in the same manner as the other offering proceeds described below.

We intend to use the proceeds from this offering principally to fund our acquisition strategy, particularly a portion of the purchase price for the planned acquisition of Partnerships in Care and the fees and expenses of the Transactions. See The Acquisition and Financing Transactions. The following table describes the sources and uses of funds relating to the Transactions assuming a closing date of July 1, 2014:

		Amount (Dollars in Thousands)
Sources of funds:		
Proposed Amended and Restated Senior Credit Facility:		
Senior Secured Term Loan B(1)	$	300,000
Senior Secured Revolving Line of Credit(1)		56,000
Common stock offered hereby by us(2)		325,000
Total sources	$	681,000
Uses of funds:		
Partnerships in Care Purchase Price and Repayment of Indebtedness	$	662,000
Fees and expenses related to the Transactions		19,000
Total uses	$	681,000

(1) In connection with the Proposed Amended and Restated Senior Credit Agreement, we anticipate raising $300.0 million (or, if we cannot obtain the consent from holders of our existing notes, $250.0 million (or such lesser amount necessary for our secured leverage ratio to remain under 3.0x)) of Senior Secured Term Loan B, which is $50.0 million more than our $250.0 million of committed Senior Secured Term Loan B. As such, we are pursuing a consent solicitation (scheduled to expire June 17, 2014) under our 2018 Indenture in order to facilitate our incurring additional permitted liens securing indebtedness so long as our secured leverage ratio is under 3.5x. If we do not receive the requisite consents, we would only borrow $250.0 million (or such lesser amount necessary for our secured leverage ratio to remain under 3.0x) of term debt and then have to issue additional unsecured debt to finance the Acquisition.

(2) Reflects anticipated proceeds after underwriting discounts and commissions.

We will not receive any proceeds from the sale of shares of our common stock by the selling stockholders in this offering. We will, however, bear the costs, other than the underwriting discount, associated with the sale of shares of common stock by the selling stockholders. See Selling Stockholders.

To the extent not used for the planned acquisition of Partnerships in Care, we plan to use the proceeds for general corporate purposes, which may include the repayment of debt under the existing Amended and Restated Senior Credit Facility. As of March 31, 2014, borrowings under the Amended and Restated Senior Credit Facility bore interest at a rate of 2.75%. The maturity date of the Amended and Restated Senior Credit Facility is February 13, 2019.

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As of the date of this prospectus supplement, we intend to use the proceeds of this offering to finance the Acquisition but we cannot predict with certainty all of the particular uses for the proceeds from this offering or the amounts that we will actually spend on the uses set forth above. Accordingly, we retain broad discretion over the use of such proceeds. The uses, amounts and timing of our actual expenditures will depend on numerous factors, including completion of the planned acquisition of Partnerships in Care, the results of our ongoing integration efforts and the amount of cash generated or used by our operations. Pending application of the proceeds as described above, we intend to pay down any revolver balance outstanding under our Amended and Restated Senior Credit Facility and place the remaining proceeds in interest bearing time deposits of a national banking association which are insured by the Federal Deposit Insurance Corporation or to invest the proceeds in bonds or other debt obligations issued or guaranteed by the United States government or one of its agencies or instrumentalities or money market funds solely invested in or collateralized by such bonds or debt obligations, to the extent the proceeds are not immediately used to fund the Acquisition.

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PRICE RANGE OF OUR COMMON STOCK

Our common stock trades on The NASDAQ Global Market under the symbol ACHC. The table below sets forth, for the quarters indicated, the high and low sales prices of our common stock as reported by The NASDAQ Global Market. As of May 31, 2014, there were 50,883,152 shares outstanding, held by 216 stockholders of record. On June 6, 2014, the last reported sale price of our common stock on The NASDAQ Global Market was $46.29 per share.

	Sale Price Per Share of Common Stock	
	High	Low
2014		
Second Quarter (through June 6, 2014)	$ 49.81	$ 38.76
First Quarter	53.87	44.00
2013		
Fourth Quarter	$ 49.14	$ 37.88
Third Quarter	41.30	30.70
Second Quarter	35.78	27.85
First Quarter	29.50	22.64
2012		
Fourth Quarter	$ 24.83	$ 18.53
Third Quarter	24.12	15.08
Second Quarter	18.60	14.40
First Quarter	16.50	9.38

DIVIDEND POLICY

We have never declared or paid dividends on our common stock. We currently intend to retain all available funds and any future earnings to fund the development and growth of our business and to repay indebtedness, and therefore we do not anticipate paying any cash dividends in the foreseeable future. Additionally, because we are a holding company, our ability to pay dividends on our common stock is limited by restrictions on the ability of our subsidiaries to pay dividends or make distributions to us, including restrictions under the terms of the agreements governing our indebtedness. Any future determination to pay dividends out of funds available thereof will be at the discretion of our board of directors, subject to compliance with covenants in current and future agreements governing our indebtedness (including our Proposed Amended and Restated Senior Credit Facility and the indenture governing our Senior Notes), and will depend upon our results of operations, financial condition, capital requirements and other factors that our board of directors deems relevant.

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CAPITALIZATION

The table below sets forth our cash and cash equivalents and our consolidated capitalization as of March 31, 2014:

- on an actual basis; and
- on an adjusted basis to give effect to the Transactions (assuming the issuance and sale of common stock as set forth on the cover of the prospectus supplement), after deducting the underwriting discount and estimated offering expenses payable by us, assuming that the Transactions closed on March 31, 2014.

You should read this table in conjunction with Use of Proceeds, Unaudited Pro Forma Condensed Combined Financial Information and the financial information incorporated by reference in this prospectus supplement.

	As of March 31, 2014	
	Actual	As Adjusted(1)
	(Unaudited)	
	(Dollars in thousands, except per share data)	
Cash and cash equivalents	$ 7,243	$ 7,362
Debt:		
Proposed Amended and Restated Senior Credit Facility:		
Senior Secured Term Loans(2)	298,125	598,125
Senior Secured Revolving Line of Credit	94,000	150,000
12.875% Senior Notes due 2018	96,264	96,264
6.125% Senior Notes due 2021	150,000	150,000
9.0% and 9.5% Revenue Bonds	24,807	24,807
Total debt (including current portion)	$ 663,196	$ 1,019,196
Stockholders Equity:		
Common stock, $0.01 par value per share; 90,000,000 shares authorized and 50,217,314 shares issued and outstanding, actual; 90,000,000 shares authorized and 57,562,312 shares issued and outstanding, as adjusted(3)	$ 502	$ 575
Preferred stock, $0.01 par value per share; 10,000,000 shares authorized; no shares issued and outstanding		
Additional paid-in capital	464,188	789,115
Retained Earnings	31,460	23,660
Total Equity	496,150	813,350
Total capitalization	$ 1,159,346	$ 1,832,546

(1) A $1.00 increase in our share price would decrease the number of shares that we issue by 155,317, and a $1.00 decrease in our share price would increase the number of shares that we issue by 162,177, assuming in either case that we raise the gross proceeds as set forth on the cover of this prospectus supplement.

(2) Assumes receipt of requisite consents in the consent solicitation to permit us to incur $300 million of Senior Secured Term Loan B. If we do not receive the requisite consents, we would only borrow $250 million of term debt and then have to issue additional unsecured debt to

finance the Acquisition.

(3) Assumes the issuance and sale of common stock as set forth on the cover of the prospectus supplement.

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UNAUDITED PRO FORMA CONDENSED COMBINED FINANCIAL INFORMATION

The tables below set forth the unaudited pro forma condensed combined financial data for Acadia giving effect to Acadia s planned acquisition of Partnerships in Care on July 1, 2014, the offering of common stock described in this prospectus supplement and Acadia s planned debt financing transactions.

With respect to this offering, the unaudited pro forma condensed combined financial data is based on the assumption that Acadia is offering 7,344,998 shares of common stock at an assumed public offering price of $46.29 per share, which was the closing price of our common stock on June 6, 2014, as reported on the NASDAQ Global Market.

With respect to Acadia s planned debt financing, the unaudited pro forma condensed combined financial data is based on the assumption that Acadia will issue $300,000,000 of incremental term loans through an amendment to its existing Amended and Restated Credit Agreement and borrow $56,000,000 on its existing revolving line of credit.

The unaudited pro forma condensed combined balance sheet as of March 31, 2014 reflects the effect of Acadia s planned acquisition of Partnerships in Care as if it occurred on March 31, 2014.

The unaudited pro forma condensed combined statements of operations give effect to each transaction as if it occurred on January 1, 2013.

The unaudited pro forma condensed combined statement of operations for the year ended December 31, 2013 combines the audited consolidated statement of operations of Acadia for that period, the unaudited consolidated statement of operations for Acadia s completed acquisitions, and the audited consolidated statement of operations of Partnerships in Care for the period from January 1, 2013 to December 31, 2013.

The unaudited pro forma condensed combined statement of operations for the three months ended March 31, 2014 combines the unaudited consolidated statement of operations of Acadia for that period with the unaudited consolidated statement of operations of Partnerships in Care for the period from January 1, 2014 to March 31, 2014.

The unaudited pro forma condensed combined financial data has been prepared using the acquisition method of accounting for business combinations under GAAP. The adjustments necessary to fairly present the unaudited pro forma condensed combined financial data have been made based on available information and in the opinion of management are reasonable. Assumptions underlying the pro forma adjustments are described in the accompanying notes, which should be read in conjunction with this unaudited pro forma condensed combined financial data. The pro forma adjustments related to the planned acquisition of Partnerships in Care are preliminary and revisions to the fair value of assets acquired and liabilities assumed may have a significant impact on the pro forma adjustments. A final valuation of assets acquired and liabilities assumed has not been completed and the completion of fair value determinations may result in changes in the values assigned to property and equipment and other assets (including intangibles) acquired and liabilities assumed.

The unaudited pro forma condensed combined financial data is for illustrative purposes only and does not purport to represent what our financial position or results of operations actually would have been had the events noted above in fact occurred on the assumed dates or to project our financial position or results of operations for any future date or future period.

The unaudited pro forma condensed combined financial data should be read in conjunction with the consolidated financial statements and notes thereto of Acadia and Partnerships in Care incorporated by reference in this prospectus supplement.

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UNAUDITED PRO FORMA CONDENSED COMBINED BALANCE SHEET

As of March 31, 2014

(In thousands)

	Acadia(1)	Partnerships in Care(2a)	Pro Forma Adjustments	Notes	Pro Forma Combined
ASSETS					
Current assets:					
Cash and cash equivalents	$ 7,243	$ 20,485	$ (20,485)	(5)	$ 7,362
			119	(8)	
Accounts receivable, net	104,585	7,641			112,226
Deferred tax assets	17,029				17,029
Other current assets	28,180	5,409			33,589
Total current assets	157,037	33,535	(20,366)		170,206
Property and equipment, net	403,366	895,673	(287,925)	(7)	1,011,114
Goodwill	665,421		84,457	(7)	749,878
Intangible assets, net	20,730		3,000	(7)	23,730
Deferred tax assets noncurrent	4,325				4,325
Other assets	32,066		11,100	(8)	43,166
Total assets	1,282,945	929,208	(209,734)		2,002,419
LIABILITIES AND EQUITY					
Current liabilities:					
Current portion of long-term debt	9,570		3,000	(9)	12,570
Accounts payable	28,405	6,410			34,815
Accrued salaries and benefits	32,257	6,292			38,549
Other accrued liabilities	27,673	8,209			35,882
Total current liabilities	97,905	20,911	3,000		121,816
Long-term debt	653,626	1,345,323	(992,323)	(9)	1,006,626
Deferred tax liabilities noncurrent	15,399	76,064	(56,985)	(7)	34,478
Other liabilities	19,865	6,284			26,149
Total liabilities	786,795	1,448,582	(1,046,308)		1,189,069
Equity:					
Common stock	502		73	(8)	575
Additional paid-in capital	464,188		324,927	(8)	789,115
Retained earnings (accumulated deficit)	31,460		(7,800)	(8)	23,660
Investment in Parent		(519,374)	519,374	(6)	
Total equity	496,150	(519,374)	836,574		813,350
Total liabilities and equity	$ 1,282,945	$ 929,208	$ (209,734)		$ 2,002,419

See accompanying notes to unaudited pro forma financial information.

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UNAUDITED PRO FORMA CONDENSED COMBINED STATEMENT OF OPERATIONS

For the Year Ended December 31, 2013

(In thousands, except per share amounts)

	Acadia(1)	Completed Acquisitions Pro Forma Adjustment(3)	Notes	Acadia Pro Forma	Partnerships in Care(2b)	Pro Forma Adjustments	Notes	Pro Forma Combined
Revenue before provision for doubtful accounts	$ 735,109	$ 23,111		$ 758,220	$ 267,031			$ 1,025,251
Provision for doubtful accounts	(21,701)	(933)		(22,634)	(11)			(22,645)
Revenue	713,408	22,178		735,586	267,020			1,002,606
Salaries, wages and benefits	407,962	12,312		420,274	151,493			571,767
Professional fees	37,171	1,567		38,738	11,294			50,032
Supplies	37,569	1,176		38,745	9,755			48,500
Rents and leases	10,049	1,228		11,277	1,605			12,882
Other operating expenses	80,572	2,625		83,197	24,050			107,247
Depreciation and amortization	17,090	501		17,591	21,173	(5,957)	(10)	32,807
Interest expense, net	37,250	2,603		39,853	77,373	(61,357)	(11)	55,869
Debt extinguishment costs	9,350			9,350				9,350
Transaction-related expenses	7,150	(1,403)	(12)	5,747		(184)	(12)	5,563
Total expenses	644,163	20,609		664,772	296,743	(67,498)		894,017
Income (loss) from continuing operations before income taxes	69,245	1,569		70,814	(29,723)	67,498		108,589
Provision (benefit) for income taxes	25,975	588		26,563	(12,844)	21,029	(13)	34,748
Income (loss) from continuing operations	$ 43,270	$ 981		$ 44,251	$ (16,879)	$ 46,469		$ 73,841
Earnings per share income (loss) from continuing operations:								
Basic	$ 0.87			$ 0.88				$ 1.29
Diluted	$ 0.86			$ 0.88				$ 1.28
Weighted average shares:								
Basic	50,004			50,004		7,345	(14)	57,349
Diluted	50,261			50,261		7,345	(14)	57,606

See accompanying notes to unaudited pro forma financial information.

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UNAUDITED PRO FORMA CONDENSED COMBINED STATEMENT OF OPERATIONS

For the Three Months Ended March 31, 2014

(In thousands, except per share amounts)

	Acadia(1)	Partnerships in Care(2c)	Pro Forma Adjustments	Notes	Pro Forma Combined
Revenue before provision for doubtful accounts	$ 206,119	$ 69,450			$ 275,569
Provision for doubtful accounts	(4,701)				(4,701)
Revenue	201,418	69,450			270,868
Salaries, wages and benefits	117,575	40,797			158,372
Professional fees	10,382	3,116			13,498
Supplies	10,064	2,305			12,369
Rents and leases	2,769	448			3,217
Other operating expenses	23,110	6,944			30,054
Depreciation and amortization	5,436	5,767	(1,963)	(10)	9,240
Interest expense, net	9,707	20,809	(16,805)	(11)	13,711
Transaction-related expenses	1,579		(9)	(12)	1,570
Total expenses	180,622	80,186	(18,777)		242,031
Income (loss) from continuing operations before income taxes	20,796	(10,736)	18,777		28,837
Provision (benefit) for income taxes	7,775	15	1,438	(13)	9,228
Income (loss) from continuing operations	$ 13,021	$ (10,751)	$ 17,339		$ 19,609
Earnings per share income (loss) from continuing operations:					
Basic	$ 0.26				$ 0.34
Diluted	$ 0.26				$ 0.34
Weighted average shares:					
Basic	50,120		7,345	(14)	57,465
Diluted	50,486		7,345	(14)	57,831

See accompanying notes to unaudited pro forma financial information.

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NOTES TO UNAUDITED PRO FORMA CONDENSED COMBINED FINANCIAL INFORMATION

(In thousands, except per share amounts)

(1) The amounts in this column represent, for Acadia, actual results for the periods presented.
(2) The historical financial statements of Partnerships in Care are prepared in accordance with U.K. GAAP and are adjusted to: (i) reconcile the financial statements to U.S. GAAP and (ii) translate the financial statements to U.S. dollars based on the historical exchange rates below. The Partnerships in Care financial statements have been reclassified to conform to Acadia s financial statement presentation.

		GBP/USD
March 31, 2014	Period End Spot Rate	$ 1.6637
Year ended December 31, 2013	Average Spot Rate	$ 1.5643
Three months ended March 31, 2014	Average Spot Rate	$ 1.6548

(a) The amounts below represent results as of March 31, 2014.

	Partnerships in Care (in £, in U.K. GAAP)	U.S. GAAP Adjustments	Notes	Partnerships in Care (in £, in U.S. GAAP)	Partnerships in Care (in $, in U.S. GAAP)
Current assets:					
Cash and cash equivalents	£ 12,313	£		£ 12,313	$ 20,485
Accounts receivable, net	4,593			4,593	7,641
Deferred tax assets					
Other current assets	3,251			3,251	5,409
Total current assets	20,157			20,157	33,535
Property and equipment, net	453,735	84,627	(4)	538,362	895,673
Goodwill					
Intangible assets, net					
Deferred tax assets noncurrent					
Other assets					
Total assets	£ 473,892	£ 84,627		£ 558,519	$ 929,208
Current liabilities:					
Current portion of long-term debt	£	£		£	$
Accounts payable	3,853			3,853	6,410
Accrued salaries and benefits	3,782			3,782	6,292
Other accrued liabilities	4,934			4,934	8,209
Total current liabilities	12,569			12,569	20,911
Long-term debt	792,206	16,427	(4)	808,633	1,345,323
Deferred tax liabilities noncurrent	2,027	43,693	(4)	45,720	76,064
Other liabilities	3,777			3,777	6,284
Total liabilities	810,579	60,120		870,699	1,448,582
Equity:					
Investment in Parent	(336,687)	24,507		(312,180)	(519,374)
Total equity	(336,687)	24,507		(312,180)	(519,374)

Total liabilities and equity	£ 473,892	£ 84,627	£ 558,519	$ 929,208

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(b) The amounts below represent results for the year ended December 31, 2013.

	Partnerships in Care (in £, in U.K. GAAP)	U.S. GAAP Adjustments	Notes	Partnerships in Care (in £, in U.S. GAAP)	Partnerships in Care (in $, in U.S. GAAP)
Revenue before provision for doubtful accounts	£ 170,703	£		£ 170,703	$ 267,031
Provision for doubtful accounts	(7)			(7)	(11)
Revenue	170,696			170,696	267,020
Salaries, wages and benefits	98,345	(1,501)	(4)	96,844	151,493
Professional fees	7,220			7,220	11,294
Supplies	6,236			6,236	9,755
Rents and leases	1,026			1,026	1,605
Other operating expenses	15,374			15,374	24,050
Depreciation and amortization	11,458	2,077	(4)	13,535	21,173
Interest expense, net	61,782	(12,320)	(4)	49,462	77,373
Transaction-related expenses					
Total expenses	201,441	(11,744)		189,697	296,743
Loss from continuing operations before income taxes	(30,745)	11,744		(19,001)	(29,723)
Benefit for income taxes	(1,715)	(6,496)	(4)	(8,211)	(12,844)
Loss from continuing operations	£ (29,030)	£ 18,240		£ (10,790)	$ (16,879)

(c) The amounts below represent results for the three months ended March 31, 2014.

	Partnerships in Care (in £, in U.K. GAAP)	U.S. GAAP Adjustments	Notes	Partnerships in Care (in £, in U.S. GAAP)	Partnerships in Care (in $, in U.S. GAAP)
Revenue before provision for doubtful accounts	£ 41,969	£		£ 41,969	$ 69,450
Provision for doubtful accounts					
Revenue	41,969			41,969	69,450
Salaries, wages and benefits	25,091	(437)	(4)	24,654	40,797
Professional fees	1,883			1,883	3,116
Supplies	1,393			1,393	2,305
Rents and leases	271			271	448
Other operating expenses	4,196			4,196	6,944
Depreciation and amortization	2,966	519	(4)	3,485	5,767
Interest expense, net	15,655	(3,080)	(4)	12,575	20,809
Transaction-related expenses					
Total expenses	51,455	(2,998)		48,457	80,186
Loss from continuing operations before income taxes	(9,486)	2,998		(6,488)	(10,736)
Benefit for income taxes	(532)	541	(4)	9	