Acadia Healthcare Company, Inc.
Form 10-K
March 01, 2019
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

(Mark One)

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2018

or

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to

Commission File Number: 001-35331

ACADIA HEALTHCARE COMPANY, INC.

(Exact Name of Registrant as Specified in Its Charter)

Delaware	45-2492228
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

6100 Tower Circle, Suite 1000

Franklin, Tennessee 37067

(Address, including zip code, of registrant's principal executive offices)

(615) 861-6000

(Registrant's telephone number, including area code)

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

Title of each Class	Name of exchange on which registered
Common Stock, $.01 par value	NASDAQ Global Select Market

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

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

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes No

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer", "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer Accelerated filer Emerging growth company
Non-accelerated filer Smaller reporting company
If an emerging growth company, indicate by check mark of the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.

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

As of June 30, 2018, the aggregate market value of the shares of common stock of the registrant held by non-affiliates was approximately $3.5 billion, based on the closing price of the registrant's common stock reported on the NASDAQ Global Select Market of $40.91 per share.

As of March 1, 2019, there were 88,455,125 shares of the registrant's common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive proxy statement for its 2019 annual meeting of stockholders to be held on May 2, 2019 are incorporated by reference into Part III of this Form 10-K.

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ACADIA HEALTHCARE COMPANY, INC.

ANNUAL REPORT ON FORM 10-K

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PART I

Unless the context otherwise requires, all references in this Annual Report on Form 10-K to "Acadia," "the Company," "we," "us" or "our" mean Acadia Healthcare Company, Inc. and its consolidated subsidiaries.

Item 1. Business.

Overview

Our business strategy is to acquire and develop behavioral healthcare facilities and improve our operating results within our facilities and our other behavioral healthcare operations. We strive to improve the operating results of our facilities by providing high-quality services, expanding referral networks and marketing initiatives while meeting the increased demand for behavioral healthcare services through expansion of our current locations as well as developing new services within existing locations. At December 31, 2018, we operated 583 behavioral healthcare facilities with approximately 18,100 beds in 40 states, the United Kingdom ("U.K.") and Puerto Rico. During the year ended December 31, 2018, we added 651 beds, including 499 added to existing facilities and 152 added through the opening of two de novo facilities. For the year ending December 31, 2019, we expect to add approximately 700 total beds exclusive of acquisitions.

We are the leading publicly traded pure-play provider of behavioral healthcare services, with operations in the United States ("U.S.") and the U.K. Management believes that we are positioned as a leading platform in a highly fragmented industry under the direction of an experienced management team that has significant industry expertise. Management expects to take advantage of several strategies that are more accessible as a result of our increased size and geographic scale, including continuing a national marketing strategy to attract new patients and referral sources, increasing our volume of out-of-state referrals, providing a broader range of services to new and existing patients and clients and selectively pursuing opportunities to expand our facility and bed count in the U.S. and U.K. through acquisitions, joint ventures and bed additions in existing facilities.

Acadia was formed as a limited liability company in the State of Delaware in 2005, and converted to a corporation on May 13, 2011. Our common stock is listed for trading on The NASDAQ Global Select Market under the symbol "ACHC." Our principal executive offices are located at 6100 Tower Circle, Suite 1000, Franklin, Tennessee 37067, and our telephone number is (615) 861-6000.

Acquisitions

2019 Acquisitions

On February 15, 2019, we completed the acquisition of Whittier Pavilion ("Whittier"), an inpatient psychiatric facility with 71 beds located in Haverhill, Massachusetts, for cash consideration of approximately $17.9 million. Also on February 15, 2019, we completed the acquisition of Mission Treatment ("Mission Treatment") for cash consideration of approximately $22.5 million and a working capital settlement. Mission Treatment operates nine comprehensive treatment centers in California, Nevada, Arizona and Oklahoma.

2017 Acquisition

On November 13, 2017, we completed the acquisition of Aspire Scotland ("Aspire"), an education facility with 36 beds located in Scotland, for cash consideration of approximately $21.3 million.

2016 Acquisitions

During 2016, we completed the acquisition of Pocono Mountain Recovery Center ("Pocono Mountain"), TrustPoint Hospital ("TrustPoint"), Serenity Knolls ("Serenity Knolls"), and Priory Group No. 1 Limited ("Priory") (collectively, the "2016 Acquisitions").

U.K. Divestiture

On November 30, 2016, we completed the sale of 21 existing U.K. behavioral health facilities and one de novo behavioral health facility with an aggregate of approximately 1,000 beds (collectively, the "U.K. Disposal Group") to BC Partners ("BC Partners") for £320 million cash (the "U.K. Divestiture").

Financing Transactions

On December 1, 2018, we exercised the option to redeem in whole $7.5 million and $15.5 million of Lee County (Florida) Industrial Development Authority Healthcare Facilities Revenue Bonds, Series 2010 with stated interest rates of 9.0% and 9.5%

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("9.0% and 9.5% Revenue Bonds") at a redemption price equal to the sum of 104% of the principal amount of the 9.0% and 9.5% Revenue Bonds plus accrued and unpaid interest. In connection with the redemption of the 9.0% and 9.5% Revenue Bonds, we recorded a debt extinguishment charge of $0.9 million, which was recorded in debt extinguishment costs in the consolidated statements of operations.

We entered into a Senior Secured Credit Facility (the "Senior Secured Credit Facility") on April 1, 2011. On December 31, 2012, we entered into the Amended and Restated Credit Agreement (the "Amended and Restated Credit Agreement") which amended and restated the Senior Secured Credit Facility. We have amended the Amended and Restated Credit Agreement from time to time as described in our prior filings with the Securities and Exchange Commission (the "SEC"). See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources—Amended and Restated Senior Credit Facility" for additional information.

On February 27, 2019, we entered into the Twelfth Amendment (the "Twelfth Amendment") to the Amended and Restated Credit Agreement. The Twelfth Amendment, among other things, modified certain definitions, including "Consolidated EBITDA", and increased our permitted Maximum Consolidated Leverage Ratio, thereby providing increased flexibility to us in terms of our financial covenants.

On February 6, 2019, we entered into the Eleventh Amendment (the "Eleventh Amendment") to the Amended and Restated Credit Agreement. The Eleventh Amendment, among other things, amended the definition of "Consolidated EBITDA" to remove the cap on non-cash charges, losses and expenses related to the impairment of goodwill, which in turn provided increased flexibility to us in terms of our financial covenants.

On March 29, 2018, we entered into a Third Repricing Facilities Amendment (the "Third Repricing Facilities Amendment", and together with the Second Repricing Facilities Amendment, the "Repricing Facilities Amendments") to the Amended and Restated Credit Agreement. The Third Repricing Facilities Amendment replaced the existing revolving credit facility and Term Loan A facility ("TLA Facility") with a new revolving credit facility and TLA Facility, respectively. The Company's line of credit on its revolving credit facility remains at $500.0 million and the Third Repricing Facility Amendment reduced the size of the TLA Facility from $400.0 million to $380.0 million to reflect the then current outstanding principal. The Third Repricing Facilities Amendment reduced the Applicable Rate by 25 basis points for the revolving credit facility and the TLA Facility by amending the definition of "Applicable Rate."

On March 22, 2018, we entered into a Second Repricing Facilities Amendment (the "Second Repricing Facilities Amendment") to the Amended and Restated Credit Agreement. The Second Repricing Facilities Amendment (i) replaced the Tranche B-1 Term Loan facility (the "Tranche B-1 Facility") and the Tranche B-2 Term Loan facility (the "Tranche B-2 Facility") with a new Term Loan B facility Tranche B-3 (the "Tranche B-3 Facility") and a new Term Loan B facility Tranche B-4 (the "Tranche B-4 Facility"), respectively, and (ii) reduced the Applicable Rate from 2.75% to 2.50% in the case of Eurodollar Rate loans and reduced the Applicable Rate from 1.75% to 1.50% in the case of Base Rate Loans.

In connection with the Repricing Facilities Amendments, we recorded a debt extinguishment charge of $0.9 million, including the discount and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of operations.

On May 10, 2017, we entered into a Third Repricing Amendment (the "Third Repricing Amendment") to the Amended and Restated Credit Agreement. The Third Repricing Amendment reduced the Applicable Rate with respect to the Tranche B-1 Facility and the Tranche B-2 Facility from 3.0% to 2.75% in the case of Eurodollar Rate loans and from

2.0% to 1.75% in the case of Base Rate Loans. In connection with the Third Repricing Amendment, the Company recorded a debt extinguishment charge of $0.8 million, including the discount and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of operations.

On November 30, 2016, we entered into a Refinancing Facilities Amendment (the "Refinancing Amendment") to the Amended and Restated Credit Agreement. The Refinancing Amendment increased our line of credit on our revolving credit facility to $500.0 million from $300.0 million and reduced our TLA Facility to $400.0 million from $600.6 million (together, the "Refinancing Facilities"). In addition, the Refinancing Amendment extended the maturity date for the Refinancing Facilities to November 30, 2021 from February 13, 2019, and lowered the effective interest rate on our line of credit on our revolving credit facility and TLA Facility by 50 basis points. In connection with the Refinancing Amendment, we recorded a debt extinguishment charge of $0.8 million, including the write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of operations.

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On November 22, 2016, we entered into a Tenth Amendment (the "Tenth Amendment") to the Amended and Restated Credit Agreement. The Tenth Amendment, among other things, (i) amended the negative covenant regarding dispositions, (ii) modified the collateral package to release any real property with a fair market value of less than $5.0 million and (iii) changed certain investment, indebtedness and lien baskets.

On September 21, 2016, we entered into a Tranche B-2 Repricing Amendment (the "Tranche B-2 Repricing Amendment") to the Amended and Restated Credit Agreement. The Tranche B-2 Repricing Amendment reduced the Applicable Rate with respect to our Tranche B-2 Facility from 3.75% to 3.00% in the case of Eurodollar Rate loans and 2.75% to 2.00% in the case of Base Rate Loans. In connection with the Tranche B-2 Repricing Amendment, we recorded a debt extinguishment charge of $3.4 million, including the discount and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of operations.

On May 26, 2016, we entered into a Tranche B-1 Repricing Amendment (the "Tranche B-1 Repricing Amendment") to the Amended and Restated Credit Agreement. The Tranche B-1 Repricing Amendment reduced the Applicable Rate with respect to our Tranche B-1 Facility from 3.5% to 3.0% in the case of Eurodollar Rate loans and 2.5% to 2.0% in the case of Base Rate Loans.

On February 16, 2016, we issued $390.0 million of 6.500% Senior Notes due 2024 (the "6.500% Senior Notes"). The 6.500% Senior Notes mature on March 1, 2024 and bear interest at a rate of 6.500% per annum, payable semi-annually in arrears on March 1 and September 1 of each year, beginning on September 1, 2016. We used the net proceeds to fund a portion of the purchase price for the acquisition of Priory and the fees and expenses for such acquisition and the related financing transactions.

On February 16, 2016, we entered into a Second Incremental Facility Amendment (the "Second Incremental Amendment") to our Amended and Restated Credit Agreement. The Second Incremental Amendment activated our Tranche B-2 Facility and added $135.0 million to the TLA Facility to our Amended and Restated Senior Secured Credit Facility (the "Amended and Restated Senior Credit Facility"), subject to limited conditionality provisions. Borrowings under the Tranche B-2 Facility were used to fund a portion of the purchase price for the acquisition of Priory and the fees and expenses for such acquisition and the related financing transactions. Borrowings under the TLA Facility were used to pay down the majority of our $300.0 million revolving credit facility.

On January 25, 2016, we entered into the Ninth Amendment (the "Ninth Amendment") to the Amended and Restated Credit Agreement. The Ninth Amendment modified certain definitions and provided increased flexibility to us in terms of our financial covenants.

On January 12, 2016, we completed the offering of 11,500,000 shares of common stock (including shares sold pursuant to the exercise of the over-allotment option that we granted to the underwriters as part of the offering) at a public offering price of $61.00 per share. The net proceeds to us from the sale of the shares, after deducting the underwriting discount of $15.8 million and additional offering related costs of $0.7 million, were approximately $685.0 million. We used the net offering proceeds to fund a portion of the purchase price for the acquisition of Priory.

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 155 combined years of experience in acquiring, integrating and operating a variety of behavioral health facilities. Prior to

joining Acadia in December 2018, our Chief Executive Officer ("CEO") served as Executive Vice President of Universal Health Services, Inc. ("UHS") since 2005, and President of UHS's behavioral health division since 1999. Following the sale of Psychiatric Solutions, Inc. ("PSI") to UHS in November 2010, certain of PSI's key former executive officers joined Acadia in February 2011. The extensive national experience and operational expertise of our management team give us what management believes to be the premier leadership team in the behavioral healthcare industry. Our management team strives to use its years of experience operating behavioral healthcare facilities to generate strong cash flow and grow a profitable business.

Favorable industry and legislative trends. According to a 2016 survey by the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services ("SAMHSA"), 18.3% of adults in the U.S. aged 18 years or older suffered from a mental illness in the prior year and 4.2% suffered from a serious mental illness. Further, approximately 8.0% of people aged 12 or older in 2016 were classified with a substance abuse disorder in the past year. According to the National Institute of Mental Health, over 20% of children, either currently or at some point in their life, have had a seriously debilitating mental disorder. Management believes the market for behavioral services will continue to grow due to increased awareness of mental health and

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substance abuse conditions and treatment options. According to a 2014 SAMHSA report, national expenditures at substance abuse treatment facilities are expected to reach $42.1 billion in 2020, up from $24.3 billion in 2009.

While the growing awareness of mental health and substance abuse conditions is expected to accelerate demand for services, recent healthcare reform in the U.S. is expected to increase access to industry services as more people obtain insurance coverage. A key aspect of reform legislation is the extension of mental health parity protections established into law by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "MHPAEA"). The MHPAEA requires employers who provide behavioral health and addiction benefits to provide such coverage to the same extent as other medical conditions. On December 13, 2016, President Obama signed the 21st Century Cures Act. The 21st Century Cures Act appropriates substantial resources for the treatment of behavioral health and substance abuse disorders and contains measures intended to strengthen the MHPAEA. On October 21, 2018, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment ("SUPPORT") for Patients and Communities Act was signed into law. The SUPPORT for Patients and Communities Act expands Medicare coverage to include Opioid Treatment Programs for services provided on or after January 2, 2020. It also includes Individuals in Medicaid Deserve Care that is Appropriate and Responsible in its Execution Act ("IMD CARE Act"), which suspends the current prohibition on using federal Medicaid funds to pay for substance use disorder treatment at inpatient treatment facilities with more than 16 beds and limits beneficiaries to no more than 30 days of inpatient treatment per 12 month period.

The mental health hospitals market in the U.K. was estimated at £14.5 billion for 2016/2017. As a result of government budget constraints and an increased focus on quality, the independent mental health hospitals market has witnessed significant expansion in the last decade, making it one of the fastest growing sectors in the U.K. healthcare industry. Demand for independent sector beds has grown significantly as a result of the National Health Service (the "NHS") reducing its bed capacity and increasing hospitalization rates. Independent sector demand is expected to further increase in light of additional bed closures and reduction in community capacity by the NHS.

Leading platform in attractive healthcare niche. We are a leading behavioral healthcare platform in an industry that is undergoing consolidation in an effort to reduce costs and expand programs to better serve the growing need for inpatient behavioral healthcare services. Management expects to take advantage of several strategies that are more accessible as a result of our increased size and geographic scale, including continuing a national marketing strategy to attract new patients and referral sources, increasing our volume of out-of-state referrals, providing a broader range of services to new and existing patients and clients and selectively pursuing opportunities to expand our facility and bed count in the U.S. and U.K.

Diversified revenue and payor bases. At December 31, 2018, we operated 583 facilities in 40 states, the U.K. and Puerto Rico. Our payor, patient and geographic diversity mitigates the potential risk associated with any single facility. For the year ended December 31, 2018, we received 33% of our revenue from public funded sources in the U.K. (including the NHS, Clinical Commissioning Groups ("CCGs") and local authorities in England, Scotland and Wales), 30% from Medicaid, 19% from commercial payors, 9% from Medicare and 9% from other payors. As we receive Medicaid payments from 46 states, the District of Columbia and Puerto Rico, management does not believe that we are significantly affected by changes in reimbursement policies in any one state or territory. No facility accounted for more than 3% of revenue for the year ended December 31, 2018, and no state or U.S. territory accounted for more than 8% of revenue for the year ended December 31, 2018. Our U.K. operations accounted for approximately 37% of our revenue for the year ended December 31, 2018. We believe that our increased geographic diversity will mitigate the impact of any financial or budgetary pressure that may arise in a particular state or market where we operate.

Strong cash flow generation and low capital requirements. We generate strong free cash flow by profitably operating our business and by actively managing our working capital. Moreover, as the behavioral healthcare business does not typically require the procurement and replacement of expensive medical equipment, our maintenance capital expenditure requirements are generally less than that of other facility-based healthcare providers. For the year ended December 31, 2018, our maintenance capital expenditures amounted to approximately 2.5% of our revenue.

Business Strategy

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

Increase margins by enhancing programs and improving performance at existing facilities. Management believes we can improve efficiencies and increase operating margins by utilizing our management’s expertise and experience within existing programs and their expertise in improving performance at underperforming facilities. Management believes the efficiencies can be realized by investing in growth in strong markets, addressing capital-constrained facilities that have underperformed and improving management

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systems. Furthermore, our recent acquisitions of additional facilities give us an opportunity to develop a marketing strategy in many markets which should help us increase the geographic footprint from which our existing facilities attract patients and referrals.

Opportunistically pursue acquisitions and partnerships. We have positioned our company as a leading provider of mental health services in the U.S. and the U.K. The behavioral healthcare industry in the U.S. and the independent behavioral healthcare industry in the U.K. are highly fragmented, and we selectively seek opportunities to expand and diversify our base of operations by acquiring additional facilities and entering into partnerships with healthcare providers to acquire and develop additional facilities. Acadia management believes there are a number of acquisition candidates available at attractive valuations, and we have a number of potential joint ventures and acquisitions in various stages of development and consideration in the U.S.

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

Drive organic growth of existing facilities. We seek to increase revenue at our facilities by providing a broader range of services to new and existing patients and clients. In addition, management intends to increase bed counts in our existing facilities. During the year ended December 31, 2018, we added 651 beds, including 499 added to existing facilities and 152 added through the opening of two de novo facilities. For the year ending December 31, 2019, we expect to add approximately 700 total beds exclusive of acquisitions. Furthermore, management believes that opportunities exist to leverage out-of-state referrals to increase volume and minimize payor concentration in the U.S., especially with respect to our youth and adolescent focused services and our substance abuse services.

U.S. Operations

Our U.S. facilities and services can generally be classified into the following categories: acute inpatient psychiatric facilities; specialty treatment facilities; residential treatment centers; and outpatient community-based services. The table below presents the percentage of our total U.S. revenue attributed to each category for the year ended December 31, 2018:

Facility/Service	U.S. Revenue for the Year Ended December 31, 2018	
Acute inpatient psychiatric facilities	43	%
Specialty treatment facilities	40	%
Residential treatment centers	15	%
Outpatient community-based services	2	%

We receive payments from the following sources for services rendered in our U.S. facilities: (i) state governments under their respective Medicaid and other programs; (ii) commercial insurers; (iii) the federal government under the Medicare program administered by the Centers for Medicare and Medicaid Services ("CMS"); and (iv) individual patients and clients. For the year ended December 31, 2018 in our U.S. facilities, we received 47% of our revenue from Medicaid, 30% from commercial payors, 15% from Medicare and 8% from other payors.

At December 31, 2018, our U.S. facilities included 213 behavioral healthcare facilities with approximately 9,300 beds in 40 states and Puerto Rico. Of our U.S. facilities, excluding comprehensive treatment centers ("CTCs"), approximately 41% are acute inpatient psychiatric facilities, approximately 41% are specialty treatment facilities, approximately 15% are residential treatment centers and approximately 3% are outpatient community-based service facilities at December 31, 2018. Of the 213 behavioral healthcare facilities, 116 are CTCs which is a subset of specialty treatment facilities. Of our CTCs, 18 are owned properties and 98 are leased properties. Of the 97 facilities that are not CTCs, 77 are owned properties and 20 are leased properties. For the years ended December 31, 2018 and 2017, our U.S. operations generated revenue of $1.9 billion and $1.8 billion, respectively.

Acute Inpatient Psychiatric Facilities

Acute inpatient psychiatric facilities provide a high level of care in order to stabilize patients that are either a threat to themselves or to others. The acute setting provides 24-hour observation, daily intervention and monitoring by psychiatrists. Generally, due to shorter lengths of stay, the related higher patient turnover, and the special security and health precautions required, acute inpatient psychiatric facilities have lower average occupancy than residential treatment centers. Our facilities that offer acute care services provide evaluation and crisis stabilization of patients with severe psychiatric diagnoses through a medical delivery model that

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incorporates structured and intensive medical and behavioral therapies with 24-hour monitoring by a psychiatrist, psychiatric trained nurses, therapists and other direct care staff. Lengths of stay for crisis stabilization and acute care range from three to five days and from five to twelve days, respectively.

Specialty Treatment Facilities

Our specialty treatment facilities include residential recovery facilities, eating disorder facilities and CTCs. We provide a comprehensive continuum of care for adults with addictive disorders and co-occurring mental disorders. Our detoxification, inpatient, partial hospitalization and outpatient treatment programs are cost-effective and give patients access to the least restrictive level of care. All programs offer individualized treatment in a supportive and nurturing environment.

The majority of our specialty treatment services are provided to patients who abuse addictive substances such as alcohol, illicit drugs or opiates, including prescription drugs. Some of our facilities also treat other addictions and behavioral disorders such as chronic pain, sexual compulsivity, compulsive gambling, mood disorders, emotional trauma and abuse. The goal of our treatment facilities is to provide the appropriate level of treatment to an individual no matter where they are in the lifecycle of their disease in order to restore the individual to a healthier, more productive life, free from dependence on illicit substances and destructive behaviors. Our treatment facilities provide a number of different treatment services such as assessment, detoxification, medication-assisted treatment, counseling, education, lectures and group therapy. We assess and evaluate the medical, psychological and emotional needs of the patient and address these needs in the treatment process. Following this assessment, an individualized treatment program is designed to provide a foundation for a lifelong recovery process. Many modalities are used in our treatment programs to support the individual, including the twelve step philosophy, cognitive/behavioral therapies, supportive therapies and continuing care.

Residential Recovery Facilities. Our inpatient facilities house and care for patients over an extended period and typically treat patients from a broadly defined regional market. We provide three basic levels of residential treatment depending on the severity of the patient’s addiction and/or behavioral disorder. Patients with the most severe dependencies are typically placed into inpatient treatment, in which the patient resides at a treatment facility. If a patient’s condition is less severe, he or she will be offered day treatment, which allows the patient to return home in the evening. The least intensive service is where the patient visits the facility for just a few hours a week to attend counseling/group sessions.

Following primary treatment, our extended care programs typically offer residential care, which allows patients to develop healthy and appropriate living skills while remaining in a safe and nurturing setting. Patients are supported in their recovery by a semi-structured living environment that allows them to begin the process of employment or to pursue educational goals and to take personal responsibility for their recovery. The structure of this treatment phase is monitored by a primary therapist who works with each patient to integrate recovery skills and build a foundation of sobriety with a strong support system. Length of stay will vary depending on the patient’s needs with a minimum stay of 30 days and could be multiple months if needed.

Our outpatient clinics serve patients that do not require inpatient treatment or are transitioning from a residential treatment program; have employment, family or school commitments; and have stabilized in their substance addiction recovery practices and are seeking ongoing continuing care.

Eating Disorder Facilities. Our eating disorder facilities provide treatment services for eating disorders and weight management, each of which may be effectively treated through a combination of medical, psychological and social

treatment programs.

Comprehensive Treatment Centers. Our CTCs specialize in providing medication-assisted and abstinent-based treatment. Medication-assisted treatment combines behavioral therapy and medication to treat substance use disorders. CTCs utilize medication-assisted treatment to individuals addicted to opiates such as opioid analgesics (prescription pain medications) and heroin. Medication is used to normalize brain chemistry to block the euphoric effects of alcohol and opioids allowing our professional staff to provide behavioral therapy. Patients begin their treatment attending the clinic almost daily. Then, through successfully progressing in treatment, patients attend less frequently depending on individual treatment plans. The length of treatment differs from patient to patient, but typically ranges from one to three years.

Each of our CTCs provide a range of comprehensive substance abuse treatment support services that include medical, counseling, vocational, educational, and other treatment services. Our behavioral therapies are delivered in an array of treatment models that may include individual and group therapy, intensive outpatient, outpatient, partial hospitalization/day treatment, road to recovery, and other programs that can be either abstinent or medication assisted based.

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Residential Treatment Centers

Residential treatment centers treat patients with behavioral disorders in a non-hospital setting, including outdoor programs. The facilities balance therapy activities with social, academic and other activities. Because the setting is less intensive, demands on staffing, security and oversight are generally lower than inpatient psychiatric facilities. In contrast to acute care psychiatric facilities, occupancy in residential treatment centers can be managed more easily given a longer length of stay. Over time, however, residential treatment centers have continued to serve increasingly severe patients who would have been treated in acute care facilities in earlier years.

We provide residential treatment care through a medical model residential treatment facility, which offers intensive, medically-driven interventions and individualized treatment regimens designed to deal with moderate to high level patient acuity. Children and adolescents admitted to these facilities typically have had multiple prior failed treatment plans, severe physical, sexual and emotional abuse, termination of parental custody, substance abuse, marked deficiencies in social, interpersonal and academic skills and a wide range of psychiatric disorders. Treatment typically is provided by an interdisciplinary team coordinating psychopharmacological, individual, group and family therapy, along with specialized accredited educational programs in both secure and unlocked environments. Lengths of stay range from three months to several years.

Certain of our residential treatment centers provide group home, therapeutic group home and therapeutic foster care programs. Our group home programs provide family-style living for youths in a single house or apartment within residential communities where supervision and support are provided by 24-hour staff. The goal of a group home program is to teach family living and social skills through individual and group counseling sessions within a real life environment. The residents are encouraged to take responsibility for the home and their health as well as actively take part in community functions. Most attend an accredited and licensed on-premises school or a local public school. We also operate therapeutic group homes that provide comprehensive treatment services for seriously, emotionally disturbed adolescents. The ultimate goal is to reunite or place these children with their families or prepare them, when appropriate, for permanent placement with a relative or an adoptive family. We also manage therapeutic foster care programs, which are considered the least restrictive form of therapeutic placement for children and adolescents with emotional disorders. Children and adolescents in our therapeutic foster care programs often are part of the child welfare or juvenile justice system. Care is delivered in private homes with experienced foster parents who are trained to work with children and adolescents with special needs.

Outpatient Community-Based Services

Our community-based services can be divided into two age groups: children and adolescents (seven to 18 years of age) and young children (three months to six years of age). Community-based programs are designed to provide therapeutic treatment to children and adolescents who have a clinically-defined emotional, psychiatric or chemical dependency disorder while enabling the youth to remain at home and within their community. Many patients who participate in community-based programs have transitioned out of a residential facility or have a disorder that does not require placement in a facility that provides 24-hour care.

Community-based programs developed for these age groups provide a unique array of therapeutic services to a very high-risk population of children. These children suffer from severe congenital, neurobiological, speech/motor and early onset psychiatric disorders. These services are provided in clinics and employ a treatment model that is consistent with our interdisciplinary medical treatment approach. Depending on their individual needs and treatment plan, children receive speech, physical, occupational and psychiatric interventions that are coordinated with services provided by their referring primary care physician. The children generally receive treatment during regular business

hours.

U.K. Operations

Overview

We are the leading independent provider of mental health services in the U.K. operating 370 inpatient behavioral health facilities with approximately 8,800 beds at December 31, 2018. The facilities are located in England, Wales, Scotland and Northern Ireland. For the years ended December 31, 2018 and 2017, our U.K. operations generated revenue of $1.1 billion and $1.0 billion, respectively, primarily through the operation and management of inpatient behavioral health facilities.

United Kingdom Healthcare and Adult Social Care Sectors

In the U.K., central government spending on health for fiscal year 2018-2019 is budgeted at approximately £152 billion, according to the U.K. government budget. This spending is primarily delivered by the NHS, which operates as three separate national public sector bodies in England, Scotland and Wales as well as the Northern Ireland Health and Social Care Board. Local Government gross spending on adult social care for the fiscal year 2018-2019 is budgeted at approximately £24 billion and is commissioned by

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local authorities in England, Scotland and Wales, which we refer to as Local Authorities and by the Northern Ireland Health and Social Care Board. The NHS, Local Authorities and Northern Ireland Health and Social Care Board commissioners dominate the U.K. health and social care markets in terms of the funding of care. With the exception of the elderly residential and nursing care market, private health insurance and self-payment play a minor role in these sectors.

The mental health market in the U.K. was estimated at £14.5 billion for 2016/2017. The independent mental health market accounted for roughly £1.6 billion of that amount, or approximately 11% market share. In the last 15 years, the independent mental health market has witnessed significant expansion mainly due to NHS outsourcing as the number of NHS in-house beds has declined. However, since 2015 overall independent sector mental health hospital bed capacity has remained largely the same.

Publicly-funded healthcare services in England are commissioned at two levels as follows: (i) nationally by NHS England which, via its Local Area Teams commissions specialized healthcare services, including specialized Mental Health Secure, Eating Disorder and Children and Adolescent ("CAMHS") services, and (ii) locally by over 200 local CCGs, which commission all acute, rehabilitation and community-based healthcare services. In Scotland and Wales, all healthcare services are commissioned by Local/Regional Health Boards.

The principal distinction between healthcare and social care relates to an individual's assessed care needs. If there is a primary health need, services are commissioned by the NHS under the general NHS principle that the services are free at the point of delivery. In the case of adult social care, individuals' healthcare-related needs have been assessed as being of secondary importance with services being means-tested. Local Authority commissioners of adult social care provided in care homes and other community settings are responsible for undertaking financial assessments to determine the level of contributions that individuals must pay towards the cost of their care. Individuals with income or capital above set statutory thresholds must fund the full cost of their care.

In recent years, the U.K. Government has placed increasing emphasis on implementing integrated care pathways across health and social care services. Integrated care pathways provide patients with highly coordinated and personalized care overseen by relevant commissioners working together to plan, arrange and monitor patient progression through each stage of the care pathway.

Additionally, mental health commissioning trends toward moving patients more quickly down care pathways, out of higher acuity, more intensive care settings towards community focused care services have increased the demand for community and rehabilitation services in the independent mental health market. The Department of Health in England recently identified priorities for essential change in mental health that include, among other things, funding providers based on the quality of their service rather than volume of patients, allocating funds to support specialized housing for people with mental health problems and adopting a new rating system and inspection process to improve the quality of care. Increasing political focus on the provision of mental health services in the U.K. and increasing support for the rights of mental health patients are expected to lead to further increases in the size of the mental health market in the U.K. In addition, rising demand for mental health services in the U.K. coupled with a constrained mental healthcare funding environment are increasing pressure to improve operational efficiency and refer patients to single provider programs with care pathways that more appropriately reflect each patient's specific mental health needs. As a result of these pressures, government reforms to NHS competition rules and an increased focus on quality, the independent mental health market witnessed significant expansion in the last decade, making it one of the fastest growing sectors in the U.K. healthcare industry.

Within its Long Term Plan for the NHS published in January 2019, NHS England set out its commitment to grow investment in mental health services faster than the NHS budget overall for each of the next five years such that Mental Health will receive a growing share of the NHS budget, worth at least £2.3 billion a year by 2023/2024.

NHS England plans to set up a network of Integrated Care Systems covering all of England by 2021 to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. NHS England's focus is upon collaboration rather than competition between providers and has recommended the reversal of many of the NHS competition reforms that had been introduced by the government in 2012.

Description of U.K. Facilities

In the U.K., we provide inpatient services through a variety of facilities, including mental health hospitals, clinics, care homes, schools, colleges and children's homes. In addition to these services, we also operate a U.K. division that leverages on our clinical knowledge to provide Employee Assistance Programs ("EAP") to organizations.

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Our U.K. facilities and services can generally be classified into the following categories: healthcare facilities, education and children's services and adult care facilities. The table below presents the percentage of our total U.K. revenue attributed to each category for the year ended December 31, 2018:

Facility/Service	U.K. Revenue for the Year Ended December 31, 2018	
Healthcare facilities	56	%
Education and Children's Services	17	%
Adult Care facilities	27	%

We receive payments from approximately 500 public funded sources in the U.K. (including the NHS, CCGs and local authorities in England, Scotland and Wales) and individual patients and clients. For the year ended December 31, 2018 in our U.K. facilities, we received 90% of our revenue from public funded sources in the U.K. (including the NHS, CCGs and local authorities in England, Scotland and Wales) and 10% from other payors.

At December 31, 2018, our U.K. facilities included 370 behavioral healthcare facilities with approximately 8,800 beds, including approximately 1,100 non-residential education places, in the U.K. Of our U.K. facilities, approximately 23% are healthcare facilities, approximately 19% are education and children's services facilities and approximately 58% are adult care facilities at December 31, 2018. At December 31, 2018, 292 of our U.K. facilities are owned properties and 78 are leased properties.

Healthcare

In the U.K., mental health hospitals provide psychiatric treatment and nursing for sufferers of mental disorders, including for patients detained under a section of the U.K.'s Mental Health Act of 1983 and 2007, and whose risk of harm to others and risk of escape from hospitals cannot be managed safely within other mental health settings. In order to manage the risks involved with treating patients, the facility is managed through the application of a range of security measures depending on the level of dependency and risk exhibited by the patient. The levels of dependency and risk stemming from the wide range of disorders treated at these hospitals determine the level of care provided, which are comprised of:

- Secure Services. Medium and Low secure facilities treat patients who may present a serious danger to others and themselves but do not need the physical security arrangements of a high security hospital. The purpose of medium secure services is to provide effective care and treatment to reduce risk, promote recovery and support patients moving through the care pathway to lower levels of security or to reestablishing themselves successfully in the community. Low secure facilities provide treatment for patients whom, because of the level of risk or challenge they present, cannot be treated in open mental health settings. Low secure services deliver intensive, comprehensive and multidisciplinary treatment to patients demonstrating disturbed behavior in the context of a serious mental disorder and require the provision of security but pose a lesser risk of harm to themselves and to others.
- Specialty Treatment Services. Specialty treatment services provide treatment relating to specific conditions including eating disorders and addiction. Our eating disorder facilities provide treatment services for eating disorders and weight management for both adults and adolescents. Our addiction services provide treatment for abuse of addictive

substances such as alcohol and illicit drugs as well as facilities for other addictions and behavioral disorders such as compulsive gambling.

- Child and Adolescent Mental Health Services. Child and adolescent mental health services provide treatment to young people in need of expert care and support for behavioral, emotional or mental health difficulties. These services are designed to enable the children and young people within our care to improve their long-term wellbeing and effectively reintegrate into the community when they are ready.
- Rehabilitation Services. Both locked and open mental health rehabilitation services provide a bridge between secure hospital facilities and community living by providing relapse prevention and social integration services as well as vocational opportunities.
- Acute Services. Acute services provide treatment relating to emergency admissions for patients at risk to themselves or others, as well as crisis intervention and treatment of behavioral emergencies.
- Care Homes. Care homes provide long-term, non-acute care for adults suffering from a mental illness or addiction, or who have a learning disability or brain injury and are unable to cope unsupported in the community.

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Other Services

- Education and Children's Services. Education and children's services provide specialist education for children and young people with special educational needs, including autism, Asperger's Syndrome, social, emotional and mental health, and specific learning difficulties, such as dyslexia. The division also offers standalone children's homes for children that require 52-week residential care to support complex and challenging behavior and fostering services.
- Adult Care. Adult Care focuses on care of service users with a variety of learning difficulties, mental health illnesses and adult autism spectrum disorders. It also includes long-term, short-term and respite nursing care to high-dependency elderly individuals who are physically frail or suffering from dementia. Care is provided in a number of settings, including in residential care homes and through supported living.
- Care First. Care First leverages our clinical knowledge to provide EAP to organizations. These support services are designed to help employees manage difficult issues in their professional or personal lives with services that include:
  - A call center for telephone counseling available 24-hours a day, seven days a week;
  - A national network of counselors available for live, face-to-face support;
  - Interactive health and wellness programs;
  - Debt management advice services; and
  - Management training.

Sources of Revenue

We receive payments from the following sources for services rendered in our facilities: (i) state governments under their respective Medicaid and other programs; (ii) commercial insurers; (iii) the federal government under the Medicare program administered by CMS; (iv) public funded sources in the U.K. (including the NHS, CCGs and local authorities in England, Scotland and Wales); and (v) individual patients and clients. We determine the transaction price based on established billing rates reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients and implicit price concessions. Contractual adjustments and discounts are based on contractual agreements, discount policies and historical experience. Implicit price concessions are based on historical collection experience. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Revenue and Accounts Receivable" for additional disclosure. Other information related to our revenue, income and other operating information is provided in our Consolidated Financial Statements.

Regulation

U.S. Overview

The healthcare industry is subject to numerous laws, regulations and rules including, among others, those related to government healthcare program participation requirements, various licensure and accreditation standards, reimbursement for patient services, health information privacy and security rules, and government healthcare program fraud and abuse provisions. Providers that are found to have violated any of these laws and regulations may be excluded from participating in government healthcare programs, subjected to loss or limitation of licenses to operate, subjected to significant fines or penalties and/or required to repay amounts received from the government for previously billed patient services.

Licensing, Certification and Accreditation

All of our facilities must comply with various federal, state and local licensing and certification regulations and undergo periodic inspection by licensing agencies to certify compliance with such regulations. The initial and continued licensure of our facilities and certification to participate in government healthcare programs depends upon

many factors including various state licensure regulations relating to quality of care, environment of care, equipment, services, staff training, personnel and the existence of adequate policies, procedures and controls. Federal, state and local agencies survey our facilities on a regular basis to determine whether the facilities are in compliance with regulatory operating and health standards and conditions for participating in government healthcare programs.

Most of our inpatient and residential facilities maintain accreditation from private entities, such as The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities ("CARF"). The Joint Commission and CARF are private organizations that have accreditation programs for a broad spectrum of healthcare facilities. The Joint Commission accredits a broad variety of healthcare organizations, including hospitals and behavioral health organizations. CARF accredits behavioral health organizations

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providing mental health and alcohol and drug use and addiction services, as well as opiate treatment programs, and many other types of healthcare programs. These accreditation programs are intended generally to improve the quality, safety, outcomes and value of healthcare services provided by accredited facilities. Certain federal and state licensing agencies as well as many in government and private healthcare payment programs require that providers be accredited as a condition of licensure, certification or participation. Accreditation is typically granted for a specified period, ranging from one to three years, and renewals of accreditation generally require completion of a renewal application and an on-site renewal survey.

Certificates of Need

Many of the states in which we operate facilities have enacted certificate of need ("CON") laws that regulate the construction or expansion of certain healthcare facilities, certain capital expenditures or changes in services or bed capacity. Failure to obtain CON approval of certain activities can result in: our inability to complete an acquisition, expansion or replacement; the imposition of civil penalties; the inability to receive Medicare or Medicaid reimbursement; or the revocation of a facility's license, any of which could harm our business.

Audits

Our healthcare facilities are also subject to federal, state and commercial payor audits to validate the accuracy of claims submitted to the government healthcare programs and commercial payors. If these audits identify overpayments, we could be required to make substantial repayments, subject to various appeal rights. Several of our facilities have undergone claims audits related to their receipt of payments during the last several years with no material overpayments identified. However, potential liability from future audits could ultimately exceed established reserves, and any excess could potentially be substantial. Further, Medicare and Medicaid regulations, as well as commercial payor contracts, also provide for withholding or suspending payments in certain circumstances, which could adversely affect our cash flow.

The Anti-Kickback Statute and Stark Law

The Anti-Kickback Statute prohibits healthcare providers and others from directly or indirectly soliciting, receiving, offering or paying any remuneration, in cash or in kind, as an inducement or reward for using, referring, ordering, recommending or arranging for such referrals or orders of services or other items paid for by a government healthcare program. The Anti-Kickback Statute may be found to have been violated if at least one purpose of the remuneration is to induce or reward referrals. A provider is not required to have actual knowledge or specific intent to commit a violation of the Anti-Kickback Statute to be found guilty of violating the law.

The Office of Inspector General of the Department of Health and Human Services has issued safe harbor regulations that protect certain types of common arrangements from prosecution or sanction under the Anti-Kickback Statute and there are also several statutory exceptions toward that end. The fact that conduct or a business arrangement does not fall within a safe harbor or exception does not automatically render the conduct or business arrangement illegal under the Anti-Kickback Statute. However, conduct and business arrangements falling outside the safe harbors may lead to increased scrutiny by government enforcement authorities.

Although management believes that our arrangements with physicians and other referral sources comply with current law and available interpretative guidance, as a practical matter it is not always possible to structure our arrangements so as to fall squarely within an available safe harbor. Where that is the case, we cannot guarantee that applicable regulatory authorities will determine these financial arrangements do not violate the Anti-Kickback Statute or other

applicable laws, including state anti-kickback laws.

In addition to the Anti-Kickback Statute, the federal Physician Self-Referral Law, also known as the Stark Law, prohibits physicians from referring Medicare patients to healthcare entities with which they or any of their immediate family members have a financial relationship for the furnishing of any "designated health services" unless certain exceptions apply. A violation of the Stark Law may result in a denial of payment; required refunds to the Medicare program; imposition of civil monetary penalties of up to $24,748 for each prohibited claim, up to $164,992 for circumvention schemes, and up to $19,639 for each day the entity fails to report required information; exclusion from government healthcare programs; and liability under the False Claims Act. There are ownership and compensation arrangement exceptions for many customary financial arrangements between physicians and facilities, including the employment exception, personal services exception, lease exception and certain recruitment exceptions. Management believes that our financial arrangements with physicians are structured to comply with the regulatory exceptions to the Stark Law. However, the Stark Law is a strict liability statute, meaning that no intent is required to violate the law, and even a technical violation may lead to significant penalties.

These laws and regulations are extremely complex and, in many cases, we do not have the benefit of regulatory or judicial interpretation. It is possible that different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our arrangements relating to facilities,

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equipment, personnel, services, capital expenditure programs and operating expenses. A determination that we have violated one or more of these laws, or the public announcement that we are being investigated for possible violations of one or more of these laws, could have a material adverse effect on our business, financial condition or results of operations. In addition, we cannot predict whether other federal or state legislation or regulations will be adopted, what form such legislation or regulations may take or what their impact on us may be.

If we are deemed to have failed to comply with the Anti-Kickback Statute, the Stark Law or other applicable laws and regulations, we could be subjected to liabilities, including criminal penalties, civil penalties, and exclusion of one or more facilities from participation in the government healthcare programs. The imposition of such penalties could have a material adverse effect on our business, financial condition or results of operations.

Eliminating Kickbacks in Recovery Act

In October 2018, President Trump signed into law the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the "SUPPORT Act"). The SUPPORT Act contains a number of provisions aimed at identifying at-risk individuals, increasing access to opioid abuse treatment, reducing overprescribing, and promoting data sharing with the primary goal of reducing the use and abuse of opioids. Additionally, the SUPPORT Act attempts to address the problem of "patient brokering" in the context of addiction treatment facilities and sober homes.

One section of the SUPPORT Act, the Eliminating Kickbacks in Recovery Act ("EKRA"), makes it a federal crime to knowingly and willfully: (1) solicit or receive any remuneration in return for referring a patient to a recovery home, clinical treatment facility, or laboratory; or (2) pay or offer any remuneration to induce such a referral or in exchange for an individual using the services of a recovery home, clinical treatment facility, or laboratory. Each conviction under the EKRA is punishable by up to $200,000 in monetary damages, imprisonment for up to ten (10) years, or both. Unlike the Anti-Kickback Statutes, EKRA is not limited to services reimbursable under a government healthcare program. The EKRA also contains exceptions similar to the Anti-Kickback Statute Safe Harbors, but those exceptions are more narrow than the Anti-Kickback Statute Safe Harbors such that practices that would be permissible under the Anti-Kickback Statute may violate EKRA.

Federal False Claims Act and Other Fraud and Abuse Provisions

The federal False Claims Act provides the government a tool to pursue healthcare providers for submitting false claims or requests for payment for healthcare items or services. Under the False Claims Act, the government may fine any person or entity that, among other things, knowingly submits, or causes the submission of, false or fraudulent claims for payment to the federal government or knowingly and improperly avoids or decreases an obligation to pay money to the federal government. The federal government has widely used the False Claims Act to prosecute Medicare and other federal healthcare program fraud such as coding errors, billing for services not provided, submitting false cost reports, and providing care that is not medically necessary or that is substandard in quality. Claims for services or items rendered in violation of the Anti-Kickback Statute or the Stark Law can provide a basis for liability under the False Claims Act as well. The False Claims Act is also implicated by the knowing failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later.

Violations of the False Claims Act are punishable by significant penalties totaling $11,181 to $22,363 for each fraudulent claim plus three times the amount of damages sustained by the government. In addition, under the qui tam, or whistleblower, provisions of the False Claims Act, private parties may bring actions under the False Claims Act on

behalf of the federal government. These private parties, known as relators, are entitled to share in any amounts recovered by the government, and, as a result, whistleblower lawsuits have increased significantly in recent years. Many states have similar false claims statutes that impose liability for the types of acts prohibited by the False Claims Act or that otherwise prohibit the submission of false or fraudulent claims to the state government or Medicaid program.

In addition to the False Claims Act, the federal government may use several criminal laws, such as the federal mail fraud, wire fraud, or health care fraud statutes, to prosecute the submission of false or fraudulent claims for payment to the federal government. Most states have also adopted generally applicable insurance fraud statutes and regulations that prohibit healthcare providers from submitting inaccurate, incorrect, or misleading claims to private insurance companies. Management believes our healthcare facilities have implemented appropriate safeguards and procedures to complete claim forms and requests for payment in an accurate manner and to operate in compliance with applicable laws. However, the possibility of billing or other errors can never be completely eliminated, and we cannot guarantee that the government or a qui tam plaintiff, upon audit or review, would not take the position that billing or other errors, should they occur, are violations of the False Claims Act.

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HIPAA Administrative Simplification and Privacy and Security Requirements

The administrative simplification provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH"), require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. HIPAA also established federal rules protecting the privacy and security of individually identifiable protected health information ("PHI"). The privacy and security regulations control the use and disclosure of PHI and the rights of patients to be informed about and control how such PHI is used and disclosed. Violations of HIPAA can result in both criminal and civil fines and penalties.

The HIPAA security regulations require healthcare providers to implement administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of PHI. HITECH has strengthened certain HIPAA rules regarding the use and disclosure of PHI, extended certain HIPAA provisions to business associates, and created security breach notification requirements including notifications to the individuals affected by the breach, the Department of Health and Human Services, and in certain cases, the media. HITECH has also increased maximum penalties for violations of HIPAA privacy rules. Management believes that we have been in material compliance with the HIPAA regulations and have developed our policies and procedures to ensure ongoing compliance, although we cannot guarantee that our facilities will not be subject to security incidents or breaches which could have a material adverse effect on our business, financial condition, or results of operations.

The Emergency Medical Treatment & Labor Act

The Emergency Medical Treatment & Labor Act ("EMTALA") is intended to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with emergency medical conditions. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer must be implemented. EMTALA imposes additional obligations on hospitals with specialized capabilities, such as ours, to accept the transfer of patients in need of such specialized capabilities if those patients present in the emergency room of a hospital that does not possess the specialized capabilities.

Mental Health Parity Legislation

The MHPAEA was signed into law in October 2008 and requires health insurance plans that offer mental health and addiction coverage to provide that coverage on par with financial and treatment coverage offered for other illnesses. The MHPAEA has some limitations because health plans that do not already cover mental health treatments are not required to do so, and health plans are not required to provide coverage for every mental health condition published in the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association. The MHPAEA also contains a cost exemption which operates to exempt a group health plan from the MHPAEA's requirements if compliance with the MHPAEA becomes too costly.

On December 13, 2016, then President Obama signed the 21st Century Cures Act. The 21st Century Cures Act appropriated substantial resources for the treatment of behavioral health and substance abuse disorders and contained measures intended to strengthen the MHPAEA.

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, "PPACA") dramatically altered the U.S. health care system. PPACA sought to provide coverage and access to substantially all Americans, to increase the quality of care provided, and to reduce the rate of growth in health care expenditures. PPACA attempted to achieve these goals by, among other things, requiring most Americans to obtain health insurance, expanding the Medicare program's use of value-based purchasing programs, bundling payments to hospitals and other providers, reducing Medicare and Medicaid payments to providers, expanding Medicaid eligibility, and tying reimbursement to the satisfaction of certain quality criteria.

On January 20, 2017, Donald Trump became President of the United States. Shortly after his inauguration, President Trump issued an executive order that, among other things, stated that it was the intent of his administration to repeal PPACA and, pending that repeal, instructed the executive branch of the federal government to defer or delay the implementation of any provision or requirement of PPACA that would impose a fiscal burden on any state or a cost, fee, tax, or penalty on any individual, family, health care provider, or health insurer. Several bills have been introduced and voted upon in the House of Representatives and United States Senate that would either repeal and replace or simply repeal PPACA, although none have been enacted to-date.

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On October 12, 2017, President Trump signed an executive order intending to expand the availability of so-called association health plans and short-term plans outside PPACA's requirements. President Trump also announced that the administration would cease making cost-sharing reduction payments to health insurance companies that help cover out-of-pocket costs for low-income individuals. Finally, the Tax Act (as defined and described below) effectively eliminated PPACA's individual health insurance mandate as of 2018 by reducing to zero the tax penalty associated with failure to maintain health insurance coverage.

During the 2018 election cycle Democrats regained control of the House of Representatives, effectively eliminating the possibility that PPACA will be repealed entirely during the next two years. Still, it remains difficult to predict whether PPACA will be replaced or modified; what the effect will be of the health care-related provisions in the Tax Act; or the impact that the President's executive actions will have on the implementation and enforcement of the provisions of PPACA or the regulations adopted or to be adopted to implement the law or the President's executive orders. In addition, if PPACA is replaced or modified, it remains unclear what the replacement plan or modifications would be, when the changes would become effective, or whether any of the existing provisions of PPACA would remain in place.

In 2018, federal district court judge in Texas ruled that PPACA in its entirety is invalid. That decision has been stayed pending appeal, and will likely remain unresolved until finally decided by the United States Supreme Court.

There have been and likely will continue to be a number of legal challenges to various provisions of the law and President Trump's executive actions. Limitations on the availability of adequate insurance coverage for patients seeking services at our facilities; any reductions in government healthcare spending; and the possible repeal, replacement or modification of PPACA could have a material adverse effect on our business, financial condition, or results of operations.

U.S. Tax Reform

On December 22, 2017, Public Law 115-97, informally referred to as the Tax Cuts and Jobs Act (the "Tax Act") was enacted into law. The Tax Act provided for significant changes to the U.S. tax code that has impacted businesses. Effective January 1, 2018, the Tax Act reduced the U.S. federal tax rate for corporations from 35% to 21% for U.S. taxable income. The Tax Act included other changes, including, but not limited to, a general elimination of U.S. federal income taxes on dividends from foreign subsidiaries, a new provision designed to tax global intangible low-taxed income, a limitation of the deduction for net operating losses, elimination of net operating loss carrybacks, immediate deductions for depreciation expense for certain qualified property, additional limitations on the deductibility of executive compensation and limitations on the deductibility of interest.

The Tax Act required a one-time remeasurement of deferred taxes to reflect their value at a lower tax rate of 21% and a one-time transition tax on certain repatriated earnings of foreign subsidiaries that is payable over eight years. Further information on the Company's accounting for such tax effects of the enactment of the Tax Act can be found in the consolidated financial statements. The Company continues to assess the impact of the Tax Act on its business.

U.K. Overview

The regulatory environment applicable to facilities in the U.K. is complex and multifaceted. The regulatory regime is made up of multiple statutes, regulations and minimum standards that are subject to continuous change. The laws and regulations applicable to the U.K. facilities include, without limitation, the Mental Capacity Act of 2005, Safeguarding Vulnerable Groups Act of 2006, Mental Health Act of 2007, Health and Social Care Act of 2008 and

Corporate Manslaughter and Corporate Homicide Act of 2007. These laws and regulations are predominantly protective in nature and share the same general underlying purpose to protect vulnerable persons from exploitation or harm. The regulatory requirements relevant to our facilities in the U.K. cover our operations from the initial establishments of new facilities, which are subject to registration and licensing requirements, to the recruitment and appointment of staff, occupational health and safety, duty of care to service users, clinical and educational standards, conduct of our professional and support staff and other areas.

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

Safeguarding Vulnerable Groups Act of 2006. The Safeguarding Vulnerable Groups Act of 2006 created the Independent Safeguarding Authority (“ISA”). In December 2012, the ISA merged with the Criminal Records Bureau to form the Discharge and Barring Service (“DBS”) and is required to establish and maintain lists of persons barred from working with children and adults. It is a criminal offense for a barred person to seek to work, or work in, activities from which they are barred. It is also generally a criminal

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offense for an employer to allow a barred person, or person who is not appropriately registered, to work in any regulated activity. The Children Act 1989 also allocates duties to Local Authorities, courts, parents, and other agencies in the U.K. to ensure children are safeguarded and their welfare is promoted.

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

The Health and Social Care Act of 2008. The Health and Social Care Act of 2008 ("HSCA"), as amended by the Care Act 2014, established the Care Quality Commission ("CQC") as the registration and regulatory body for health and adult social care in England. Under the HSCA, service providers carrying out "regulated activities" must be registered with the CQC for each separate regulated activity provided. Where the service provider is a company, each regulated activity/location must also have an individual registered as the registered manager. Registration depends both on an assessment of the fitness of the registered provider and also the individual registered manager. Regulated activities include the provision of residential accommodation together with nursing or personal care and the provision of treatment for a disease, disorder or injury by or under the supervision of a social worker or a multidisciplinary team which includes a social worker where the treatment is for a mental disorder.

The Care Act 2014. The Care Act 2014 came into force on April 1, 2015 along with a range of supporting regulations and a single set of statutory guidance. The Care Act 2014 requires Local Authorities to set personal budgets for individuals that are appropriate to meeting those individuals' assessed eligible care and support needs. The Care Act 2014 also imposes new statutory duties upon Local Authorities to ensure the supply of diverse, good quality, local services, including a duty to plan for future demand and to ensure that services are high quality and sustainable.

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

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

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

Regulatory and Enforcement Bodies in the U.K.

The primary healthcare regulatory enforcement bodies in the U.K. are NHS Improvement, the CQC, Healthcare Inspectorate Wales ("HIW"), Care Inspectorate Wales ("CIW"), Healthcare Improvement Scotland ("HIS"), Social Care and Social Work Improvement Scotland ("SCSWIS") and Regulation and Quality Improvement Authority ("RQIA"). In addition, the Office for Standards in Education, Children's Services and Skills ("OFSTED"), Estyn, Education Scotland and other regulatory bodies regulate and inspect education services in England, Wales and Scotland, as applicable. These enforcement bodies control and administer the registration, inspection and complaints procedures set out under the applicable laws and regulations. The enforcement bodies have the power to terminate a facility's registration, refuse to register a facility, impose admissions holds, or impose significant fines if a service provider fails to meet the key minimum standards and requirements prescribed under the various laws and regulations. In addition, NHS Counter Fraud Authority ("CFA") regulations apply to service providers which hold material contracts with the NHS, and they must submit an annual self-assessment of compliance against a number of standards aimed at fraud detection, prevention and reporting. The NHS CFA is a Special Health Authority, charged with identifying, investigating and preventing fraud within both public and private health bodies. See "Risk Factors— If we fail to comply with extensive laws and government regulations, we could suffer penalties or be required to make significant changes to our operations."

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Our primary regulators continually review their regulatory regimes and may extend their enforcement powers with the intention of holding parent companies and senior executives accountable for material breaches of regulations depending on the circumstances. Additionally, there are other regulators in the U.K. who may take enforcement action against us, including (i) the Health and Safety Executive ("HSE") for violations of the Health and Safety at Work Act in connection with patient incidents at our facilities; (ii) the Information Commissioners Office ("ICO") for breaches of data protection legislation (and following the introduction of the General Data Protection Regulations (the "GDPR") which became effective in May 2018, fines for material breaches may be as high as 4% of global turnover); and (iii) Her Majesty's Revenue and Customs ("HMRC") who in November 2017 established the Social Care Compliance Scheme (the "SCCS") for social care providers in the U.K. with the aim of addressing the issue of potential underpayments of the National Minimum Wage ("NMW") to workers who are paid a fixed allowance to undertake "sleep-in shifts" at care homes and other facilities at night. See "—Our operating costs are subject to increases, including due to statutorily mandated increases in the wages and salaries of our staff" for further details on U.K. staffing risks to which we are subject.

NHS Improvement. NHS Improvement now incorporates Monitor, the former economic regulator for the NHS in England. NHS Improvement is responsible for regulating the market for NHS funded services in England. It fulfills this role through licensing NHS Foundation Trusts and certain other healthcare providers and, together with the NHS England, sets the Tariff Rules for national and local pricing of NHS services. NHS Improvement's role is to oversee the NHS healthcare market, at all times protecting and promoting patients' interests, tackling abuses by commissioners and/or providers and dealing with unjustifiable restrictions on competition.

The CQC. The CQC is the independent regulator for health and adult social care in England. The CQC is distinct from NHS Improvement in that it focuses on quality and ensuring the maintenance of standards in health and social care practices. The CQC licenses NHS and adult social care service providers to enable it to keep a check on safety and quality standards. The CQC also carries out facility inspections. Care homes for young adults (including specialist college accommodation) are registered and inspected by the CQC. In addition, the CQC is responsible for monitoring the financial viability of corporate providers of adult social care.

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

CIW. Social care and social services in Wales are regulated by the CIW. CIW carries out unannounced inspections and measure against regulations. Children's homes in Wales are inspected by CIW.

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

SCSWIS. Care services in Scotland are regulated by the Care Inspectorate Scotland (also known as SCSWIS) and all care services in Scotland must be registered with them. As well as registration, SCSWIS inspects services against the National Care Standards and they can take action to force services to improve and can close services if necessary. Independent schools with boarding facilities must register their boarding provision with SCSWIS for the regulation of care as a school care accommodation service.

RQIA. In Northern Ireland, RQIA is Northern Ireland's independent health and social care regulator. RQIA is responsible for registering, inspecting and encouraging improvement in a range of health and social care services in accordance with the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and its supporting regulations. RQIA inspections are based on certain minimum care standards.

OFSTED. OFSTED was established under the Education (Schools) Act of 1992 and regulates and inspects services in England that care for children and young people, and services providing education and skills for learners of all ages. OFSTED carries out routine day school and further education college inspections to ensure compliance with inspection frameworks.

Estyn. In Wales, Estyn is led by Her Majesty's Chief Inspector of Education and Training and inspects quality standards in all education provisions in Wales including children's homes, independent and residential schools and colleges.

Education Scotland. In Scotland, the education provision for independent schools with boarding facilities is regulated by Education Scotland.

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Risk Management and Insurance

The healthcare industry in general continues to experience an increase in the frequency and severity of litigation and claims. As is typical in the healthcare industry, we could be subject to claims that our services have resulted in injury to our patients or clients or other adverse effects. In addition, resident, visitor and employee injuries could also subject us to the risk of litigation. While management believes that quality care is provided to patients and clients in our facilities and that we materially comply with all applicable regulatory requirements, an adverse determination in a legal proceeding or government investigation could have a material adverse effect on our business, financial condition or results of operations.

Our statutory workers' compensation program is fully insured with a $0.5 million deductible per accident. A portion of the Company's professional liability risks are insured through a wholly-owned insurance subsidiary. We are self-insured for professional liability claims up to $3.0 million per claim and have obtained reinsurance coverage from a third party to cover claims in excess of the retention limit. The reinsurance policy has a coverage limit of $75.0 million in the aggregate. The Company's reinsurance receivables are recognized consistent with the related liabilities and include known claims and any incurred but not reported claims that are covered by current insurance policies in place.

Environmental Matters

We are subject to various federal, state and local environmental laws that: (i) regulate certain activities and operations that may have environmental or health and safety effects, such as the handling, storage, transportation, treatment and disposal of medical waste products generated at our facilities, the identification and warning of the presence of asbestos-containing materials in buildings, as well as the removal of such materials, the presence of other hazardous substances in the indoor environment, and protection of the environment and natural resources in connection with the development or construction of our facilities; (ii) impose liability for costs of cleaning up, and damages to natural resources from, past spills, waste disposals on and off-site, or other releases of hazardous materials or regulated substances; and (iii) regulate workplace safety. Some of our facilities generate infectious or other hazardous medical waste due to the illness or physical condition of our patients. The management of infectious medical waste is subject to regulation under various federal, state and local environmental laws, which establish management requirements for such waste. These requirements include record-keeping, notice and reporting obligations. Each of our facilities has an agreement with a waste management company for the disposal of medical waste. The use of such companies, however, does not completely protect us from violations of medical waste laws or from related third-party claims for clean-up costs.

From time to time, our operations have resulted in, or may result in, non-compliance with, or liability pursuant to, environmental or health and safety laws or regulations. Management believes that our operations are generally in compliance with environmental and health and safety regulatory requirements or that any non-compliance will not result in a material liability or cost to achieve compliance. Historically, the costs of achieving and maintaining compliance with environmental laws and regulations at our facilities have not been material. However, we cannot assure you that future costs and expenses required for us to comply with any new or changes in existing environmental and health and safety laws and regulations or new or discovered environmental conditions will not have a material adverse effect on our business, financial condition or results of operations.

We have not been notified of and management is otherwise currently not aware of any contamination at our currently or formerly operated facilities that could result in material liability or cost to us under environmental laws or regulations for the investigation and remediation of such contamination, and we currently are not undertaking any

remediation or investigation activities in connection with any such contamination conditions. There may, however, be environmental conditions currently unknown to us relating to our prior, existing or future sites or operations or those of predecessor companies whose liabilities we may have assumed or acquired which could have a material adverse effect on our business.

New laws, regulations or policies or changes in existing laws, regulations or policies or their enforcement, future spills or accidents or the discovery of currently unknown conditions or non-compliances may give rise to investigation and remediation liabilities, compliance costs, fines and penalties, or liability and claims for alleged personal injury or property damage due to substances or materials used in our operations, any of which may have a material adverse effect on our business, financial condition or results of operations.

Competition

The healthcare industry is highly competitive. Our principal competitors include other behavioral healthcare service companies, including UHS, private equity firms, and the NHS in the U.K. We also compete against hospitals and general healthcare facilities that provide mental health services. An important part of our business strategy is to continue making targeted acquisitions of other behavioral health facilities. However, reduced capacity, the passage of mental health parity legislation and increased demand for mental health services are likely to attract other potential buyers, including diversified healthcare companies and possibly other pure-play behavioral healthcare companies.

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The mental health services sector in the U.K. comprises hospitals or establishments that provide psychiatric treatment for illness or mental disorder at all security and treatment levels. We operate in several highly competitive markets in the U.K. with a variety of for-profit, the NHS and other not-for-profit groups in each of our markets. Most competition is regional or local, based on relevant catchment areas and procurement initiatives. The NHS is often the dominant provider, although the trend has been towards increased outsourcing, whereby the NHS is both a provider and customer of mental healthcare services. NHS in-house beds accounts for approximately 70% of the total mental health hospital beds providing care in the U.K., with independent providers accounting for the remaining approximately 30% of beds.

In addition to the competition we face for acquisitions, we must also compete for patients. Patients are referred to our behavioral healthcare facilities through a number of different sources, including healthcare practitioners, public programs, other treatment facilities, managed care organizations, unions, emergency departments, judicial officials, social workers, police departments and word of mouth from previously treated patients and their families, among others. These referral sources may instead refer patients to hospitals that are able to provide a full suite of medical services or to other behavioral healthcare centers.

Employees

At December 31, 2018, we had approximately 42,100 employees (approximately 20,800 in the U.S. and approximately 21,300 in the U.K), of which 28,600 were employed full-time. At December 31, 2018, labor unions represented approximately 460 of our U.S. employees at five of our U.S. facilities through eight collective bargaining agreements. Organizing activities by labor unions and certain potential changes in federal labor laws and regulations could increase the likelihood of employee unionization in the future. The Royal College of Nursing is the trade union for full and part-time nurses, nursing cadets and healthcare assistants in the U.K.

Typically, our inpatient facilities are staffed by a chief executive officer, medical director, director of nursing, chief financial officer, clinical director and director of performance improvement. Psychiatrists and other physicians working in our facilities are licensed medical professionals who are generally not employed by us and work in our facilities as independent contractors or medical staff members.

Seasonality of Demand for Services

Our residential recovery and other inpatient facilities typically experience lower patient volumes and revenue during the holidays, and our child and adolescent facilities typically experience lower patient volumes and revenue during the summer months, holidays and other periods when school is out of session.

Available Information

Our Internet website address is www.acadiahealthcare.com. We make available our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and all amendments to those reports free of charge on our website on the Investors webpage under the caption “SEC Filings” as soon as reasonably practicable after such material is electronically filed with, or furnished to, the SEC. Our website and the information contained therein or linked thereto are not intended to be incorporated into this Annual Report on Form 10-K.

Item 1A. Risk Factors

Any of the following risks could materially and adversely affect our business, financial condition or results of operations. These risks should be carefully considered before making an investment decision regarding us. The risks and uncertainties described below are not the only ones we face and there may be additional risks that we are not presently aware of or that we currently consider not likely to have a significant impact. If any of the following risks actually occurred, our business, financial condition and operating results could suffer, and the trading price of our common stock could decline.

Fluctuations in our operating results, quarter to quarter earnings and other factors, including factors outside our control, may result in significant decreases in the price of our common stock.

The stock markets experience volatility, in some cases unrelated to operating performance. These broad market fluctuations may adversely affect the trading price of our common stock and, as a result, there may be significant volatility in the market price of our common stock. If we are unable to operate our facilities as profitably as we have in the past or as our investors expect us to in the future, the market price of our common stock will likely decline when it becomes apparent that the market expectations may not be realized. In addition to our operating results, many economic and other 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

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herein, outcomes of political elections, 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, managed care contract negotiations and terminations, changes in general conditions in the economy or the financial markets or other developments affecting the healthcare industry.

An incident involving one or more of our patients or the failure by one or more of our facilities to provide appropriate care could result in increased regulatory burdens, governmental investigations, negative publicity and adversely affect the trading price of our common stock.

Because the patients we treat suffer from severe mental health and chemical dependency disorders, patient incidents, including deaths, sexual abuse, assaults and elopements, occur from time to time. If one or more of our facilities experiences an adverse patient incident or is found to have failed to provide appropriate patient care, an admissions hold, loss of accreditation, license revocation or other adverse regulatory action could be taken against us. Any such patient incident or adverse regulatory action could result in governmental investigations, judgments or fines and have a material adverse effect on our business, financial condition and results of operations. In addition, we have been and could become the subject of negative publicity or unfavorable media attention, whether warranted or unwarranted, that could have a significant, adverse effect on the trading price of our common stock or adversely impact our reputation and how our referral sources and payors view us.

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

Healthcare companies in both the U.S. and the U.K. may be subject to investigations by various governmental agencies. Certain of our individual facilities have received, and from time to time, other facilities may receive, subpoenas, civil investigative demands, audit reports and other inquiries from, and may be subject to investigation by, federal and state agencies. See “Item 3. Legal Proceedings” for additional information about pending investigations. These investigations can result in repayment obligations, and violations of the False Claims Act can result in substantial monetary penalties and fines, the imposition of a corporate integrity agreement and exclusion from participation in governmental health programs. If we incur significant costs responding to or resolving these or future inquiries or investigations, our business, financial condition and results of operations could be materially adversely affected.

Further, under the False Claims Act, private parties are permitted to bring qui tam or “whistleblower” lawsuits against companies that submit false claims for payments to, or improperly retain overpayments from, the government. Because qui tam lawsuits are filed under seal, we could be named in one or more such lawsuits of which we are not aware. We may also be subject to substantial reputational harm as a result of the public announcement of any investigation into such claims.

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

A significant portion of our revenue is derived from government healthcare programs. For the year ended December 31, 2018, we derived approximately 39% of our revenue from the Medicare and Medicaid programs and 33% of our revenue from public funded sources in the U.K. (including the NHS, CCGs and local authorities in England, Scotland and Wales). See “— Structural shifts in the U.K. behavioral healthcare market may adversely affect us” for further details on U.K. funding risks to which we are subject.

Government payors in the U.S., such as Medicaid, generally reimburse us on a fee-for-service basis based on predetermined reimbursement rate schedules. As a result, we are limited in the amount we can record as revenue for our services from these government programs, and if we have a cost increase, we typically will not be able to recover this increase. In addition, the federal government and many state governments, are operating under significant budgetary pressures, and they may seek to reduce payments under their Medicaid programs for services such as those we provide. Government payors also tend to pay on a slower schedule. In addition to limiting the amounts they will pay for the services we provide their members, government payors may, among other things, impose prior authorization and concurrent utilization review programs that may further limit the services for which they will pay and shift patients to lower levels of care and reimbursement. Therefore, if governmental entities reduce the amounts they will pay for our services, or if they elect not to continue paying for such services altogether, or if a total or partial repeal of PPACA results in significant contraction of the number of individuals covered by state Medicaid programs, our business, financial condition or results of operations could be adversely affected. In addition, if governmental entities slow their payment cycles further, our cash flow from operations could be negatively affected.

Commercial payors such as managed care organizations, private health insurance programs and labor unions generally reimburse us for the services rendered to insured patients based upon contractually determined rates. These commercial payors are under significant pressure to control healthcare costs. In addition to limiting the amounts they will pay for the services we provide their members, commercial payors may, among other things, impose prior authorization and concurrent utilization review programs

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that may further limit the services for which they will pay and shift patients to lower levels of care and reimbursement. These actions may reduce the amount of revenue we derive from commercial payors.

Changes in these government programs in recent years have resulted in limitations on reimbursement and, in some cases, reduced levels of reimbursement for healthcare services. Payments from federal and state government healthcare programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations, requirements for utilization review, and federal and state funding restrictions, all of which could materially increase or decrease program payments, as well as affect the cost of providing service to patients and the timing of payments to facilities. We are unable to predict the effect of recent and future policy changes on our operations. In addition, since most states operate with balanced budgets and since the Medicaid program is often a state's largest program, some states can be expected to enact or consider enacting legislation formulated to reduce their Medicaid expenditures. Furthermore, the potential repeal, replacement or modification of PPACA, may negatively affect the availability of taxpayer funds for Medicare and Medicaid programs. If the rates paid or the scope of services covered by government payors are reduced, there could be a material adverse effect on our business, financial condition and results of operations.

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

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

At December 31, 2018, we had approximately $3.2 billion of total debt (net of debt issuance costs, discounts and premiums of $41.1 million), which included approximately $1.7 billion of debt under our Amended and Restated Senior Credit Facility (including approximately $365.8 million of Senior Secured Term A Loans and approximately $1.4 billion of Senior Secured Term B Loans), $150.0 million of debt under our 6.125% Senior Notes (the "6.125% Senior Notes"), $300.0 million of debt under our 5.125% Senior Notes (the "5.125% Senior Notes"), $650.0 million of debt under our 5.625% Senior Notes and $390.0 million of debt under our 6.500% Senior Notes. See "Item 1. Business—Financing Transactions" for additional details regarding our outstanding indebtedness.

Our substantial debt could have important consequences to our business. For example, it could:

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

- place us at a competitive disadvantage compared to our competitors that have less debt;
- limit our ability to borrow additional funds; and
- limit our ability to pay dividends, redeem stock or make other distributions.

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

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

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

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

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

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

- incur or guarantee additional debt and issue certain preferred stock;
- pay dividends on our common stock or redeem, repurchase or retire our equity interests or subordinated debt;
- transfer or sell our assets;
- make certain payments or investments;
- make capital expenditures;
- create certain liens on assets;
- create restrictions on the ability of our subsidiaries to pay dividends or make other payments to us;
- engage in certain transactions with our affiliates; and
- merge or consolidate with other companies.

The Amended and Restated Senior Credit Facility also requires us to meet certain financial ratios, including a fixed charge coverage ratio and a consolidated leverage ratio. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources —Amended and Restated Senior Credit Facility".

The restrictions may prevent us from taking actions that management believes would be in the best interests of our business, and may make it difficult for us to successfully execute our business strategy or effectively compete with companies that are not similarly restricted. We also may incur future debt obligations that might subject us to additional restrictive covenants that could affect our financial and operational flexibility. Our ability to comply with these covenants in future periods will largely depend on the pricing of our products and services, our success at

implementing cost reduction initiatives and our ability to successfully implement our overall business strategy. We cannot assure you that we will be granted waivers or amendments to our financing arrangements if for any reason we are unable to comply with our financial covenants. The breach of any of these covenants and restrictions could result in a default under the indentures governing the Senior Notes or under the Amended and Restated Senior Credit Facility, which could result in an acceleration of our debt.

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

We may incur substantial additional debt, including additional notes and other debt, in the future. Although the indentures governing our outstanding Senior Notes and our Amended and Restated Senior Credit Facility contain restrictions on the incurrence of

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additional debt, these restrictions are subject to a number of significant qualifications and exceptions, and under certain circumstances, the amount of debt that could be incurred in compliance with these restrictions could be substantial. If new debt is added to our existing debt levels, the related risks that we now face would intensify and we may not be able to meet all our debt obligations.

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

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

Expanding our international operations poses additional risks to our business.

Our business or financial performance may be adversely affected due to the risks of operating internationally, including but not limited to the following: economic and political instability, failure to comply with foreign laws and regulations and adverse changes in the health care policy of the U.K. (including decreases in funding for the services provided by our U.K. facilities), adverse changes in law and regulations affecting our operations in the U.K., difficulties and costs of staffing and managing our operations in the U.K. If any of these events were to materialize, they could lead to disruption of our business, significant expenditures and/or damages to our reputation, which could have a material adverse effect on our results of operations, financial condition or prospects.

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

With significant operations in the U.K., our business and operations may be adversely affected by economic and political conditions in the U.K.

The global financial markets continue to experience significant volatility as a result of, among other things, economic and political instability in the wake of the referendum in the U.K. on June 23, 2016, in which the voters approved an exit from the European Union (“Brexit”). The U.K.’s exit from the European Union is expected to occur by the end of March 2019, but the U.K. government has thus far not passed a withdrawal agreement through Parliament, and has

experienced difficulty in its efforts to do so. If an agreement can be passed by March 29, 2019, there will be a transition period through December 2020 to allow for businesses and individuals to adjust to changes. Otherwise, the U.K. is expected to be required to leave the European Union without an agreement or transition period in place. Brexit has created political and economic uncertainty, particularly in the U.K. and the European Union. Uncertainty over the terms of the U.K.'s expected departure from the European Union and the exit itself could negatively impact the U.K. and other economies, which could adversely affect our financial position and results of operations. The outlook for the global economy in 2019 and beyond remains uncertain as negotiations to determine the future terms of the U.K.'s relationship with the European Union continue. Such global market instability may hinder future economic growth. Any of these effects of Brexit, among others, could adversely affect our assets, business, cash flow, condition (financial or otherwise), liquidity, prospects and results of operations.

Changes in the method pursuant to which the LIBOR rates are determined and potential phasing out of LIBOR after 2021 may affect our financial results.

LIBOR and certain other interest "benchmarks" may be subject to regulatory guidance and/or reform that could cause interest rates under our current or future debt agreements to perform differently than in the past or cause other unanticipated consequences. The U.K.'s Financial Conduct Authority, which regulates LIBOR, has announced that it intends to stop encouraging or requiring

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banks to submit rates for the calculation of LIBOR rates after 2021, and it is unclear if LIBOR will cease to exist or if new methods of calculating LIBOR will evolve. If LIBOR ceases to exist or if the methods of calculating LIBOR change from their current form, interest rates on our current or future debt obligations may be adversely affected.

We have recorded goodwill impairment charges and may be required to record additional charges to future earnings if our goodwill becomes further impaired or our intangible assets become impaired.

We are required under U.S. generally accepted accounting principles ("GAAP") to annually review, or more frequently if events indicate the carrying value of a reporting unit may not be recoverable, our goodwill and indefinite-lived intangible assets for impairment. For the year ended December 31, 2018, we recorded a non-cash goodwill impairment charge of $325.9 million related to our U.K. Facilities. We may be required to record additional charges to earnings during any period in which a further impairment of our goodwill or other intangible assets is determined which could adversely affect our results of operations. Our evaluation of goodwill and the need for any further impairment in subsequent periods is sensitive to revisions to our current projections. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations— Critical Accounting Policies — Goodwill and Indefinite-Lived Intangible Assets" for additional information.

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

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

With respect to our facilities in the U.K., we compete with various providers, including the NHS, staffing agencies and other employers, in attracting and retaining qualified management, medical, nursing, care and teaching personnel. Competition for such employees is intense and has resulted in increases to our labor and recruiting costs, which has adversely affected our operating margins. Competitors, in particular the NHS, may offer more attractive wages, pension plans or other benefits than us and we may not be able to provide similar offerings to our prospective employees as a result of cost or other reasons.

A shortage of nurses, qualified addiction counselors, and other medical support personnel has been a significant operating issue facing us and other healthcare providers, particularly for our facilities in the U.K. Such shortages have resulted in increased utilization of agency staff, which is significantly more expensive than staff we employ. As a result, we have experienced increased labor costs in the U.K., which has adversely affected our results of operations. We also may be required to enhance wages and benefits to hire nurses, qualified addiction counselors and other medical support personnel, hire more expensive temporary personnel or increase our recruiting and marketing costs relating to labor. The use of temporary or agency staff could also heighten the risk one of our facilities experiences an adverse patient incident. Further, because we generally recruit our personnel from the local area where the relevant facility is located, the availability in certain areas of suitably qualified personnel can be limited, particularly care home management, qualified teaching personnel and nurses. In addition, certain of our facilities are required to maintain specified staffing levels. To the extent we cannot meet those levels, we may be required to limit the services provided by these facilities, which would have a corresponding adverse effect on our net operating revenue. Certain of our treatment facilities are located in remote geographical areas, far from population centers, which increases this risk.

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

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

A principal element of our business strategy is to grow by acquiring other companies and assets in the behavioral healthcare industry. Growth, especially rapid growth, through acquisitions exposes us to a variety of operational and financial risks. We summarize the most significant of these risks below.

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Integration risks

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

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

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

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

Successful integration depends on the ability to effect any required changes in operations or personnel, which may entail unforeseen liabilities. The integration of acquired businesses may expose us to certain risks, including the following: difficulty in integrating these businesses in a cost-effective manner, including the establishment of effective management information and financial control systems; unforeseen legal, regulatory, contractual, employment or other issues arising out of the combination; combining corporate cultures; maintaining employee morale and retaining key employees; potential disruptions to our on-going business caused by our senior management’s focus on integrating these businesses; and performance of the combined assets not meeting our expectations or plans. A failure to properly integrate these businesses could have a corresponding material adverse effect on our business, results of operations, financial condition or prospects.

Benefits may not materialize

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

Assumptions of unknown liabilities

Facilities that we acquire may have unknown or contingent liabilities, including, but not limited to, liabilities for uncertain tax positions, liabilities for failure to comply with healthcare laws and regulations and liabilities for unresolved litigation or regulatory reviews. Although we typically attempt to exclude significant liabilities from our acquisition transactions and seek indemnification from the sellers of such facilities, the purchase agreement for some of our significant acquisitions contain minimal representations and warranties about the entities and business that we acquired. In addition, we have no indemnification rights against the sellers under some purchase agreements and all of the purchase price consideration was paid at closing. Therefore, we may incur material liabilities for the past activities of acquired entities and facilities. Even in those acquisitions in which we have such rights, we may experience difficulty enforcing the sellers' obligations, or we may incur material liabilities for the past activities of acquired facilities. Such liabilities and related legal or other costs and/or resulting damage to a facility's reputation could negatively impact our business, financial condition or results of operations.

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Competing for acquisitions

We face competition for acquisition candidates primarily from other for-profit healthcare companies, as well as from not-for-profit entities. Some of our competitors may have greater resources than we do. As a result, we may pay more to acquire a target business or may agree to less favorable deal terms than we would have otherwise. Our principal competitors for acquisitions have included Universal Health Services and private equity firms. Also, suitable acquisitions may not be accomplished due to unfavorable terms. Further, the cost of an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for an acquired facility, the acquired facility's results of operations, the fair value of assets acquired and liabilities assumed, effects of subsequent legislation and limits on rate increases. In addition, we may have to pay cash, incur debt, or issue equity securities to pay for any such acquisition, which could adversely affect our financial results, result in dilution to our stockholders, result in increased fixed obligations or impede our ability to manage our operations. There can be no assurances that we will be able to acquire facilities at historical or expected rates or on favorable terms.

Managing growth

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

Joint ventures may use significant resources, may be unsuccessful and could expose us to unforeseen liabilities.

As part of our growth strategy, we have completed, or have announced plans to complete, a number of joint ventures and strategic alliances. These joint ventures may involve significant cash expenditures, debt incurrence, additional operating losses and expenses, and compliance risks that could negatively impact our business, financial condition or results of operations. Further, there is often a significant delay between our formation of a joint venture and the time that a de novo facility can be constructed and have a positive financial impact on our results of operations.

The nature of a joint venture requires us to consult with and share certain decision-making powers with unaffiliated third parties, some of which may be not-for-profit healthcare systems. If our joint venture partners do not fulfill their obligations, the affected joint venture may not be able to operate according to its business or strategic plans. In that case, our financial condition and results of operations may be materially adversely affected or we may be required to increase our level of financial commitment to the joint venture. Moreover, differences in economic or business interests or goals among joint venture participants could result in delayed decisions, failures to agree on major issues and even litigation. If these differences cause the joint ventures to deviate from their business or strategic plans, or if our joint venture partners take actions contrary to our policies, objectives or the best interests of the joint venture, our business, financial condition and results of operations could be negatively impacted. In addition, our relationships with not-for-profit healthcare systems and the joint venture agreements that govern these relationships are intended to be structured to comply with current revenue rulings published by the Internal Revenue Service ("IRS"), as well as case law relevant to joint ventures between for-profit and not-for-profit healthcare entities. Material changes in these authorities could adversely affect our relationships with not-for-profit healthcare systems and related joint venture arrangements.

The majority of our revenue from our operations in the U.K. is not guaranteed and is being generated either from spot purchasing or under framework agreements where no volume commitments are given. In addition, there can be no assurance that we can achieve any fee rate increases in the future or will not suffer any fee rate decreases.

Any decline in demand for our services in the U.K. from publicly funded entities or private payers or any failure by us to extend current agreements or enter into alternative agreements on comparable terms with such entities could have an adverse effect on our average daily census ("ADC"), which would have a corresponding negative impact on our business, results of operations and financial condition. Further, there can be no assurances that we will be able to implement fee rate increases, which are a driver of our revenue from our operations, or not suffer from any decline in fee rates in the future. Should the effect of any increase in annual wages or other operating costs of the business exceed the effect of any increase in our fee rates or should our fee rates suffer a decline, we would have to absorb any costs that cannot be offset by our fees, which could have a negative impact on our business, results of operations and financial condition.

Publicly funded entities

A significant portion of our services funded by U.K. publicly funded entities are commissioned on a spot-purchase basis at prices determined by prevailing market conditions. It is generally a matter for the relevant commissioner to determine whether to use our services, and there is no guarantee that previous spot market purchasing activity by a commissioner will continue in the future or

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at all. We also have a number of fixed-term framework agreements which grant us preferred provider status with Local Authorities or the NHS typically lasting between one to three years. While we and the commissioners typically agree on pricing for 12 months, at times with discounts related to the number of beds purchased, the commissioners do not make minimum purchasing commitments under such agreements. As such, commissioners may decide to place existing and new service users with our competitors, including their own in-house service providers, on short notice. We also have a small number of fixed-period block contracts, where a set number of beds are paid for at a discount to spot prices regardless of occupancy. While we may have flexibility to increase spot rates for new admissions, any fee increases under our block contracts are restricted by the terms and conditions of those block contracts.

The rates that we charge publicly-funded entities for our services are negotiated individually with commissioners and historically have been subject to annual review on April 1 of each year, with customary adjustments based on the Retail Prices Index ("RPI"), Consumer Price Index ("CPI") or sector specific costs indices. However, the current economic climate and the U.K. government's overriding economic policy to control public spending means that, in the short term at least, commissioners are resistant to fee increases, often expecting that efficiency savings be made to offset inflationary cost increases in accordance with national policy. As a result, there can be no assurance that we can maintain the payment terms of our arrangements with publicly funded entities, including with respect to the timing of payments.

Further, following expiration of contracts there can be no assurance that negotiations with commissioners will result in the extension or renewal of existing arrangements or the entering into of alternative arrangements for those services. Commissioners may also require that following the expiration date of current agreements with us, they contract with us on a spot basis rather than through a block arrangement or reduce the number of beds subject to block arrangements. Even if we are successful in extending current agreements or in entering into alternative arrangements, the duration of such extensions or arrangements is uncertain, and we may be unsuccessful in implementing rate increases under such agreements.

In addition, changing commissioning structures and practices, such as those under the Health and Social Care Act 2012, involve tendering processes that could result in failing to remain or become an approved provider. There are currently a number of commissioning initiatives involving public and independent providers that could change the distribution of in-patient beds in the U.K. Certain services that were historically commissioned centrally by NHS England are moving towards more local commissioning to better meet patient needs and to enhance local care pathways. These initiatives could cause our ADC to decrease in areas where there is surplus capacity or more focus on community-based treatment. Further, if we are not invited to participate in initiatives or do not meet the local commissioning standards, our ADC could be adversely affected.

In January 2019, NHS England published its Long Term Plan for the NHS, central to which will be the creation of a network of integrated care systems. The plan makes little mention of the role of independent sector providers and it is most likely that the integrated care systems will be dominated by the incumbent NHS provider trusts. The NHS competition reforms introduced in 2012 gave independent sector providers statutory protection against unfair treatment by commissioners. NHS England's proposed reversal of these reforms presents a risk that this protection could be lost such that it will become more difficult for independent sector providers to challenge commissioners' preferential treatment of NHS provider trusts.

Private payers

Although we have agreements in place with a number of private medical insurance ("PMI") plans where pricing is generally agreed annually, there is no obligation on the PMI plans to refer its members to us or to pay for its members

to use our services. Further, we may not be able to renew our existing arrangements with PMI plans on terms comparable to what it has achieved in the past. Fee rates for self-paying individuals are adjusted on January 1 of each year depending on capacity and demand in the relevant service markets. Fees paid or reimbursed by PMI plans are typically adjusted in line with specific contract terms and are generally based on RPI and specific wage indices. Demand in both the PMI market and the self-pay is dependent on economic conditions, which impacts the number of people with sufficient income or capital to pay for insurance coverage or treatment themselves.

Structural shifts in the U.K. behavioral healthcare market may adversely affect us.

Publicly funded entities

Payments for our services by publicly funded entities in the U.K., particularly the NHS and Local Authorities, account for the vast majority of our U.K. revenue. We expect publicly funded entities in the U.K. to continue to generate the significant majority of our revenue from our operations in the U.K. Budget constraints, public spending cuts or other financial pressures could cause such publicly funded entities to spend less money on the type of services that we provide, or political or U.K. government policy changes could mean that fewer of such services are purchased by publicly funded entities from independent sector providers in favor of protecting NHS and Local Authority in-house services.

While the outsourcing by the NHS in England of healthcare services has been increasing in recent years, the need of the NHS in England to achieve substantial efficiency savings is likely to result in continued funding pressure in the pricing of such services. For instance, NHS Improvement, the NHS economic regulator, has, under NHS Tariff Rules, determined national prices across a range of

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NHS services and has issued extensive guidance on how they are to be applied, including provision for local variations to national tariffs, subject to approval by NHS Improvement. While none of our services are currently subject to national prices, the future application of any national prices regime upon our services could have a material adverse impact on our revenue.

In addition, the allocation of funding responsibility for adult social care may be subject to change at some time in the future under the provisions of the Care Act 2014 under which individuals identified as being required to pay for their own care under the relevant means test will be required to take funding responsibility up to a specified lifetime monetary cap, with Local Authorities responsible for the remainder of expenses for personal care, excluding "daily living" expenses. Should this cap be introduced, it would potentially place greater funding responsibility with public sector bodies over the longer term, which would potentially exacerbate the current funding challenges faced by such bodies.

Private payers

Payments for our services in the U.K. by PMI plans account for a small portion of our U.K. revenue. In addition, payments for our services in the U.K. by self-pay patients, who purchase treatment on a spot basis account for a small portion of our U.K. revenue. Many of the patients who use our acute healthcare services in the U.K. do so because their PMI plan recognizes our facilities as being an appropriate provider of the psychiatric treatment services required by the patient. Our ability to attract patients who are funded by PMI plans could be adversely impacted if one or more PMI plans withdraws recognition status from our facilities, for example, as a result of a change in a PMI plan's recognition status standards. In addition, many PMI plans have been changing the terms of their policies and shortening the length of time they will cover a stay at one of our U.K. facilities.

There can be no assurance that the entities or individuals who fund our services will not reduce or cease spending on the types of services that we provide or that alternative service or funding models for mental healthcare, learning disabilities care, specialist education or elderly care will not emerge. Any such funding or structural change in the markets where we operate could have a material adverse effect on our ADC, which would have a corresponding negative impact on our business, results of operations and financial condition.

We are reliant upon maintaining strong relationships with commissioners employed by publicly funded entities, psychiatric and other medical consultants, and any change in those relationships may adversely affect us.

The relationships that we have with commissioners is a key driver of referrals for our facilities in the U.K. Referrals to our U.K. business by the NHS accounted for a significant percentage of our revenue for the year ended December 31, 2018. Should there be a major reorganization of publicly funded entities, such as the NHS reorganization announced in 2010 and implemented between 2012 and 2013, we may need to rebuild such relationships which could result in a decrease in the number of referrals made to our facilities, which could have a corresponding material adverse effect on our business, results of operations, financial condition or prospects. Any actual or perceived deterioration in service quality, any serious incidents at our facilities or any other event that could cause commissioners to prefer other service providers over us could also adversely impact referrals from commissioners. Further, our business also depends, in part, on psychiatric and other medical consultants referring their patients to us for treatment either as in-patients or day patients. From time to time, consultants may decide to relocate or reposition their practices, retire or refer patients elsewhere with the result that there is a decrease in the number of referrals made to our facilities. A deterioration in relationships with commissioners or consultants or the decision by one or more commissioners or consultants to refer patients to our competitors or to stop all referrals would have an adverse effect on the ADC at our facilities in the U.K., which would have a corresponding negative impact on our business, results of operations and financial

condition.

Our operating costs are subject to increases, including due to statutorily mandated increases in the wages and salaries of our staff.

The most significant operating expense for our facilities is wage costs, which represent the staff costs incurred in providing our services and running our facilities, and which are primarily driven by the number of employees and pay rates. The number of employees employed by us is primarily linked to the number of facilities we operate and the number of individuals cared for by us. While we can reduce the number of employees should occupancy rates decrease at our facilities, there is a limit on the extent to which this can be done without impacting quality of our services.

Furthermore, in April 2016, a new “National Living Wage” was introduced across the U.K. which was increased in April 2017 and April 2018 and is scheduled to increase again in April 2019 with further annual increases expected until at least 2021. These changes to the National Living Wage have and will increase our operating costs and, unless we can increase revenue or reduce other costs, will reduce our margins.

In the U.K., there has been an increase in enforcement action by HMRC against employers who do not pay the NMW. In 2017 and early 2018 this action extended to fixed allowance payments for sleep-in shifts in the care sector. The industry standard practice has been to pay a fixed allowance to employees who sleep at sites at night with a “top-up” if an employee is woken and provides care

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to residents during the night. In July 2018, the Court of Appeal determined that sleep-in shifts were not subject to NMW legislation and HMRC stepped back from its enforcement action. However, it is still possible the Court of Appeal's judgment may be appealed to the Supreme Court such that if it were to be overturned, HMRC would recommence its enforcement activity. In such circumstances, we may be subject to (i) increased payments to employees for sleep-in shifts on an on-going basis; (ii) payments of up to 6 years of arrears to employees or former employees who have carried out sleep-in shifts at our U.K. facilities; and (iii) payments of interest and penalties to HMRC, all of which would have a corresponding negative impact on our business, results of operations and financial condition.

We also have a number of recurring costs including insurance, utilities and rental costs, and may face increases to other recurring costs such as regulatory compliance costs. There can be no assurance that any of our recurring costs will not grow at a faster rate than our revenue. As a result, any increase in our operating costs could have a material adverse effect on our business, results of operations and financial condition.

We care for a large number of vulnerable individuals with complex needs and any care quality deficiencies could adversely impact our brand, reputation and ability to market our services effectively.

Our future growth will partly depend on our ability to maintain our reputation for providing quality patient care and, through new programs and marketing activities, increased demand for our services. Factors such as increased acuity of our patients, health and safety incidents at our facilities, regulatory enforcement actions, negative press or general customer dissatisfaction could lead to deterioration in the level of our quality ratings or the public perception of the quality of our services (including as a result of negative publicity about our industry generally), which in turn could lead to a loss of patient placements, referrals and self-pay patients or service users. Any impairment of our reputation, loss of goodwill or damage to the value of our brand name could have a material adverse effect on our business, results of operations and financial condition.

Many of our service users have complex medical conditions or special needs, are vulnerable and often require a substantial level of care and supervision. There is a risk that one or more service users could be harmed by one or more of our employees, either intentionally, through negligence or by accident. Further, individuals cared for by us have in the past engaged, and may in the future engage, in behavior that results in harm to themselves, our employees or to one or more other individuals, including members of the public. A serious incident involving harm to one or more service users or other individuals could result in negative publicity. Such negative publicity could have a material adverse effect on our brand, reputation and ADC, which would have a corresponding negative impact on our business, results of operations and financial condition. Furthermore, the damage to our reputation or to the reputation of the relevant facility from any such incident could be exacerbated by any failure on our part to respond effectively to such incident.

We are and in the future may become involved in legal proceedings based on negligence or breach of a contractual or statutory duty from service users or their family members or from employees or former employees.

From time to time, we are subject to complaints and claims from service users and their family members alleging professional negligence, medical malpractice or mistreatment. We are also subject to claims for unlawful detention from time to time when patients allege they should not have been detained under the Mental Health Act or where the appropriate procedures were not correctly followed.

Similarly, there may be substantial claims from employees in respect of personal injuries sustained in the performance of their duties, particularly in respect of incidents involving patients detained under the Mental Health Act and where

future employment prospects are impaired. Current or former employees may also make claims against us in relation to breaches of employment legislation.

We may also be involved in coroner's inquests (or the Scottish equivalent) where there is a fatality at one of our facilities in the U.K. resulting in an adverse coroner's verdict or civil claims by individuals or criminal prosecutions by regulatory authorities. Any fines imposed by the courts are likely to be substantial in view of the Sentencing Council guidelines published in November 2015, which materially increase fines for corporate manslaughter and certain health and safety offenses. There may also be safeguarding incidents at our facilities which, depending on the circumstances, may result in custodial sentences or other criminal sanctions for the member of staff involved.

The incurrence of any legal fees, damage awards or other fines as summarized above as well as any impact on our brand or reputation as a result of being involved in any legal proceedings are likely to have a material adverse impact on our business, results of operations and financial condition.

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We handle sensitive personal data which are protected by numerous U.S. and U.K. laws in the ordinary course of business and any failure to maintain the confidentiality of such data could result in legal liability and reputational harm.

We collect, process and store sensitive personal data as part of our business. In the event of a security breach, sensitive personal data could become public. We are currently not aware of any material incidences of potential data breach; however, there can be no assurance that such breaches will not arise in future. Although we have in place policies and procedures to prevent such breaches, breaches could occur either as a result of a breach by our employees or as a result of a breach by a third party to whom we have provided sensitive personal data, and we could face liability under data protection laws.

In addition to U.S. data protection laws, we are subject to similar, and in some cases more restrictive, U.K. data protection laws. For example, the GDPR was introduced in May 2018 and provides heightened data protection requirements including more stringent consent requirements, data protection and security measures and requirements to appoint a data protection officer. Following a full scale review of the business's operations we have taken appropriate steps to ensure compliance with U.K. data protection laws and regulations; all internal policies and procedures have been reviewed and a full training module has been rolled out to all staff at all sites and central functions. Nevertheless we cannot guarantee that our facilities will not be subject to data breaches which could have a material adverse effect on our business, financial condition, or results of operations.

Liability under data protection laws may result in sanctions, including substantial fines and/or compensation to those affected. Additionally, liability may cause us to suffer damage to our brand and reputation, which could have a material adverse effect on our business, results of operations and financial condition.

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

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

We carry a large self-insured retention and may be responsible for significant amounts not covered by insurance. In addition, our insurance may be inadequate, premiums may increase and, if there is a significant deterioration in our claims experience, insurance may not be available on acceptable terms.

We maintain liability insurance intended to cover service user, third-party and employee personal injury claims. Due to the structure of our insurance program under which we carry a large self-insured retention, there may be substantial claims in respect of which the liability for damages and costs falls to us before being met by any insurance underwriter. There may also be claims in excess of our insurance coverage or claims which are not covered by our

insurance due to other policy limitations or exclusions or where we have failed to comply with the terms of the policy. Furthermore, there can be no assurance that we will be able to obtain liability insurance coverage in the future on acceptable terms, or without substantial premium increases or at all, particularly if there is a deterioration in our claim experience history. A successful claim against us not covered by or in excess of our insurance coverage could have a material adverse effect on our business, results of operations and financial condition.

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

We have significant U.K. operations. Accordingly, we translate revenue and other results denominated in a foreign currency into U.S. dollars ("USD") for our consolidated financial statements. During periods of a strengthening USD or weakening British pound ("GBP"), our reported international revenue and expenses could be reduced because foreign currencies may translate into fewer USD. Following the Brexit vote and subsequent developments, the GBP dropped to its lowest level against the USD in more than 30 years. If the U.K. government is unable to pass a Brexit agreement by March 29, 2019, the exchange rate may significantly decline. If the exchange rate declines, our results of operations will be negatively impacted in future periods.

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

We incur significant transaction-related costs in connection with acquisitions and other strategic transactions.

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

Our ability to grow our business through organic expansion either by developing new facilities or by modifying existing facilities is dependent upon many factors.

Our ability to grow our business through organic expansion is dependent on capacity and occupancy at our facilities. Should our facilities reach maximum occupancy, we may need to implement other growth strategies either by developing new facilities or by modifying existing facilities.

Our facilities typically need to be purpose-designed in order to enable the type and quality of service that we provide. Consequently, we must either develop sites to create facilities or purchase or lease existing facilities, which may require substantial modification. We must be able to identify suitable sites and there is no guarantee that such sites will be available at all, or at an economically viable cost or in areas of sufficient demand for our services. The subsequent successful development and construction of a new facility is contingent upon, among other things, negotiation of construction contracts, regulatory permits and planning consents and satisfactory completion of construction. Similarly, our ability to expand existing facilities is also dependent upon various factors, including identification of appropriate expansion projects, permitting, licensure, financing, integration into our relationships with payors and referral sources, and margin pressure as new facilities are filled with patients.

Delays caused by difficulties in respect of any of the above factors may lead to cost overruns and longer periods before a return is generated on an investment, if at all. We may incur significant capital expenditure but due to a regulatory, planning or other reason, may find that we are prevented from opening a new facility or modifying an existing facility. Moreover, even when incurring such development capital expenditure, there is no guarantee that we can fill beds when they become available. Upon operational commencement of a new facility, we typically expect that it will take approximately 12-18 months to reach our targeted occupancy level. Any delays or stoppages in our projects, the unsatisfactory completion or construction of such projects or the failure of such projects to increase our occupancy levels could have a material adverse effect on our ADC, which would have a corresponding negative impact on our business, results of operations and financial condition.

We may fail to deal with clinical waste in accordance with applicable regulations or otherwise be in breach of relevant medical, health and safety or environmental laws and regulations.

As part of our normal business activities, we produce and store clinical waste which may produce effects harmful to the environment or human health. The storage and transportation of such waste is strictly regulated. Our waste disposal services are outsourced and should the relevant service provider fail to comply with relevant regulations, we could face sanctions or fines which could adversely affect our brand, reputation, business or financial condition.

Health and safety risks are inherent in the services that we provide and are constantly present in our facilities, primarily in respect of food and water quality, as well as fire safety and the risk that service users may cause harm to themselves, other service users or employees. From time to time, we have experienced, like other providers of similar services, undesirable health and safety incidents. Some of our activities are particularly exposed to significant medical risks relating to the transmission of infections or the prescription and administration of drugs for residents and patients. If any of the above medical or health and safety risks were to materialize, we may be held liable, fined and any registration certificate could be suspended or withdrawn for failure to comply with applicable regulations, which may have a material adverse impact on our business, results of operations and financial condition.

The value of our real estate assets will be subject to fluctuations in the U.K. real estate market.

We hold a large portfolio of real estate assets, including significant real estate assets in the U.K. The value of our U.K. property portfolio is subject to, among other things, the conditions of the real estate market in the U.K. The average values of real estate in the U.K., as in other European countries, experienced sharp declines from 2007 as a result of the credit crisis, economic recession and

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reduced confidence in global financial markets. Although real estate asset values have recovered and stabilized in recent years in the U.K., there can be no assurance that this improvement will continue or be sustainable. Real estate asset values could decline substantially, particularly if the U.K. economy or the Eurozone economy as a whole were to suffer a further recession or debt crisis, and could result in declines in the carrying values of our real estate assets (and the value at which we could dispose of such assets). Any of the above may have a material adverse effect on our business, results of operations and financial condition.

Our business could be disrupted if our information systems fail or if our databases are destroyed or damaged.

Our information technology platform supports, among other things, management control of patient administration, billing and financial information and reporting processes. For example, patients in our U.K. facilities and some of our U.S. facilities have an Electronic Patient Record that allows our caregivers and nurses to see all information about a patient's care and treatment. Although we have taken measures to mitigate potential information technology security risks and have information technology continuity plans across our business intended to minimize the impact of information technology failures, there can be no assurance that such measures and plans will be effective. Any failure in or breach of our information technology systems could adversely impact our business, results of operations and financial condition.

We are subject to volatility in the global capital and credit markets as well as significant developments in macroeconomic and political conditions that are out of our control.

Our business can be affected by a number of factors that are beyond our control, such as general macroeconomic conditions, conditions in the financial services markets, geopolitical conditions and other general political and economic developments. These conditions and developments may continue to put pressure on the economy in the U.K., which could have a negative effect on our business. There may be a shortage of liquidity and credit in the U.K. or worldwide and this can be exacerbated by adverse developments in global or national political and/or macroeconomic conditions. In particular, we have historically financed the development of new facilities and the modification of our existing facilities through a variety of sources, including our own cash reserves and debt financing. While we intend to seek to finance new and existing developments from similar sources in the future, there may be insufficient cash reserves to fund the budgeted capital expenditure and market conditions and other factors may prevent us from obtaining debt financing on appropriate terms or at all. In addition, market conditions may limit the number of financial institutions that are willing to provide financing to landlords with whom we wish to contract to build homes for learning disability services, new schools or new mental health facilities which can then be made available to us under a long-term operating lease. If conditions in the U.K. or the global economy remain uncertain or weaken further, this could materially adversely impact our ADC, which would have a corresponding negative impact on our business, results of operations and financial condition.

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

We face several risks inherent in conducting business internationally, including compliance with international and U.S. laws and regulations that apply to our international operations. These laws and regulations include U.S. laws such as the Foreign Corrupt Practices Act and other U.S. federal laws and regulations established by the Office of Foreign Asset Control, local laws such as the U.K. Bribery Act 2010 or other local laws which prohibit corrupt payments to governmental officials or certain payments or remunerations to customers. Given the high level of complexity of these laws, however, there is a risk that some provisions may be inadvertently breached by us, for example through fraudulent or negligent behavior of individual employees, our failure to comply with certain formal

documentation requirements, or otherwise. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or our employees, implementation of compliance programs, and prohibitions on the conduct of our business. Any such violations could include prohibitions on our ability to conduct business in the U.K. and could materially damage our reputation, our brand, our international expansion efforts, our ability to attract and retain employees, our business and our operating results. Our success depends, in part, on our ability to anticipate these risks and manage these challenges.

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

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

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effect on our overall effective tax rate. In addition, the Tax Act made significant changes to the rules applicable to the taxation of corporations. The Company continues to analyze the effects of the Tax Act on its business.

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

During periods of high unemployment, governmental entities often experience budget deficits as a result of increased costs and lower than expected tax collections. These budget deficits at the federal, state and local levels have decreased, and may continue to decrease, spending for health and human service programs, including Medicare and Medicaid in the U.S., which are significant payor sources for our facilities. In periods of high unemployment, we also face the risk of potential declines in the population covered under private insurance, patient decisions to postpone or decide against receiving behavioral healthcare services, potential increases in the uninsured and underinsured populations we serve and further difficulties in collecting patient co-payment and deductible receivables.

A sizable portion of our revenue from certain residential recovery, eating disorder facilities, comprehensive treatment centers and youth programs is from self-payors. Accordingly, a sustained downturn in the U.S. economy could restrain the ability of our patients and the families of our students to pay for services.

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

Our reimbursement may be adversely affected by the repeal, replacement or modification of PPACA.

On January 20, 2017, Donald Trump became President of the United States. Shortly after his inauguration, President Trump issued an executive order that, among other things, stated that it was the intent of his administration to repeal PPACA. Several bills have been introduced and voted upon in the House of Representatives and United States Senate that would either repeal and replace or simply repeal PPACA, although no such comprehensive legislation has been enacted to-date. The Tax Act does, however, effectively repeal the individual mandate to obtain and maintain health insurance by eliminating the tax penalty associated with failing to do so. There are also numerous legal challenges to the validity of PPACA.

If PPACA is modified or ruled invalid, we may experience a significant decrease in reimbursement from state Medicaid programs. We may also experience a significant increase in uncompensated care if many of our patients who currently obtain private health insurance coverage or Medicaid coverage under the provisions of PPACA are no longer able to maintain that coverage. Finally, PPACA currently works in conjunction with MHPAEA to require that third-party payors reimburse providers of certain mental health and substance abuse treatment services on an out-of-network basis. If PPACA or this particular provision thereof is eliminated, we may experience a significant decrease in out-of-network reimbursement at certain of our facilities.

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

Companies operating in the behavioral healthcare industry in the U.S. are required to comply with extensive and complex laws and regulations at the federal, state and local government levels relating to, among other things: billing practices and prices for services; relationships with physicians and other referral sources; necessity and quality of medical care; condition and adequacy of facilities; qualifications of medical and support personnel; confidentiality, privacy and security issues associated with health-related information and PHI; EMTALA compliance; handling of controlled substances; certification, licensure and accreditation of our facilities; operating policies and procedures; activities regarding competitors; state and local land use and zoning requirements; and addition or expansion of facilities and services.

Among the laws applicable to our operations are the federal Anti-Kickback Statute, the Stark Law, the federal False Claims Act, EKRA, and similar state laws. These laws impact the relationships that we may have with physicians and other potential referral sources. We have a variety of financial relationships with physicians and other professionals who refer patients to our facilities, including employment contracts, leases and professional service agreements. The OIG has issued certain safe harbor regulations that outline practices that are deemed acceptable under the Anti-Kickback Statute, and similar regulatory exceptions have been promulgated by CMS under the Stark Law. While we endeavor to ensure that our arrangements with referral sources comply with an

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applicable safe harbor to the Anti-Kickback Statute where possible, certain of our current arrangements with physicians and other potential referral sources may not qualify for such protection. Failure to meet a safe harbor does not mean that the arrangement automatically violates the Anti-Kickback Statute, but may subject the arrangement to greater scrutiny. Even if our arrangements are found to be in compliance with the Anti-Kickback Statue, they may still face scrutiny under the newly enacted EKRA law. Moreover, while we believe that our arrangements with physicians comply with applicable Stark Law exceptions, the Stark Law is a strict liability statute for which no intent to violate the law is required.

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

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

All of our facilities that handle and dispense controlled substances must comply with strict federal and state regulations regarding the purchase, storage, distribution and disposal of such controlled substances. The potential for theft or diversion of such controlled substances for illegal uses has led the federal government as well as a number of states and localities to adopt stringent regulations not applicable to many other types of healthcare providers. Compliance with these regulations is expensive and these costs may increase in the future.

Property owners and local authorities have attempted, and may in the future attempt, to use or enact zoning ordinances to eliminate our ability to operate a given treatment facility or program. Local governmental authorities in some cases also have attempted to use litigation and the threat of prosecution to force the closure of certain comprehensive treatment facilities. If any of these attempts were to succeed or if their frequency were to increase, our revenue would be adversely affected and our operating results might be harmed. In addition, such actions may require us to litigate which would increase our costs.

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

Federal, state and local regulations determine the capacity at which many of our U.S. facilities may be operated. State licensing standards require many of our U.S. facilities to have minimum staffing levels; minimum amounts of residential space per student or patient and adhere to other minimum standards. Local regulations require us to follow

land use guidelines at many of our U.S. facilities, including those pertaining to fire safety, sewer capacity and other physical plant matters.

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

Our operations in the U.K. are subject to a high level of regulation and supervision, ranging from the initial establishment of new facilities, which are subject to registration and licensing requirements, to the recruitment and appointment of staff, occupational health and safety, duty of care to service users, clinical and educational standards, conduct of our professional and support staff, the environment, public health and other areas. The regulatory requirements differ across our divisions, though almost all of our activity in England in relation to mental healthcare, elderly care and learning disability care are regulated by the CQC and in Scotland, Wales and Northern Ireland, its local equivalent. In addition, our children's homes, residential schools and colleges in England are regulated by OFSTED, and in Scotland and Wales by their local equivalent, and all of our schools must be licensed by the Department for Education. See "Item 1. Business—Regulation—U.K. Overview" for further details on the key U.K. regulations to which we are subject.

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Inspections by CQC, OFSTED, and other regulators can be carried out on both an announced and unannounced basis depending on the specific regulatory provisions relating to the different healthcare, social care and specialist education services we provide.

A failure to comply with regulations, the receipt of a poor rating or a lower rating, or the receipt of a negative report that leads to a determination of regulatory non-compliance or our failure to cure any defect noted in an inspection report could result in reputational damage, fines, the revocation or suspension of the registration of any facility or service or a decrease in, or cessation of, the services provided by us at any given facility. Additionally, where placements are funded by Local Authorities, most Local Authorities monitor performance and where there are shortcomings may impose punitive measures. These can, for example, include the suspension of new placements (known in the industry as “embargoes”) and, in extreme cases, removal of all residents placed by that authority, which in turn may affect the level of referrals from other publicly funded entities and our occupancy levels.

Furthermore, new regulations or regulatory bodies may be introduced in the future or existing regulations and regulatory bodies may be amended or replaced and we may not adapt to such changes quickly enough, or in a cost-efficient manner. For example, the U.K. government appointed Monitor (now part of NHS Improvement) as the market regulator for healthcare providers in 2012 by way of a licensing regime. Any failure by us to comply with the licensing regime could result in NHS Improvement revoking our license, which would mean we would be unable to operate. In addition, such regulatory changes may preclude management from executing its business plan as intended, including the timing for new developments and openings.

We cannot guarantee that current laws, regulations and regulatory assessment methodologies will not be modified or replaced in the future. There can be no assurance that our business, results of operations and financial condition will not be adversely affected by any future regulatory developments or that the cost of compliance with new regulations will not be material.

If we fail to cultivate new or maintain established relationships with referral sources, our business, financial condition or results of operations could be adversely affected.

Our ability to grow or even to maintain our existing level of business depends significantly on our ability to establish and maintain close working relationships with physicians, managed care companies, insurance companies, educational consultants and other referral sources. We may not be able to maintain our existing referral source relationships or develop and maintain new relationships in existing or new markets. If we lose existing relationships with our referral sources, the number of people to whom we provide services may decline, which may adversely affect our revenue. If we fail to develop new referral relationships, our growth may be restrained.

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

There are currently numerous legislative and regulatory initiatives in both the U.S. and the U.K. addressing patient privacy and information security concerns. In particular, federal regulations issued under HIPAA require our U.S. facilities to comply with standards to protect the privacy, security and integrity of PHI. These requirements include the adoption of certain administrative, physical, and technical safeguards; development of adequate policies and procedures, training programs and other initiatives to ensure the privacy of PHI is maintained; entry into appropriate agreements with so-called business associates; and affording patients certain rights with respect to their PHI, including notification of any breaches. Compliance with these regulations requires substantial expenditures, which could negatively impact our business, financial condition or results of operations. In addition, our management has spent,

and may spend in the future, substantial time and effort on compliance measures.

In addition to HIPAA, we are subject to similar, and in some cases more restrictive, state and federal privacy regulations. For example, the federal government and some states impose laws governing the use and disclosure of health information pertaining to mental health and/or substance abuse treatment that are more stringent than the rules that apply to healthcare information generally. As public attention is drawn to the issues of the privacy and security of medical information, states may revise or expand their laws concerning the use and disclosure of health information, or may adopt new laws addressing these subjects.

Violations of the privacy and security regulations could subject our operations to substantial civil monetary penalties and substantial other costs and penalties associated with a breach of data security, including criminal penalties. We may also be subject to substantial reputational harm if we experience a substantial security breach involving PHI.

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

Recent developments with respect to the implementation of PPACA have created uncertainty for many healthcare providers. For example, the Tax Act will effectively repeal the individual health insurance mandate imposed under PPACA by eliminating the tax penalty associated with failure to obtain and maintain coverage. Additionally, President Trump’s administration has taken certain

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executive actions that may promote the availability of alternative forms of health insurance outside PPACA's requirements and otherwise affect the implementation of PPACA. We cannot predict how these changes to, or the potential repeal, replacement or further modification of, PPACA will affect our business, results of operations, cash flow, capital resources and liquidity, or whether we will be able to adapt successfully thereto.

We are similarly unable to guarantee that current U.K. laws, regulations and regulatory assessment methodologies will not be modified or replaced in the future. Additionally, there is a risk that budget constraints, public spending cuts (such as the cuts announced by the U.K. government in the 2010 Comprehensive Spending Review and implemented in the 2011 and 2012 government budgets) or other financial pressures could cause the NHS and Local Authorities to reduce funding for the types of services that we provide. Although the government has announced that revenue funding for the NHS in England will grow by an average of 3.4% a year over the next five years from 2019, most of this funding will be needed to cover increases in NHS pay and to meet increased demand, particularly for acute and emergency services. Such policy changes in the U.K. could lead to fewer services from the independent sector being purchased by publicly funded entities or material changes being made to their procurement practices, any of which could materially reduce our revenue. These and other future developments and amendments may negatively impact our operations, which could have a material adverse effect on our business, financial condition or results of operations. See "—Expanding our operations internationally poses additional risks to our business."

The industry trend on value-based purchasing may negatively impact our revenue.

There is a trend in the healthcare industry toward value-based purchasing of healthcare services. These value-based purchasing programs include both public reporting of quality data and preventable adverse events tied to the quality and efficiency of care provided by facilities. Governmental programs including Medicare and Medicaid currently require hospitals to report certain quality data to receive full reimbursement updates. In addition, Medicare does not reimburse for care related to certain preventable adverse events. Many large commercial payors currently require hospitals to report quality data, and several commercial payors do not reimburse hospitals for certain preventable adverse events.

We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively impact our revenue if we are unable to meet quality standards established by both governmental and private payers.

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

The healthcare industry is highly competitive, and competition among healthcare providers (including hospitals) for patients, physicians and other healthcare professionals has intensified in recent years. There are other healthcare facilities that provide behavioral and other mental health services comparable to those offered by our facilities in each of the geographical areas in which we operate. Some of our competitors are owned by tax-supported governmental agencies or by non-profit corporations and may have certain financial advantages not available to us, including endowments, charitable contributions, tax-exempt financing and exemptions from sales, property and income taxes. Some of our for-profit competitors are local, independent operators or physician groups with strong established reputations within the surrounding communities, which may adversely affect our ability to attract a sufficiently large number of patients in markets where we compete with such providers. We also face competition from other for-profit entities, who may possess greater financial, marketing or research and development resources than us or may invest more funds in renovating their facilities or developing technology.

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

The NHS is the principal provider and customer of mental healthcare services in the U.K. NHS in-house beds account for approximately 70% of the total mental health hospital beds providing care in the U.K. As the preferred provider, there is often a bias toward referrals to NHS, and therefore NHS facilities have maintained high occupancy rates. Under the NHS Long Term Plan, preferential treatment of NHS providers is likely to increase and while independent operators may have emerged to satisfy the demand for mental health services not supplied by the NHS, this trend could be reversed. In addition to the NHS, we face competition in the U.K. from independent sector providers and other publicly funded entities for individuals requiring care and for appropriate sites on which to develop or expand facilities in the U.K. Should we fail to compete effectively with our peers and competitors in the industry, or if the competitive environment intensifies, individuals may be referred elsewhere for services that we provide, negatively impacting our ability to secure referrals and limiting the expansion of our business.

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

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

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

The success and competitive advantage of our facilities depends, in part, on the number and quality of the psychiatrists and other physicians on the medical staffs of our facilities and our maintenance of good relations with those medical professionals. Although we employ psychiatrists and other physicians at many of our facilities, psychiatrists and other physicians generally are not employees of our facilities, and, in a number of our markets, they have admitting privileges at competing hospitals providing acute or inpatient behavioral healthcare services. Such physicians (including psychiatrists) may terminate their affiliation with us at any time or admit their patients to competing healthcare facilities or hospitals. If we are unable to attract and retain sufficient numbers of quality psychiatrists and other physicians by providing adequate support personnel and facilities that meet the needs of those psychiatrists and other physicians, they may stop referring patients to our facilities and our results of operations may decline.

It may become difficult for us to attract and retain an adequate number of psychiatrists and other physicians to practice in certain of the communities in which our facilities are located. Our failure to recruit psychiatrists and other physicians to these communities or the loss of such medical professionals in these communities could make it more difficult to attract patients to our facilities and thereby may have a material adverse effect on our business, financial condition or results of operations. Additionally, our ability to recruit psychiatrists and other physicians is closely regulated. The form, amount and duration of assistance we can provide to recruited psychiatrists and other physicians is limited by the Stark Law, the Anti-Kickback Statute, state anti-kickback statutes, and related regulations.

Some of our employees are represented by labor unions and any work stoppage could adversely affect our business.

Increased labor union activity could adversely affect our labor costs. At December 31, 2018, labor unions represented approximately 460 of our employees at five of our U.S. facilities through eight collective bargaining agreements. The Royal College of Nursing represents nursing employees at our facilities in the U.K. We cannot assure you that employee relations will remain stable. Furthermore, there is a possibility that work stoppages could occur as a result of union activity, which could increase our labor costs and adversely affect our business, financial condition or results of operations. To the extent that a greater portion of our employee base unionizes and the terms of any collective bargaining agreements are significantly different from our current compensation arrangements, it is possible that our labor costs could increase materially and our business, financial condition or results of operations could be adversely affected.

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

The expertise and efforts of our senior executives and the chief executive officer, chief financial officer, medical directors, physicians and other key members of our facility management personnel are important to the success of our business. The loss of the services of one or more of our senior executives, including our U.K. senior management team, or of a significant portion of our facility management personnel could significantly undermine our management expertise and our ability to provide efficient, quality healthcare services at our facilities, which could have a material adverse effect on our business, results of operations and financial condition. In December 2018, Joey A. Jacobs was replaced as our chief executive officer by Debra K. Osteen. There can be no assurance that the change in our chief executive officer will not result in the departure of other key executives or local facility management personnel.

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

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

- regulate certain activities and operations that may have environmental or health and safety effects, such as the generation, handling and disposal of medical wastes;

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- impose liability for costs of cleaning up, and damages to natural resources from, past spills, waste disposals on and off-site, or other releases of hazardous materials or regulated substances; and
- regulate workplace safety.

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

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

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

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

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

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

Controls designed to reduce inpatient services may reduce our revenue.

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

Additionally, the outsourcing of behavioral healthcare to the private sector is a relatively recent development in the U.K. There has been some opposition to outsourcing. While we anticipate that the NHS will continue to rely increasingly upon outsourcing, we

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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 40 states, the U.K. and Puerto Rico, we have substantial operations in the U.K., Pennsylvania, California, Arizona and Arkansas, which makes us especially sensitive to regulatory, economic, environmental and competitive conditions and changes in those locations.

For the year ended December 31, 2018, our revenue in the U.K. represented approximately 37% of our total revenue. Revenue from Pennsylvania, California, Arizona and Arkansas represented approximately 7%, 5%, 4% and 4% of our total revenue for the year ended December 31, 2018, respectively. This concentration makes us particularly sensitive to legislative, regulatory, economic, environmental and competition changes in those locations. Any material change in the current payment programs or regulatory, economic, environmental or competitive conditions in these locations could have a disproportionate effect on our overall business results. If our facilities in these locations are adversely affected by changes in regulatory and economic conditions, our business, financial condition or results of operations could be adversely affected.

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

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

In accordance with our internal policies and procedures, as well as EMTALA, we provide a medical screening examination to any individual who comes to one of our hospitals seeking medical treatment (whether or not such individual is eligible for insurance benefits and regardless of ability to pay) to determine if such individual has an emergency medical condition. If it is determined that such person has an emergency medical condition, we provide such further medical examination and treatment as is required to stabilize the patient's medical condition, within the facility's capability, or arrange for the transfer of the individual to another medical facility in accordance with applicable law and the treating hospital's written procedures. Our hospitals may face substantial civil penalties if we fail to provide appropriate screening and stabilizing treatment or fail to facilitate other appropriate transfers as required by EMTALA.

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

Collection of receivables from third-party payors and patients is critical to our operating performance. Our primary collection risks relate to uninsured patients and the portion of the bill that is the patient's responsibility, which primarily includes co-payments and deductibles. We determine the transaction price based on established billing rates reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients and implicit price concessions. Contractual adjustments and discounts are based on contractual agreements, discount policies and historical experience. Implicit price concessions are based on historical collection experience. At December 31, 2018, our estimated implicit price concessions represented approximately 13% of our accounts receivable balance as of such date. Significant changes in business office operations, payor mix, economic conditions or trends in federal and state governmental health coverage (including the repeal, replacement or modification of PPACA) could affect our collection of accounts receivable, cash flow and results of operations. If we experience

unexpected increases in the growth of uninsured and underinsured patients or in bad debt expenses, our results of operations will be harmed.

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

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

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Failure to maintain effective internal control over financial reporting in accordance with Section 404 of the Sarbanes-Oxley Act of 2002 (the "Sarbanes-Oxley Act"), could have a material adverse effect on our business.

We are required to maintain internal control over financial reporting under Section 404 of the Sarbanes-Oxley Act. If we are unable to maintain adequate internal control over financial reporting, we may be unable to report our financial information on a timely basis, may suffer adverse regulatory consequences or violations of NASDAQ listing rules and may breach the covenants under our financing arrangements. There could also be a negative reaction in the financial markets due to a loss of investor confidence in us and the reliability of our financial statements. If we or our independent registered public accounting firm identify any material weakness in our internal control over financial reporting in the future (including any material weakness in the controls of businesses we have acquired), their correction could require additional remedial measures which could be costly, time-consuming and could have a material adverse effect on our business.

We are responsible for an underfunded pension liability related to our acquisition of Partnerships in Care. In addition, we may be required to increase funding of the pension plans and/or be subject to restrictions on the use of excess cash.

Partnerships in Care is the sponsor of a defined benefit pension plan (the Partnerships in Care Limited Pension and Life Assurance Plan) that covers approximately 180 members in the U.K., most of whom are inactive and retired former employees. As of May 1, 2005, this plan was closed to new participants but then-current participants continue to accrue benefits, and effective May 2015, active participants no longer accrued benefits. At December 31, 2018, the net deficit recognized under GAAP in respect of this plan was £2.8 million.

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

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

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

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

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

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

- a classified board of directors;
- a prohibition on stockholder action through written consent;
- a requirement that special meetings of stockholders be called only upon a resolution approved by a majority of our directors then in office;
- advance notice requirements for stockholder proposals and nominations; and
- the authority of the board of directors to issue preferred stock with such terms as the board of directors may determine.

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

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

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

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

Item 1B. Unresolved Staff Comments.

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None.

Item 2. Properties.

The following table lists, by state or country, the number of behavioral healthcare facilities directly or indirectly owned and operated by us at December 31, 2018:

State	Facilities	Operated Beds
Alaska	1	—
Arizona	3	425
Arkansas	6	713
California	22	462
Delaware	2	100
Florida	6	481
Georgia	5	332
Illinois	1	164
Indiana	8	303
Iowa	1	—
Kansas	1	—
Kentucky	1	—
Louisiana	6	364
Maine	4	—
Maryland	3	—
Massachusetts	13	144
Michigan	6	375
Mississippi	3	428
Missouri	2	239
Montana	1	108
Nevada	4	144
New Hampshire	2	—
New Jersey	1	—
New Mexico	2	210
North Carolina	10	431
Ohio	4	146
Oklahoma	1	108
Oregon	6	—
Pennsylvania	30	1,455
Rhode Island	2	—
South Carolina	1	42
South Dakota	1	126
Tennessee	7	761
Texas	4	407
Utah	6	147
Vermont	1	—

Virginia	7	279
Washington	7	137
West Virginia	7	—
Wisconsin	14	35
International		
Puerto Rico	1	172
United Kingdom	370	8,846
	583	18,084

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See “Business— U.S. Operations” and “Business— U.K. Operations— Description of U.K. Facilities” for a summary descripti of our U.S. and U.K. facilities that we own and lease. We currently lease approximately 61,000 square feet of office space at 6100 Tower Circle, Franklin, Tennessee, for our corporate headquarters. Our headquarters and facilities are generally well maintained and in good operating condition.

Item 3. Legal Proceedings.

We are, from time to time, subject to various claims, lawsuits, governmental investigations and regulatory actions, including claims for damages for personal injuries, medical malpractice, overpayments, breach of contract, securities law violations, tort and employment related claims. In these actions, plaintiffs request a variety of damages, including, in some instances, punitive and other types of damages that may not be covered by insurance. In addition, healthcare companies are subject to numerous investigations by various governmental agencies. Certain of our individual facilities have received, and from time to time, other facilities may receive, subpoenas, civil investigative demands, audit requests and other inquiries from, and may be subject to investigation by, federal and state agencies. These investigations can result in repayment obligations, and violations of the False Claims Act can result in substantial monetary penalties and fines, the imposition of a corporate integrity agreement and exclusion from participation in governmental health programs. In addition, the federal False Claims Act permits private parties to bring qui tam, or “whistleblower,” suits against companies that submit false claims for payments to, or improperly retain overpayments from, the government. Some states have adopted similar state whistleblower and false claims provisions.

During the third quarter of 2018, the U.S. Attorney’s Office for the Southern District of West Virginia served subpoenas on seven of our comprehensive treatment centers located in West Virginia requesting various documents from January 2012 to the date of the subpoena. The U.S. Attorney’s Office has advised us that the civil aspect of the investigation is a False Claims Act investigation focused on claims submitted by the centers for certain lab services. We are cooperating fully with the government’s investigation and have established a reserve of $19.0 million relating to our billing for lab services in West Virginia which was recorded in other accrued liabilities on the consolidated balance sheets and legal settlements expense on the consolidated statements of operations. At this time, we cannot predict the potential liability, and changes in the reserve may be required in future periods as discussions with the government continue and additional information becomes available.

In the fall of 2017, the Department of Health and Human Services Office of Inspector General issued subpoenas to three of our facilities requesting certain documents from January 2013 to the date of the subpoenas. The U.S. Attorney’s Office for the Middle District of Florida issued a civil investigative demand to one of our facilities in December 2017 requesting certain documents from November 2012 to the date of the demand. The government’s investigation of these four facilities is focused on claims not eligible for payment because of alleged violations of certain regulatory requirements relating to, among other things, medical necessity, admission eligibility, discharge decisions, length of stay and patient care issues. We are cooperating with the government’s investigation but are not able to quantify any potential liability in connection with these investigations.

Item 4. Mine Safety Disclosures

Not applicable.

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PART II

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

Our common stock is listed for trading on The NASDAQ Global Select Market under the symbol "ACHC."

Stockholders

As of March 1, 2019, there were approximately 552 holders of record of our common stock.

Recent Sales of Unregistered Securities

None.

Issuer Purchases of Equity Securities

During the three months ended December 31, 2018, the Company withheld shares of Company common stock to satisfy employee minimum statutory tax withholding obligations payable upon the vesting of restricted stock, as follows:

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs
October 1 – October 31	892	$ 37.67	—	—
November 1 – November 30	3,011	$ 40.91	—	—
December 1 – December 31	38,963	$ 29.24	—	—
Total	42,866			

Dividends

We have never declared or paid dividends on our common stock. We currently intend to retain all available funds and any future earnings to fund the development and growth of our business and to repay indebtedness, and therefore we do not anticipate paying any cash dividends in the foreseeable future. Additionally, because we are a holding

company, our ability to pay dividends on our common stock is limited by restrictions on the ability of our subsidiaries to pay dividends or make distributions to us, including restrictions under the terms of the agreements governing our indebtedness. Any future determination to pay dividends will be at the discretion of our board of directors, subject to compliance with covenants in current and future agreements governing our indebtedness (including our Amended and Restated Senior Credit Facility and the indenture governing our Senior Notes), and will depend upon our results of operations, financial condition, capital requirements and other factors that our board of directors deems relevant.

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Item 6. Selected Financial Data.

The selected financial data presented below for the years ended December 31, 2018, 2017 and 2016, and at December 31, 2018 and 2017, is derived from our audited consolidated financial statements included elsewhere in this Annual Report on Form 10-K. The selected financial data for the years ended December 31, 2015 and 2014, and at December 31, 2016, 2015 and 2014, is derived from our audited consolidated financial statements not included herein. The selected consolidated financial data below should be read in conjunction with the "Management's Discussion and Analysis of Financial Condition and Results of Operations" and with our consolidated financial statements and notes thereto included elsewhere in this Annual Report on Form 10-K. The selected financial data presented below does not give effect to our acquisitions prior to the respective date of such acquisitions.

	Year Ended December 31,				
	2018	2017	2016	2015	2014
	(In thousands, except per share data)				
Income Statement Data:					
Revenue before provision for doubtful accounts	$3,012,442	$2,877,234	$2,852,823	$1,829,619	$1,030,784
Provision for doubtful accounts	—	(40,918)	(41,909)	(35,127)	(26,183)
Revenue	3,012,442	2,836,316	2,810,914	1,794,492	1,004,601
Salaries, wages and benefits (1)	1,659,348	1,536,160	1,541,854	973,732	575,412
Professional fees	227,425	196,223	185,486	116,463	52,482
Supplies	119,314	114,439	117,425	80,663	48,422
Rents and leases	80,282	76,775	73,348	32,528	12,201
Other operating expenses	354,498	331,827	312,556	206,746	110,654
Depreciation and amortization	158,832	143,010	135,103	63,550	32,667
Interest expense, net	185,410	176,007	181,325	106,742	48,221
Debt extinguishment costs	1,815	810	4,253	10,818	—
Legal settlements expense	22,076	—	—	—	—
Loss on impairment	337,889	—	—	—	—
Loss on divestiture	—	—	178,809	—	—
(Gain) loss on foreign currency derivatives	—	—	(523)	1,926	(15,262)
Transaction-related expenses	34,507	24,267	48,323	36,571	13,650
(Loss) income from continuing operations, before income taxes	(168,954)	236,798	32,955	164,753	126,154
Provision for income taxes	6,532	37,209	28,779	53,388	42,922
(Loss) income from continuing operations	(175,486)	199,589	4,176	111,365	83,232
Income (loss) from discontinued operations, net of income taxes	—	—	—	111	(192)
Net (loss) income	(175,486)	199,589	4,176	111,476	83,040
Net (income) loss attributable to noncontrolling interests	(264)	246	1,967	1,078	—
Net (loss) income attributable to Acadia	$(175,750)	$199,835	$6,143	$112,554	$83,040

Healthcare Company, Inc.					
(Loss) income from continuing operations per share basic	$(2.01)	$2.30	$0.07	$1.65	$1.51
(Loss) income from continuing operations per share diluted	$(2.01)	$2.30	$0.07	$1.64	$1.50
Balance Sheet Data (as of end of period):					
Cash and cash equivalents	$50,510	$67,290	$57,063	$11,215	$94,040
Total assets	6,172,504	6,424,502	6,024,726	4,279,208	2,206,955
Total debt	3,193,487	3,239,888	3,287,809	2,240,744	1,079,635
Total equity	2,333,307	2,572,871	2,167,724	1,683,028	880,965

(1) Salaries, wages and benefits for the years ended December 31, 2018, 2017, 2016, 2015 and 2014 include $22.0 million, $23.5 million, $28.3 million, $20.5 million and $10.1 million, respectively, of equity-based compensation expense.

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Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

You should read the following discussion and analysis of our financial condition and results of operations with our audited consolidated financial statements and notes thereto included elsewhere in this Annual Report on Form 10-K.

Forward-Looking Statements

This Annual Report on Form 10-K contains "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements include any statements that address future results or occurrences. In some cases you can identify forward-looking statements by terminology such as "may," "might," "will," "would," "should," "could" or the negative thereof. Generally, the words "anticipate," "believe," "continue," "expect," "intend "estimate," "project," "plan" and similar expressions identify forward-looking statements. In particular, statements about our expectations, beliefs, plans, objectives, assumptions or future events or performance contained are forward-looking statements.

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

- our significant indebtedness, our ability to meet our debt obligations, and our ability to incur substantially more debt;
- difficulties in successfully integrating the operations of acquired facilities or realizing the potential benefits and synergies of our acquisitions and joint ventures;
- our ability to implement our business strategies in the U.S. and the U.K. and adapt to the regulatory and business environment in the U.K.;
- potential difficulties operating our business in light of political and economic instability in the U.K. and globally relating to the U.K.'s departure from the European Union;
- the impact of fluctuations in foreign exchange rates, including the devaluations of the GBP relative to the USD;
    - the impact of payments received from the government and third-party payors on our revenue and results of operations including the significant dependence of our U.K. facilities on payments received from the NHS;
- our ability to recruit and retain quality psychiatrists and other physicians, nurses, counselors and other medical support personnel;
- the impact of competition for staffing on our labor costs and profitability;
- the impact of increases to our labor costs in the U.S. and the U.K.;
- the occurrence of patient incidents, which could result in negative media coverage, adversely affect the price of our securities and result in incremental regulatory burdens and governmental investigations;
- our future cash flow and earnings;
- our restrictive covenants, which may restrict our business and financing activities;
- our ability to make payments on our financing arrangements;
- the impact of the economic and employment conditions in the U.S. and the U.K. on our business and future results of operations;
- compliance with laws and government regulations;
- the impact of claims brought against us or our facilities including claims for damages for personal injuries, medical malpractice, overpayments, breach of contract, securities law violations, tort and employee related claims;
- the impact of governmental investigations, regulatory actions and whistleblower lawsuits;

- the impact of healthcare reform in the U.S. and abroad, including the potential repeal, replacement or modification of the Patient Protection and Affordable Care Act;
- the impact of adverse weather conditions, including the effects of hurricanes;

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- the impact of our highly competitive industry on patient volumes;
- our dependence on key management personnel, key executives and local facility management personnel;
- our acquisition, joint venture and de novo strategies, which expose us to a variety of operational and financial risks, as well as legal and regulatory risks;
- the impact of state efforts to regulate the construction or expansion of healthcare facilities on our ability to operate and expand our operations;
- our potential inability to extend leases at expiration;
- the impact of controls designed to reduce inpatient services on our revenue;
- the impact of different interpretations of accounting principles on our results of operations or financial condition;
- the impact of environmental, health and safety laws and regulations, especially in locations where we have concentrated operations;
- the impact of an increase in uninsured and underinsured patients or the deterioration in the collectability of the accounts of such patients on our results of operations;
- the risk of a cyber-security incident and any resulting violation of laws and regulations regarding information privacy or other negative impact;
- the impact of laws and regulations relating to privacy and security of patient health information and standards for electronic transactions;
- our ability to cultivate and maintain relationships with referral sources;
- the impact of a change in the mix of our U.S. and U.K. earnings, adverse changes in our effective tax rate and adverse developments in tax laws generally;
- changes in interpretations, assumptions and expectations regarding the Tax Act, including additional guidance that may be issued by federal and state taxing authorities;
- failure to maintain effective internal control over financial reporting;
- the impact of fluctuations in our operating results, quarter to quarter earnings and other factors on the price of our securities;
- the impact of the trend for insurance companies and managed care organizations to enter into sole source contracts on our ability to obtain patients;
- the impact of value-based purchasing programs on our revenue; and
- those risks and uncertainties described from time to time in our filings with the SEC.

Given these risks and uncertainties, you are cautioned not to place undue reliance on such forward-looking statements. These risks and uncertainties may cause our actual future results to be materially different than those expressed in our forward-looking statements. These forward-looking statements are made only as of the date of this Annual Report on Form 10-K. We do not undertake and specifically decline any obligation to update any such statements or to publicly announce the results of any revisions to any such statements to reflect future events or developments.

Overview

Our business strategy is to acquire and develop behavioral healthcare facilities and improve our operating results within our facilities and our other behavioral healthcare operations. We strive to improve the operating results of our facilities by providing high-quality services, expanding referral networks and marketing initiatives while meeting the increased demand for behavioral healthcare services through expansion of our current locations as well as developing new services within existing locations. At December 31, 2018, we operated 583 behavioral healthcare facilities with approximately 18,100 beds in 40 states, the U.K. and Puerto Rico. During the year ended December 31, 2018, we added 651 beds, including 499 added to existing facilities and 152 added through the opening of two de novo facilities. For the year ending December 31, 2019, we expect to add approximately 700 total beds exclusive of acquisitions.

We are the leading publicly traded pure-play provider of behavioral healthcare services, with operations in the U.S. and the U.K. Management believes that we are positioned as a leading platform in a highly fragmented industry under the direction of an

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experienced management team that has significant industry expertise. Management expects to take advantage of several strategies that are more accessible as a result of our increased size and geographic scale, including continuing a national marketing strategy to attract new patients and referral sources, increasing our volume of out-of-state referrals, providing a broader range of services to new and existing patients and clients and selectively pursuing opportunities to expand our facility and bed count in the U.S. and U.K. through acquisitions, joint ventures and bed additions in existing facilities.

Acquisitions

2019 Acquisitions

On February 15, 2019, we completed the acquisition of Whittier, an inpatient psychiatric facility with 71 beds located in Haverhill, Massachusetts, for cash consideration of approximately $17.9 million. Also on February 15, 2019, we completed the acquisition of Mission Treatment for cash consideration of approximately $22.5 million and a working capital settlement. Mission Treatment operates nine comprehensive treatment centers in California, Nevada, Arizona and Oklahoma.

2017 Acquisition

On November 13, 2017, we completed the acquisition of Aspire, an education facility with 36 beds located in Scotland, for cash consideration of approximately $21.3 million.

2016 U.S. Acquisitions

On June 1, 2016, we completed the acquisition of Pocono Mountain, an inpatient psychiatric facility with 108 beds located in Henryville, Pennsylvania, for cash consideration of approximately $25.4 million.

On May 1, 2016, we completed the acquisition of TrustPoint, an inpatient psychiatric facility with 100 beds located in Murfreesboro, Tennessee, for cash consideration of approximately $62.7 million.

On April 1, 2016, we completed the acquisition of Serenity Knolls, an inpatient psychiatric facility with 30 beds located in Forest Knolls, California, for cash consideration of approximately $10.0 million.

Priory

On February 16, 2016, we completed the acquisition of Priory for a total purchase price of approximately $2.2 billion, including cash consideration of approximately $1.9 billion and the issuance of 4,033,561 shares of our common stock to shareholders of Priory. Priory was the leading independent provider of behavioral healthcare services in the U.K. operating 324 facilities with approximately 7,100 beds at the acquisition date.

The Competition and Markets Authority (the “CMA”) in the U.K. reviewed our acquisition of Priory. On July 14, 2016, the CMA announced that our acquisition of Priory was referred for a phase 2 investigation unless we offered acceptable undertakings to address the CMA’s competition concerns relating to the provision of behavioral healthcare services in certain markets. On July 28, 2016, the CMA announced that we had offered undertakings to address the CMA’s concerns and that, in lieu of a phase 2 investigation, the CMA would consider our undertakings.

On October 18, 2016, we signed a definitive agreement with BC Partners for the sale of 21 existing U.K. behavioral health facilities and one de novo behavioral health facility with an aggregate of approximately 1,000 beds. On November 10, 2016, the CMA accepted our undertakings to sell the U.K. Disposal Group to BC Partners and confirmed that the divestiture satisfied the CMA's concerns about the impact of our acquisition of Priory on competition for the provision of behavioral healthcare services in certain markets in the U.K. As a result of the CMA's acceptance of our undertakings, our acquisition of Priory was not referred for a phase 2 investigation. On November 30, 2016, we completed the sale of the U.K. Disposal Group to BC Partners for £320 million cash.

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Results of Operations

The following table illustrates our consolidated results of operations for the respective periods shown (dollars in thousands):

	Year Ended December 31,					
	2018		2017		2016	
	Amount	%	Amount	%	Amount	%
Revenue before provision for doubtful accounts	$3,012,442		$2,877,234		$2,852,823	
Provision for doubtful accounts	—		(40,918)		(41,909)	
Revenue	3,012,442	100.0%	2,836,316	100.0%	2,810,914	100.0%
Salaries, wages and benefits	1,659,348	55.1%	1,536,160	54.2%	1,541,854	54.9%
Professional fees	227,425	7.5%	196,223	6.9%	185,486	6.6%
Supplies	119,314	4.0%	114,439	4.0%	117,425	4.2%
Rents and leases	80,282	2.7%	76,775	2.7%	73,348	2.6%
Other operating expenses	354,498	11.8%	331,827	11.7%	312,556	11.1%
Depreciation and amortization	158,832	5.3%	143,010	5.0%	135,103	4.8%
Interest expense, net	185,410	6.2%	176,007	6.2%	181,325	6.4%
Debt extinguishment costs	1,815	0.1%	810	0.0%	4,253	0.1%
Legal settlements expense	22,076	0.7%	—	0.0%	—	0.0%
Loss on impairment	337,889	11.2%	—	0.0%	—	0.0%
Loss on divestiture	—	—%	—	—%	178,809	6.4%
Gain on foreign currency derivatives	—	—%	—	—%	(523)	—%
Transaction-related expenses	34,507	1.1%	24,267	0.9%	48,323	1.7%
	3,181,396	105.7%	2,599,518	91.6%	2,777,959	98.8%
(Loss) income before income taxes	(168,954)	-5.7%	236,798	8.4%	32,955	1.2%
Provision for income taxes	6,532	0.2%	37,209	1.3%	28,779	1.0%
Net (loss) income	(175,486)	-5.9%	199,589	7.0%	4,176	0.1%
Net (income) loss attributable to noncontrolling interest	(264)	-0.1%	246	0.0%	1,967	0.1%
Net (loss) income attributable to Acadia Healthcare Company, Inc.	$(175,750)	-5.8%	$199,835	7.0%	$6,143	0.2%

Segments

At December 31, 2018, the U.S. Facilities segment included 213 behavioral healthcare facilities with approximately 9,300 beds in 40 states and Puerto Rico, and the U.K. Facilities segment included 370 behavioral healthcare facilities with approximately 8,800 beds in the U.K.

The following table sets forth percent changes in same facility operating data for our U.S. Facilities for the years ended December 31, 2018 and 2017 compared to same periods in the previous years:

	Year Ended December 31,	
	2018	2017
U.S. Same Facility Results (a)		
Revenue growth	5.4%	6.6%
Patient days growth	2.7%	4.8%
Admissions growth	4.3%	6.2%
Average length of stay change (b)	-1.6%	-1.4%
Revenue per patient day growth	2.7%	1.7%
EBITDA margin change (c)	-20bps	-10bps

(a) Results for the periods presented include facilities we have operated more than one year and exclude certain closed services.

(b) Average length of stay is defined as patient days divided by admissions.

(c) Segment EBITDA is defined as income before provision for income taxes, equity-based

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compensation expense, debt extinguishment costs, legal settlements expense, loss on impairment, loss on divestiture, gain on foreign currency derivatives, transaction-related expenses, interest expense and depreciation and amortization. Management uses Segment EBITDA as an analytical indicator to measure the performance of our segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA is commonly used as an analytical indicator within the health care industry, and also serves as a measure of leverage capacity and debt service ability. Segment EBITDA should not be considered as a measure of financial performance under GAAP, and the items excluded from Segment EBITDA are significant components in understanding and assessing financial performance. Because Segment EBITDA is not a measurement determined in accordance with GAAP and is thus susceptible to varying calculations, Segment EBITDA, as presented, may not be comparable to other similarly titled measures of other companies.

The following table sets forth percent changes in same facility operating data for our U.K. Facilities for the years ended December 31, 2018 and 2017 compared to the same periods in the previous years:

	Year Ended December 31,	
	2018	2017
U.K. Same Facility Results (a,c)		
Revenue growth	4.7%	3.6%
Patient days growth	1.6%	2.1%
Admissions growth	-0.4%	7.4%
Average length of stay change (b)	2.0%	-5.0%
Revenue per patient day growth	3.1%	1.5%
EBITDA margin change (d,e)	-240bps	80bps

(a) Results for the periods presented include facilities we have operated more than one year and exclude the elderly care division and certain closed services.
(b) Average length of stay is defined as patient days divided by admissions.
(c) Revenue and revenue per patient day for the previous year is adjusted to reflect the foreign currency exchange rate for the comparable period of the current year in order to eliminate the effect of changes in the exchange rate.
(d) See definition of Segment EBITDA in U.S. Same Facility Results table above.
(e) U.K. EBITDA margin for the years ended December 31, 2018 and 2017 was affected by lower census and higher operating expenses including contract labor in particular. Our census did not reach a sufficient level to absorb the higher wages and operating costs, which adversely affected our margins.

Year Ended December 31, 2018 Compared to the Year Ended December 31, 2017

Revenue. Revenue increased $176.1 million, or 6.2%, to $3.0 billion for the year ended December 31, 2018 from $2.8 billion for the year ended December 31, 2017 resulting from same facility revenue growth of 5.2% and the increase in the exchange rate between USD and GBP of $36.2 million. During the year ended December 31, 2018, we generated $1.9 billion of revenue, or 63.2% of our total revenue, from our U.S. Facilities and $1.1 billion of revenue, or 36.8% of our total revenue, from our U.K. Facilities. During the year ended December 31, 2017, we generated $1.8 billion of revenue, or 63.8% of our total revenue, from our U.S. Facilities and $1.0 billion of revenue, or 36.2% of our total revenue, from our U.K. Facilities.

U.S. same facility revenue increased by $96.7 million, or 5.4%, for the year ended December 31, 2018 compared to the year ended December 31, 2017, resulting from same facility growth in patient days of 2.7% and an increase in same facility revenue per day of 2.7%. U.S. same facility revenue was impacted by a fourth quarter 2018 accounts

receivable adjustment of approximately $8.0 million primarily related to our CTCs and the state Medicaid programs in Wisconsin. U.K. same facility revenue increased by $45.2 million, or 4.7%, for the year ended December 31, 2018 compared to the year ended December 31, 2017, resulting from same facility growth in patient days of 1.6% and an increase in same facility revenue per day of 3.1%. Consistent with the same facility patient day growth in 2017, the growth in same facility patient days for the year ended December 31, 2018 compared to the year ended December 31, 2017 resulted from the addition of beds to our existing facilities and ongoing demand for our services.

Salaries, wages and benefits. Salaries, wages and benefits ("SWB") expense was $1.7 billion for the year ended December 31, 2018 compared to $1.5 billion for the year ended December 31, 2017, an increase of $123.2 million. SWB expense included $22.0 million and $23.5 million of equity-based compensation expense for the years ended December 31, 2018 and 2017, respectively. Excluding equity-based compensation expense, SWB expense was $1.6 billion, or 54.4% of revenue, for the year ended December 31, 2018, compared to $1.5 billion, or 53.3% of revenue, for the year ended December 31, 2017. Same facility SWB expense was

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$1.5 billion for the year ended December 31, 2018, or 51.6% of revenue compared to $1.4 billion for the year ended December 31, 2017, or 51.1% of revenue.

Professional fees. Professional fees were $227.4 million for the year ended December 31, 2018, or 7.5% of revenue, compared to $196.2 million for the year ended December 31, 2017, or 6.9% of revenue. The $31.2 million increase was primarily attributable to higher contract labor costs in our U.K. Facilities. Contract labor costs in our U.K. Facilities were higher primarily due to the ongoing nursing and clinical labor shortage and our dependence on higher cost agency labor. Same facility professional fees were $196.7 million for the year ended December 31, 2018, or 6.8% of revenue, compared to $169.4 million, for the year ended December 31, 2017, or 6.2% of revenue.

Supplies. Supplies expense was $119.3 million for the year ended December 31, 2018, or 4.0% of revenue, compared to $114.4 million for the year ended December 31, 2017, or 4.0% of revenue. Same facility supplies expense was $111.1 million for the year ended December 31, 2018, or 3.9% of revenue, compared to $107.7 million for the year ended December 31, 2017, or 3.9% of revenue.

Rents and leases. Rents and leases were $80.3 million for the year ended December 31, 2018, or 2.7% of revenue, compared to $76.8 million for the year ended December 31, 2017, or 2.7% of revenue. Same facility rents and leases were $64.5 million for the year ended December 31, 2018, or 2.2% of revenue, compared to $62.7 million for the year ended December 31, 2017, or 2.3% of revenue.

Other operating expenses. Other operating expenses consisted primarily of purchased services, utilities, insurance, travel and repairs and maintenance expenses. Other operating expenses were $354.5 million for the year ended December 31, 2018, or 11.8% of revenue, compared to $331.8 million for the year ended December 31, 2017, or 11.7% of revenue. Same facility other operating expenses were $329.1 million for the year ended December 31, 2018, or 11.5% of revenue, compared to $314.8 million for the year ended December 31, 2017, or 11.5% of revenue.

Depreciation and amortization. Depreciation and amortization expense was $158.8 million for the year ended December 31, 2018, or 5.3% of revenue, compared to $143.0 million for the year ended December 31, 2017, or 5.0% of revenue. The increase in depreciation and amortization was attributable to depreciation associated with capital expenditures and real estate acquisitions during 2017 and 2018.

Interest expense. Interest expense was $185.4 million for the year ended December 31, 2018 compared to $176.0 million for the year ended December 31, 2017. The increase in interest expense was primarily a result of higher interest rates applicable to our variable-rate debt slightly offset by the lower interest rates as a result of the Repricing Facilities Amendments to the Amended and Restated Credit Agreement.

Debt extinguishment costs. Debt extinguishment costs for the year ended December 31, 2018 represented $0.6 million of cash charges and $0.3 million of non-cash charges recorded in connection with the Repricing Facilities Amendments to the Amended and Restated Credit Agreement and $0.9 million of cash charges in connection with the redemption of the 9.0% and 9.5% Revenue Bonds. Debt extinguishment costs for the year ended December 30, 2017 represent $0.5 million of charges and $0.3 of non-cash charges recorded in connection with the Third Repricing Amendment to the Amended and Restated Senior Credit Facility.

Legal settlements expense. Legal settlement costs of $22.1 million for the year ended December 31, 2018 represent $19.0 million related to the government investigation of the Company’s billing for lab services in West Virginia and $3.1 million related to the resolution of the shareholder class action lawsuit filed in 2011 in connection with our merger with PHC, Inc. d/b/a Pioneer Behavioral Health (“PHC”).

Loss on impairment. Loss on impairment of $337.9 million for the year ended December 31, 2018 represents a non-cash goodwill impairment charge of $325.9 million and a non-cash long-lived asset impairment charge of $12.0 million related to our U.K. Facilities.

Transaction-related expenses. Transaction-related expenses were $34.5 million for the year ended December 31, 2018 compared to $24.3 million for the year ended December 31, 2017. Transaction-related expenses represent costs incurred in the respective periods primarily related to our acquisitions and related integrated efforts and, for 2018, to the CEO transition.

In December 2018, Mr. Joey A. Jacobs was removed from his positions as the CEO and Chairman of the Board of directors (the “Board”) of the Company. Also in December 2018, Ms. Debra K. Osteen was elected by the Board to serve as the Company’s CEO. In connection with this CEO transition, the Company recorded a charge of $14.0 million, which was comprised of cash payments to

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Mr. Jacobs of $8.1 million, the accelerated vesting of Mr. Jacobs' restricted stock awards of $5.0 million, a cash payment to Ms. Osteen of $0.4 million and other costs of $0.5 million. CEO transition costs of $14.0 million were recorded in transaction-related expenses in the consolidated statements of operations.

Transaction-related expenses are as summarized below (in thousands):

	Year Ended December 31,	
	2018	2017
CEO transition costs	$14,033	$—
Termination and closure costs	11,829	16,190
Legal, accounting and other fees	8,645	8,077
	$34,507	$24,267

Provision for income taxes. For the year ended December 31, 2018, the provision for income taxes was $6.5 million, reflecting an effective tax rate of (3.9)%, compared to $37.2 million, reflecting an effective tax rate of 15.7%, for 2017. The change in the effective tax rate for the year ended December 31, 2018 was primarily attributable to the disparity in the accounting treatment and the tax treatment of the loss on impairment recorded in 2018.

Year Ended December 31, 2017 Compared to the Year Ended December 31, 2016

Revenue before provision for doubtful accounts. Revenue before provision for doubtful accounts increased $24.4 million, or 0.9%, to $2.9 billion for the year ended December 31, 2017 from $2.9 billion for the year ended December 31, 2016. The increase related primarily to revenue generated during the year ended December 31, 2017 from the facilities acquired in our 2016 Acquisitions, particularly the acquisition of Priory, offset by the reduction in revenue before provision for doubtful accounts related to the U.K. Divestiture of $154.7 million and the decline in the exchange rate between USD and GBP of $45.5 million. During the year ended December 31, 2017, we generated $1.8 billion of revenue, or 63.8% of our total revenue, from our U.S. Facilities and $1.0 billion of revenue, or 36.2% of our total revenue, from our U.K. Facilities. During year ended December 31, 2016, we generated $1.7 billion of revenue, or 60.5% of our total revenue, from our U.S. Facilities and $1.1 billion of revenue, or 39.5% of our total revenue, from our U.K. Facilities.

U.S. same facility revenue increased by $109.1 million, or 6.6%, for the year ended December 31, 2017 compared to the year ended December 31, 2016, resulting from same facility growth in patient days of 4.8% and an increase in same facility revenue per day of 1.7%. U.K. same facility revenue increased by $28.9 million, or 3.6%, for the year ended December 31, 2017 compared to the year ended December 31, 2016, resulting from same facility growth in patient days of 2.1% and an increase in same facility revenue per day of 1.5%. Consistent with the same facility patient day growth in 2016, the growth in same facility patient days for the year ended December 31, 2017 compared to the year ended December 31, 2016 resulted from the addition of beds to our existing facilities and ongoing demand for our services.

Provision for doubtful accounts. The provision for doubtful accounts was $40.9 million for the year ended December 31, 2017, or 1.4% of revenue before provision for doubtful accounts, compared to $41.9 million for the year ended December 31, 2016, or 1.5% of revenue before provision for doubtful accounts.

Salaries, wages and benefits. Salaries, wages and benefits ("SWB") expense was $1.5 billion for the year ended December 31, 2017 compared to $1.5 billion for the year ended December 31, 2016, a decrease of $5.7 million. SWB expense included $23.5 million and $28.3 million of equity-based compensation expense for the years ended December 31, 2017 and 2016, respectively. Excluding equity-based compensation expense, SWB expense was $1.5 billion, or 53.3% of revenue, for the year ended December 31, 2017, compared to $1.5 billion, or 53.8% of revenue, for the year ended December 31, 2016. The slight decrease in SWB expense, excluding equity-based compensation expense, was primarily attributable to the reduction in expense related to the U.K. Divestiture and the decline in the exchange rate between USD and GBP offset by SWB expense incurred by the facilities acquired in our 2016 Acquisitions, particularly the acquisition of Priory. Same facility SWB expense was $1.3 billion for the year ended December 31, 2017, or 50.9% of revenue compared to $1.3 billion for the year ended December 31, 2016, or 51.0% of revenue.

Professional fees. Professional fees were $196.2 million for the year ended December 31, 2017, or 6.9% of revenue, compared to $185.5 million for the year ended December 31, 2016, or 6.6% of revenue. The $10.7 million increase was primarily attributable professional fees incurred by the facilities acquired in our 2016 Acquisitions, particularly the acquisition of Priory, and higher contract labor costs in our U.K. Facilities offset by the reduction in expense related to the U.K. Divestiture and the decline in the exchange rate between USD and GBP. Same facility professional fees were $160.1 million for the year ended December 31, 2017, or 6.2% of revenue, compared to $145.0 million, for the year ended December 31, 2016, or 5.9% of revenue.

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Supplies. Supplies expense was $114.4 million for the year ended December 31, 2017, or 4.0% of revenue, compared to $117.4 million for the year ended December 31, 2016, or 4.2% of revenue. The $3.0 million decrease was primarily attributable to the reduction in expense related to the U.K. Divestiture and the decline in the exchange rate between USD and GBP offset by supplies expense incurred by the facilities acquired in our 2016 Acquisitions, particularly the acquisition of Priory. Same facility supplies expense was $103.5 million for the year ended December 31, 2017, or 4.0% of revenue, compared to $100.2 million for the year ended December 31, 2016, or 4.1% of revenue.

Rents and leases. Rents and leases were $76.8 million for the year ended December 31, 2017, or 2.7% of revenue, compared to $73.3 million for the year ended December 31, 2016, or 2.6% of revenue. The $3.4 million increase was primarily attributable to rents and leases incurred by the facilities acquired in our 2016 Acquisitions, particularly the acquisition of Priory slightly offset by the reduction in expense related to the U.K. Divestiture and the decline in the exchange rate between USD and GBP. Same facility rents and leases were $58.0 million for the year ended December 31, 2017, or 2.2% of revenue, compared to $57.5 million for the year ended December 31, 2016, or 2.3% of revenue.

Other operating expenses. Other operating expenses consisted primarily of purchased services, utilities, insurance, travel and repairs and maintenance expenses. Other operating expenses were $331.8 million for the year ended December 31, 2017, or 11.7% of revenue, compared to $312.6 million for the year ended December 31, 2016, or 11.1% of revenue. The $19.2 million increase was primarily attributable to other operating expenses incurred by the facilities acquired in our 2016 Acquisitions, particularly the acquisition of Priory slightly offset by the reduction in expense related to the U.K. Divestiture and the decline in the exchange rate between USD and GBP. Same facility other operating expenses were $297.8 million for the year ended December 31, 2017, or 11.4% of revenue, compared to $273.3 million for the year ended December 31, 2016, or 11.1% of revenue.

Depreciation and amortization. Depreciation and amortization expense was $143.0 million for the year ended December 31, 2017, or 5.0% of revenue, compared to $135.1 million for the year ended December 31, 2016, or 4.8% of revenue. The increase in depreciation and amortization was attributable to depreciation associated with capital expenditures during 2016 and 2017 and real estate acquired as part of the 2016 Acquisitions, particularly the acquisition of Priory, offset by reduction in expense related to the U.K. Divestiture and the decline in the exchange rate between USD and GBP.

Interest expense. Interest expense was $176.0 million for the year ended December 31, 2017 compared to $181.3 million for the year ended December 31, 2016. The decrease in interest expense was primarily a result of the lower interest rates in connection with amendments to the Amended and Restated Senior Credit Facility and the debt paydown on November 30, 2016 using proceeds from the U.K. Divestiture. Interest expense was also impacted by higher interest rates applicable to our variable-rate debt, borrowings under the Amended and Restated Senior Credit Facility and the issuance of the 6.500% Senior Notes on February 16, 2016.

Debt extinguishment costs. Debt extinguishment costs for the year ended December 30, 2017 represent $0.5 million of charges and $0.3 of non-cash charges recorded in connection with the Third Repricing Amendment to the Amended and Restated Senior Credit Facility. Debt extinguishment costs for the year ended December 31, 2016 represent $1.1 million of cash charges and $3.2 million of non-cash charges recorded in connection with the Tranche B-2 Repricing Amendment and the Refinancing Amendment.

Loss on divestiture. As part of our divestitures in the U.K. and U.S., we recorded $178.8 million of loss on divestiture for the year ended December 31, 2016, which included an allocation of goodwill to the disposal groups of approximately $106.9 million, loss on the sale of properties of approximately $45.0 million, transaction-related

expenses of approximately $26.8 million and write-off of intangible assets of approximately $0.1 million.

Gain on foreign currency derivatives. We entered into foreign currency forward contracts during the year ended December 31, 2016 in connection with (i) acquisitions in the U.K. and (ii) certain transfers of cash between the U.S. and the U.K. under our cash management and foreign currency risk management programs. Exchange rate changes between the contract date and the settlement date resulted in a gain on foreign currency derivatives of $0.5 million for the year ended December 31, 2016.

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Transaction-related expenses. Transaction-related expenses were $24.3 million for the year ended December 31, 2017 compared to $48.3 million for the year ended December 31, 2016. Transaction-related expenses represent costs incurred in the respective periods, primarily related to the 2016 Acquisitions, the U.K. Divestiture and the related integration efforts, as summarized below (in thousands):

	Year Ended December 31,	
	2017	2016
Termination and closure costs	$16,190	$15,449
Legal, accounting and other fees	8,077	18,024
Advisory and financing commitment fees	—	14,850
	$24,267	$48,323

Provision for income taxes. For the year ended December 31, 2017, the provision for income taxes was $37.2 million, reflecting an effective tax rate of 15.7%, compared to $28.8 million, reflecting an effective tax rate of 87.3%, for 2016. The decrease in the effective tax rate for the year ended December 31, 2017 was primarily attributable to the Company's estimate of the one-time tax benefit on revaluation of deferred tax items pursuant to the enactment of the Tax Act as well as changes in the foreign exchange rate between USD and GBP in 2017 and the disparity between the accounting treatment and the tax treatment of the U.K. Divestiture on November 30, 2016.

Liquidity and Capital Resources

Cash provided by continuing operating activities for the year ended December 31, 2018 was $416.6 million compared to $401.3 million for the year ended December 31, 2017. The increase in cash provided by continuing operating activities was primarily attributable to growth in same facility operations. Days sales outstanding at December 31, 2018 was 39 compared to 38 at December 31, 2017. At December 31, 2018 and December 31, 2017, we had working capital of $34.0 million and $94.2 million, respectively.

Cash used in investing activities for the year ended December 31, 2018 was $361.0 million compared to $336.5 million for the year ended December 31, 2017. Cash used in investing activities for the year ended December 31, 2018 primarily consisted of $341.5 million of cash paid for capital expenditures and $18.4 million of cash paid for real estate. Cash paid for capital expenditures for the year ended December 31, 2018 consisted of $74.1 million of routine capital expenditures and $267.4 million of expansion capital expenditures. We define expansion capital expenditures as those that increase the capacity of our facilities or otherwise enhance revenue. Routine or maintenance capital expenditures were approximately 2.5% of revenue for the year ended December 31, 2018. Cash used in investing activities for the year ended December 31, 2017 primarily consisted of $274.1 million of cash paid for capital expenditures, $41.1 million of cash paid for real estate acquisitions and cash paid for acquisitions of $18.2 million. Cash paid for capital expenditures for the year ended December 31, 2017 consisted of $70.8 million of routine capital expenditures and $203.4 million of expansion capital expenditures.

Cash used in financing activities for the year ended December 31, 2018 was $67.3 million compared to $60.1 million for the year ended December 31, 2017. Cash used in financing activities for the year ended December 31, 2018 primarily consisted of principal payments on long-term debt of $39.7 million, repayment of long-term debt of $21.9 million and common stock withheld for minimum statutory taxes of $3.4 million. Cash provided by financing activities for the year ended December 31, 2017 primarily consisted of principal payments on long-term debt of $34.8 million, repayment of long-term debt of $22.5 million and common stock withheld for minimum statutory taxes of $3.5 million.

We had total available cash and cash equivalents of $50.5 million, $67.3 million and $57.1 million at December 31, 2018, 2017 and 2016, respectively, of which approximately $18.0 million, $20.4 million and $41.4 million was held by our foreign subsidiaries, respectively. Our strategic plan does not require the repatriation of foreign cash in order to fund our operations in the U.S., and it is our current intention to permanently reinvest our foreign cash and cash equivalents outside of the U.S.

Amended and Restated Senior Credit Facility

We entered into a Senior Secured Credit Facility on April 1, 2011. On December 31, 2012, we entered into the Amended and Restated Credit Agreement which amended and restated the Senior Secured Credit Facility. We have amended the Amended and Restated Credit Agreement from time to time as described in our prior filings with the SEC.

On January 25, 2016, we entered into the Ninth Amendment to our Amended and Restated Credit Agreement. The Ninth Amendment modified certain definitions and provides increased flexibility to us in terms of our financial covenants. Our baskets for

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permitted investments were also increased to provide increased flexibility for us to invest in non-wholly owned subsidiaries, joint ventures and foreign subsidiaries. As a result of the Ninth Amendment, we may invest in non-wholly owned subsidiaries and joint ventures up to 10.0% of our and our subsidiaries' total assets in any consecutive four fiscal quarter period, and up to 12.5% of our and our subsidiaries' total assets during the term of the Amended and Restated Credit Agreement. We may also invest in foreign subsidiaries that are not loan parties up to 10% of our and our subsidiaries' total assets in any consecutive four fiscal quarter period, and up to 15% of our and our subsidiaries' total assets during the term of the Amended and Restated Credit Agreement. The foregoing permitted investments are subject to an aggregate cap of 25% of our and our subsidiaries' total assets in any fiscal year.

On February 16, 2016, we entered into the Second Incremental Facility Amendment to our Amended and Restated Credit Agreement. The Second Incremental Amendment activated a new $955.0 million incremental Term Loan B facility and added $135.0 million to the Term Loan A facility to our Amended and Restated Senior Secured Credit Facility, subject to limited conditionality provisions. Borrowings under the Tranche B-2 Facility were used to fund a portion of the purchase price for the acquisition of Priory and the fees and expenses for such acquisition and the related financing transactions. Borrowings under the TLA Facility were used to pay down the majority of our $300.0 million revolving credit facility.

On May 26, 2016, we entered into a Tranche B-1 Repricing Amendment to the Amended and Restated Credit Agreement. The Tranche B-1 Repricing Amendment reduced the Applicable Rate with respect to the Tranche B-1 Facility from 3.5% to 3.0% in the case of Eurodollar Rate loans and 2.5% to 2.0% in the case of Base Rate Loans.

On September 21, 2016, we entered into a Tranche B-2 Repricing Amendment to the Amended and Restated Credit Agreement. The Tranche B-2 Repricing Amendment reduced the Applicable Rate with respect to the Tranche B-2 Facility from 3.75% to 3.00% in the case of Eurodollar Rate loans and 2.75% to 2.00% in the case of Base Rate Loans. In connection with the Tranche B-2 Repricing Amendment, we recorded a debt extinguishment charge of $3.4 million, including the discount and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of operations.

On November 22, 2016, we entered into a Tenth Amendment to the Amended and Restated Credit Agreement. The Tenth Amendment, among other things, (i) amended the negative covenant regarding dispositions, (ii) modified the collateral package to release any real property with a fair market value of less than $5.0 million and (iii) changed certain investment, indebtedness and lien baskets.

On November 30, 2016, we entered into a Refinancing Facilities Amendment to the Amended and Restated Credit Agreement. The Refinancing Amendment increased our line of credit on our revolving credit facility to $500.0 million from $300.0 million and reduced our TLA Facility to $400.0 million from $600.6 million. In addition, the Refinancing Amendment extended the maturity date for the Refinancing Facilities to November 30, 2021 from February 13, 2019, and lowered our effective interest rate on our line of credit on our revolving credit facility and TLA Facility by 50 basis points. In connection with the Refinancing Amendment, we recorded a debt extinguishment charge of $0.8 million, including the write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of operations.

On May 10, 2017, we entered into the Third Repricing Amendment to the Amended and Restated Credit Agreement. The Third Repricing Amendment reduced the Applicable Rate with respect to the Tranche B-1 Facility and the Tranche B-2 Facility from 3.0% to 2.75% in the case of Eurodollar Rate loans and 2.0% to 1.75% in the case of Base Rate Loans. In connection with the Third Repricing Amendment, we recorded a debt extinguishment charge of $0.8 million, including the discount and write-off of deferred financing costs, which was recorded in debt

extinguishment costs in the consolidated statements of operations.

On March 22, 2018, we entered into a Second Repricing Facilities Amendment to the Amended and Restated Credit Agreement. The Second Repricing Facilities Amendment (i) replaced the Tranche B-1 Facility and the Tranche B-2 Facility with a new Tranche B-3 Facility and a new Tranche B-4 Facility, respectively, and (ii) reduced the Applicable Rate from 2.75% to 2.50% in the case of Eurodollar Rate loans and reduced the Applicable Rate from 1.75% to 1.50% in the case of Base Rate Loans.

On March 29, 2018, we entered into a Third Repricing Facilities Amendment to the Amended and Restated Credit Agreement. The Third Repricing Facilities Amendment replaced the existing revolving credit facility and TLA Facility with a new revolving credit facility and TLA Facility, respectively. Our line of credit on the revolving credit facility remains at $500.0 million and the Third Repricing Facility Amendment reduced the size of the TLA Facility from $400.0 million to $380.0 million to reflect the then current outstanding principal. The Third Repricing Facilities Amendment reduced the Applicable Rate for the revolving credit facility and the TLA Facility by amending the definition of “Applicable Rate” and replacing the rate table therein with the table set forth below.

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In connection with the Repricing Facilities Amendments, we recorded a debt extinguishment charge of $0.9 million, including the discount and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of operations.

On February 6, 2019, we entered into the Eleventh Amendment to the Amended and Restated Credit Agreement. The Eleventh Amendment, among other things, amended the definition of "Consolidated EBITDA" to remove the cap on non-cash charges, losses and expenses related to the impairment of goodwill, which in turn provided increased flexibility to us in terms of our financial covenants.

On February 27, 2019, we entered into the Twelfth Amendment to the Amended and Restated Credit Agreement. The Twelfth Amendment, among other things, modified certain definitions, including "Consolidated EBITDA", and increased our permitted Maximum Consolidated Leverage Ratio, thereby providing increased flexibility to us in terms of our financial covenants.

We had $486.7 million of availability under the revolving line of credit and had standby letters of credit outstanding of $13.3 million related to security for the payment of claims required by our workers' compensation insurance program at December 31, 2018. Borrowings under the revolving line of credit are subject to customary conditions precedent to borrowing. The Amended and Restated Credit Agreement requires quarterly term loan principal repayments of our TLA Facility of $4.8 million for March 31, 2019 to December 31, 2019, $7.1 million for March 31, 2020 to December 31, 2020, and $9.5 million for March 31, 2021 to September 30, 2021, with the remaining principal balance of the TLA Facility due on the maturity date of November 30, 2021. We are required to repay the Tranche B-3 Facility in equal quarterly installments of $1.2 million on the last business day of each March, June, September and December, with the outstanding principal balance of the Tranche B-3 Facility due on February 11, 2022. We are required to repay the Tranche B-4 Facility in equal quarterly installments of approximately $2.3 million on the last business day of each March, June, September and December, with the outstanding principal balance of the Tranche B-4 Facility due on February 16, 2023. On December 29, 2017, the Company made an additional payment of $22.5 million, including $7.7 million on the Tranche B-1 Facility and $14.8 million on the Tranche B-2 Facility. On April 17, 2018, we made an additional payment of $15.0 million, including $5.1 million on the Tranche B-3 Facility and $9.9 million on the Tranche B-4 Facility.

Borrowings under the Amended and Restated Credit Agreement are guaranteed by each of our wholly-owned domestic subsidiaries (other than certain excluded subsidiaries) and are secured by a lien on substantially all of our and such subsidiaries' assets. Borrowings with respect to the TLA Facility and our revolving credit facility (collectively, "Pro Rata Facilities") under the Amended and Restated Credit Agreement bear interest at a rate tied to Acadia's Consolidated Leverage Ratio (defined as consolidated funded debt net of up to $50.0 million of unrestricted and unencumbered cash to consolidated EBITDA, in each case as defined in the Amended and Restated Credit Agreement). The Applicable Rate (as defined in the Amended and Restated Credit Agreement) for the Pro Rata Facilities was 2.5% for Eurodollar Rate Loans (as defined in the Amended and Restated Credit Agreement) and 1.5% for Base Rate Loans (as defined in the Amended and Restated Credit Agreement) at December 31, 2018. Eurodollar Rate Loans with respect to the Pro Rata Facilities bear interest at the Applicable Rate plus the Eurodollar Rate (as defined in the Amended and Restated Credit Agreement) (based upon the LIBOR Rate (as defined in the Amended and Restated Credit Agreement) prior to commencement of the interest rate period). Base Rate Loans with respect to the Pro Rata Facilities bear interest at the Applicable Rate plus the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate and (iii) the Eurodollar Rate plus 1.0%. At December 31, 2018, the Pro Rata Facilities bore interest at a rate of LIBOR plus 2.5%. In addition, we are required to pay a commitment fee on undrawn amounts under our revolving credit facility.

The interest rates and the unused line fee on unused commitments related to the Pro Rata Facilities are based upon the following pricing tiers:

Pricing Tier	Consolidated Leverage Ratio	Eurodollar Rate Loans	Base Rate Loans	Commitment Fee
1	< 3.50:1.0	1.50 %	0.50 %	0.20 %
2	>3.50:1.0 but < 4.00:1.0	1.75 %	0.75 %	0.25 %
3	>4.00:1.0 but < 4.50:1.0	2.00 %	1.00 %	0.30 %
4	>4.50:1.0 but < 5.25:1.0	2.25 %	1.25 %	0.35 %
5	>5.25:1.0	2.50 %	1.50 %	0.40 %

Eurodollar Rate Loans with respect to the Tranche B-3 Facility bear interest at the Tranche B-3 Facility Applicable Rate (as defined below) plus the Eurodollar Rate (subject to a floor of 0.75% and based upon the LIBOR Rate prior to commencement of the interest rate period). Base Rate Loans bear interest at the Tranche B-3 Facility Applicable Rate plus the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate and (iii) the Eurodollar Rate plus 1.0%. As used herein, the term “Tranche B-3 Facility Applicable Rate” means, with respect to Eurodollar Rate Loans, 2.50%, and with respect to Base Rate Loans, 1.50%. The Tranche B-4 Facility

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bears interest as follows: Eurodollar Rate Loans bear interest at the Applicable Rate (as defined in the Amended and Restated Credit Agreement) plus the Eurodollar Rate (subject to a floor of 0.75% and based upon the LIBOR Rate prior to commencement of the interest rate period) and Base Rate Loans bear interest at the Applicable Rate plus the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate and (iii) the Eurodollar Rate plus 1.0%. As used herein, the term "Applicable Rate" means, with respect to Eurodollar Rate Loans, 2.50%, and with respect to Base Rate Loans, 1.50%.

The lenders who provided the Tranche B-3 Facility and Tranche B-4 Facility are not entitled to benefit from our maintenance of its financial covenants under the Amended and Restated Credit Agreement. Accordingly, if we fail to maintain its financial covenants, such failure shall not constitute an event of default under the Amended and Restated Credit Agreement with respect to the Tranche B-3 Facility or Tranche B-4 Facility until and unless the Amended and Restated Senior Credit Facility is accelerated or the commitment of the lenders to make further loans is terminated.

The Amended and Restated Credit Agreement requires us and our subsidiaries to comply with customary affirmative, negative and financial covenants, including a fixed charge coverage ratio, consolidated leverage ratio and consolidated senior secured leverage ratio. We may be required to pay all of our indebtedness immediately if we default on any of the numerous financial or other restrictive covenants contained in any of its material debt agreements. We may be required to pay all of our indebtedness immediately if we default on any of the numerous financial or other restrictive covenants contained in any of our material debt agreements. Set forth below is a brief description of such covenants, all of which are subject to customary exceptions, materiality thresholds and qualifications:

a) the affirmative covenants include the following: (i) delivery of financial statements and other customary financial information; (ii) notices of events of default and other material events; (iii) maintenance of existence, ability to conduct business, properties, insurance and books and records; (iv) payment of taxes; (v) lender inspection rights; (vi) compliance with laws; (vii) use of proceeds; (viii) further assurances; and (ix) additional collateral and guarantor requirements.

b) the negative covenants include limitations on the following: (i) liens; (ii) debt (including guaranties); (iii) investments; (iv) fundamental changes (including mergers, consolidations and liquidations); (v) dispositions; (vi) sale leasebacks; (vii) affiliate transactions; (viii) burdensome agreements; (ix) restricted payments; (x) use of proceeds; (xi) ownership of subsidiaries; (xii) changes to line of business; (xiii) changes to organizational documents, legal name, state of formation, form of entity and fiscal year; (xiv) prepayment or redemption of certain senior unsecured debt; and (xv) amendments to certain material agreements. The Company is generally not permitted to issue dividends or distributions other than with respect to the following: (w) certain tax distributions; (x) the repurchase of equity held by employees, officers or directors upon the occurrence of death, disability or termination subject to cap of $500,000 in any fiscal year and compliance with certain other conditions; (y) in the form of capital stock; and (z) scheduled payments of deferred purchase price, working capital adjustments and similar payments pursuant to the merger agreement or any permitted acquisition.

c) The financial covenants include maintenance of the following:

- the fixed charge coverage ratio may not be less than 1.25:1.00 as of the end of any fiscal quarter;
- the total leverage ratio may not be greater than the following levels as of the end of each fiscal quarter listed below:

	March 31	June 30	September 30	December 31
2018	6.50x	6.25x	6.00x	6.00x
2019	6.25x	6.25x	6.25x	6.00x
2020	5.75x	5.75x	5.75x	5.50x
2021	5.25x	5.25x	5.00x	5.00x

- the secured leverage ratio may not be greater than 3.50x as of the end of each fiscal quarter beginning September 30, 2018 and each fiscal quarter thereafter.

The Company was in compliance with all of the above covenants.

Senior Notes

6.125% Senior Notes Due 2021

On March 12, 2013, we issued $150.0 million of 6.125% Senior Notes due 2021. The 6.125% Senior Notes mature on March 15, 2021 and bear interest at a rate of 6.125% per annum, payable semi-annually in arrears on March 15 and September 15 of each year.

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5.125% Senior Notes due 2022

On July 1, 2014, we issued $300.0 million of 5.125% Senior Notes due 2022. The 5.125% Senior Notes mature on July 1, 2022 and bear interest at a rate of 5.125% per annum, payable semi-annually in arrears on January 1 and July 1 of each year.

5.625% Senior Notes due 2023

On February 11, 2015, we issued $375.0 million of 5.625% Senior Notes due 2023. On September 21, 2015, we issued $275.0 million of additional 5.625% Senior Notes. The additional notes formed a single class of debt securities with the 5.625% Senior Notes issued in February 2015. Giving effect to this issuance, we have outstanding an aggregate of $650.0 million of 5.625% Senior Notes. The 5.625% Senior Notes mature on February 15, 2023 and bear interest at a rate of 5.625% per annum, payable semi-annually in arrears on February 15 and August 15 of each year.

6.500% Senior Notes due 2024

On February 16, 2016, we issued $390.0 million of 6.500% Senior Notes due 2024. The 6.500% Senior Notes mature on March 1, 2024 and bear interest at a rate of 6.500% per annum, payable semi-annually in arrears on March 1 and September 1 of each year, beginning on September 1, 2016.

The indentures governing the Senior Notes contain covenants that, among other things, limit the Company’s ability and the ability of its restricted subsidiaries to: (i) pay dividends, redeem stock or make other distributions or investments; (ii) incur additional debt or issue certain preferred stock; (iii) transfer or sell assets; (iv) engage in certain transactions with affiliates; (v) create restrictions on dividends or other payments by the restricted subsidiaries; (vi) merge, consolidate or sell substantially all of the Company’s assets; and (vii) create liens on assets.

The Senior Notes issued by the Company are guaranteed by each of the Company’s subsidiaries that guarantee the Company’s obligations under the Amended and Restated Senior Credit Facility. The guarantees are full and unconditional and joint and several.

The Company may redeem the Senior Notes at its option, in whole or part, at the dates and amounts set forth in the indentures.

9.0% and 9.5% Revenue Bonds

On November 11, 2012, in connection with the acquisition of The Pavilion at HealthPark, LLC (“Park Royal”), we assumed debt of $23.0 million. The fair market value of the debt assumed was $25.6 million and resulted in a debt premium balance being recorded as of the acquisition date. The debt consisted of $7.5 million and $15.5 million of 9.0% and 9.5% Revenue Bonds, respectively.

On December 1, 2018, we exercised the option to redeem in whole the 9.0% and 9.5% Revenue Bonds at a redemption price equal to the sum of 104% of the principal amount of the 9.0% and 9.5% Revenue Bonds plus accrued and unpaid interest. In connection with the redemption of the 9.0% and 9.5% Revenue Bonds, we recorded a debt extinguishment charge of $0.9 million, which was recorded in debt extinguishment costs in the consolidated statements of operations.

The 9.0% bonds in the amount of $7.5 million had a maturity date of December 1, 2030 and required yearly principal payments beginning in 2013. The 9.5% bonds in the amount of $15.5 million had a maturity date of December 1, 2040 and required yearly principal payments beginning in 2031. The principal payments established a bond sinking fund to be held with the trustee and shall be sufficient to redeem the principal amounts of the 9.0% and 9.5% Revenue Bonds on their respective maturity dates. At December 31, 2017, $2.3 million was recorded within other assets on the consolidated balance sheets related to the debt service reserve fund requirements. The yearly principal payments, which established a bond sinking fund, will increase the debt service reserve fund requirements. The bond premium amount of $2.6 million was amortized as a reduction of interest expense over the life of the revenue bonds using the effective interest method.

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Contractual Obligations

The following table presents a summary of contractual obligations (dollars in thousands):

	Payments Due by Period				
	Less Than 1 Year	1-3 Years	3-5 Years	More Than 5 Years	Total
Long-term debt (1)	$208,486	$862,641	$2,445,645	$396,338	$3,913,110
Operating leases	64,958	118,899	99,254	777,684	1,060,795
Purchase and other obligations (2)	4,087	36,233	1,980	26,095	68,395
Total obligations and commitments	$277,531	$1,017,773	$2,546,879	$1,200,117	$5,042,300

(1) Amounts include required principal and interest payments. The projected interest payments reflect interest rates in place on our variable-rate debt at December 31, 2018.
(2) Amounts relate to purchase obligations, including capital lease payments.

Off-Balance Sheet Arrangements

At December 31, 2018, we had standby letters of credit outstanding of $13.3 million related to security for the payment of claims as required by our workers' compensation insurance program.

Market Risk

Interest Rate Risk

Our interest expense is sensitive to changes in market interest rates. Our long-term debt outstanding at December 31, 2018 was composed of $1.5 billion of fixed-rate debt and $1.7 billion of variable-rate debt with interest based on LIBOR plus an applicable margin. A hypothetical 10% increase in interest rates (which would equate to a 0.50% higher rate on our variable-rate debt) would decrease our net income and cash flows by $7.3 million on an annual basis based upon our borrowing level at December 31, 2018.

LIBOR and certain other interest "benchmarks" may be subject to regulatory guidance and/or reform that could cause interest rates under our current or future debt agreements to perform differently than in the past or cause other unanticipated consequences. The U.K.'s Financial Conduct Authority, which regulates LIBOR, has announced that it intends to stop encouraging or requiring banks to submit rates for the calculation of LIBOR rates after 2021, and it is unclear if LIBOR will cease to exist or if new methods of calculating LIBOR will evolve. If LIBOR ceases to exist or if the methods of calculating LIBOR change from their current form, interest rates on our current or future debt obligations may be adversely affected.

Foreign Currency Risk

The functional currency for our U.K. facilities is the British pound or GBP. Our revenue and earnings are sensitive to changes in the GBP to USD exchange rate from the translation of our earnings into USD at exchange rates that may

fluctuate. Based upon the level of our U.K. operations relative to the Company as a whole, a hypothetical 10% change (which would equate to an increase or decrease in the exchange rate of 0.13) would cause a change in our net income of approximately $8.6 million on an annual basis.

In May 2016, we entered into multiple cross currency swap agreements with an aggregate notional amount of $650.0 million to manage foreign currency exchange risk by effectively converting a portion of our fixed-rate USD denominated senior notes, including the semi-annual interest payments thereunder, to fixed-rate, GBP-denominated debt of £449.3 million. The cross currency swap agreements limit the impact of changes in the exchange rate on our cash flows and leverage.

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Critical Accounting Policies

Our consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the U.S. In preparing our financial statements, we are required to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenue, and expenses included in the financial statements. Estimates are based on historical experience and other available information, the results of which form the basis of such estimates. While management believes our estimation processes are reasonable, actual results could differ from our estimates. The following accounting policies are considered critical to the portrayal of our financial condition and operating performance and involve highly subjective and complex assumptions and assessments:

Revenue and Accounts Receivable

In May 2014, the Financial Accounting Standards Board ("FASB") and the International Accounting Standards Board issued Accounting Standards Update ("ASU") 2014-09. ASU 2014-09's core principle is that a company will recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which we expect to be entitled in exchange for those goods or services. We adopted ASU 2014-09 using the modified retrospective method effective January 1, 2018. As a result of certain changes required by ASU 2014-09, the majority of our provision for doubtful accounts are recorded as a direct reduction to revenue instead of being presented as a separate line item on the consolidated statements of operations. The adoption of ASU 2014-09 did not have a significant impact on our consolidated financial statements.

Our revenue is primarily derived from services rendered to patients for inpatient psychiatric and substance abuse care, outpatient psychiatric care and adolescent residential treatment. We receive payments from the following sources for services rendered in our facilities: (i) state governments under their respective Medicaid and other programs; (ii) commercial insurers; (iii) the federal government under the Medicare program administered by CMS; (iv) publicly funded sources in the U.K. (including the NHS, CCGs and local authorities in England, Scotland and Wales) and (v) individual patients and clients. We determine the transaction price based on established billing rates reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients and implicit price concessions. Contractual adjustments and discounts are based on contractual agreements, discount policies and historical experience. Implicit price concessions are based on historical collection experience.

We derive a significant portion of our revenue from Medicare, Medicaid and other payors that receive discounts from established billing rates. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex, subject to interpretation and adjustment, and may include multiple reimbursement mechanisms for different types of services provided in the Company's inpatient facilities and cost settlement provisions. Management estimates the transaction price on a payor-specific basis given its interpretation of the applicable regulations or contract terms. The services authorized and provided and related reimbursement are often subject to interpretation that could result in payments that differ from our estimates. Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management.

Settlements under cost reimbursement agreements with third-party payors are estimated and recorded in the period in which the related services are rendered and are adjusted in future periods as final settlements are determined. Final determination of amounts earned under the Medicare and Medicaid programs often occurs in subsequent years because of audits by such programs, rights of appeal and the application of numerous technical provisions. In the opinion of management, adequate provision has been made for any adjustments and final settlements. However, there can be no assurance that any such adjustments and final settlements will not have a material effect on the Company's

financial condition or results of operations. Our cost report receivables were $10.3 million and $9.0 million at December 31, 2018 and 2017, respectively, and were included in other current assets in the consolidated balance sheets. Management believes that these receivables are properly stated and are not likely to be settled for a significantly different amount. The net adjustments to estimated cost report settlements resulted in increases to revenue of $0.5 million, $0.2 million and $0.7 million for the years ended December 31, 2018, 2017 and 2016, respectively.

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The following table presents revenue by payor type and as a percentage of revenue in our U.S. Facilities for the years ended December 31, 2018, 2017 and 2016 (in thousands):

	Year Ended December 31,					
	2018		2017		2016	
	Amount	%	Amount	%	Amount	%
Commercial	$573,089	30.1 %	$569,242	30.8 %	$534,468	30.7 %
Medicare	280,340	14.7 %	281,270	15.2 %	266,868	15.3 %
Medicaid	893,644	46.9 %	796,375	43.0 %	725,508	41.7 %
Self-Pay	134,054	7.1 %	169,727	9.2 %	185,094	10.6 %
Other	23,568	1.2 %	33,942	1.8 %	28,418	1.7 %
Revenue before provision for doubtful accounts	1,904,695	100.0%	1,850,556	100.0%	1,740,356	100.0%
Provision for doubtful accounts	—		(40,712)		(41,831)	
Revenue	$1,904,695		$1,809,844		$1,698,525	

The following table presents revenue by payor type and as a percentage of revenue in our U.K. Facilities for the years ended December 31, 2018, 2017 and 2016 (in thousands):

	Year Ended December 31,					
	2018		2017		2016	
	Amount	%	Amount	%	Amount	%
U.K. public funded sources	$1,000,828	90.3 %	$922,159	89.8 %	$1,021,888	92.0 %
Self-Pay	104,824	9.5 %	95,687	9.3 %	83,066	7.5 %
Other	2,095	0.2 %	8,832	0.9 %	5,485	0.5 %
Revenue before provision for doubtful accounts	1,107,747	100.0%	1,026,678	100.0%	1,110,439	100.0%
Provision for doubtful accounts	—		(206)		(78)	
Revenue	$1,107,747		$1,026,472		$1,110,361	

The following tables present a summary of our aging of accounts receivable at December 31, 2018 and 2017:

December 31, 2018

	Current	30-90	90-150	>150	Total
Commercial	14.8 %	6.3 %	2.7 %	5.3 %	29.1 %
Medicare	9.8 %	1.8 %	0.6 %	0.9 %	13.1 %
Medicaid	22.4 %	6.4 %	3.4 %	7.4 %	39.6 %
NHS	6.0 %	2.4 %	0.0 %	0.0 %	8.4 %
Self-Pay	1.8 %	1.7 %	1.7 %	3.2 %	8.4 %
Other	0.4 %	0.3 %	0.2 %	0.5 %	1.4 %
Total	55.2 %	18.9 %	8.6 %	17.3%	100.0%

December 31, 2017

	Current		30-90		90-150		>150		Total	
Commercial	15.3	%	8.7	%	3.2	%	6.9	%	34.1	%
Medicare	9.4	%	1.6	%	0.5	%	1.1	%	12.6	%
Medicaid	19.8	%	6.4	%	2.5	%	5.2	%	33.9	%
NHS	7.0	%	3.4	%	0.2	%	0.0	%	10.6	%
Self-Pay	1.8	%	1.4	%	1.4	%	3.2	%	7.8	%
Other	0.3	%	0.3	%	0.2	%	0.2	%	1.0	%
Total	53.6	%	21.8	%	8.0	%	16.6	%	100.0	%

Medicaid accounts receivable at December 31, 2018 and 2017 included approximately $1.5 million and $0.9 million, respectively, of accounts pending Medicaid approval.

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Insurance

We are subject to medical malpractice and other lawsuits due to the nature of the services we provide. A portion of our professional liability risks are insured through a wholly-owned insurance subsidiary. We are self-insured for professional liability claims up to $3.0 million per claim and have obtained reinsurance coverage from a third party to cover claims in excess of the retention limit. The reinsurance policy has a coverage limit of $75.0 million in the aggregate. Our reinsurance receivables are recognized consistent with the related liabilities and include known claims and any incurred but not reported claims that are covered by current insurance policies in place. The reserve for professional and general liability risks was estimated based on historical claims, demographic factors, industry trends, severity factors, and other actuarial assumptions. The estimated accrual for professional and general liabilities could be significantly affected should current and future occurrences differ from historical claim trends and expectations. While claims are monitored closely when estimating professional and general liability accruals, the complexity of the claims and wide range of potential outcomes often hampers timely adjustments to the assumptions used in these estimates. The professional and general liability reserve was $42.8 million at December 31, 2018, of which $5.0 million was included in other accrued liabilities and $37.8 million was included in other long-term liabilities. The professional and general liability reserve was $55.0 million at December 31, 2017, of which $22.8 million was included in other accrued liabilities and $32.2 million was included in other long-term liabilities. We estimate receivables for the portion of professional and general liability reserves that are recoverable under our insurance policies. Such receivable was $8.2 million at December 31, 2018, of which $2.1 million was included in other current assets and $6.1 million was included in other assets, and such receivable was $22.7 million at December 31, 2017, of which $17.6 million was included in other current assets and $5.1 million was included in other assets.

Our statutory workers' compensation program is fully insured with a $0.5 million deductible per accident. The workers' compensation liability was $19.3 million at December 31, 2018, of which $10.0 million was included in accrued salaries and benefits and $9.3 million was included in other long-term liabilities, and such liability was $18.5 million at December 31, 2017, of which $10.0 million was included in accrued salaries and benefits and $8.5 million was included in other long-term liabilities. The reserve for workers compensation claims was based upon independent actuarial estimates of future amounts that will be paid to claimants. Management believes that adequate provisions have been made for workers' compensation and professional and general liability risk exposures.

Property and Equipment and Other Long-Lived Assets

Property and equipment are recorded at cost. Depreciation is calculated on the straight-line basis over the estimated useful lives of the assets, which typically range from 10 to 50 years for buildings and improvements, three to seven years for equipment and the shorter of the lease term or estimated useful lives for leasehold improvements. When assets are sold or retired, the corresponding cost and accumulated depreciation are removed from the related accounts and any gain or loss is recorded in the period of sale or retirement. Repair and maintenance costs are expensed as incurred. Depreciation expense was $158.8 million, $143.0 million and $134.8 million for the years ended years ended December 31, 2018, 2017 and 2016, respectively.

The carrying values of long-lived assets are reviewed for possible impairment whenever events, circumstances or operating results indicate that the carrying amount of an asset may not be recoverable. If this review indicates that the asset will not be recoverable, as determined based upon the undiscounted cash flows of the operating asset over the remaining useful lives, the carrying value of the asset will be reduced to its estimated fair value. Fair value estimates are based on independent appraisals, market values of comparable assets or internal evaluations of future net cash flows.

We performed our impairment review of long-lived assets in the fourth quarter of 2018, which indicated the carrying amounts of certain long-lived assets in our U.K. Facilities may not be recoverable. This created a non-cash loss on impairment of $12.0 million for the year ended December 31, 2018, which was recorded in loss on impairment on our consolidated statements of operations. No impairment was recorded for the years ended December 31, 2017 and 2016.

Goodwill and Indefinite-Lived Intangible Assets

In January 2017, the FASB issued ASU 2017-04, “Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment” (“ASU 2017-04”). ASU 2017-04 simplifies the measurement of goodwill by eliminating the requirement to calculate the implied fair value of goodwill (step 2 of the current impairment test) to measure the goodwill impairment charge. Instead, entities record impairment charges based on the excess of a reporting unit’s carrying amount over its fair value. ASU 2017-04 is effective for fiscal years beginning after December 15, 2019. Early adoption is permitted. We elected to early adopt ASU 2017-04 on January 1, 2018.

Our goodwill and other indefinite-lived intangible assets, which consist of license and accreditations, trade names and certificates of need intangible assets that are not amortized, are evaluated for impairment annually during the fourth quarter or more

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frequently if events indicate the carrying value of a reporting unit may not be recoverable. We have two operating segments, U.S. Facilities and U.K. Facilities, for segment reporting purposes, each of which represents a reporting unit for purposes of the Company's goodwill impairment test.

Our annual goodwill impairment test performed as of October 1, 2018 considered the recent financial performance, including the labor market pressures faced by our U.K. Facilities. The impairment test for the U.S. Facilities indicated estimated fair value exceeded carrying value, and therefore no impairment was recorded. The impairment test for the U.K. Facilities indicated carrying value exceeded the estimated fair value. The difference was recorded as a non-cash loss on impairment of $325.9 million for the year ended December 31, 2018 within loss on impairment in the consolidated statements of operations. Our annual impairment tests of goodwill and other indefinite-lived intangible assets in 2017 and 2016 resulted in no impairment charges.

In performing the goodwill impairment test, we used a combination of the income and market approaches to estimate fair value of our reporting units. Determining fair value requires substantial judgement and use significant unobservable inputs, which are categorized as Level 3 fair value measurements. For the income approach, we used a discounted cash flow model in which cash flows are projected using internal forecasts over future periods, plus a terminal value, and are discounted to present value using a risk-adjusted rate of return. Our internal forecasts include estimates of growth rates based on our current views of the long-term outlook of each reporting unit and may materially differ from actual results. Discount rate assumptions are based on an assessment of the risk inherent in the future cash flows of each reporting unit. The discount rates used in our analysis range from 9.0% to 10.5% and correspond to the risks inherent in each reporting unit. For the market approach, we compared our reporting units to guideline companies actively traded in public markets and included a control premium, which was based on acquisition premiums of selected companies similar to our reporting units. Estimating fair values of our reporting units includes substantial judgement and significant estimates and may materially differ from actual results. Changes in assumptions, industry or peer groups could negatively impact estimated fair value.

Income Taxes

We use the asset and liability method of accounting for income taxes. Under this method, deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes and net operating loss and tax credit carryforwards. The amount of deferred taxes on these temporary differences is determined using the tax rates that are expected to apply in the period when the asset is realized or the liability is settled, as applicable, based on tax rates and laws in the respective tax jurisdiction enacted as of the balance sheet date.

We review our deferred tax assets for recoverability and establish a valuation allowance based on historical taxable income, projected future taxable income, applicable tax strategies, and the expected timing of the reversals of existing temporary differences. A valuation allowance is provided when it is more likely than not that some portion or all of the deferred tax assets will not be realized.

We report a liability for unrecognized tax benefits resulting from uncertain tax positions taken or expected to be taken in a tax return. We recognize interest and penalties, if any, related to unrecognized tax benefits in income tax expense.

We also have accruals for taxes and associated interest that may become payable in future years as a result of audits by tax authorities. We accrue for tax contingencies when it is more likely than not that a liability to a taxing authority has been incurred and the amount of the contingency can be reasonably estimated. Although we believe that the positions taken on previously filed tax returns are reasonable, we nevertheless have established tax and interest

reserves in recognition that various taxing authorities may challenge the positions taken by us resulting in additional liabilities for taxes and interest. These amounts are reviewed as circumstances warrant and adjusted as events occur that affect our potential liability for additional taxes, such as lapsing of applicable statutes of limitations, conclusion of tax audits, additional exposure based on current calculations, identification of new issues, release of administrative guidance, or rendering of a court decision affecting a particular tax issue.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Information with respect to this Item is provided under the caption “Market Risk” under “Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations.”

Item 8. Financial Statements and Supplementary Data

Information with respect to this Item is contained in our consolidated financial statements beginning on Page F-1 of this Annual Report on Form 10-K.

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Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

As of the end of the period covered by this report, our management conducted an evaluation, with the participation of our chief executive officer and chief financial officer, of the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")). Based on this evaluation, our chief executive officer and chief financial officer have concluded that our disclosure controls and procedures are effective to ensure that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms and that such information is accumulated and communicated to management, including our chief executive officer and chief financial officer, as appropriate to allow timely decisions regarding required disclosure.

Reports on Internal Control Over Financial Reporting

Pursuant to Section 404 of the Sarbanes-Oxley Act of 2002, we have included a report of management's assessment of the design and operating effectiveness of our internal controls as part of this report. Our independent registered public accounting firm also reported on the effectiveness of internal control over financial reporting. Management's report and the independent registered public accounting firm's report are included in our consolidated financial statements beginning on page F-1 of this report under the captions entitled "Management's Report on Internal Control Over Financial Reporting" and "Report of Independent Registered Public Accounting Firm."

Changes in Internal Control Over Financial Reporting

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2018 that have materially affected or are reasonably likely to materially affect our internal control over financial reporting.

Item 9B. Other Information.

On February 27, 2019, we entered into the Twelfth Amendment to the Amended and Restated Credit Agreement. The Twelfth Amendment, among other things, modified certain definitions, including "Consolidated EBITDA", and increased our permitted Maximum Consolidated Leverage Ratio, thereby providing increased flexibility to us in terms of our financial covenants. The Company entered into the Eleventh Amendment on February 6, 2018, that among other things, amended the definition of "Consolidated EBITDA" to remove the cap on non-cash charges, losses and expenses related to the impairment of goodwill, which in turn provided increased flexibility to us in terms of our financial covenants. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources—Amended and Restated Senior Credit Facility" for additional information about our Amended and Restated Credit Agreement.

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PART III

Item 10. Directors, Executive Officers and Corporate Governance.

Directors

The information with respect to our directors set forth under the caption “Election of Directors” in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 2, 2019 is incorporated herein by reference.

Audit Committee

The information with respect to our Audit Committee and our audit committee financial experts serving on the Audit Committee is set forth under the caption “Corporate Governance – Committees of the Board of Directors – Audit Committee” in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 2, 2019 is incorporated herein by reference.

Executive Officers

The information with respect to our executive officers set forth under the caption “Management – Executive Officers” in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 2, 2019 is incorporated herein by reference.

Section 16(a) Compliance

The information with respect to compliance with Section 16(a) of the Exchange Act set forth under the caption “Security Ownership of Certain Beneficial Owners and Management—Section 16(a) Beneficial Ownership Reporting Compliance” in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 2, 2019 is incorporated herein by reference.

Stockholder Nominees

The information with respect to the procedures by which stockholders may recommend nominees to the Board of Directors set forth under the caption “Corporate Governance – Nomination of Directors – Nominations by Our Stockholders” in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 2, 2019 is incorporated herein by reference.

Corporate Governance Documents

We have adopted a Code of Conduct that applies to all of our directors, officers and employees and a Code of Ethics for Senior Financial Officers. These documents, as well as the charters of the Audit Committee, Compensation Committee and Nominating and Governance Committee, are available on our website at www.acadiahealthcare.com on the Investors webpage under the caption “Corporate Governance.” Upon the written request of any person, we will furnish, without charge, a copy of any of these documents. Requests should be directed to Acadia Healthcare Company, Inc., 6100 Tower Circle, Suite 1000, Franklin, Tennessee 37067, Attention: Christopher L. Howard, Esq. We intend to disclose any amendments to our Code of Ethics and any waiver from a provision of our code, as required by the SEC, on our website.

Item 11. Executive Compensation

The information with respect to the compensation of our executive officers set forth under the captions “Executive Compensation” and “Compensation Discussion and Analysis” and the information set forth under the captions “Director Compensation,” “Corporate Governance – Compensation Committee Interlocks and Insider Participation,” and “Compensation Committee Report” in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 2, 2019 is incorporated herein by reference.

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

The information with respect to security ownership of certain beneficial owners and management and related stockholder matters set forth under the caption “Security Ownership of Certain Beneficial Owners and Management” in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 2, 2019 is incorporated herein by reference.

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Equity Compensation Plan Information

The following table provides information at December 31, 2018 with respect to compensation plans (including individual compensation arrangements) under which shares of Common Stock are authorized for issuance:

Plan Category	Number of Securities to be Issued upon Exercise of Outstanding Options, Warrants and Rights	Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights	Number of Securities Remaining Available for Future Issuance under Equity Compensation Plans (1)
Equity Compensation Plans Approved by Stockholders (2)	2,478,707 (3)	$ 44.64	3,261,276
Equity Compensation Plans Not Approved by Stockholders (4)	10,000	$ 5.46	—
Total	2,488,707		3,261,276

(1) Excludes shares to be issued upon exercise of outstanding options and vesting of outstanding restricted stock units.
(2) Represents securities issued or available for issuance under the Acadia Healthcare Company, Inc. Incentive Compensation Plan.
(3) Includes 484,111 shares that may be issued upon vesting of outstanding restricted stock units that vest over three years, assuming that maximum performance goals are attained in all three years.
(4) Includes stock options issued pursuant to the PHC, Inc. 2004 Non-Employee Director Stock Option Plan. On November 1, 2011, we issued options to purchase shares of our Common Stock as replacements for PHC, Inc. options.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The information with respect to certain relationships and related transactions and director independence set forth under the captions “Certain Relationships and Related Transactions” and “Corporate Governance – Independence of the Board of Directors” in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 2, 2019 is incorporated herein by reference.

Item 14. Principal Accountant Fees and Services

The information with respect to the fees paid to and services provided by our principal accountants set forth under the caption “Ratification of Appointment of Independent Registered Public Accounting Firm” in our Definitive Proxy Statement for the Annual Meeting of Stockholders to be held May 2, 2019 is incorporated herein by reference.

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PART IV

Item 15. Exhibits and Financial Statement Schedules.

(a) The following documents are filed as part of this Annual Report on Form 10-K:

1. Consolidated Financial Statements :

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

2. Financial Statement Schedules :

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

3. Exhibits :

Exhibit No.	Exhibit Description
2.1	Agreement and Plan of Merger, dated May 23, 2011, by and among Acadia Healthcare Company, Inc. (the "Company"), Acadia Merger Sub, LLC and PHC, Inc. (a)
2.2	Agreement and Plan of Merger, dated February 17, 2011, by and among the Company (f/k/a Acadia Healthcare Company, LLC), Acadia—YFCS Acquisition Company, Inc., Acadia—YFCS Holdings, Inc., Youth & Family Centered Services, Inc., each of the stockholders who are signatories thereto, and TA Associates, Inc., solely in the capacity as Stockholders' Representative. (b)
2.3	Asset Purchase Agreement, dated as of March 15, 2011, between Universal Health Services, Inc. and PHC, Inc. for the acquisition of MeadowWood Behavioral Health System. (c)
2.4	Membership Interest Purchase Agreement, dated December 30, 2011, by and among Hermitage Behavioral, LLC, Haven Behavioral Healthcare Holdings, LLC and Haven Behavioral Healthcare, Inc. (d)
2.5	Asset Purchase Agreement, dated August 28, 2012, by and between Timberline Knolls, LLC, and TK Behavioral, LLC. (e)
2.6	Acquisition Agreement, dated November 21, 2012, by and among (i) Behavioral Centers of America, LLC, (ii) Behavioral Centers of America Holdings, LLC, (iii) Linden BCA Blocker Corp., (iv) SBOF-BCA Holdings Corporation, (v) HEP BCA Holdings Corp. (vi) Siguler Guff Small Buyout Opportunities Fund, LP, and Siguler Guff Small Buyout Opportunities Fund (F), LP, (vii) Health Enterprise Partners, L.P., HEP BCA Co-Investors, LLC, (viii) Linden Capital Partners A, LP, (ix) Commodore Acquisition Sub, LLC, and (x) the Company (the "BCA Purchase Agreement"). (f)
2.7	Amendment No. 1, dated as of December 31, 2012, to the BCA Purchase Agreement. (g)

2.8 Membership Interest Purchase Agreement, dated November 23, 2012 by and among 2C4K, L.P., ARTC Acquisitions, Inc., Acadia Vista, LLC and the Company. (f)

2.9 Amendment, dated as of December 31, 2012, to Membership Interest Purchase Agreement by and among 2C4K, LP, ARTC Acquisitions, Inc., Acadia Vista, LLC and the Company. (g)

2.10 Stock Purchase Agreement, dated as of March 29, 2013, by and among First Ten Broeck Tampa, Inc., UMC Ten Broeck, Inc., Capestrano Holding 12, Inc., Donald R. Dizney, David A. Dizney and Acadia Merger Sub, LLC. (h)

2.11 Agreement, dated June 3, 2014, by and among Partnerships in Care Holdings Limited, The Royal Bank of Scotland plc, Piper Holdco 2, Ltd. and the Company. (i)

2.12 Agreement and Plan of Merger, dated as of October 29, 2014, by and among the Company, Copper Acquisition Co., Inc. and CRC Health Group, Inc. (j)

2.13 Sale and Purchase Deed, dated as of December 31, 2015, by and among Whitewell UK Investments 1 Limited, the institutional sellers named therein, Appleby Trust (Jersey) Limited, the management sellers named therein, and the Company. (cc)

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2.14	Amendment to Sale and Purchase Deed, by and among Whitewell UK Investments 1 Limited, the institutional sellers named therein, Appleby Trust (Jersey) Limited, the management sellers named therein, and the Company. (dd)
3.1	Amended and Restated Certificate of Incorporation, as filed on October 28, 2011 with the Secretary of State of the State of Delaware, as amended by the Certificate of Amendment filed on May 25, 2017. (kk)
3.2	Amended and Restated Bylaws of the Company, as amended May 25, 2017. (kk)
4.1	Indenture, dated as of March 12, 2013, among the Company, the Guarantors named therein and U.S. Bank National Association, as Trustee. (l)
4.2	Form of 6.125% Senior Note due 2021. (Included in Exhibit 4.1)
4.3	Registration Rights Agreement, dated March 12, 2013, among the Company, the Guarantors named therein and Merrill Lynch, Pierce, Fenner & Smith Incorporated. (l)
4.4	Indenture, dated as of July 1, 2014, among the Company, the Guarantors named therein and U.S. Bank National Association, as Trustee. (m)
4.5	Supplemental Indenture, dated as of August 4, 2014, to the Indenture, dated as of July 1, 2014, among the Company, the Guarantors named therein and U.S. Bank National Association, as Trustee. (n)
4.6	Form of 5.125% Senior Note due 2022. (Included in Exhibit 4.4)
4.7	Registration Rights Agreement, dated July 1, 2014, among the Company, the Guarantors named therein and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC. (m)
4.8	Indenture, dated February 11, 2015, by and among the Company, the Guarantors named therein and U.S. Bank National Association, as Trustee. (o)
4.9	Form of 5.625% Senior Note due 2023. (Included in Exhibit 4.8)
4.10	Registration Rights Agreement, dated February 11, 2015, by and among the Company, the Guarantors named therein and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as Representatives of the Initial Purchasers. (o)
4.11	Registration Rights Agreement, dated September 21, 2015, by and among the Company, the Guarantors named therein and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as Representatives of the Initial Purchasers. (bb)
4.12	Indenture, dated February 16, 2016, by and among the Company, the Guarantors named therein and U.S. Bank National Association, as Trustee. (ff)
4.13	Form of 6.500% Senior Note due 2024. (Included in Exhibit 4.12)

4.14 Registration Rights Agreement, dated February 16, 2016, by and among the Company, the Guarantors named therein and Merrill Lynch, Pierce, Fenner & Smith Incorporated and Jefferies LLC, as Representatives of the Initial Purchasers. (ff)

4.15 Amended and Restated Stockholders Agreement, dated as of October 29, 2014, by and among the Company and each of the stockholders named therein. (j)

4.16 Specimen Acadia Healthcare Company, Inc. Common Stock Certificate to be issued to holders of Acadia Healthcare Company, Inc. Common Stock. (p)

4.17 Third Amended and Restated Registration Rights Agreement, dated as of December 31, 2015, by and among the Company and each of the parties named therein. (cc)

4.18 Joinder, dated February 16, 2016, to the Third Amended and Restated Registration Rights Agreement dated as of December 31, 2015, by and among the Company and each of the parties named therein. (ff)

10.1 Amended and Restated Credit Agreement, dated December 31, 2012, by and among Bank of America, NA (Administrative Agent, Swing Line Lender and L/C Issuer) and the Company (f/k/a Acadia Healthcare Company, LLC), the guarantors listed on the signature pages thereto, and the lenders listed on the signature pages thereto (the “Credit Agreement”). (g)

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10.2	First Amendment, dated March 11, 2013, to the Credit Agreement. (l)
10.3	Second Amendment, dated June 28, 2013, to the Credit Agreement. (q)
10.4	Third Amendment, dated September 30, 2013, to the Credit Agreement. (r)
10.5	Fourth Amendment, dated February 13, 2014, to the Credit Agreement. (s)
10.6	Fifth Amendment, dated June 16, 2014, to the Credit Agreement. (t)
10.7	Sixth Amendment, dated December 15, 2014, to the Credit Agreement. (u)
10.8	Seventh Amendment, dated February 6, 2015, to the Credit Agreement. (o)
10.9	First Incremental Facility Amendment, dated February 11, 2015, to the Credit Agreement. (o)
10.10	Eighth Amendment, dated April 22, 2015, to the Credit Agreement. (aa)
10.11	Ninth Amendment, dated January 25, 2016, to the Credit Agreement. (ee)
10.12	Second Incremental Facility Amendment, dated February 16, 2016, to the Credit Agreement. (ff)
10.13	Tranche B-1 Repricing Amendment, dated May 26, 2016, to the Credit Agreement. (gg)
10.14	Tranche B-2 Repricing Amendment, dated September 21, 2016, to the Credit Agreement. (hh)
10.15	Tenth Amendment, dated November 22, 2016, to the Credit Agreement. (ii)
10.16*	Eleventh Amendment, dated February 6, 2019, to the Credit Agreement.
10.17*	Twelfth Amendment, dated February 27, 2019, to the Credit Agreement.
10.18	Refinancing Facilities Amendment, dated November 30, 2016, to the Credit Agreement. (ii)
10.19	Third Repricing Amendment, dated May 10, 2017, to the Amended and Restated Credit Agreement. (jj)
10.20	Second Refinancing Facilities Amendment, dated March 22, 2018, to the Credit Agreement. (ll)
10.21	Third Refinancing Facilities Amendment, dated March 29, 2018, to the Credit Agreement. (mm)
†10.22	Amended and Restated Employment Agreement, dated April 7, 2014, among the Company, Acadia Management Company, Inc. and Joey A. Jacobs. (v)
†10.23	Amended and Restated Employment Agreement, dated April 7, 2014, among the Company, Acadia Management Company, Inc. and Brent Turner. (v)
†10.24	

	Amended and Restated Employment Agreement, dated April 7, 2014, among the Company, Acadia Management Company, Inc. and Ronald M. Fincher. (v)
†10.25	Amended and Restated Employment Agreement, dated April 7, 2014, among the Company, Acadia Management Company, Inc. and Christopher L. Howard. (v)
†10.26	Employment Agreement, dated April 7, 2014, by and among the Company, Acadia Management Company, Inc. and David M. Duckworth. (v)
†10.27	Employment Agreement, dated as of December 16, 2018, by and between Acadia Management Company, Inc. and Debra K. Osteen. (nn)
†10.28	PHC, Inc.'s 2004 Non-Employee Director Stock Option Plan. (w)
†10.29	Acadia Healthcare Company, Inc. Incentive Compensation Plan, effective May 23, 2013. (x)
†10.30	First Amendment, effective May 19, 2016, to the Acadia Healthcare Company, Inc. Incentive Compensation Plan. (y)
†10.31	Form of Restricted Stock Unit Agreement. (oo)
†10.32	Form of Incentive Stock Option Agreement. (b)
†10.33	Form of Non-Qualified Stock Option Agreement. (b)

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†10.34	Form of Restricted Stock Agreement. (oo)
†10.35	Form of Stock Appreciation Rights Agreement. (b)
†10.36	Acadia Healthcare Company, Inc. Nonqualified Deferred Compensation Plan, effective February 1, 2013. (z)
†10.37	Nonmanagement Director Compensation Program, effective January 1, 2013. (z)
10.38	Form of Indemnification Agreement (for directors and officers affiliated with Waud Capital Partners or Bain Capital). (k)
10.39	Form of Indemnification Agreement (for directors and officers not affiliated with Waud Capital Partners or Bain Capital). (k)
21*	Subsidiaries of the Company.
23*	Consent of Independent Registered Public Accounting Firm.
31.1*	Rule 13a-14(a) Certification of the Chief Executive Officer of the Company pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2*	Rule 13a-14(a) Certification of the Chief Financial Officer of the Company pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1*	Section 1350 Certification of Chairman of the Board and Chief Executive Officer of the Company pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2*	Section 1350 Certification of Chief Financial Officer of the Company pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS**	XBRL Instance Document.
101.SCH**	XBRL Taxonomy Extension Schema Document.
101.CAL**	XBRL Taxonomy Calculation Linkbase Document.
101.LAB**	XBRL Taxonomy Labels Linkbase Document.
101.PRE**	XBRL Taxonomy Presentation Linkbase Document.

† Indicates management contract or compensatory plan or arrangement.
* Filed herewith.
**

The XBRL related information in Exhibit 101 to this Annual Report on Form 10-K shall not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, or otherwise subject to liability of that section and shall not be incorporated by reference into any filing or other document pursuant to the Securities Act of 1933, as amended, except as shall be expressly set forth by specific reference in such filing or document.

(a) Incorporated by reference to exhibits filed with PHC, Inc.'s Current Report on Form 8-K filed May 25, 2011 (File No. 001-33323).

(b) Incorporated by reference to exhibits filed with the Company's registration statement on Form S-4, as amended (File No. 333-175523), originally filed with the SEC on July 13, 2011.

(c) Incorporated by reference to exhibits filed with PHC, Inc.'s Current Report on Form 8-K filed March 18, 2011 (File No. 001-33323).

(d) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 5, 2012 (File No. 001-35331).

(e) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed September 4, 2012 (File No. 001-35331).

(f) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed November 27, 2012 (File No. 001-35331).

(g) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 2, 2013 (File No. 001-35331).

(h) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed April 4, 2013 (File No. 001-35331).

(i) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed June 6, 2014 (File No. 001-35331).

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(j) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed October 30, 2014 (File No. 001-35331).
(k) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed November 1, 2011 (File No. 001-35331).
(l) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed March 12, 2013 (File No. 001-35331).
(m) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed July 2, 2014 (File No. 001-35331).
(n) Incorporated by reference to exhibits filed with the Company's registration statement on Form S-4 filed August 8, 2014 (File No. 333-198004).
(o) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed February 12, 2015 (File No. 001-35331).
(p) Incorporated by reference to exhibits filed with the Company's registration statement on Form S-1, as amended (File No. 333-175523), originally filed with the SEC on November 23, 2011.
(q) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended June 30, 2013 (File No. 001-35331).
(r) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended September 30, 2013 (File No. 001-35331).
(s) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed February 19, 2014 (File No. 001-35331).
(t) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed June 17, 2014 (File No. 001-35331).
(u) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed December 15, 2014 (File No. 001-35331).
(v) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed April 11, 2014 (File No. 001-35331).
(w) Incorporated by reference to exhibits filed with PHC, Inc.'s registration statement on Form S-8 filed April 5, 2005 (File No. 333-123842).
(x) Incorporated by reference to exhibits filed with the Company's registration statement on Form S-8 filed July 30, 2013 (File No. 333-190232).
(y) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended June 30, 2016 (File No. 001-35331).
(z) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended March 31, 2013 (File No. 001-35331).
(aa) Incorporated by reference to exhibits filed with the Company's Quarterly Report on Form 10-Q for the three months ended March 31, 2015 (File No. 001-35331).
(bb) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed September 21, 2015 (File No. 001-35331).
(cc) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 4, 2016 (File No. 001-35331).
(dd) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 8, 2016 (File No. 001-35331).
(ee) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed January 27, 2016 (File No. 001-35331).
(ff) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed February 16, 2016 (File No. 001-35331).
(gg)

Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed May 26, 2016 (File No. 001-35331).

(hh) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed September 21, 2016 (File No. 001-35331).

(ii) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed November 30, 2016 (File No. 001-35331).

(jj) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed May 10, 2017 (File No. 001-35331).

(kk) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed May 25, 2017 (File No. 001-35331).

(ll) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed March 27, 2018 (File No. 001-35331).

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(mm) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed April 2, 2018 (File No. 001-35331).

(nn) Incorporated by reference to exhibits filed with the Company's Current Report on Form 8-K filed December 17, 2018 (File No. 001-35331).

(oo) Incorporated by reference to exhibits filed with the Company's Current Report on Form 10-Q for the three months ended March 31, 2018 (File No. 001-35331).

Item 16. Form 10-K Summary.

None.

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INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

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MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f). Under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting at December 31, 2018 based on the framework in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (COSO). Based on that evaluation, our management concluded that our internal control over financial reporting was effective at December 31, 2018.

Our accompanying consolidated financial statements have been audited by the independent registered public accounting firm of Ernst & Young LLP. Reports of the independent registered public accounting firm, including the independent registered public accounting firm's report on our internal control over financial reporting, are included in this report.

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders

Acadia Healthcare Company, Inc.

Opinion on Internal Control over Financial Reporting

We have audited Acadia Healthcare Company, Inc.'s internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, Acadia Healthcare Company, Inc. (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of Acadia Healthcare Company, Inc. as of December 31, 2018 and 2017, and the related consolidated statements of operations, comprehensive (loss) income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes and our report dated March 1, 2019 expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those

policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Ernst & Young LLP

Nashville, Tennessee

March 1, 2019

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders

Acadia Healthcare Company, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Acadia Healthcare Company, Inc. (the Company) as of December 31, 2018 and 2017, the related consolidated statements of operations, comprehensive (loss) income, shareholders' equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes (collectively referred to as the “consolidated financial statements”). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated March 1, 2019 expressed an unqualified opinion thereon.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company’s financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ Ernst & Young LLP

We have served as the Company’s auditor since 2006.

Nashville, Tennessee

March 1, 2019

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Acadia Healthcare Company, Inc.

Consolidated Balance Sheets

	December 31,	
	2018	2017
	(In thousands, except share and per share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$50,510	$67,290
Accounts receivable, net	318,087	296,925
Other current assets	81,820	107,335
Total current assets	450,417	471,550
Property and equipment:		
Land	430,771	450,342
Building and improvements	2,423,594	2,370,918
Equipment	444,538	400,596
Construction in progress	294,848	173,693
Less accumulated depreciation	(485,985)	(347,419)
Property and equipment, net	3,107,766	3,048,130
Goodwill	2,396,412	2,751,174
Intangible assets, net	88,990	87,348
Deferred tax assets	3,468	3,731
Derivative instrument assets	60,524	12,997
Other assets	64,927	49,572
Total assets	$6,172,504	$6,424,502
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$34,112	$34,830
Accounts payable	117,740	102,299
Accrued salaries and benefits	113,299	99,047
Other accrued liabilities	151,226	141,213
Total current liabilities	416,377	377,389
Long-term debt	3,159,375	3,205,058
Deferred tax liabilities	80,372	80,333
Other liabilities	154,267	166,434
Total liabilities	3,810,391	3,829,214
Redeemable noncontrolling interests	28,806	22,417
Equity:		
Preferred stock, $0.01 par value; 10,000,000 shares authorized, no shares issued	—	—

Common stock, $0.01 par value; 180,000,000 shares authorized;		
87,444,473 and 87,060,114 issued and outstanding as of		
December 31, 2018 and 2017, respectively	874	871
Additional paid-in capital	2,541,987	2,517,545
Accumulated other comprehensive loss	(462,377)	(374,118)
Retained earnings	252,823	428,573
Total equity	2,333,307	2,572,871
Total liabilities and equity	$6,172,504	$6,424,502

See accompanying notes.

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Acadia Healthcare Company, Inc.

Consolidated Statements of Operations

	Year Ended December 31,		
	2018	2017	2016
	(In thousands, except per share amounts)		
Revenue before provision for doubtful accounts	$3,012,442	$2,877,234	$2,852,823
Provision for doubtful accounts	—	(40,918)	(41,909)
Revenue	3,012,442	2,836,316	2,810,914
Salaries, wages and benefits (including equity-based compensation expense of $22,001, $23,467 and $28,345, respectively)	1,659,348	1,536,160	1,541,854
Professional fees	227,425	196,223	185,486
Supplies	119,314	114,439	117,425
Rents and leases	80,282	76,775	73,348
Other operating expenses	354,498	331,827	312,556
Depreciation and amortization	158,832	143,010	135,103
Interest expense, net	185,410	176,007	181,325
Debt extinguishment costs	1,815	810	4,253
Legal settlements expense	22,076	—	—
Loss on impairment	337,889	—	—
Loss on divestiture	—	—	178,809
Gain on foreign currency derivatives	—	—	(523)
Transaction-related expenses	34,507	24,267	48,323
Total expenses	3,181,396	2,599,518	2,777,959
(Loss) income before income taxes	(168,954)	236,798	32,955
Provision for income taxes	6,532	37,209	28,779
Net (loss) income	(175,486)	199,589	4,176
Net (income) loss attributable to noncontrolling interests	(264)	246	1,967
Net (loss) income attributable to Acadia Healthcare Company, Inc.	$(175,750)	$199,835	$6,143
Earnings per share attributable to Acadia Healthcare Company, Inc. stockholders:			
Basic	$(2.01)	$2.30	$0.07
Diluted	$(2.01)	$2.30	$0.07
Weighted-average shares outstanding:			
Basic	87,288	86,948	85,701
Diluted	87,288	87,060	85,972

See accompanying notes.

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Acadia Healthcare Company, Inc.

Consolidated Statements of Comprehensive (Loss) Income

	Year Ended December 31,		
	2018	2017	2016
	(In thousands)		
Net (loss) income	$(175,486)	$199,589	$4,176
Other comprehensive (loss) income:			
Foreign currency translation (loss) gain	(127,521)	206,784	(477,967)
Gain (loss) on derivative instruments, net of tax of $12.7 million, $(22.9) million and $29.1, respectively	36,799	(33,431)	40,598
Pension liability adjustment, net of tax of $0.3 million, $0.4 million and $(1.3) million, respectively	2,463	2,099	(7,554)
Other comprehensive (loss) gain	(88,259)	175,452	(444,923)
Comprehensive (loss) income	(263,745)	375,041	(440,747)
Comprehensive (income) loss attributable to noncontrolling interests	(264)	246	1,967
Comprehensive (loss) income attributable to Acadia Healthcare Company, Inc.	$(264,009)	$375,287	$(438,780)

See accompanying notes.

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Acadia Healthcare Company, Inc.

Consolidated Statements of Equity

(In thousands)

	Common Stock Shares	Amount	Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Total
Balance at January 1, 2016	70,746	$ 707	$1,572,972	$ (104,647)	$213,996	$1,683,028
Common stock issued under stock incentive plans	408	5	1,379	—	—	1,384
Common stock withheld for minimum statutory taxes	—	—	(10,230)	—	—	(10,230)
Equity-based compensation expense	—	—	28,345	—	—	28,345
Issuance of common stock, net	15,534	155	901,824	—	—	901,979
Other comprehensive loss	—	—	—	(444,923)	—	(444,923)
Other	—	—	1,998	—	—	1,998
Net income attributable to Acadia Healthcare Company, Inc. stockholders	—	—	—	—	6,143	6,143
Balance at December 31, 2016	86,688	867	2,496,288	(549,570)	220,139	2,167,724
Common stock issued under stock incentive plans	372	4	2,065	—	—	2,069
Common stock withheld for minimum statutory taxes	—	—	(5,524)	—	—	(5,524)
Equity-based compensation expense	—	—	23,467	—	—	23,467
Cumulative effect of change in accounting principle	—	—	—	—	8,599	8,599
Other comprehensive loss	—	—	—	175,452	—	175,452
Other	—	—	1,249	—	—	1,249
Net income attributable to Acadia Healthcare Company, Inc. stockholders	—	—	—	—	199,835	199,835
Balance at December 31, 2017	87,060	871	2,517,545	(374,118)	428,573	2,572,871
	384	3	371	—	—	374

Common stock issued under stock incentive plans						
Common stock withheld for minimum statutory taxes	—	—	(3,781)	—	—	(3,781)
Equity-based compensation expense	—	—	22,001	—	—	22,001
Other comprehensive loss	—	—	—	(88,259)	—	(88,259)
Other	—	—	5,851	—	—	5,851
Net loss attributable to Acadia Healthcare Company, Inc. stockholders	—	—	—	—	(175,750)	(175,750)
Balance at December 31, 2018	87,444	$ 874	$2,541,987	$ (462,377)	$252,823	$2,333,307

See accompanying notes.

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Acadia Healthcare Company, Inc.

Consolidated Statements of Cash Flows

	Year Ended December 31,		
	2018	2017	2016
	(In thousands)		
Operating activities:			
Net (loss) income	$(175,486)	$199,589	$4,176
Adjustments to reconcile net (loss) income to net cash provided by continuing operating activities:			
Depreciation and amortization	158,832	143,010	135,103
Amortization of debt issuance costs	10,456	9,855	10,324
Equity-based compensation expense	22,001	23,467	28,345
Deferred income taxes	(9,714)	31,372	28,647
Debt extinguishment costs	1,815	810	4,253
Legal settlements expense	22,076	—	—
Loss on impairment	337,889	—	—
Loss on divestiture	—	—	178,809
Gain on foreign currency derivatives	—	—	(523)
Other	12,371	11,412	4,715
Change in operating assets and liabilities, net of effect of acquisitions:			
Accounts receivable, net	(16,821)	(28,570)	(15,718)
Other current assets	13,864	20,808	(20,648)
Other assets	2,762	(3,176)	(4,354)
Accounts payable and other accrued liabilities	26,054	(10,113)	22,693
Accrued salaries and benefits	15,748	(8,988)	(8,572)
Other liabilities	(5,219)	11,794	4,484
Net cash provided by continuing operating activities	416,628	401,270	371,734
Net cash used in discontinued operating activities	(2,548)	(1,693)	(10,256)
Net cash provided by operating activities	414,080	399,577	361,478
Investing activities:			
Cash paid for acquisitions, net of cash acquired	—	(18,191)	(683,455)
Cash paid for capital expenditures	(341,462)	(274,177)	(307,472)
Cash paid for real estate acquisitions	(18,383)	(41,057)	(40,757)
Settlement of foreign currency derivatives	—	—	523
Cash received on divestitures	—	—	373,266
Other	(1,119)	(3,101)	(2,470)
Net cash used in investing activities	(360,964)	(336,526)	(660,365)
Financing activities:			
Borrowings on long-term debt	—	—	1,480,000
Borrowings on revolving credit facility	—	—	179,000
Principal payments on revolving credit facility	—	—	(337,000)
Principal payments on long-term debt	(39,738)	(34,805)	(49,941)

Repayment of assumed debt	—	—	(1,348,389)
Repayment of long-term debt	(21,920)	(22,500)	(200,594)
Payment of debt issuance costs	—	—	(36,649)
Issuances of common stock, net	—	—	685,097
Common stock withheld for minimum statutory taxes, net	(3,407)	(3,455)	(8,846)
Other	(2,265)	686	(3,837)
Net cash (used in) provided by financing activities	(67,330)	(60,074)	358,841
Effect of exchange rate changes on cash	(2,566)	7,250	(14,106)
Net (decrease) increase in cash and cash equivalents	(16,780)	10,227	45,848
Cash and cash equivalents at beginning of the period	67,290	57,063	11,215
Cash and cash equivalents at end of the period	$50,510	$67,290	$57,063
Supplemental Cash Flow Information:			
Cash paid for interest	$175,204	$159,098	$161,146
Cash paid for income taxes	$6,720	$10,291	$15,483
Effect of acquisitions:			
Assets acquired, excluding cash	$—	$19,649	$2,516,880
Liabilities assumed	—	(1,458)	(1,616,543)
Issuance of common stock in connection with acquisition	—	—	(216,882)
Cash paid for acquisitions, net of cash acquired	$—	$18,191	$683,455

See accompanying notes.

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Acadia Healthcare Company, Inc.

Notes to Consolidated Financial Statements

December 31, 2018

1. Description of Business and Basis of Presentation

Description of Business

Acadia Healthcare Company, Inc. (the "Company") develops and operates inpatient psychiatric facilities, residential treatment centers, group homes, substance abuse facilities and facilities providing outpatient behavioral healthcare services to serve the behavioral health and recovery needs of communities throughout the United States ("U.S."), the United Kingdom ("U.K.") and Puerto Rico. At December 31, 2018, the Company operated 583 behavioral healthcare facilities with approximately 18,100 beds in 40 states, the U.K. and Puerto Rico.

Basis of Presentation

The business of the Company is conducted through limited liability companies, partnerships and C-corporations. The Company's consolidated financial statements include the accounts of the Company and all subsidiaries controlled by the Company through its' direct or indirect ownership of majority interests and exclusive rights granted to the Company as the controlling member of an entity. All intercompany accounts and transactions have been eliminated in consolidation.

The accompanying consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("GAAP"). The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates. The majority of the Company's expenses are "cost of revenue" items. Costs that could be classified as general and administrative expenses include the Company's corporate office costs, which were $86.6 million, $76.4 million and $86.8 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Certain reclassifications have been made to prior years to conform to the current year presentation.

2. Summary of Significant Accounting Policies

Cash and Cash Equivalents

The Company considers all highly liquid investments with original maturities of three months or less to be cash equivalents. At times, cash and cash equivalent balances may exceed federally insured limits. Management believes that the Company mitigates any risks by depositing cash and investing in cash equivalents with major financial institutions.

Insurance

The Company is subject to medical malpractice and other lawsuits due to the nature of the services the Company provides. A portion of the Company's professional liability risks are insured through a wholly-owned insurance

subsidiary. The Company is self-insured for professional liability claims up to $3.0 million per claim and has obtained reinsurance coverage from a third party to cover claims in excess of the retention limit. The reinsurance policy has a coverage limit of $75.0 million in the aggregate. The Company's reinsurance receivables are recognized consistent with the related liabilities and include known claims and any incurred but not reported claims that are covered by current insurance policies in place. The reserve for professional and general liability risks was estimated based on historical claims, demographic factors, industry trends, severity factors, and other actuarial assumptions. The estimated accrual for professional and general liabilities could be significantly affected should current and future occurrences differ from historical claim trends and expectations. While claims are monitored closely when estimating professional and general liability accruals, the complexity of the claims and wide range of potential outcomes often hampers timely adjustments to the assumptions used in these estimates. The professional and general liability reserve was $42.8 million at December 31, 2018, of which $5.0 million was included in other accrued liabilities and $37.8 million was included in other long-term liabilities. The professional and general liability reserve was $55.0 million at December 31, 2017, of which $22.8 million was included in other accrued liabilities and $32.2 million was included in other long-term liabilities. The Company estimates receivables for the portion of professional and general liability reserves that are recoverable under the Company's insurance policies. Such receivable was $8.2 million at December 31, 2018, of which $2.1 million was included in other current assets and $6.1 million was included in other assets, and such receivable was $22.7 million at December 31, 2017, of which $17.6 million was included in other current assets and $5.1 million was included in other assets.

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The Company's statutory workers' compensation program is fully insured with a $0.5 million deductible per accident. The workers' compensation liability was $19.3 million at December 31, 2018, of which $10.0 million was included in accrued salaries and benefits and $9.3 million was included in other long-term liabilities, and such liability was $18.5 million at December 31, 2017, of which $10.0 million was included in accrued salaries and benefits and $8.5 million was included in other long-term liabilities. The reserve for workers compensation claims was based upon independent actuarial estimates of future amounts that will be paid to claimants. Management believes that adequate provisions have been made for workers' compensation and professional and general liability risk exposures.

Property and Equipment and Other Long-Lived Assets

Property and equipment are recorded at cost. Depreciation is calculated on the straight-line basis over the estimated useful lives of the assets, which typically range from 10 to 50 years for buildings and improvements, three to seven years for equipment and the shorter of the lease term or estimated useful lives for leasehold improvements. When assets are sold or retired, the corresponding cost and accumulated depreciation are removed from the related accounts and any gain or loss is recorded in the period of sale or retirement. Repair and maintenance costs are expensed as incurred. Depreciation expense was $158.8 million, $143.0 million and $134.8 million for the years ended years ended December 31, 2018, 2017 and 2016, respectively.

The carrying values of long-lived assets are reviewed for possible impairment whenever events, circumstances or operating results indicate that the carrying amount of an asset may not be recoverable. If this review indicates that the asset will not be recoverable, as determined based upon the undiscounted cash flows of the operating asset over the remaining useful lives, the carrying value of the asset will be reduced to its estimated fair value. Fair value estimates are based on independent appraisals, market values of comparable assets or internal evaluations of future net cash flows.

The Company performed its impairment review of long-lived assets in the fourth quarter of 2018, which indicated the carrying amounts of certain long-lived assets in our U.K. Facilities may not be recoverable. This created a non-cash loss on impairment of $12.0 million for the year ended December 31, 2018, which was recorded in loss on impairment on our consolidated statements of operation. No impairment was recorded for the years ended December 31, 2017 and 2016.

Goodwill and Indefinite-Lived Intangible Assets

In January 2017, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") ASU 2017-04, "Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment" ("ASU 2017-04"). ASU 2017-04 simplifies the measurement of goodwill by eliminating the requirement to calculate the implied fair value of goodwill (step 2 of the current impairment test) to measure the goodwill impairment charge. Instead, entities will record impairment charges based on the excess of a reporting unit's carrying amount over its fair value. ASU 2017-04 is effective for fiscal years beginning after December 15, 2019. Early adoption is permitted. The Company elected to early adopt ASU 2017-04 on January 1, 2018.

The Company's goodwill and other indefinite-lived intangible assets, which consist of license and accreditations, trade names and certificates of need intangible assets that are not amortized, are evaluated for impairment annually during the fourth quarter or more frequently if events indicate the carrying value of a reporting unit may not be recoverable. The Company has two operating segments, the Company's facilities in the U.S (the "U.S. Facilities") and the facilities in

the U.K. (the "U.K. Facilities"), for segment reporting purposes, each of which represents a reporting unit for purposes of the Company's goodwill impairment test.

The Company's annual goodwill impairment test performed as of October 1, 2018 considered the recent financial performance, including the labor market pressures faced by the U.K. Facilities. The impairment test for the U.S. Facilities indicated estimated fair value exceeded carrying value, and therefore no impairment was recorded. The impairment test for the U.K. Facilities indicated carrying value exceeded the estimated fair value. The difference was recorded as a non-cash loss on impairment of $325.9 million for the year ended December 31, 2018 within loss on impairment in the consolidated statements of operations. The Company's annual impairment tests of goodwill and other indefinite-lived intangible assets in 2017 and 2016 resulted in no impairment charges.

In performing the goodwill impairment test, the Company used a combination of the income and market approaches to estimate fair value of our reporting units. Determining fair value requires substantial judgement and use significant unobservable inputs, which are categorized as Level 3 fair value measurements. For the income approach, the Company used a discounted cash flow model in which cash flows are projected using internal forecasts over future periods, plus a terminal value, and are discounted to present value using a risk-adjusted rate of return. The Company's internal forecasts include estimates of growth rates based on our current views of the long-term outlook of each reporting unit and may materially differ from actual results. Discount rate assumptions are based on an assessment of the risk inherent in the future cash flows of each reporting unit. The discount rates used in its analysis range from 9.0% to 10.5% and correspond to the risks inherent in each reporting unit. For the market approach, we compared our reporting units to guideline companies actively traded in public markets and included a control premium, which was based on acquisition premiums of selected companies similar to our reporting units. Estimating fair values of our reporting units includes substantial judgement and

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significant estimates and may materially differ from actual results. Changes in assumptions, industry or peer groups could negatively impact estimated fair value.

Other Current Assets

Other current assets consisted of the following (in thousands):

	December 31,	
	2018	2017
Prepaid expenses	$30,802	$27,320
Other receivables	19,205	21,427
Cost report receivable	10,340	9,028
Workers' compensation deposits – current portion	10,000	10,000
Inventory	5,055	4,787
Insurance receivable – current portion	2,049	17,588
Income taxes receivable	2,380	15,056
Other	1,989	2,129
Other current assets	$81,820	$107,335

Other Accrued Liabilities

Other accrued liabilities consisted of the following (in thousands):

	December 31,	
	2018	2017
Accrued expenses	$44,938	$37,268
Accrued interest	32,838	36,370
Unearned income	32,154	31,342
Accrued legal settlements	22,076	—
Insurance liability – current portion	4,956	22,788
Accrued property taxes	4,136	3,945
Income taxes payable	3,041	1,012
Other	7,087	8,488
Other accrued liabilities	$151,226	$141,213

Stock Compensation

The Company measures and recognizes the cost of employee services received in exchange for awards of equity instruments based on the grant-date fair value in accordance with Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") 718, " Compensation—Stock Compensation ." The Company uses the Black-Scholes valuation model to determine grant-date fair value for equity awards and uses straight-line amortization

of share-based compensation expense over the requisite service period of the respective awards.

Earnings Per Share

Basic and diluted earnings per share are calculated in accordance with FASB ASC 260, “Earnings Per Share,” based on the weighted-average number of shares outstanding in each period and dilutive stock options and non-vested shares, to the extent such securities have a dilutive effect on earnings per share.

Income Taxes

The Company uses the asset and liability method of accounting for income taxes. Under this method, deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes and net operating loss and tax credit carryforwards. The amount of deferred taxes on these temporary differences is determined using the tax rates that are expected to apply in the period when the asset is realized or the liability is settled, as applicable, based on tax rates and laws in the respective tax jurisdiction enacted as of the balance sheet date.

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The Company reviews its deferred tax assets for recoverability and establishes a valuation allowance based on historical taxable income, projected future taxable income, applicable tax strategies, and the expected timing of the reversals of existing temporary differences. A valuation allowance is provided when it is more likely than not that some portion or all of the deferred tax assets will not be realized.

The Company records a liability for unrecognized tax benefits resulting from uncertain tax positions taken or expected to be taken in a tax return. The Company recognizes interest and penalties, if any, related to unrecognized tax benefits in income tax expense.

The Tax Act was enacted on December 22, 2017. The Tax Act reduced the U.S. federal corporate tax rate from 35% to 21%, required companies to pay a one-time transition tax on earnings of certain foreign subsidiaries that were previously tax deferred and created new taxes on certain foreign sourced earnings. See additional disclosure described in Note 10 – Income Taxes.

Recent Accounting Pronouncements

In August 2018, the FASB issued ASU 2018-15, “Intangibles—Goodwill and Other—Internal-Use Software (Subtopic 350-40): Customer’s Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract” (“ASU 2018-15”). ASU 2018-15 requires a customer in a cloud computing arrangement that is a service contract to follow the internal-use software guidance in ASC 350-402 to determine which implementation costs to capitalize as assets. ASU 2018-15 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2019. Early adoption is permitted. Management is evaluating the impact of ASU 2018-15 on the Company’s consolidated financial statements.

In August 2017, the Financial Accounting Standards Board (“FASB”) issued Accounting Standards Update (“ASU”) 2017-12, “Derivatives and Hedging (Topic 815): Targeted Improvements to Accounting for Hedging Activities” (“ASU 2017-12”). ASU 2017-12 amends the hedge accounting model to enable entities to better portray the economics of their risk management activities in the financial statements and simplifies the application of hedge accounting in certain situations. ASU 2017-12 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2018. Early adoption is permitted. Management is evaluating the impact of ASU 2017-12 on the Company’s consolidated financial statements.

In August 2016, the FASB issued ASU 2016-15, “Statement of Cash Flows (Topic 230): Classification of Certain Cash Receipts and Cash Payments” (“ASU 2016-15”). ASU 2016-15 addresses treatment of how certain cash receipts and cash payments are presented and classified in the statement of cash flows to reduce the diversity in practice. ASU 2016-15 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2017. The Company adopted ASU 2016-15 on January 1, 2018. There is no significant impact on the Company’s consolidated financial statements.

In March 2016, the FASB issued ASU 2016-02, “Leases” (“ASU 2016-02”). ASU 2016-02’s core principle is to increase transparency and comparability among organizations by recognizing lease assets and liabilities on the balance sheet and disclosing key information. ASU 2016-02 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2018. Additionally, ASU 2016-02 would permit both public and nonpublic organizations to adopt the new standard early. ASU 2016-02 requires application either retrospectively to each prior reporting period presented in the financial statements or retrospectively at the beginning of the period of adoption.

The Company will adopt ASU 2016-02 retrospectively at the beginning of the period of adoption and will record a cumulative-effect adjustment to retained earnings on January 1, 2019. The Company expects to elect the package of practical expedients offered in the transition guidance which allows management to not reassess lease identification, lease classification and initial direct costs. The Company also expects to elect the accounting policy practical expedients by class of underlying asset to: (i) combine associated lease and non-lease components into a single lease component; and (ii) exclude recording short-term leases as right-of-use assets and liabilities on the balance sheet.

The Company has substantially completed its evaluation of the financial impact of the new standard as it relates to the Company's lease portfolio, which primarily consists of real estate leases integral for facility operations. Management believes the largest effect of adopting the new standard will be to record a significant amount of right-of-use assets and liabilities for current operating leases. Management continues to evaluate the impact ASU 2016-02 will have on the Company's internal controls, policies, and procedures. See Note 13 – Leases for the Company's aggregate minimum lease payments under non-cancelable operating leases under accounting guidance at December 31, 2018.

The Company is continuing to refine its approach under ASU 2016-02, including finalizing its transition calculations, controls and disclosure policies. The Company will finalize its accounting assessment and quantitative impact of adoption of ASU 2016-02 during the first quarter of 2019. The Company will continue to monitor industry activities and any additional accounting guidance and will adjust the Company's assessment and implementation plans accordingly.

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In January 2016, the FASB issued ASU 2016-01, “Financial Instruments-Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities” (“ASU 2016-01”). ASU 2016-01 amends how entities recognize, measure, present and disclose certain financial assets and financial liabilities. It requires entities to measure equity investments (except for those accounted for under equity method) at fair value and recognize any changes in fair value in net income. ASU 2016-15 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2017. The Company adopted ASU 2016-01 on January 1, 2018. There was no significant impact on the Company’s consolidated financial statements.

In May 2014, the FASB and the International Accounting Standards Board issued ASU 2014-09, “Revenue from Contracts with Customers (Topic 606)” (“ASU 2014-09”). ASU 2014-09’s core principle is that a company will recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. ASU 2014-09 is effective for fiscal years, and interim periods within those years, beginning after December 15, 2017. The Company adopted ASU 2014-09 on January 1, 2018 as described in Note 3 – Revenue.

3. Revenue

ASU 2014-09 requires companies to exercise more judgment and recognize revenue using a five-step process. The Company adopted ASU 2014-09 using the modified retrospective method for all contracts effective January 1, 2018 and is using a portfolio approach to group contracts with similar characteristics and analyze historical cash collections trends. Modified retrospective adoption requires entities to apply the standard retrospectively to the most current period presented in the financial statements, requiring the cumulative effect of the retrospective application as an adjustment to the opening balance of retained earnings at the date of initial application. Prior periods have not been adjusted. No cumulative-effect adjustment in retained earnings was recorded as the adoption of ASU 2014-09 did not significantly impact the Company’s reported historical revenue.

As a result of certain changes required by ASU 2014-09, the majority of the Company’s provision for doubtful accounts are recorded as a direct reduction to revenue instead of being presented as a separate line item on the consolidated statements of operations. The adoption of ASU 2014-09 has no impact on the Company’s accounts receivable as it was historically recorded net of allowance for doubtful accounts and contractual adjustments, and the Company has eliminated the presentation of allowance for doubtful accounts on the consolidated balance sheets. At December 31, 2018 and 2017, estimated implicit price concessions of $47.0 million and $40.9 million, respectively, had been recorded as reductions to our accounts receivable balances to enable us to record our revenues and accounts receivable at the estimated amounts we expected to collect. The adoption of ASU 2014-09 did not have a significant impact on the Company’s consolidated statements of operations. The impact of adopting ASU 2014-09 on the consolidated statements of operations for the year ended December 31, 2018 was as follows (in thousands):

	Year Ended December 31, 2018	
	As Reported	Prior to Adopting ASU 2014-09
Revenue before provision for doubtful accounts	$3,012,442	$3,060,180

Provision for doubtful accounts	—	(47,738)
Revenue	$3,012,442	$3,012,442

The Company evaluated the nature, amount, timing and uncertainty of revenue and cash flows using the five-step process provided within ASU 2014-09.

Revenue is primarily derived from services rendered to patients for inpatient psychiatric and substance abuse care, outpatient psychiatric care and residential treatment. The services provided by the Company have no fixed duration and can be terminated by the patient or the facility at any time, and therefore, each treatment is its own stand-alone contract.

Services ordered by a healthcare provider in an episode of care are not separately identifiable and therefore have been combined into a single performance obligation for each contract. The Company recognizes revenue as its performance obligations are completed. The performance obligation is satisfied over time as the customer simultaneously receives and consumes the benefits of the healthcare services provided. For inpatient services, the Company recognizes revenue equally over the patient stay on a daily basis. For outpatient services, the Company recognizes revenue equally over the number of treatments provided in a single episode of care. Typically, patients and third-party payors are billed within several days of the service being performed or the patient being discharged, and payments are due based on contract terms.

As our performance obligations relate to contracts with a duration of one year or less, the Company elected the optional exemption in ASC 606-10-50-14(a). Therefore, the Company is not required to disclose the transaction price for the remaining performance obligations at the end of the reporting period or when the Company expects to recognize the revenue. The Company has

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minimal unsatisfied performance obligations at the end of the reporting period as our patients typically are under no obligation to remain admitted in our facilities.

The Company disaggregates revenue from contracts with customers by service type and by payor within each of the Company's segments.

U.S. Facilities

The Company's U.S. Facilities and services provided by the U.S. Facilities can generally be classified into the following categories: acute inpatient psychiatric facilities; specialty treatment facilities; residential treatment centers; and outpatient community-based services.

Acute inpatient psychiatric facilities. Acute inpatient psychiatric facilities provide a high level of care in order to stabilize patients that are either a threat to themselves or to others. The acute setting provides 24-hour observation, daily intervention and monitoring by psychiatrists.

Specialty treatment facilities. Specialty treatment facilities include residential recovery facilities, eating disorder facilities and comprehensive treatment centers. The Company provides a comprehensive continuum of care for adults with addictive disorders and co-occurring mental disorders. Inpatient, including detoxification and rehabilitation, partial hospitalization and outpatient treatment programs give patients access to the least restrictive level of care.

Residential treatment centers. Residential treatment centers treat patients with behavioral disorders in a non-hospital setting, including outdoor programs. The facilities balance therapy activities with social, academic and other activities.

Outpatient community-based services. Outpatient community-based programs are designed to provide therapeutic treatment to children and adolescents who have a clinically-defined emotional, psychiatric or chemical dependency disorder while enabling the youth to remain at home and within their community.

The table below presents total U.S. revenue attributed to each category (in thousands):

	Year Ended December 31,		
	2018	2017	2016
Acute inpatient psychiatric facilities	$814,124	$757,211	$694,151
Specialty treatment facilities	761,017	725,151	702,225
Residential treatment centers	293,053	284,637	256,539
Outpatient community-based services	36,501	42,845	45,610
Revenue	$1,904,695	$1,809,844	$1,698,525

The Company receives payments from the following sources for services rendered in our U.S. Facilities: (i) state governments under their respective Medicaid and other programs; (ii) commercial insurers; (iii) the federal government under the Medicare program administered by the Centers for Medicare and Medicaid Services ("CMS"); and (iv) individual patients and clients. As the period between the time of service and time of payment is typically one year or less, the Company elected the practical expedient under ASC 606-10-32-18 and did not adjust for the effects of a significant financing component.

The Company determines the transaction price based on established billing rates reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients and implicit price concessions. Contractual adjustments and discounts are based on contractual agreements, discount policies and historical experience. Implicit price concessions are based on historical collection experience. Most of our U.S. Facilities have contracts containing variable consideration. However, it is unlikely a significant reversal of revenue will occur when the uncertainty is resolved, and therefore, the Company has included the variable consideration in the estimated transaction price. Subsequent changes resulting from a patient's ability to pay are recorded as bad debt expense, which is included as a component of other operating expenses in the consolidating statements of operations. Bad debt expense for the year ended December 31, 2018 was not significant.

The Company derives a significant portion of its revenue from Medicare, Medicaid and other payors that receive discounts from established billing rates. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex, subject to interpretation and adjustment, and may include multiple reimbursement mechanisms for different types of services provided in the Company's inpatient facilities and cost settlement provisions. Management estimates the transaction price on a payor-specific basis given its interpretation of the applicable regulations or contract terms. The services

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authorized and provided and related reimbursement are often subject to interpretation that could result in payments that differ from the Company's estimates. Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management.

Settlements under cost reimbursement agreements with third-party payors are estimated and recorded in the period in which the related services are rendered and are adjusted in future periods as final settlements are determined. Final determination of amounts earned under the Medicare and Medicaid programs often occurs in subsequent years because of audits by such programs, rights of appeal and the application of numerous technical provisions. In the opinion of management, adequate provision has been made for any adjustments and final settlements. However, there can be no assurance that any such adjustments and final settlements will not have a material effect on the Company's financial condition or results of operations. The Company's cost report receivables were $10.3 million and $9.0 million for the years ended December 31, 2018 and 2017, respectively, and were included in other current assets in the consolidated balance sheets. Management believes that these receivables are properly stated and are not likely to be settled for a significantly different amount. The net adjustments to estimated cost report settlements resulted in increases to revenue of $0.5 million, $0.2 million and $0.7 million for the years ended December 31, 2018, 2017 and 2016, respectively.

The Company provides care without charge to patients who are financially unable to pay for the healthcare services they receive based on Company policies and federal and state poverty thresholds. Such amounts determined to qualify as charity care are not reported as revenue. The cost of providing charity care services were $4.7 million, $5.3 million and $5.6 million for the years ended December 31, 2018, 2017 and 2016, respectively. The estimated cost of charity care services was determined using a ratio of cost to gross charges determined from our most recently filed Medicare cost reports and applying that ratio to the gross charges associated with providing charity care for the period.

The following table presents revenue by payor type and as a percentage of revenue in our U.S. Facilities for the years ended December 31, 2018, 2017 and 2016 (in thousands):

	Year Ended December 31,					
	2018		2017		2016	
	Amount	%	Amount	%	Amount	%
Commercial	$573,089	30.1 %	$569,242	30.8 %	$534,468	30.7 %
Medicare	280,340	14.7 %	281,270	15.2 %	266,868	15.3 %
Medicaid	893,644	46.9 %	796,375	43.0 %	725,508	41.7 %
Self-Pay	134,054	7.1 %	169,727	9.2 %	185,094	10.6 %
Other	23,568	1.2 %	33,942	1.8 %	28,418	1.7 %
Revenue before provision for doubtful accounts	1,904,695	100.0%	1,850,556	100.0%	1,740,356	100.0%
Provision for doubtful accounts	—		(40,712)		(41,831)	
Revenue	$1,904,695		$1,809,844		$1,698,525	

U.K. Facilities

The Company's U.K. Facilities and services provided by the U.K. Facilities can generally be classified into the following categories: healthcare facilities, education and children's services, adult care facilities and elderly care facilities.

Healthcare facilities. Healthcare facilities provide psychiatric treatment and nursing for sufferers of mental disorders, including for patients 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.

Education and children's services. Education and children's services provide specialist education for children and young people with special educational needs, including autism, Asperger's Syndrome, social, emotional and mental health, and specific learning difficulties, such as dyslexia. The division also offers standalone children's homes for children that require 52-week residential care to support complex and challenging behavior and fostering services.

Adult care facilities. Adult care focuses on care of individuals with a variety of learning difficulties, mental health illnesses and adult autism spectrum disorders. It also includes long-term, short-term and respite nursing care to high-dependency elderly individuals who are physically frail or suffering from dementia. Care is provided in a number of settings, including in residential care homes and through supported living.

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The table below presents total U.K. revenue attributed to each category (in thousands):

	Year Ended December 31,		
	2018	2017	2016
Healthcare facilities	$615,741	$567,747	$683,467
Education and Children's Services	192,129	170,328	146,703
Adult Care facilities	299,877	288,397	280,191
Revenue	$1,107,747	$1,026,472	$1,110,361

The Company receives payments from approximately 500 public funded sources in the U.K. (including the National Health Service ("NHS"), Clinical Commissioning Groups ("CCGs") and local authorities in England, Scotland and Wales) and individual patients and clients. The Company determines the transaction price based on established billing rates by payor and is reduced by implicit price concessions. Implicit price concessions are insignificant in our U.K. Facilities. There is no significant variable consideration in our U.K. Facilities' contracts. As the period between the time of service and time of payment is typically one year or less, the Company elected the practical expedient under ASC 606-10-32-18 and did not adjust for the effects of a significant financing component.

The following table presents revenue by payor type and as a percentage of revenue in our U.K. Facilities for the years ended December 31, 2018, 2017 and 2016 (in thousands):

	Year Ended December 31,								
	2018			2017			2016		
	Amount	%		Amount	%		Amount	%	
U.K. public funded sources	$1,000,828	90.3	%	$922,159	89.8	%	$1,021,888	92.0	%
Self-Pay	104,824	9.5	%	95,687	9.3	%	83,066	7.5	%
Other	2,095	0.2	%	8,832	0.9	%	5,485	0.5	%
Revenue before provision for doubtful accounts	1,107,747	100.0	%	1,026,678	100.0	%	1,110,439	100.0	%
Provision for doubtful accounts	—			(206)			(78)		
Revenue	$1,107,747			$1,026,472			$1,110,361		

The Company's contract liabilities primarily consist of unearned revenue in our U.K. Facilities due to the timing of payments received mainly in our education and children's services and healthcare facilities. Contract liabilities are included in other accrued liabilities on the consolidated balance sheets. A summary of the activity in unearned revenue in the U.K. Facilities is as follows (in thousands):

Balance at December 31, 2017	$30,812
Payments received	167,604
Revenue recognized	(164,917)
Foreign currency translation loss	(2,260)
Balance at December 31, 2018	$31,239

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4. Earnings Per Share

The following table sets forth the computation of basic and diluted earnings per share for the years ended December 31, 2018, 2017 and 2016 (in thousands except per share amounts):

	Year Ended December 31,		
	2018	2017	2016
Numerator:			
Net (loss) income attributable to Acadia Healthcare Company, Inc.	$(175,750)	$199,835	$6,143
Denominator:			
Weighted average shares outstanding for basic earnings per share	87,288	86,948	85,701
Effects of dilutive instruments	—	112	271
Shares used in computing diluted earnings per common share	87,288	87,060	85,972
Earnings per share attributable to Acadia Healthcare Company, Inc. stockholders:			
Basic	$(2.01)	$2.30	$0.07
Diluted	$(2.01)	$2.30	$0.07

For the year ended December 31, 2018, approximately 0.1 million of the outstanding restricted stock and shares of common stock issuable upon exercise of outstanding stock option awards have been excluded from the calculation of diluted earnings per share because the net loss for the year ended December 31, 2018 causes such securities to be anti-dilutive. Approximately 1.9 million, 1.4 million and 1.1 million shares of common stock issuable upon exercise of outstanding stock options were excluded from the calculation of diluted earnings per share for the years ended December 31, 2018, 2017 and 2016, respectively, because their effect would have been anti-dilutive.

5. Acquisitions

The Company’s strategy is to acquire and develop behavioral healthcare facilities and improve operating results within its facilities and its other behavioral healthcare operations.

2019 Acquisitions

On February 15, 2019, the Company completed the acquisition of Whittier Pavilion (“Whittier”), an inpatient psychiatric facility with 71 beds located in Haverhill, Massachusetts, for cash consideration of approximately $17.9 million. Also on February 15, 2019, the Company completed the acquisition of Mission Treatment (“Mission Treatment”) for cash consideration of approximately $22.5 million and a working capital settlement. Mission Treatment operates nine comprehensive treatment centers in California, Nevada, Arizona and Oklahoma.

2017 Acquisition

On November 13, 2017, we completed the acquisition of Aspire Scotland, an education facility with 36 beds located in Scotland, for cash consideration of approximately $21.3 million.

2016 U.S. Acquisitions

On June 1, 2016, the Company completed the acquisition of Pocono Mountain Recovery Center ("Pocono Mountain"), an inpatient psychiatric facility with 108 beds located in Henryville, Pennsylvania, for cash consideration of approximately $25.4 million.

On May 1, 2016, the Company completed the acquisition of TrustPoint Hospital ("TrustPoint"), an inpatient psychiatric facility with 100 beds located in Murfreesboro, Tennessee, for cash consideration of approximately $62.7 million.

On April 1, 2016, the Company completed the acquisition of Serenity Knolls ("Serenity Knolls"), an inpatient psychiatric facility with 30 beds located in Forest Knolls, California, for cash consideration of approximately $10.0 million.

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Priory

On February 16, 2016, the Company completed the acquisition of Priory Group No. 1 Limited ("Priory") for a total purchase price of approximately $2.2 billion, including cash consideration of approximately $1.9 billion and the issuance of 4,033,561 shares of its common stock to shareholders of Priory. Priory was the leading independent provider of behavioral healthcare services in the U.K. operating 324 facilities with approximately 7,100 beds at February 16, 2016.

The Competition and Markets Authority (the "CMA") in the U.K. reviewed the Company's acquisition of Priory. On July 14, 2016, the CMA announced that the Company's acquisition of Priory was referred for a phase 2 investigation unless the Company offered acceptable undertakings to address the CMA's competition concerns relating to the provision of behavioral healthcare services in certain markets. On July 28, 2016, the CMA announced that the Company had offered undertakings to address the CMA's concerns and that, in lieu of a phase 2 investigation, the CMA would consider the Company's undertakings.

On October 18, 2016, the Company signed a definitive agreement with BC Partners ("BC Partners") for the sale of 21 existing U.K. behavioral health facilities and one de novo behavioral health facility with an aggregate of approximately 1,000 beds (collectively, the "U.K. Disposal Group"). On November 10, 2016, the CMA accepted the Company's undertakings to sell the U.K. Disposal Group to BC Partners and confirmed that the divestiture satisfied the CMA's concerns about the impact of the Company's acquisition of Priory on competition for the provision of behavioral healthcare services in certain markets in the U.K. As a result of the CMA's acceptance of the undertakings, the Company's acquisition of Priory was not referred for a phase 2 investigation. On November 30, 2016, the Company completed the sale of the U.K. Disposal Group to BC Partners for £320 million cash (the "U.K. Divestiture").

In conjunction with the sale, the Company recorded a loss on divestiture of $175.0 million in the consolidated statements of operations for the year ended December 31, 2016. The loss on divestiture consisted of an allocation of goodwill to the U.K. Disposal Group of $106.9 million, loss on the sale of properties of $42.0 million and estimated transaction-related expenses of $26.1 million. The allocation of goodwill was based on the fair value of the U.K. Disposal Group relative to the total fair value of the Company's U.K. Facilities segment.

The consolidated statements of operations for the year ended December 31, 2016 include revenue of $154.7 million and income before income taxes of $81.2 million related to the U.K. Disposal Group excluding the loss on divestiture.

Transaction-related expenses

Transaction-related expenses represent costs primarily related to our acquisitions and related integration efforts and, for 2018, to the Chief Executive Officer ("CEO") transition. In December 2018, Mr. Joey A. Jacobs was removed from his positions as CEO and Chairman of the Board of directors (the "Board") of the Company. Also in December 2018, Ms. Debra K. Osteen was elected by the Board to serve as the Company's CEO. In connection with this CEO transition, the Company recorded a charge of $14.0 million, which was comprised of cash payments to Mr. Jacobs of $8.1 million, the accelerated vesting of Mr. Jacobs' restricted stock awards of $5.0 million, a cash payment to Ms. Osteen of $0.4 million and other costs of $0.5 million. CEO transition costs of $14.0 million were recorded in transaction-related expenses in the consolidated statements of operations.

Transaction-related expenses comprised the following costs for the years ended years ended December 31, 2018, 2017 and 2016 (in thousands):

	Year Ended December 31,		
	2018	2017	2016
CEO transition costs	$14,033	$—	$—
Termination and closure costs	11,829	16,190	15,449
Legal, accounting and other	8,645	8,077	18,024
Advisory and financing commitment fees	—	—	14,850
	$34,507	$24,267	$48,323

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6. Other Intangible Assets

Other identifiable intangible assets and related accumulated amortization consisted of the following at December 31, 2018 and 2017 (in thousands):

	Gross Carrying Amount		Accumulated Amortization	
	December 31, 2018	December 31, 2017	December 31, 2018	December 31, 2017
Intangible assets subject to amortization:				
Contract intangible assets	$2,100	$ 2,100	$(2,100)	$ (2,100)
Non-compete agreements	1,147	1,147	(1,147)	(1,147)
	3,247	3,247	(3,247)	(3,247)
Intangible assets not subject to amortization:				
Licenses and accreditations	12,343	12,266	—	—
Trade names	60,109	60,586	—	—
Certificates of need	16,538	14,496	—	—
	88,990	87,348	—	—
Total	$92,237	$ 90,595	$(3,247)	$ (3,247)

All the Company’s definite-lived intangible assets are fully amortized. The Company’s licenses and accreditations, trade names and certificate of need intangible assets have indefinite lives and are, therefore, not subject to amortization.

7. Long-Term Debt

Long-term debt consisted of the following (in thousands):

	December 31, 2018	December 31, 2017
Amended and Restated Senior Credit Facility:		
Senior Secured Term A Loans	$ 365,750	$ 380,000
Senior Secured Term B Loans	1,372,912	1,398,400
Senior Secured Revolving Line of Credit	—	—
6.125% Senior Notes due 2021	150,000	150,000
5.125% Senior Notes due 2022	300,000	300,000
5.625% Senior Notes due 2023	650,000	650,000
6.500% Senior Notes due 2024	390,000	390,000
9.0% and 9.5% Revenue Bonds	—	21,920
Other long-term debt	5,953	—
Less: unamortized debt issuance costs, discount and	(41,128)	(50,432)

premium		
	3,193,487	3,239,888
Less: current portion	(34,112)	(34,830)
Long-term debt	$ 3,159,375	$ 3,205,058

Amended and Restated Senior Credit Facility

The Company entered into a senior secured credit facility (the “Senior Secured Credit Facility”) on April 1, 2011. On December 31, 2012, the Company entered into an Amended and Restated Credit Agreement (the “Amended and Restated Credit Agreement”) which amended and restated the Senior Secured Credit Facility (the “Amended and Restated Senior Credit Facility”). The Company has amended the Amended and Restated Credit Agreement from time to time as described in the Company’s prior filings with the SEC.

On May 10, 2017, the Company entered into a Third Repricing Amendment (the “Third Repricing Amendment”) to the Amended and Restated Credit Agreement. The Third Repricing Amendment reduced the Applicable Rate with respect to the Term Loan B facility Tranche B-1 (the “Tranche B-1 Facility”) and the Term Loan B facility Tranche B-2 (the “Tranche B-2 Facility”) from 3.00% to 2.75% in the case of Eurodollar Rate loans and from 2.00% to 1.75% in the case of Base Rate Loans. In connection with the Third Repricing Amendment, the Company recorded a debt extinguishment charge of $0.8 million, including the discount and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of operations.

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On March 22, 2018, the Company entered into a Second Repricing Facilities Amendment (the "Second Repricing Facilities Amendment") to the Amended and Restated Credit Agreement. The Second Repricing Facilities Amendment (i) replaced the Tranche B-1 Facility and the Tranche B-2 Facility with a new Term Loan B facility Tranche B-3 (the "Tranche B-3 Facility") and a new Term Loan B facility Tranche B-4 (the "Tranche B-4 Facility"), respectively, and (ii) reduced the Applicable Rate from 2.75% to 2.50% in the case of Eurodollar Rate loans and reduced the Applicable Rate from 1.75% to 1.50% in the case of Base Rate Loans.

On March 29, 2018, the Company entered into a Third Repricing Facilities Amendment to the Amended and Restated Credit Agreement (the "Third Repricing Facilities Amendment", and together with the Second Repricing Facilities Amendment, the "Repricing Facilities Amendments"). The Third Repricing Facilities Amendment replaced the existing revolving credit facility and Term Loan A facility ("TLA Facility") with a new revolving credit facility and TLA Facility, respectively. The Company's line of credit on its revolving credit facility remains at $500.0 million and the Third Repricing Facility Amendment reduced the size of the TLA Facility from $400.0 million to $380.0 million to reflect the then current outstanding principal. The Third Repricing Facilities Amendment reduced the Applicable Rate by 25 basis points for the revolving credit facility and the TLA Facility by amending the definition of "Applicable Rate."

In connection with the Repricing Facilities Amendments, the Company recorded a debt extinguishment charge of $0.9 million, including the discount and write-off of deferred financing costs, which was recorded in debt extinguishment costs in the consolidated statements of operations.

On February 6, 2019, the Company entered into the Eleventh Amendment (the "Eleventh Amendment") to the Amended and Restated Credit Agreement. The Eleventh Amendment, among other things, amended the definition of "Consolidated EBITDA" to remove the cap on non-cash charges, losses and expenses related to the impairment of goodwill, which in turn provided increased flexibility to the Company in terms of the Company's financial covenants.

On February 27, 2019, the Company entered into the Twelfth Amendment (the "Twelfth Amendment") to the Amended and Restated Credit Agreement. The Twelfth Amendment, among other things, modified certain definitions, including "Consolidated EBITDA", and increased our permitted Maximum Consolidated Leverage Ratio, thereby providing increased flexibility to the Company in terms of the Company's financial covenants.

The Company had $486.7 million of availability under the revolving line of credit and had standby letters of credit outstanding of $13.3 million related to security for the payment of claims required by its workers' compensation insurance program at December 31, 2018. Borrowings under the revolving line of credit are subject to customary conditions precedent to borrowing. The Amended and Restated Credit Agreement requires quarterly term loan principal repayments of our TLA Facility of $4.8 million for March 31, 2019 to December 31, 2019, $7.1 million for March 31, 2020 to December 31, 2020, and $9.5 million for March 31, 2021 to September 30, 2021, with the remaining principal balance of the TLA Facility due on the maturity date of November 30, 2021. The Company is required to repay the Tranche B-3 Facility in equal quarterly installments of $1.2 million on the last business day of each March, June, September and December, with the outstanding principal balance of the Tranche B-3 Facility due on February 11, 2022. The Company is required to repay the Tranche B-4 Facility in equal quarterly installments of approximately $2.3 million on the last business day of each March, June, September and December, with the outstanding principal balance of the Tranche B-4 Facility due on February 16, 2023. On December 29, 2017, the Company made an additional payment of $22.5 million, including $7.7 million on the Tranche B-1 Facility and $14.8 million on the Tranche B-2 Facility. On April 17, 2018, the Company made an additional payment of $15.0 million, including $5.1 million on the Tranche B-3 Facility and $9.9 million on the Tranche B-4 Facility.

Borrowings under the Amended and Restated Senior Credit Facility are guaranteed by each of the Company's wholly-owned domestic subsidiaries (other than certain excluded subsidiaries) and are secured by a lien on substantially all of the assets of the Company and such subsidiaries. Borrowings with respect to the TLA Facility and the Company's revolving credit facility (collectively, "Pro Rata Facilities") under the Amended and Restated Credit Agreement bear interest at a rate tied to Acadia's Consolidated Leverage Ratio (defined as consolidated funded debt net of up to $50.0 million of unrestricted and unencumbered cash to consolidated EBITDA, in each case as defined in the Amended and Restated Credit Agreement). The Applicable Rate (as defined in the Amended and Restated Credit Agreement) for the Pro Rata Facilities was 2.5% for Eurodollar Rate Loans (as defined in the Amended and Restated Credit Agreement) and 1.5% for Base Rate Loans (as defined in the Amended and Restated Credit Agreement) at December 31, 2018. Eurodollar Rate Loans with respect to the Pro Rata Facilities bear interest at the Applicable Rate plus the Eurodollar Rate (as defined in the Amended and Restated Credit Agreement) (based upon the LIBOR Rate (as defined in the Amended and Restated Credit Agreement) prior to commencement of the interest rate period). Base Rate Loans with respect to the Pro Rata Facilities bear interest at the Applicable Rate plus the highest of (i) the federal funds rate plus 0.50%, (ii) the prime rate and (iii) the Eurodollar Rate plus 1.0%. At December 31, 2018, the Pro Rata Facilities bore interest at a rate of LIBOR plus 2.5%. In addition, the Company is required to pay a commitment fee on undrawn amounts under the revolving line of credit.

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The Amended and Restated Credit Agreement requires the Company and its subsidiaries to comply with customary affirmative, negative and financial covenants, including a fixed charge coverage ratio, consolidated leverage ratio and senior secured leverage ratio. The Company may be required to pay all of its indebtedness immediately if it defaults on any of the numerous financial or other restrictive covenants contained in any of its material debt agreements. The Company was in compliance with such covenants.

Senior Notes

6.125% Senior Notes due 2021

On March 12, 2013, the Company issued $150.0 million of 6.125% Senior Notes due 2021 (the "6.125% Senior Notes"). The 6.125% Senior Notes mature on March 15, 2021 and bear interest at a rate of 6.125% per annum, payable semi-annually in arrears on March 15 and September 15 of each year.

5.125% Senior Notes due 2022

On July 1, 2014, the Company issued $300.0 million of 5.125% Senior Notes due 2022 (the "5.125% Senior Notes"). The 5.125% Senior Notes mature on July 1, 2022 and bear interest at a rate of 5.125% per annum, payable semi-annually in arrears on January 1 and July 1 of each year.

5.625% Senior Notes due 2023

On February 11, 2015, the Company issued $375.0 million of 5.625% Senior Notes due 2023 (the "5.625% Senior Notes"). On September 21, 2015, the Company issued $275.0 million of additional 5.625% Senior Notes. The additional notes formed a single class of debt securities with the 5.625% Senior Notes issued in February 2015. Giving effect to this issuance, the Company has outstanding an aggregate of $650.0 million of 5.625% Senior Notes. The 5.625% Senior Notes mature on February 15, 2023 and bear interest at a rate of 5.625% per annum, payable semi-annually in arrears on February 15 and August 15 of each year.

6.500% Senior Notes due 2024

On February 16, 2016, the Company issued $390.0 million of 6.500% Senior Notes due 2024 (the "6.500% Senior Notes"). The 6.500% Senior Notes mature on March 1, 2024 and bear interest at a rate of 6.500% per annum, payable semi-annually in arrears on March 1 and September 1 of each year, beginning on September 1, 2016.

The indentures governing the 6.125% Senior Notes, 5.125% Senior Notes, 5.625% Senior Notes and 6.500% Senior Notes (together, the "Senior Notes") contain covenants that, among other things, limit the Company's ability and the ability of its restricted subsidiaries to: (i) pay dividends, redeem stock or make other distributions or investments; (ii) incur additional debt or issue certain preferred stock; (iii) transfer or sell assets; (iv) engage in certain transactions with affiliates; (v) create restrictions on dividends or other payments by the restricted subsidiaries; (vi) merge, consolidate or sell substantially all of the Company's assets; and (vii) create liens on assets.

The Senior Notes issued by the Company are guaranteed by each of the Company's subsidiaries that guarantee the Company's obligations under the Amended and Restated Senior Credit Facility. The guarantees are full and unconditional and joint and several.

The Company may redeem the Senior Notes at its option, in whole or part, at the dates and amounts set forth in the indentures.

9.0% and 9.5% Revenue Bonds

On November 11, 2012, in connection with the acquisition of The Pavilion at HealthPark, LLC ("Park Royal"), the Company assumed debt of $23.0 million. The fair market value of the debt assumed was $25.6 million and resulted in a debt premium balance being recorded as of the acquisition date. The debt consisted of $7.5 million and $15.5 million of Lee County (Florida) Industrial Development Authority Healthcare Facilities Revenue Bonds, Series 2010 with stated interest rates of 9.0% and 9.5% ("9.0% and 9.5% Revenue Bonds"), respectively.

On December 1, 2018, the Company exercised the option to redeem in whole the 9.0% and 9.5% Revenue Bonds at a redemption price equal to the sum of 104% of the principal amount of the 9.0% and 9.5% Revenue Bonds plus accrued and unpaid interest. In connection with the redemption of the 9.0% and 9.5% Revenue Bonds, the Company recorded a debt extinguishment charge of $0.9 million, which was recorded in debt extinguishment costs in the consolidated statements of operations.

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The 9.0% bonds in the amount of $7.5 million had a maturity date of December 1, 2030 and required yearly principal payments beginning in 2013. The 9.5% bonds in the amount of $15.5 million had a maturity date of December 1, 2040 and required yearly principal payments beginning in 2031. The principal payments established a bond sinking fund to be held with the trustee and shall be sufficient to redeem the principal amounts of the 9.0% and 9.5% Revenue Bonds on their respective maturity dates. At December 31, 2017, $2.3 million was recorded within other assets on the consolidated balance sheets related to the debt service reserve fund requirements. The yearly principal payments, which established a bond sinking fund, will increase the debt service reserve fund requirements. The bond premium amount of $2.6 million was amortized as a reduction of interest expense over the life of the revenue bonds using the effective interest method.

Debt Issuance Costs

Debt issuance costs are deferred and amortized to interest expense over the term of the related debt. Debt issuance costs at December 31, 2018 were $37.8 million, net of accumulated amortization of $36.5 million. Debt issuance costs at December 31, 2017 were $46.5 million, net of accumulated amortization of $27.5 million. Amortization expense related to debt issuance costs, which is included in interest expense on the consolidated statements of operations, was $9.0 million, $8.6 million and $8.6 million, respectively, for the years ended December 31, 2018, 2017 and 2016.

Other

The aggregate maturities of long-term debt at December 31, 2018 were as follows (in thousands):

2019	$34,112
2020	43,679
2021	483,501
2022	764,855
2023	1,518,468
Thereafter	390,000
Total	$3,234,615

8. Equity

Preferred Stock

The Company’s amended and restated certificate of incorporation provides that up to 10,000,000 shares of preferred stock may be issued. The Board of Directors has the authority to issue preferred stock in one or more series and to fix for each series the voting powers (full, limited or none), and the designations, preferences and relative participating, optional or other special rights and qualifications, limitations or restrictions on the stock and the number of shares constituting any series and the designations of this series, without any further vote or action by the stockholders.

Common Stock

The Company’s amended and restated certificate of incorporation provides that up to 180,000,000 shares of common stock may be issued. Holders of the Company’s common stock are entitled to one vote for each share held of record on

all matters on which stockholders may vote. There are no preemptive, conversion, redemption or sinking fund provisions applicable to shares of the Company's common stock. In the event of liquidation, dissolution or winding up, holders of the Company's common stock are entitled to share ratably in the assets available for distribution, subject to any prior rights of any holders of preferred stock then outstanding. Delaware law prohibits the Company from paying any dividends unless it has capital surplus or net profits available for this purpose. In addition, the Amended and Restated Senior Credit Facility imposes restrictions on the Company's ability to pay dividends.

9. Equity-Based Compensation

Equity Incentive Plans

The Company issues stock-based awards, including stock options, restricted stock and restricted stock units, to certain officers, employees and non-employee directors under the Acadia Healthcare Company, Inc. Incentive Compensation Plan (the "Equity Incentive Plan"). At December 31, 2018, a maximum of 8,200,000 shares of the Company's common stock were authorized for

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issuance as stock options, restricted stock and restricted stock units or other share-based compensation under the Equity Incentive Plan, of which 3,261,276 were available for future grant. Stock options may be granted for terms of up to ten years. The Company recognizes expense on all share-based awards on a straight-line basis over the requisite service period of the entire award. Grants to employees generally vest in annual increments of 25% each year, commencing one year after the date of grant. The exercise prices of stock options are equal to the closing price of the Company's common stock on the most recent trading date prior to the date of grant.

The Company recognized $22.0 million, $23.5 million and $28.3 million in equity-based compensation expense for the years ended December 31, 2018, 2017 and 2016, respectively. Stock compensation expense for the years ended December 31, 2018 and 2017 included forfeiture adjustments and restricted stock unit adjustments based on actual performance compared to vesting targets of $(5.5) million and $(5.7) million, respectively. At December 31, 2018, there was $34.7 million of unrecognized compensation expense related to unvested options, restricted stock and restricted stock units, which is expected to be recognized over the remaining weighted average vesting period of 1.2 years.

At December 31, 2018, there were no warrants outstanding and exercisable. The Company recognized a deferred income tax benefit of $7.0 million and $9.2 million for the years ended December 31, 2018 and 2017, respectively, related to equity-based compensation expense.

Stock Options

Stock option activity during 2016, 2017 and 2018 was as follows (aggregate intrinsic value in thousands):

	Number of Options	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (in years)	Aggregate Intrinsic Value
Options outstanding at January 1, 2016	694,743	$ 42.87	7.70	$ 20,717
Options granted	503,850	57.98	9.28	297
Options exercised	(57,397)	31.92	N/A	1,530
Options cancelled	(140,250)	57.13	N/A	N/A
Options outstanding at December 31, 2016	1,000,946	48.42	7.46	8,166
Options granted	259,300	42.25	9.30	205
Options exercised	(87,367)	25.92	N/A	1,636
Options cancelled	(198,313)	54.71	N/A	N/A
Options outstanding at December 31, 2017	974,566	47.89	7.46	3,802
Options granted	374,700	37.54	9.21	246
Options exercised	(20,989)	17.83	N/A	383
Options cancelled	(128,737)	50.83	N/A	N/A
Options outstanding at December 31, 2018	1,199,540	$ 44.64	7.26	$ 2,717

Options exercisable at December 31, 2017	405,634	$ 41.20	6.05	$ 3,549
Options exercisable at December 31, 2018	534,164	$ 44.98	5.73	$ 2,386

Fair values are estimated using the Black-Scholes option pricing model. The following table summarizes the grant-date fair value of options and the assumptions used to develop the fair value estimates for options granted during the years ended December 31, 2018, 2017 and 2016:

	Year Ended December 31,		
	2018	2017	2016
Weighted average grant-date fair value of options	$13.67	$14.39	$18.96
Risk-free interest rate	2.2 %	2.0 %	1.4 %
Expected volatility	37 %	33 %	33 %
Expected life (in years)	5.1	5.5	5.5

The Company’s estimate of expected volatility for stock options is based upon the volatility of our stock price over the expected life of the award. The risk-free interest rate is the approximate yield on U. S. Treasury Strips having a life equal to the expected option life on the date of grant. The expected life is an estimate of the number of years an option will be held before it is exercised.

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Other Stock-Based Awards

Restricted stock activity during 2016, 2017 and 2018 was as follows:

	Number of Shares	Weighted Average Grant-Date Fair Value
Unvested at January 1, 2016	944,562	$ 52.74
Granted	387,347	55.38
Cancelled	(122,178)	57.02
Vested	(365,312)	47.18
Unvested at December 31, 2016	844,419	$ 55.76
Granted	404,224	42.38
Cancelled	(145,981)	55.03
Vested	(292,794)	53.07
Unvested at December 31, 2017	809,868	$ 50.19
Granted	480,137	36.84
Cancelled	(88,989)	47.57
Vested	(395,959)	50.41
Unvested at December 31, 2018	805,057	$ 42.40

Restricted stock unit activity during 2016, 2017 and 2018 was as follows:

	Number of Units	Weighted Average Grant-Date Fair Value
Unvested at January 1, 2016	218,084	$ 56.97
Granted	230,750	56.95
Cancelled	—	—
Vested	(175,235)	52.71
Unvested at December 31, 2016	273,599	$ 59.68
Granted	219,840	43.23

Cancelled	—	—
Vested	(132,530)	58.67
Unvested at December 31, 2017	360,909	$ 50.04
Granted	285,358	42.26
Cancelled	(89,173)	55.44
Vested	(72,983)	49.64
Unvested at December 31, 2018	484,111	$ 44.52

Restricted stock awards are time-based vesting awards that vest over a period of three or four years and are subject to continuing service of the employee or non-employee director over the ratable vesting periods. The fair values of the restricted stock awards were determined based on the closing price of the Company’s common stock on the trading date immediately prior to the grant date.

Restricted stock units are granted to employees and are subject to Company performance compared to pre-established targets and, in the case of the 2018 awards, Company performance compared to peers. In addition to Company performance, these performance-based restricted stock units are subject to the continuing service of the employee during the two- or three-year period covered by the awards. The performance condition for the restricted stock units is based on the Company’s achievement of annually established targets for diluted earnings per share. Additionally, the number of shares issuable pursuant to restricted stock units granted during 2018 is subject to adjustment based on the Company’s three-year annualized total stockholder return relative to a peer group consisting of S&P 1500 companies within the Healthcare Providers & Services 6 digit GICS industry group and selected other companies deemed to be peers. The number of shares issuable at the end of the applicable vesting period of restricted stock units ranges from 0% to 200% of the targeted units based on the Company’s actual performance compared to the targets and, for 2018 awards, performance compared to peers.

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The fair values of restricted stock units were determined based on the closing price of the Company's common stock on the trading date immediately prior to the grant date for units subject to performance conditions, or at its Monte-Carlo simulation value for units subject to market conditions.

10. Income Taxes

Provision for income taxes consists of the following for the periods presented (in thousands):

	Year Ended December 31,		
	2018	2017	2016
Current:			
Federal	$13,961	$3,325	$572
State	1,113	680	(863)
Foreign	1,172	1,832	423
Total current	16,246	5,837	132
Deferred:			
Federal	(7,176)	27,179	45,077
State	(10)	4,408	1,491
Foreign	(2,528)	(215)	(17,921)
Total deferred provision	(9,714)	31,372	28,647
Provision for income taxes	$6,532	$37,209	$28,779

A reconciliation of the U.S. federal statutory rate to the effective tax rate is as follows for the periods presented:

	Year Ended December 31,		
	2018	2017	2016
U.S. federal statutory rate on income before income taxes	21.0 %	35.0 %	35.0 %
Impact of foreign operations	9.5	(14.1)	(13.5)
Impact of foreign divestiture	—	—	39.2
Impacts of SAB 118	6.7	—	—
Effects of statutory rate change	—	(8.5)	(14.5)
State income taxes, net of federal tax effect	(1.4)	2.1	7.5
Permanent differences	(4.1)	1.8	8.3
Goodwill impairment	(36.6)	—	—
Transaction-related items	—	—	25.9
Change in valuation allowance	(1.4)	1.6	2.8
Unrecognized tax benefit release	3.1	(0.8)	(7.2)
Interest disallowance	(2.2)	—	—
Federal tax credits	1.0	—	—

Other	0.5	(1.4)	3.8
Effective income tax rate	(3.9)%	15.7 %	87.3 %

The domestic and foreign components of income (loss) before income taxes are as follows (in thousands):

	Year Ended December 31,		
	2018	2017	2016
Foreign	$(228,350)	$120,905	$(144,717)
Domestic	59,396	115,893	177,672
Total	$(168,954)	$236,798	$32,955

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The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and liabilities of the Company at December 31, 2018 and December 31, 2017 were as follows (in thousands):

	December 31,	
	2018	2017
Deferred tax assets:		
Net operating losses and tax credit carryforwards – federal and state	$27,294	$29,409
Bad debt allowance	898	827
Accrued compensation and severance	15,229	14,179
Pension reserves	595	1,494
Insurance reserves	13,994	13,483
Leases	5,374	5,332
Accrued expenses	4,231	3,114
Interest carryforwards	32,272	5,074
Other assets	2,284	1,747
Total gross deferred tax assets	102,171	74,659
Less: valuation allowance	(24,079)	(21,155)
Deferred tax assets	78,092	53,504
Deferred tax liabilities:		
Fixed asset basis difference	(48,698)	(54,214)
Prepaid items	(1,728)	(1,490)
Intangible assets	(87,628)	(70,820)
Accrued expenses	—	—
Other liabilities	(16,942)	(3,582)
Total deferred tax liabilities	(154,996)	(130,106)
Total net deferred tax liability	$(76,904)	$(76,602)

The Company records a valuation allowance to reduce its net deferred tax assets to the amount that is more likely than not to be realized. At December 31, 2018 and 2017, the Company carried a valuation allowance against deferred tax assets of $24.1 million and $21.2 million, respectively.

The Company had domestic net operating loss carryforwards at December 31, 2018 and 2017 of approximately $0.0 million and $12.2 million, respectively. The foreign net operating loss carryforwards at December 31, 2018 and 2017 are approximately $81.0 million and $93.9 million, respectively, and have no expiration.

The Company has state net operating loss carryforwards at December 31, 2018 and 2017 of approximately $236.0 million and $256.9 million, respectively. These net operating loss carryforwards, if not used to offset future taxable income, will expire from 2019 to 2037. In addition, the Company has certain state tax credits of $0.9 million which will begin to expire in 2028 if not utilized.

Income taxes receivable was $2.4 million and $15.1 million at December 31, 2018 and 2017, respectively, and was included in other current assets in the consolidated balance sheets. Income taxes payable of $3.0 million and

$1.0 million at December 31, 2018 and 2017, respectively, was included in other accrued liabilities in the consolidated balance sheets.

The Company has recorded income taxes payable related to unrecognized tax benefits of $0.9 million and $6.4 million at December 31, 2018 and 2017, respectively, in other liabilities in the consolidated balance sheets. A reconciliation of the beginning and ending amount of unrecognized income tax benefits net of the federal benefit is as follows (in thousands):

	2018	2017
Balance at January 1	$6,104	$6,949
Additions based on tax positions related to the current year	52	5,488
Additions for tax positions of prior years	—	95
Reductions as a result of the lapse of applicable statutes of limitations and settlements with tax authorities	(5,443)	(6,428)
Balance at December 31	$713	$6,104

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The Company recognizes interest and penalties related to unrecognized tax benefits in its consolidated balance sheets. At December 31, 2018 and 2017, the cumulative amounts recognized were $0.1 million and $0.1 million, respectively. It is possible the amount of unrecognized tax benefit could change in the next twelve months as a result of a lapse of the statute of limitations and settlements with taxing authorities; however, management does not anticipate the change will have a material impact on the Company's consolidated financial statements.

The Company's uncertain tax positions are related to tax years that remain subject to examination by the relevant taxing authorities. The Company and its subsidiaries file income tax returns in federal and in many state and local jurisdictions as well as foreign jurisdictions. The Company may be subject to examination by the Internal Revenue Service ("IRS") for calendar year 2015 through 2017. Additionally, any net operating losses that were generated in prior years and utilized in these years may also be subject to examination by the IRS. In foreign jurisdictions, the Company may be subject to examination for calendar years 2014 through 2017. Generally, for state tax purposes, the Company's 2012 through 2017 tax years remain open for examination by the tax authorities. At the date of this report there were no audits or inquires that had progressed sufficiently to predict their ultimate outcome.

One of the Company's Puerto Rico subsidiaries was granted a tax exemption for which a tax credit of up to 15% of eligible payroll expenses is available to offset up to 50% of the income taxes attributed to that entity.

U.S. Tax Reform

On December 22, 2017, Public Law 115-97, informally referred to as The Tax Cuts and Jobs Act (the "Tax Act") was enacted into law. The Tax Act provided for significant changes to the U.S. tax code that has impacted businesses. Effective January 1, 2018, the Tax Act reduced the U.S. federal tax rate for corporations from 35% to 21%, for U.S. taxable income. The Tax Act included other changes, including, but not limited to, a general elimination of U.S. federal income taxes on dividends from foreign subsidiaries, a new provision designed to tax global intangible low-taxed income, a limitation of the deduction for net operating losses, elimination of net operating loss carrybacks, immediate deductions for depreciation expense for certain qualified property, additional limitations on the deductibility of executive compensation and limitations on the deductibility of interest.

ASC 740 "Income Taxes" ("ASC 740") requires the Company to recognize the effect of tax law changes in the period of enactment. However, the SEC staff issued Staff Accounting Bulletin 118 ("SAB 118") which allowed the Company to record provisional amounts during a measurement period similar to the measurement period used when accounting for business combinations.

The Tax Act required a one-time remeasurement of deferred taxes to reflect their value at a lower tax rate of 21% and a one-time transition tax on certain repatriated earnings of foreign subsidiaries that is payable over eight years. At December 31, 2018, the Company has completed its accounting for the tax effects of the enactment of the Tax Act. At December 31, 2018, the Company has recorded a reduction in net deferred taxes of $20.6 million related to the remeasurement of its deferred tax balance. In addition, the Company has recorded a one-time transition tax liability in relation to its foreign subsidiaries of $0.0 million at December 31, 2018. The Company continues to assess the impact of the Tax Act on its business.

Deferred Tax Assets and Liabilities

The Company remeasured certain deferred tax assets and liabilities based on the rates at which they are expected to reverse in the future, which is generally 21%. As a result of the reduction in the corporate income tax rate, the Company was required to revalue its net deferred tax assets and liabilities to account for the future impact of lower corporate tax rates on this deferred amount and record any change in the value of such asset or liability as a one-time non-cash charge or benefit on its income statement. The Company recorded a reduction in net deferred taxes of $20.2 million as of December 31, 2017 and an additional reduction of $0.4 million as of December 31, 2018 for a total reduction in net deferred taxes of $20.6 million related to the remeasurement of its deferred tax balance.

U.S. Tax on Foreign Earnings

The one-time transition tax is based on total post-1986 earnings and profits that the Company previously deferred from U.S. income taxes. At December 31, 2018, the Company has completed the earnings and profits analysis for its foreign subsidiaries to calculate the effects of the one-time transition tax and has recorded a one-time transition tax liability amount of $0.0 million. As part of the analysis of the Tax Act, the Company made an adjustment regarding the treatment of foreign dividends of $10.9 million during the twelve months ended December 31, 2018. The change in the provisional estimate recorded at December 31, 2017 was recognized under the law that existed prior to December 22, 2017.

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The Company has continued to analyze the impacts for Global Intangible Low-Taxed Income ("GILTI"), Foreign-Derived Intangible Income, the Base Erosion and Anti-Abuse Tax and any remaining impacts of the foreign income provisions of the Tax Act. At December 31, 2018, the Company has recorded a tax liability amount of $0.0 million relating to such items.

The Tax Act subjects a U.S. shareholder to tax on GILTI earned by certain foreign subsidiaries. The FASB Staff Q&A, Topic 740, No. 5, "Accounting for Global Intangible Low-Taxed Income", states that an entity can make an accounting policy election to either recognize deferred taxes for temporary basis differences expected to reverse as GILTI in future years or to provide for the tax expense related to GILTI in the year the tax is incurred as a period expense only. The Company elects to account for GILTI in the year the tax is incurred.

11. Derivatives

The Company entered into foreign currency forward contracts during the years ended December 31, 2018 and 2017 in connection with certain transfers of cash between the U.S. and U.K. under the Company's cash management and foreign currency risk management programs. Foreign currency forward contracts limit the economic risk of changes in the exchange rate between US Dollars ("USD") and British Pounds ("GBP") associated with cash transfers.

In May 2016, the Company entered into multiple cross currency swap agreements with an aggregate notional amount of $650.0 million to manage foreign currency risk by effectively converting a portion of its fixed-rate USD-denominated senior notes, including the semi-annual interest payments thereunder, to fixed-rate GBP-denominated debt of £449.3 million. The senior notes effectively converted include $150.0 million aggregate principal amount of 6.125% Senior Notes, $300.0 million aggregate principal amount of 5.125% Senior Notes and $200.0 million aggregate principal amount of 5.625% Senior Notes. During the term of the swap agreements, the Company will receive semi-annual interest payments in USD from the counterparties at fixed interest rates, and the Company will make semi-annual interest payments in GBP to the counterparties at fixed interest rates. The interest payments under the cross-currency swap agreements result in £24.7 million of annual cash flows, from the Company's U.K. business being converted to $35.8 million (at a 1.45 exchange rate).

The Company has designated the cross currency swap agreements and certain forward contracts entered into during 2017 and 2018 as qualifying hedging instruments and is accounting for these as net investment hedges. The fair value of these derivatives at December 31, 2018 and 2017 of $60.5 million and $13.0 million, respectively, are recorded as a derivative instruments asset on the consolidated balance sheets. The gains and losses resulting from fair value adjustments to the cross currency swap agreements are recorded in accumulated other comprehensive income as the swaps are effective in hedging the designated risk. Cash flows related to the cross currency swaps are included in operating activities in the consolidated statements of cash flows.

12. Fair Value Measurements

The carrying amounts reported for cash and cash equivalents, accounts receivable, other current assets, accounts payable and other current liabilities approximate fair value because of the short-term maturity of these instruments.

The carrying amounts and fair values of the Company's Amended and Restated Senior Credit Facility, 6.125% Senior Notes, 5.125% Senior Notes, 5.625% Senior Notes, 6.500% Senior Notes, 9.0% and 9.5% Revenue Bonds, other long-term debt and derivative instruments at December 31, 2018 and 2017 were as follows (in thousands):

	Carrying Amount December 31,		Fair Value December 31,	
	2018	2017	2018	2017
Amended and Restated Senior Credit Facility	$1,715,338	$1,749,185	$1,715,338	$1,749,185
6.125% Senior Notes due 2021	$148,657	$148,098	$147,542	$150,134
5.125% Senior Notes due 2022	$296,946	$296,174	$283,583	$296,914
5.625% Senior Notes due 2023	$643,289	$641,891	$609,516	$651,519
6.500% Senior Notes due 2024	$383,304	$382,251	$369,888	$397,541
9.0% and 9.5% Revenue Bonds	$—	$22,289	$—	$22,289
Other long-term debt	$5,953	$—	$5,953	$—
Derivative instruments	$60,524	$12,997	$60,524	$12,997

The Company’s Amended and Restated Senior Credit Facility, 6.125% Senior Notes, 5.125% Senior Notes, 5.625% Senior Notes, 6.500% Senior Notes, 9.0% and 9.5% Revenue Bonds and other long-term debt were categorized as Level 2 in the GAAP fair

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value hierarchy. Fair values were based on trading activity among the Company's lenders and the average bid and ask price as determined using published rates.

The fair values of the derivative instruments were categorized as Level 2 in the GAAP fair value hierarchy and were based on observable market inputs including applicable exchange rates and interest rates.

13. Leases

The Company is obligated under certain operating leases to rent space for its facilities and other office space. The original terms of the leases typically range from five to 30 years, with optional renewal periods.

Aggregate minimum lease payments under non-cancelable operating leases with original or remaining lease terms in excess of one year were as follows at December 31, 2018 (in thousands):

2019	$64,958
2020	61,704
2021	57,195
2022	51,570
2023	47,684
Thereafter	777,684
Total minimum rental obligations	$1,060,795

During the years ended December 31, 2018, 2017 and 2016, rent expense was $80.3 million, $76.8 million and $73.3 million, respectively.

14. Commitments and Contingencies

The Company is, from time to time, subject to various claims, lawsuits, governmental investigations and regulatory actions, including claims for damages for personal injuries, medical malpractice, overpayments, breach of contract, securities law violations, tort and employment related claims. In these actions, plaintiffs request a variety of damages, including, in some instances, punitive and other types of damages that may not be covered by insurance. In addition, healthcare companies are subject to numerous investigations by various governmental agencies. Certain of the Company's individual facilities have received, and from time to time, other facilities may receive, subpoenas, civil investigative demands, audit requests and other inquiries from, and may be subject to investigation by, federal and state agencies. These investigations can result in repayment obligations, and violations of the False Claims Act can result in substantial monetary penalties and fines, the imposition of a corporate integrity agreement and exclusion from participation in governmental health programs. In addition, the federal False Claims Act permits private parties to bring qui tam, or "whistleblower," suits against companies that submit false claims for payments to, or improperly retain overpayments from, the government. Some states have adopted similar state whistleblower and false claims provisions.

During the third quarter of 2018, the U.S. Attorney's Office for the Southern District of West Virginia served subpoenas on seven of our comprehensive treatment centers located in West Virginia requesting various documents from January 2012 to present. The U.S. Attorney's Office has advised us that the civil aspect of the investigation is a

False Claims Act investigation focused on claims submitted by the centers for certain lab services. The Company is cooperating fully with the government's investigation and has established a reserve of $19.0 million relating to the Company's billing for lab services in West Virginia which was recorded in other accrued liabilities on the consolidated balance sheets and in legal settlements expense on the consolidated statements of operations. Changes in the reserve may be required in future periods as discussions with the government continue and additional information becomes available.

In the fall of 2017, the Department of Health and Human Services Office of Inspector General issued subpoenas to three of the Company's facilities requesting certain documents from January 2013 to the date of the subpoenas. The U.S. Attorney's Office for the Middle District of Florida issued a civil investigative demand to one of the Company's facilities in December 2017 requesting certain documents from November 2012 to the date of the demand. The government's investigation of these four facilities is focused on claims not eligible for payment because of alleged violations of certain regulatory requirements relating to, among other things, medical necessity, admission eligibility, discharge decisions, length of stay and patient care issues. The Company is cooperating with the government's investigation but is not able to quantify any potential liability in connection with these investigations.

On January 15, 2019, the Company paid $3.1 million in connection with a class action lawsuit filed in 2011 on behalf of the shareholders of PHC, Inc. d/b/a Pioneer Behavioral Health ("PHC") related to the merger of the Company with PHC. At December

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31, 2018 $3.1 million was recorded in other accrued liabilities on the consolidated balance sheets and in legal settlements expense on the consolidated statements of operations.

15. Noncontrolling Interests

Noncontrolling interests in the consolidated financial statements represents the portion of equity held by noncontrolling partners in the Company's non-wholly owned subsidiaries. At December 31, 2018, the Company operated four facilities and owns between 60% and 80% of the equity interests, and noncontrolling partners own the remaining equity interests. The initial value of the noncontrolling interests is based on the fair value of contributions, and the Company consolidates the operations of each facility based on its equity ownership and its control of the entity. The noncontrolling interests are reflected as redeemable noncontrolling interests on the accompanying consolidated balance sheets based on put rights that could require the Company to purchase the noncontrolling interests upon the occurrence of a change in control.

The components of redeemable noncontrolling interests are as follows (in thousands):

Balance at January 1, 2017	$17,754
Acquisition of redeemable noncontrolling interests	4,909
Net loss attributable to noncontrolling interests	(246)
Balance at December 31, 2017	22,417
Acquisition of redeemable noncontrolling interests	6,125
Net income attributable to noncontrolling interests	264
Balance at December 31, 2018	$28,806

16. Segment Information

The Company operates in one line of business, which is operating acute inpatient psychiatric facilities, specialty treatment facilities, residential treatment centers and facilities providing outpatient behavioral healthcare services. As management reviews the operating results of its U.S. Facilities and its U.K. Facilities separately to assess performance and make decisions, the Company's operating segments include its U.S. Facilities and U.K. Facilities. At December 31, 2018, the U.S. Facilities included 213 behavioral healthcare facilities with approximately 9,300 beds in 40 states and Puerto Rico, and the U.K. Facilities included 370 behavioral healthcare facilities with approximately 8,800 beds in the U.K.

The following tables set forth the financial information by operating segment, including a reconciliation of Segment EBITDA to income before income taxes (in thousands):

	Year Ended December 31,		
	2018	2017	2016
Revenue:			
U.S. Facilities	$1,904,695	$1,809,844	$1,698,525
U.K. Facilities	1,107,747	1,026,472	1,110,361

Corporate and Other	—	—	2,028
	$3,012,442	$2,836,316	$2,810,914
Segment EBITDA (1) :			
U.S. Facilities	$488,207	$475,260	$443,341
U.K. Facilities	185,755	198,566	245,046
Corporate and Other	(80,386)	(69,467)	(79,797)
	$593,576	$604,359	$608,590

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	Year Ended December 31,		
	2018	2017	2016
Segment EBITDA(1)	$593,576	$604,359	$608,590
Plus (less):			
Equity-based compensation expense	(22,001)	(23,467)	(28,345)
Debt extinguishment costs	(1,815)	(810)	(4,253)
Legal settlements expense	(22,076)	—	—
Loss on impairment	(337,889)	—	—
Loss on divestiture	—	—	(178,809)
Gain on foreign currency derivatives	—	—	523
Transaction-related expenses	(34,507)	(24,267)	(48,323)
Interest expense, net	(185,410)	(176,007)	(181,325)
Depreciation and amortization	(158,832)	(143,010)	(135,103)
(Loss) income before income taxes	$(168,954)	$236,798	$32,955

	U.S. Facilities	U.K. Facilities	Corporate and Other	Consolidated
Goodwill:				
Balance at January 1, 2018	$2,042,592	$708,582	$ —	$2,751,174
Loss on impairment	—	(325,875)	—	(325,875)
Increase from contribution of redeemable noncontrolling interests	2,245	—	—	2,245
Foreign currency translation loss	—	(31,894)	—	(31,894)
Prior year purchase price adjustments	—	762	—	762
Balance at December 31, 2018	$2,044,837	$351,575	$ —	$2,396,412

	December 31,	
	2018	2017
Assets (2) :		
U.S. Facilities	$3,779,040	$3,567,126
U.K. Facilities	2,175,809	2,647,150
Corporate and Other	217,655	210,226
	$6,172,504	$6,424,502

(1) Segment EBITDA is defined as income before provision for income taxes, equity-based compensation expense, debt extinguishment costs, legal settlements expense, loss on impairment, loss on divestiture, gain on foreign currency derivatives, transaction-related expenses, interest expense and depreciation and amortization. The Company uses Segment EBITDA as an analytical indicator to measure the performance of the Company's segments and to develop strategic objectives and operating plans for those segments. Segment EBITDA is commonly used as an analytical indicator within the health care industry, and also serves as a measure of leverage capacity and debt service ability. Segment EBITDA should not be considered as a measure of financial performance under GAAP, and the items excluded from Segment

EBITDA are significant components in understanding and assessing financial performance. Because Segment EBITDA is not a measurement determined in accordance with GAAP and is thus susceptible to varying calculations, Segment EBITDA, as presented, may not be comparable to other similarly titled measures of other companies.

(2) Assets include property and equipment for the U.S. Facilities of $1.4 billion, U.K. Facilities of $1.7 billion and corporate and other of $44.9 million at December 31, 2018. Assets include property and equipment for the U.S. Facilities of $1.2 billion, U.K. Facilities of $1.8 billion and corporate and other of $49.2 million at December 31, 2017.

17. Employee Benefit Plans

Defined Contribution Plan

The Company maintains a qualified defined contribution 401(k) plan covering substantially all of its employees in the U.S. The Company may, at its discretion, make contributions to the plan. The Company recorded expense of $3.5 million, $0.2 million, and $0.1 million related to the 401(k) plan for the years ended December 31, 2018, 2017 and 2016, respectively.

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Partnerships in Care Pension Plan

As part of the acquisition of Partnerships in Care on July 1, 2014, the Company assumed a frozen contributory defined benefit retirement plan ("Partnerships in Care Pension Plan") covering substantially all of the employees of Partnerships in Care and its subsidiaries prior to May 1, 2005 at which time, the Partnerships in Care Plan was frozen to new participants. Effective May 2015, the active participants no longer accrue benefits. The benefits under the Partnerships in Care Pension Plan were primarily based on years of service and final average earnings.

The Company accounts for the Partnerships in Care Pension Plan in accordance with ASC 715-30 "Compensation — Defined Benefit Plans", ("ASC 715-30"). In accordance with ASC 715-30, the Company recognizes the unfunded liability of the Partnerships in Care Pension Plan on the Company's consolidated balance sheet and unrecognized gains (losses) and prior service credits (costs) as changes in other comprehensive income (loss). The measurement date of the Partnerships in Care Pension Plan's assets and liabilities coincides with the Company's year-end. The Company's pension benefit obligation is measured using actuarial calculations that incorporate discount rates, rate of compensation increases, when applicable, expected long-term returns on plan assets and consider expected age of retirement and mortality. Expected return on plan assets is determined by using the specific asset distribution at the measurement date.

The following table summarizes the funded status (unfunded liability) of the Partnerships in Care Pension Plan based upon actuarial valuations prepared at December 31, 2018 and 2017 (in thousands):

	2018	2017
Projected benefit obligation	$57,993	$67,288
Fair value of plan assets	54,491	58,493
Unfunded liability	$3,502	$8,795

The following table summarizes changes in the Partnerships in Care Pension Plan net pension liability at December 31, 2018 and 2017 (in thousands):

	2018	2017
Net pension liability at beginning of period	$8,795	$10,700
Employer contributions	(2,267)	(809)
Net pension expense	283	426
Pension liability adjustment	(2,803)	(2,544)
Foreign currency translation (loss) gain	(506)	1,022
Net pension liability at end of period	$3,502	$8,795

A pension liability of $3.5 million and $8.8 million were recorded within other liabilities on the consolidated balance sheets at December 31, 2018 and 2017. The following assumptions were used to determine the plan benefit obligation:

Discount rate	2.8	%	2.5	%
Compensation increase rate	3.3	%	3.3	%
Measurement date	December 31, 2018		December 31, 2017	

A summary of the components of net pension plan expense for the years ended December 31, 2018 and 2017 is as follows (in thousands):

	2018	2017
Interest cost on projected benefit obligation	$1,602	$1,738
Expected return on assets	(1,319)	(1,312)
Net pension expense	$283	$426

Assumptions used to determine the net periodic pension plan expense for the years ended December 31, 2018 and 2017 were as follows:

	2018		2017	
Discount rate	2.8	%	2.5	%
Expected long-term rate of return on plan assets	2.8	%	2.5	%

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The Company recognizes changes in the funded status of the pension plan as a direct increase or decrease to stockholders' equity through accumulated other comprehensive income. The accumulated other comprehensive income (loss) related to the Partnerships in Care Pension Plan, net of taxes, for the years ended December 31, 2018, 2017 and 2016 was $(1.8) million, $(4.5) million and $(6.1) million, respectively.

The trustees of the Partnerships in Care Pension Plan are required to invest assets in the best interest of the Partnerships in Care Pension Plan's members and also ensure liquid assets are available to make benefit payments as they become due. Performance of the Partnerships in Care Pension Plan's assets are monitored quarterly, at a minimum, and asset allocations are adjusted as needed. The Partnerships in Care Pension Plan's weighted-average asset allocations by asset category at December 31, 2018 and 2017 were as follows:

	December 31, 2018		December 31, 2017	
Cash and cash equivalents	1.3	%	0.7	%
U.K. government obligation	15.0	%	19.0	%
Annuity contracts	38.6	%	38.6	%
Equity securities	25.4	%	29.4	%
Debt securities	15.8	%	9.9	%
Other	3.9	%	2.4	%

At December 31, 2018 and 2017, the Partnerships in Care Pension Plan cash and cash equivalents were classified as Level 1 in the GAAP fair value hierarchy. Fair values were based on utilizing quoted prices (unadjusted) in active markets for identical assets. The U.K. government obligations, annuity contracts, equity securities, debt securities and other investments were classified as Level 2 in the GAAP fair value hierarchy. Fair values were based on data points that are observable, such as quoted prices, interest rates and yield curves.

18. Other Comprehensive Loss

The components of accumulated other comprehensive loss are as follows (in thousands):

	Foreign Currency Translation Adjustments	Change in Fair Value of Derivative Instruments	Pension Plan	Total
Balance at January 1, 2016	$ (106,309)	$ —	$1,662	$(104,647)
Foreign currency translation loss	(477,772)	—	(195)	(477,967)
Gain on derivative instruments, net of tax	—	40,598	—	40,598

of $29.1 million				
Pension liability adjustment, net of tax of $(1.3) million	—	—	(7,554)	(7,554)
Balance at December 31, 2016	(584,081)	40,598	(6,087)	(549,570)
Foreign currency translation gain	207,341	—	(557)	206,784
Loss on derivative instruments, net of tax of $(22.9) million	—	(33,431)	—	(33,431)
Pension liability adjustment, net of tax of $0.4 million	—	—	2,099	2,099
Balance at December 31, 2017	(376,740)	7,167	(4,545)	(374,118)
Foreign currency translation gain	(127,788)	—	267	(127,521)
Gain on derivative instruments, net of tax of $12.7 million	—	36,799	—	36,799
Pension liability adjustment, net of tax of $0.3 million	—	—	2,463	2,463
Balance at December 31, 2018	$ (504,528)	$ 43,966	$(1,815)	$(462,377)

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19. Quarterly Information (Unaudited)

The tables below present summarized unaudited quarterly results of operations for the years ended December 31, 2018 and 2017. Management believes that all necessary adjustments have been included in the amounts stated below for a fair presentation of the results of operations for the periods presented when read in conjunction with the Company's consolidated financial statements for the years ended December 31, 2018 and 2017. Results of operations for a particular quarter are not necessarily indicative of results of operations for an annual period and are not predictive of future periods.

	Quarter Ended March 31,	June 30,	September 30,	December 31,
	(In thousands except per share amounts)			
2018:				
Revenue	$742,241	$765,738	$ 760,916	$ 743,547
Income (loss) before income taxes	$48,088	$69,258	$ 55,036	$ (341,336)
Net income (loss) attributable to Acadia Healthcare Company, Inc. stockholders	$50,819 (1)	$58,836	$ 46,232	$ (331,637) (2)
Basic earnings per share attributable to Acadia Healthcare Company, Inc. stockholders	$0.58 (1)	$0.67	$ 0.53	$ (3.80) (2)
Diluted earnings per share attributable to Acadia Healthcare Company, Inc. stockholders	$0.58 (1)	$0.67	$ 0.53	$ (3.80) (2)
2017:				
Revenue	$679,194	$715,896	$ 716,714	$ 724,512
Income before income taxes	$48,484	$66,216	$ 61,459	$ 60,689
Net income attributable to Acadia Healthcare Company, Inc. stockholders	$34,958	$49,630	$ 45,618	$ 69,629 (3)
Basic earnings per share attributable to Acadia Healthcare Company, Inc. stockholders	$0.40	$0.57	$ 0.52	$ 0.80 (3)
Diluted earnings per share attributable to Acadia Healthcare Company, Inc. stockholders	$0.40	$0.57	$ 0.52	$ 0.80 (3)

(1) Includes tax benefits of $10.5 million pursuant to a change in the Company's provisional amounts recorded at December 31, 2017 related to the enactment of the Tax Act.
(2) Includes loss on impairment of $337.9 million and legal settlements expense of $22.1 million.
(3) Includes a one-time tax benefit of $20.2 million on revaluation of deferred tax items pursuant to the enactment of the Tax Act.

20. Subsequent Events

On February 15, 2019, the Company completed the acquisition of Whittier, an inpatient psychiatric facility with 71 beds located in Haverhill, Massachusetts, for cash consideration of approximately $17.9 million. Also on February 15, 2019, the Company completed the acquisition of Mission Treatment for cash consideration of approximately $22.5 million and a working capital settlement. Mission Treatment operates nine comprehensive treatment centers in California, Nevada, Arizona and Oklahoma.

On February 6, 2019, the Company entered into the Eleventh Amendment to the Amended and Restated Credit Agreement. The Eleventh Amendment, among other things, amended the definition of “Consolidated EBITDA” to remove the cap on non-cash charges, losses and expenses related to the impairment of goodwill, which in turn provided increased flexibility to the Company in terms of the Company’s financial covenants.

On February 27, 2019, the Company entered into the Twelfth Amendment to the Amended and Restated Credit Agreement. The Twelfth Amendment, among other things, modified certain definitions, including “Consolidated EBITDA”, and increased our permitted Maximum Consolidated Leverage Ratio, thereby providing increased flexibility to the Company in terms of the Company’s financial covenants.

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21. Financial Information for the Company and Its Subsidiaries

The Company conducts substantially all of its business through its subsidiaries. The 6.125% Senior Notes, 5.125% Senior Notes, 5.625% Senior Notes and 6.500% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by all of the Company's subsidiaries that guarantee the Company's obligations under the Amended and Restated Senior Credit Facility. Presented below is condensed consolidating financial information for the Company and its subsidiaries at December 31, 2018 and 2017, and for the years ended December 31, 2018, 2017 and 2016. The information segregates the parent company (Acadia Healthcare Company, Inc.), the combined wholly-owned subsidiary guarantors, the combined non-guarantor subsidiaries and eliminations.

Acadia Healthcare Company, Inc.

Condensed Consolidating Balance Sheets

December 31, 2018

(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Current assets:					
Cash and cash equivalents	$—	$32,471	$18,039	$—	$50,510
Accounts receivable, net	—	248,218	69,869	—	318,087
Other current assets	—	60,160	21,660	—	81,820
Total current assets	—	340,849	109,568	—	450,417
Property and equipment, net	—	1,219,803	1,887,963	—	3,107,766
Goodwill	—	1,936,057	460,355	—	2,396,412
Intangible assets, net	—	56,611	32,379	—	88,990
Deferred tax assets – noncurrent	1,841	—	3,468	(1,841)	3,468
Derivative instruments	60,524	—	—	—	60,524
Investment in subsidiaries	5,190,771	—	—	(5,190,771)	—
Other assets	306,495	52,824	9,548	(303,940)	64,927
Total assets	$5,559,631	$3,606,144	$2,503,281	$(5,496,552)	$6,172,504
Current liabilities:					
Current portion of long-term debt	$34,112	$—	$—	$—	$34,112
Accounts payable	—	79,463	38,277	—	117,740
Accrued salaries and benefits	—	84,150	29,149	—	113,299
Other accrued liabilities	32,837	42,062	76,327	—	151,226

Total current liabilities	66,949	205,675	143,753	—	416,377
Long-term debt	3,159,375	—	303,940	(303,940)	3,159,375
Deferred tax liabilities – noncurrent	—	31,874	50,339	(1,841)	80,372
Other liabilities	—	107,866	46,401	—	154,267
Total liabilities	3,226,324	345,415	544,433	(305,781)	3,810,391
Redeemable noncontrolling interests	—	—	28,806	—	28,806
Total equity	2,333,307	3,260,729	1,930,042	(5,190,771)	2,333,307
Total liabilities and equity	$5,559,631	$3,606,144	$2,503,281	$ (5,496,552)	$ 6,172,504

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Acadia Healthcare Company, Inc.

Condensed Consolidating Balance Sheets

December 31, 2017

(In thousands)

	Parent	Combined Subsidiary Guarantors	Combined Non-Guarantors	Consolidating Adjustments	Total Consolidated Amounts
Current assets:					
Cash and cash equivalents	$—	$46,860	$20,430	$—	$67,290
Accounts receivable, net	—	230,890	66,035	—	296,925
Other current assets	—	85,746	21,589	—	107,335
Total current assets	—	363,496	108,054	—	471,550
Property and equipment, net	—	1,086,802	1,961,328	—	3,048,130
Goodwill	—	1,936,057	815,117	—	2,751,174
Intangible assets, net	—	57,628	29,720	—	87,348
Deferred tax assets – noncurrent	2,370	—	3,731	(2,370)	3,731
Derivative instruments	12,997	—	—	—	12,997
Investment in subsidiaries	5,429,386	—	—	(5,429,386)	—
Other assets	381,913	38,860	7,807	(379,008)	49,572
Total assets	$5,826,666	$3,482,843	$2,925,757	$(5,810,764)	$6,424,502
Current liabilities:					
Current portion of long-term debt	$34,550	$—	$280	$—	$34,830
Accounts payable	—	70,767	31,532	—	102,299
Accrued salaries and benefits	—	69,057	29,990	—	99,047
Other accrued liabilities	36,196	27,676	77,341	—	141,213
Total current liabilities	70,746	167,500	139,143	—	377,389
Long-term debt	3,183,049	—	401,017	(379,008)	3,205,058
Deferred tax liabilities – noncurrent	—	27,975	54,728	(2,370)	80,333
Other liabilities	—	103,112	63,322	—	166,434
Total liabilities	3,253,795	298,587	658,210	(381,378)	3,829,214
Redeemable noncontrolling interests	—	—	22,417	—	22,417
Total equity	2,572,871				