Alliance HealthCare Services, Inc
Form 10-K
March 15, 2013

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

ý ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended: December 31, 2012
OR

¨ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to
Commission File Number: 1-16609

ALLIANCE HEALTHCARE SERVICES, INC.
(Exact name of registrant as specified in its charter)

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

100 Bayview Circle, Suite 400, Newport Beach, California 92660
(Address of principal executive office)
Registrant's telephone number, including area code: (949) 242-5300
Securities registered pursuant to Section 12(b) of the Act:

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

Securities registered pursuant to Section 12(g) of the Act:
None
Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ¨ No ý
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 ý
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 ý No ¨
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ý No ¨
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ¨
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

| Large accelerated filer ¨ | Accelerated filer ¨ |
|---|---|
| Non-accelerated filer ý (Do not check if a smaller reporting company) | Smaller reporting company ¨ |

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant as of June 30, 2012, based upon the closing price of the Common Stock as reported by the New York Stock Exchange on such date, was $53.2 million.

The number of shares outstanding of Common Stock, $.01 par value, as of March 14, 2013 was 10,607,810 shares.

Documents Incorporated by Reference

The registrant's definitive proxy statement for the Annual Meeting of Stockholders, to be filed within 120 days of December 31, 2012 is incorporated by reference into Part III of this Annual Report on Form 10-K to the extent stated herein.

PART I

Cautionary Statement Regarding Forward-looking Statements

This Annual Report on Form 10-K, including Item 1, Business; Item 1A, Risk Factors; and Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, particularly in the section entitled Liquidity and Capital Resources, and elsewhere in this Annual Report on Form 10-K, includes "forward-looking statements" within the meaning of the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. In some cases you can identify these statements by forward-looking words, such as "may," "will," "should," "expect," "plan," "anticipate," "believe," "estimate," "predict," "seek," "intend" and "continue" or similar words. Forward-looking statements m use different phrases. Forward-looking statements address, among other things, our future expectations, projections of our future results of operations or of our financial condition and other forward-looking information and include statements related to the Company's improvement plan, including its efforts to stabilize and grow the Imaging Division, grow the Radiation Oncology Division, and increase organizational efficiency through the Journey to Excellence and Project Phoenix initiative, as well as expected annualized savings.

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

(a) future legislation and other healthcare regulatory reform actions, and the effect of that legislation and other regulatory actions on our business,

(b) our expectations with respect to future MRI, PET/CT and radiation oncology volumes and revenues,

(c) the effect of seasonality on our business,

(d) expectations with respect to capital expenditures in 2013, and

(e) the effect of recent accounting pronouncements on our results of operations and cash flows or financial position.

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

- our high degree of leverage and our ability to service our debt;
- factors affecting our leverage, including interest rates;
- the risk that the counterparties to our interest rate swap agreements fail to satisfy their obligations under those agreements;
- our ability to obtain financing;
- the effect of operating and financial restrictions in our debt instruments;
- the accuracy of our estimates regarding our capital requirements;
- intense levels of competition in our industry;
- changes in the rates or methods of third-party reimbursements for diagnostic imaging and radiation oncology services;
- fluctuations or unpredictability of our revenues, including as a result of seasonality;
- changes in the healthcare regulatory environment;
- our ability to keep pace with technological developments within our industry;
- the growth or decline in the market for MRI and other services;
- the disruptive effect of hurricanes and other natural disasters;
- adverse changes in general domestic and worldwide economic conditions and instability and disruption of credit and equity markets;
- our ability to successfully integrate acquisitions; and
- other factors discussed under Risk Factors in this Annual Report on Form 10-K and that are otherwise described or updated from time to time in our SEC reports.

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

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ITEM 1. BUSINESS

General

We are a leading national provider of advanced outpatient diagnostic imaging and radiation therapy services, based upon annual revenue and number of systems deployed. Our principal sources of revenue are derived from providing magnetic resonance imaging ("MRI") and positron emission tomography/computed tomography ("PET/CT") services through our Imaging Division and radiation oncology services through our Radiation Oncology Division. Unless the context otherwise requires, the words "we," "us," "our," "Company" or "Alliance" as used in this Annual Report on Form 10-K refers to Alliance HealthCare Services, Inc. and our direct and indirect subsidiaries. We provide imaging and therapeutic services primarily to hospitals and other healthcare providers on a shared-service and full-time service basis. We also provide services through fixed-site imaging centers, primarily to hospitals or health systems. Our imaging services normally include the use of our imaging systems, technologists to operate the systems, equipment maintenance and upgrades and management of day-to-day shared-service and fixed-site diagnostic imaging operations. We also provide non scan-based services, which include only the use of our imaging systems under a short-term contract. We operate our radiation oncology business through our wholly owned subsidiary, Alliance Oncology, LLC, which we sometimes refer to as our Radiation Oncology Division. This division includes a wide range of services for cancer patients covering initial consultation, preparation for treatment, simulation of treatment, actual radiation oncology delivery, therapy management and follow-up care. Our services include the use of our linear accelerators or stereotactic radiosurgery systems, therapists to operate those systems, administrative staff, equipment maintenance and upgrades, and management of day-to-day operations.

MRI, PET/CT and radiation oncology services generated 42%, 33% and 18% of our revenue, respectively, for the year ended December 31, 2012 and 42%, 34% and 15% of our revenue, respectively, for the year ended December 31, 2011. Our remaining revenue was comprised of other modality diagnostic imaging services revenue, primarily computed tomography ("CT"), professional radiology services, and management contract revenue. We had 490 diagnostic imaging and radiation oncology systems, including 267 MRI systems (of which 19 are operating leases) and 119 positron emission tomography ("PET") or PET/CT systems (of which 9 are operating leases) and served over 1,000 clients in 45 states at December 31, 2012. We operated 128 fixed-site imaging centers (one in an unconsolidated joint venture), which constitute systems installed in hospitals or other medical buildings on or near hospital campuses, including modular buildings, systems installed inside medical groups' offices, parked mobile systems, and free-standing fixed-site imaging centers, which include systems installed in a medical office building, ambulatory surgical center, or other retail space at December 31, 2012. Of the 128 fixed-site imaging centers, 97 were MRI fixed-site imaging centers, 21 were PET or PET/CT fixed-site imaging centers, ten were other modality fixed-site imaging centers and one was in an unconsolidated joint venture. We also operated 29 radiation oncology centers and stereotactic radiosurgery facilities (including one radiation oncology center as an unconsolidated joint venture) at December 31, 2012.

We generated approximately 81% and 80% of our revenues for the year ended December 31, 2012 and 2011, respectively, by providing services to hospitals and other healthcare providers; we refer to those revenues as wholesale revenues. We typically generate our wholesale revenues from contracts that require our clients to pay us based on the number of scans we perform on patients on our clients' behalf, although some pay us a flat fee for a period of time regardless of the number of scans we perform. Wholesale payments are due to us independent of our clients' receipt of retail reimbursement from third-party payors, although receipt of reimbursement from third-party payors may affect demand for our services. We typically deliver our services for a set number of days per week through exclusive, long-term contracts with hospitals and other healthcare providers. The initial terms of these contracts average approximately three years in length for mobile services and approximately five to 10 years in length for fixed-site arrangements. These contracts often contain automatic renewal provisions and certain contracts have cancellation clauses if the hospital or other healthcare provider purchases its own system. We price our contracts based on the type of system used, the scan volume, and the number of ancillary services provided. Competitive pressures also affect our pricing.

We generated approximately 19% and 20% of our revenues for the year ended December 31, 2012 and 2011, respectively, by providing services directly to patients from our sites located at or near hospitals or other healthcare provider facilities; we refer to these revenues as retail revenues. We generate our revenue from these sites from direct

billings to patients or their third-party payors, including Medicare, and we record this revenue net of contractual discounts and other arrangements for providing services at discounted prices. We typically receive a higher price per scan, or treatment, under retail billing than we do under wholesale billing.

Fixed-site imaging centers and radiation oncology centers can be structured as either wholesale or retail arrangements. Our contracts for radiation oncology services average approximately 8 to 15 years in length. We include revenues from these centers in either our wholesale or retail revenues.

Our clients contract with us to provide diagnostic imaging and radiation oncology systems and services to:

- take advantage of our extensive diagnostic imaging and radiation oncology project management experience;
- avoid capital investment and financial risk associated with the purchase of their own systems;
- provide access to MRI, PET and PET/CT, radiation oncology and other services for their patients when the demand for these services does not justify the purchase of dedicated, full-time systems;
- benefit from upgraded imaging systems and technology without direct capital expenditures;
- eliminate the need to recruit, train and manage qualified technologists or therapists and oncologists;
- make use of our ancillary services; and
- gain access to services under our regulatory and licensing approvals when they do not have these approvals.

We were incorporated in the state of Delaware on May 27, 1987.

Significant 2012 Corporate Events

On April 28, 2012, we announced the appointment of Larry C. Buckelew as Interim Chief Executive Officer ("CEO"), which became effective on June 1, 2012, immediately succeeding Paul S. Viviano. Mr. Buckelew has served Alliance HealthCare Services since 2009 as a company director, including membership on the Audit and Compensation Committees. Previous to Mr. Buckelew's appointment as CEO, he served as President and CEO of Gambro Healthcare, Inc. from November 2000 through October 2005, and served in numerous executive and management positions, including positions with American Hospital Supply Corporation, Baxter International, Inc., Sunrise Medical, Inc., Teleflex, Inc., and Surgical Services, Inc. Upon Mr. Buckelew's appointment, he resigned from both the Audit and Compensation Committees of our Board of Directors.

Effective June 1, 2012, Richard A. Jones was appointed as President of the Imaging Division of Alliance HealthCare Services. Mr. Jones has been with Alliance since December 23, 1996, serving as Regional Vice President of the Northeast region from December 2003 to October 2008, then as Senior Vice President of the Northeast region from October 2008 to August 2011 and since August 2011 as Executive Vice President of the Imaging Division.

Effective June 4, 2012, Michael Shea was appointed as Chief Operating Officer. Previously, Mr. Shea was a Senior Vice President of Operations at DaVita, Inc. for operations in California, Nevada, and Arizona. Mr. Shea was also the senior executive in charge of DaVita’s Hospital Services Group. Prior to DaVita, he was the Senior Vice President of Business development and marketing at TeamHealth, a publicly held outsourced physician services company.

In October 2012, we reached an agreement with our lenders for a second amendment to our Credit Agreement ("the amendment") dated December 1, 2009. The amendment modified the existing financial covenants, now requiring us to maintain a maximum ratio of consolidated total debt to Consolidated Adjusted EBITDA less minority interest expense of 5.00 to 1.00 through September 30, 2014, 4.75 to 1.00 from October 1, 2014 through September 30, 2015, 4.50 to 1.00 from October 1, 2015 through December 31, 2015 and 4.25 to 1.00 thereafter. The minimum ratio of consolidated Adjusted EBITDA less minority interest expense to consolidated interest expense will remain unchanged (See Note 2 to our Consolidated Financial Statements included elsewhere in this Report).

In connection with the execution of the amendment, we raised $30.0 million from the sale of certain imaging assets, which we then leased from the purchasers under competitive terms. The $30.0 million in proceeds from the sale and lease transactions was combined with $44.5 million of our own cash to make a total payment of $74.5 million to permanently reduce borrowings outstanding under the term loan facility. This prepayment made in connection with the amendment satisfies all future mandatory amortization payments under the terms of the Credit Agreement, which matures in June 2016.

On December 7, 2012, our Board of Directors approved a 1-for-5 reverse stock split for our outstanding common stock (the “Reverse Stock Split”). The Reverse Stock Split was effective as of the close of trading on December 26, 2012, and our common stock commenced trading on a post-split basis at the opening of the market on December 27, 2012.

On January 31, 2013, our common stock was approved for listing on The NASDAQ Global Market (“NASDAQ”). Our common stock ceased trading on the New York Stock Exchange as of the closing of the market on February 8, 2013, and commenced trading on NASDAQ at the opening of the market on February 11, 2013.

Industry Overview

Diagnostic imaging services are noninvasive procedures that generate representations of the internal anatomy and convert them to film or digital media. Diagnostic imaging systems facilitate the early diagnosis of diseases and disorders, often minimizing the cost and amount of care required and reducing the need for costly and invasive diagnostic procedures. Radiation oncology is the practice of delivering ionizing radiation therapy to treat malignant and benign disease processes

under the direction of a radiation oncologist. The market of radiation oncology providers is highly fragmented with approximately 70% of services still performed in hospitals.

MRI

MRI technology involves the use of high-strength magnetic fields to produce computer-processed cross-sectional images of the body. Due to its superior image quality, MRI is the preferred imaging technology forevaluating soft tissue and organs, including the brain, spinal cord and other internal anatomy. With advances in MRI technology, MRI is increasingly being used for new applications such as imaging of the heart, chest and abdomen. MRI can detect conditions like multiple sclerosis, tumors, strokes, infections, and injuries to the spine, joints, ligaments, and tendons. Unlike X-Rays and CT, which are other diagnostic imaging technologies, MRI does not expose patients to potentially harmful radiation.

MRI technology was first patented in 1974, and MRI systems first became commercially available in 1983. Since then, manufacturers have offered increasingly sophisticated MRI systems and related software to increase the speed of each scan and improve image quality. Magnet strengths are measured in tesla, and MRI systems typically use magnets with strengths ranging from 0.2 to 3.0 tesla. The 1.0 and 1.5 tesla strengths are generally considered optimal because they are strong enough to produce relatively fast scans but are not so strong as to create discomfort for most patients. Manufacturers have worked to gradually enhance other components of the machines to make them more versatile. Many of the hardware and software systems in recently manufactured machines are modular and can be upgraded for much lower costs than purchasing new systems.

The MRI industry has historically experienced growth as a result of:

- recognition of MRI as a cost-effective, noninvasive diagnostic tool;
- superior soft-tissue image quality of MRI versus that of other diagnostic imaging technologies;
- wider physician acceptance and availability of MRI technology;
- growth in the number of MRI applications;
- MRI's safety when compared to other diagnostic imaging technologies, because it does not use potentially harmful radiation; and
- increased overall demand for healthcare services, including diagnostic services, for the aging population.

PET, PET/CT and CT

PET is a nuclear medicine procedure that produces images of the body's metabolic and biologic functions. PET can provide earlier detection of certain cancers, coronary diseases or neurologic problems than other diagnostic imaging systems. It is also useful for the monitoring of these conditions. PET can detect the presence of disease at an early stage. The ability of PET technology to measure metabolic activity assists in the identification of lesions and the assessment of organ health. A growing body of clinical research supports PET as a diagnostic tool for cancer diagnosis, staging, and treatment monitoring. Early detection of these conditions enables a broader range of treatments. The expansion of Centers for Medicare & Medicaid Services ("CMS") coverage has driven the growth of PET. Since 1998, CMS has expanded coverage of PET procedures to include the diagnosis, staging, and restaging of lung, esophageal, colorectal, breast, head and neck cancers, lymphoma, and melanoma. Additionally, Medicare covers the use of PET scans for the diagnosis and treatment of dementia and neurodegenerative diseases, as well as for brain, cervical, ovarian, pancreatic, small lung cell, and testicular cancers. Under CMS's current national coverage determination, PET is covered for the detection of pre-treatment metastases in newly diagnosed cervical cancer, as well as for brain, ovarian, pancreatic, small cell lung, and testicular cancers, where provided as part of certain types of clinical trials. In April 2009, CMS adopted a coverage framework that replaces the four-part diagnosis, staging, restaging and monitoring categories with a two-part framework. This new framework differentiates fluorodeoxyglucose ("FDG") PET imaging used to inform the initial treatment strategy from other uses to guide subsequent treatment strategies after the completion of initial treatment. This change applies to all national coverage determinations that address coverage of FDG PET for oncologic conditions.

In CT imaging, a computer analyzes the information received from an X-Ray beam to produce multiple cross-sectional images of a particular organ or area of the body. CT imaging is used to detect tumors and other conditions affecting bones and internal organs.

A PET/CT system fuses together the results of a PET and CT scan at the scanner level. The PET portion of the scan detects the metabolic signal of cancer cells and the CT portion of the scan provides a detailed image of the internal

anatomy that reveals the location, size and shape of abnormal cancerous growths.

Other Diagnostic Imaging Services

Other diagnostic imaging technologies include: nuclear medicine or gamma camera, ultrasound, mammography, bone densitometry and general X-Ray.

Radiation Oncology

Radiation oncology is the medical practice of delivering radiation therapy under the direction of a trained physician, a radiation oncologist. Radiation oncology uses ionizing radiation to most commonly treat cancer, along with non-malignant conditions. In general, radiation therapy is delivered in daily treatments over a period that varies from a single day (single treatment) to many weeks (40 or more treatments). Ionizing radiation damages a cell's DNA and other vital macromolecules that the cell and the body then has to repair. Cancer cells are less able to repair the DNA and macromolecules damage than are normal healthy cells, which usually can repair the damage in the first 4-6 hours after an individual treatment. Over the period during and after the radiation therapy is delivered in one or more daily radiation therapy treatments, the cancer cells are preferentially destroyed while normal cells are able to recover. Eventually, the cancer cells within the irradiated volume are reduced in number and eradicated while the normal surrounding tissue survives-effecting a cure, or control of the disease in that treated volume.

We estimate that approximately 50-60% of all newly diagnosed cancer patients today will be treated with some form of radiation therapy for their cancer therapy, throughout their life time. Radiation therapy often is used together with other oncology treatments such as chemotherapy and surgery. A typical radiation oncology department provides a wide range of services for cancer patients. These include: initial consultation; preparation for treatment; imaging, planning, and simulation for the treatment; delivery of radiation therapy treatments; management of the total course of therapy; and follow-up care. A number of different technologies can deliver the radiation, including linear accelerators and radioactive isotopes.

Our radiation oncology business offers the following treatment options:

- Conventional beam therapy (“CBT”). CBT is the least sophisticated, but the most established form of radiation therapy delivered by a linear accelerator. It is the simplest form to deliver, using two dimensional planning, and is typically reserved for use in patients where high precision and conformality of the radiation therapy is not required or when a cure is not envisioned (palliative care).
- 3-D conformal radiation therapy (“3D-CRT”). 3D-CRT uses three dimensional imaging data and three dimensional treatment planning to more accurately and effectively plan and deliver linear accelerator radiation treatments. It is the most common form of technology used in practices and may be supplanted by IMRT or in conjunction with IGRT when the specific case requires a higher level of precision or conformality.
- Intensity modulated radiation therapy (“IMRT”). IMRT entails the use of hundreds to thousands of beams or beamlets of radiation delivered by a linear accelerator whose intensity is adjusted individually during that actual daily treatment delivery to allow the radiation that is delivered to conform as closely as possible to the three dimensional volume of the tumor and simultaneously reduce the dose to neighboring normal healthy tissues. It requires extremely sophisticated and time consuming treatment planning to determine what beam's shapes and orientations should be used and what their intensities should be to provide the optimal patient treatment based on the patient's anatomy of their normal tissues and the targeted tumor volume. Extensive treatment quality assurance is required to insure that all the beams are modulated and delivered correctly.
- Image guided radiation therapy (“IGRT”). IGRT uses a number of different types of imaging technologies to localize precisely the patient and the tumor target volume at the time of each treatment delivery to ensure that the radiation is delivered to the correct location. IGRT is not a radiation treatment in and of itself; it is used in support of advanced forms of treatment delivery such as 3D-CRT, IMRT, stereotactic body radiotherapy and stereotactic radiosurgery.
- Stereotactic radiosurgery (“SRS”) and Stereotactic Body Radiotherapy (“SBRT”). Originally developed for intracranial applications (SRS) but now being used in a range of extracranial applications (SBRT) such as spine, lung, liver, prostate, and other disease sites, SRS/SBRT delivers a very high dose of radiation in one to five treatments as opposed to the 10 to 40 treatments used for 3D-CRT, IMRT and IGRT. SRS/SBRT needs to be as precisely planned for and delivered as possible because a very high dose of radiation therapy is delivered in five or fewer treatments and results in a more potent dose effect that destroys all cells, cancer and normal alike, that reside within the targeted volume; this results in a “surgical ablative” response to the treated volume. SRS/SBRT is delivered with a range of advanced technologies such as the CyberKnife®, Gamma Knife®, BrainLab,™ Novalis-Tx,™ TrueBeam STx,™ Trilogy,™ VERO, TomoTherapy®, Elekta Infinity™ and Axesse.™
- Low dose rate brachytherapy (“LDR”). LDR allows the radiation oncologist to treat cancer by delivering the dose of radiation from the “inside out.” Radioactive isotopes encased in a metal jacket the size of a grain of rice (“seeds”) are

implanted directly in the tumor through needles, with the seeds permanently left in place, or left in place temporarily within catheters (thin hollow tubes) and removed with the catheters when treatment is completed. The radioactive isotopes decay over time (days to years) to an inert form and in the process gradually release ionizing radiation, called gamma rays, which are generally of low energy and thus deposit their therapy over short distances thereby treating the cancer over time (hours to days).

- High dose rate brachytherapy ("HDR"). Like LDR, HDR allows the radiation oncologist to treat cancer by delivering the dose of radiation from the "inside out." Unlike LDR, HDR utilizes temporary seeds, made of radioactive isotopes,

that deliver a much higher dose of radiation over a much shorter period of time. These seeds are inserted and removed several times, over several minutes, one to two times per day, for 1-30 treatments delivered over 1-45 days, through catheters that are left in place for the entire course of care and then removed when the treatment course is completed.

Imaging and Radiation Oncology Settings

We typically provide diagnostic imaging services and radiation oncology services in one of the following settings:

- Outsourced. Imaging systems, largely located in mobile trailers but also provided in fixed facilities, provide services to a hospital or clinic on a shared-service or full-time basis. Generally, the hospital or clinic contracts with the imaging service provider to perform scans of its patients, and that hospital or clinic, instead of a third-party payor, pays the imaging service provider directly.
- Hospitals and clinics. Imaging and/or radiation oncology systems are located in a hospital or clinic. These systems are primarily used by patients of the hospital or clinic, and the hospital or clinic bills third-party payors, such as health insurers, including Medicare or Medicaid.
- Independent centers. Systems are located in permanent facilities not generally owned by hospitals or clinics. These centers depend upon physician referrals for their patients and generally do not maintain dedicated, contractual relationships with hospitals or clinics. In fact, these centers may compete with hospitals or clinics that have their own systems to provide imaging and/or radiation oncology services to these patients. Like hospitals and clinics, these centers bill third-party payors for their services.

All of our radiation oncology services are provided in a hospital setting or at an independent radiation oncology center.

Our Competitive Strengths

A leading national provider of shared-service and fixed-site MRI and PET/CT services

We are a leading national provider of shared-service and fixed-site MRI and PET/CT services, based on annual revenue and number of diagnostic imaging systems deployed. As of December 31, 2012, we had 267 MRI systems and 119 PET or PET/CT systems in operation. Our size allows us to achieve operating, sourcing and administrative efficiencies, including (i) the ability to maximize utilization through efficient deployment of our mobile systems and (ii) equipment and medical supply sourcing savings and favorable maintenance contracts from equipment manufacturers and other suppliers.

Ability to expand into radiation oncology using our leading national position in MRI and PET/CT services

We have relationships with more than 1,000 hospitals and healthcare providers in 45 states throughout the nation. This national footprint has enabled us to leverage our position as a trusted partner to healthcare providers to expand our services beyond diagnostic imaging and into radiation oncology, transforming us into a more complete outsourced service provider to our clients.

Comprehensive diagnostic and treatment solutions

We offer our clients a comprehensive diagnostic imaging and radiation oncology solution, as well as ancillary services, such as marketing support, education, training and billing assistance. In many cases, we provide services under our regulatory and licensing approvals for clients who lack that authority. We believe that a comprehensive service solution is an important factor when potential clients select a diagnostic imaging or radiation oncology provider.

Exclusive, long-term contracts with a diverse client base

We primarily generate revenues from exclusive, long-term contracts with hospitals and other healthcare providers. These contracts average approximately three years in length for mobile services, approximately five to 10 years in length for fixed-site arrangements and approximately 10 to 20 years in length for radiation oncology contracts. During the year ended December 31, 2012, no single client accounted for more than 2% of our revenue.

Reduced reimbursement risk

For the year ended December 31, 2012, we generated approximately 81% of our revenues by billing hospitals and other healthcare providers rather than billing patients or other third-party payors. These payments are due to us regardless of the clients' receipt of payment from patients or reimbursement from third-party payors, including commercial payors, Medicare and Medicaid. Importantly, this contrasts with the vast majority of other diagnostic imaging and radiation oncology providers, who typically collect directly from patients and third-party payors and are therefore directly exposed to reimbursement cuts and higher experiences of bad debt. Our wholesale model reduces

our exposure to patient bad debt, as evidenced by our bad debt expense of only 0.6% of revenues for the year ended December 31, 2012. Further, our short-term exposure to Medicare

reimbursement cuts is limited because we received only approximately 4% of our imaging revenues directly from Medicare for the year ended December 31, 2012.

Significant cash flow generation

We have generated significant cash flows and have maintained attractive margins over a sustained period of time. We attribute our strong cash flows and margins to: (1) comprehensive imaging and treatment solutions, (2) the substantial value proposition for customers, (3) the strength of our customer relationships, (4) the largely wholesale nature of our revenues and (5) our economies of scale.

Experienced management team

Our senior management team consists of professionals with significant experience within the hospital and healthcare services industry. Our experienced management team includes six senior executive officers who average approximately 25 years of industry experience.

Advanced MRI, PET/CT, and radiation oncology systems

Our technologically advanced imaging systems can perform high quality scans more rapidly and can be used for a wider variety of imaging applications than less advanced systems. Moreover, technological change in this field is gradual and most of our systems can be upgraded with software and hardware enhancements, which should allow us to continue to provide advanced technology without replacing entire systems. Our radiation oncology services use advanced radiation oncology technology, including IGRT, IMRT and SRS.

Our Services

We provide our outsourcing imaging services on the following bases:

- Shared Service. We offered 55% of our systems on a part-time basis. These systems are located in mobile trailers that we transport to our clients' locations. We schedule deployment of these mobile systems so that multiple clients can share use of the same system. The typical shared-service contract has a term of approximately three years.

- Full-Time Service. We offered 32% of our systems on a full-time, long-term basis. These systems are located in either mobile units or buildings located at or near a hospital or clinic. We provide full-time service systems for the exclusive use of a particular hospital or clinic. We typically offer full-time services under contracts that range from five to 10 years in length. Our relationships with our higher-volume shared-service clients have, from time to time, evolved into full-time arrangements.

- Interim and Rental Services. We offered 13% of our systems to clients on an unstaffed basis. These systems are located in mobile trailers that we transport to our clients' locations. These clients may be unable to maintain the extra capacity to accommodate periods of peak demand for imaging services or may require temporary assistance until they can develop permanent imaging service centers at or near their facilities. Generally, we do not provide technologists to operate our systems in these arrangements.

We offer all of our radiation oncology services on a full-time, long-term basis.

Our Strategy

We are committed to three initiatives to counter the pressures that persist in the economy and healthcare services industry. The three critical elements that we have defined to drive Alliance's continued success are:

- to grow imaging services,
- to expand radiation oncology services and
- to drive a culture of organizational efficiency.

Grow Imaging Services

Our Imaging Division has proactively defined and developed a plan to grow imaging services. Now that the imaging division has been stabilized, we have centered our plan on two key areas:

- developing a compelling value proposition
- driving operating efficiency/cost structure.

Developing a Compelling Value Proposition

We believe we are market leaders in being a hospital-centric partner. Our traditional wholesale model is well received and has a proven track record of success. Alliance is building on the success of this model by creating an expanded value proposition that we believe will make us indispensible to our customers. We have engaged a sales consulting firm that is assisting in designing a refined sales strategy and shaping a compelling value proposition to offer to hospital customers. We will continue to offer the traditional services for which Alliance is well known, however, our expanded offerings are being designed to maximize profitability for our hospital customers. We intend to help augment the performance of radiology departments by offering expert consulting and value-added services such as-strategy and analytics, market intelligence, staff recruiting and training, understanding referral patterns and driving operational excellence initiatives and efficiencies.

We have undertaken extensive market and customer segmentation work, which we have used to tailor the value proposition to different types, or segments, of hospital customers. The segmentation effort was useful in terms of providing focused efforts in the most profitable and cost efficient manner. As a result of this process, we divided the sales force into two business development teams with an executive leading each team. The first team is focused on driving new, high-quality sales opportunities more quickly and the second team is dedicated to improving contract renewals of existing customers. Some of our sales initiatives include assessing talent and staffing levels, new training programs and next-generation sales force management program development, which includes defining new sales and renewals processes, metrics and redesigned reporting. Additionally, the sales and business development compensation programs have were revamped to align the refined strategies with our focus on how best to meet our customers' needs.

We are focused on continuing to improve sales management and sales support infrastructure to increase the pace of new business and retain current customers through renewals. We believe a strengthened sales force will enable us to further diversify our business, pursue growth in low market share territories and focus on converting mature mobile customers to fixed-sites. We believe that the ability of our sales force to effectively cross-sell mobile and fixed-site MRI, mobile and fixed-site PET/CT, radiation oncology, professional radiology services and women's breast healthcare centers will provide us with future growth and margin enhancement.

Finally, in conjunction with our refined sales strategy, we have launched a process to revamp our core marketing processes. This initiative includes new training programs for our account executives, identifying core metrics and dashboards to be monitored against, developing territory plans and implementing a national marketing program, which includes new messaging, collateral and content management. Additionally, we are refocusing the Imaging Division's marketing footprint by identifying locations with high probability for success given macro factors, contractual factors and renewal priorities.

Driving Operating Efficiency/Cost Structure

Our Imaging Division is dedicated to managing the core imaging business in an efficient and cost effective manner in order to provide continued generation of strong operating cash flow. We have decreased the number of our regions in our Imaging Division from four to two, while continuing to standardize policies and procedures nationwide. In doing so, we believe we will continue to benefit from our regional managements' direct contact and knowledge of markets we serve, while enhancing quality, consistency and efficiency across the regions.

The significant cost savings program initiated during 2011 was heavily concentrated within our Imaging Division and supported our operating efficiency initiative. This cost savings effort has strengthened our Imaging Division on a national scale by restructuring routes of the mobile fleet to minimize logistical costs, appropriately aligning staffing levels with utilization and optimizing sourcing opportunities with all of our suppliers, including service contract providers and medical supply vendors. To support this program, we invested in a full time procurement office to manage these efforts company-wide and renegotiate price and terms on our behalf. Further, we retired many systems from our fleet during 2012 by employing more efficient routing and eliminating customers that were unprofitable or marginally profitable. During 2012 we traded-in or sold 45 MRIs, 10 PET/CTs, and 31 other systems. This exercise enabled us to eliminate the on-going maintenance of these systems as well as reduce unnecessary overhead required to manage a large mobile fleet. As a result of these efforts and the decision to terminate unprofitable customers, our revenue declined $21.4 million, or 4.3%, in 2012 while our cost of revenue declined $26.5 million, or 9.5%, and total expenses including SG&A decreased $27.6 million, or 7.7%, compared to 2011, mostly stemming from our careful analysis of appropriately reducing our existing customer base in light of customer profitability.

As we enter 2013, we will continue to examine possible reduction to our costs through consistent tracking of customer profitability, seeking further expense reductions and maximizing operational efficiencies to improve margins. To do so, in 2012, we created and continue to create dynamic reporting tools and dashboards to optimize business objectives and provide visibility into the cost drivers of our business. We are also consistently assessing the talent levels of our management team and in 2012 we reorganized our Imaging Division's organizational structure to align with our company-wide strategy of investing in strategic leadership. We believe these efforts will enable our Imaging Division to continue to operate our mobile, shared-service and fixed-site MRI and PET/CT business to maximize efficiency, clinical excellence and cash flow.

Expand Radiation Oncology Services

Radiation oncology is an established, growing form of treatment that has exhibited strong operating margins and a strong return on investment for us to date. Radiation oncology represents a significant opportunity for us, as we believe PET/CT technology is increasingly used for the early detection of cancer and approximately 50-60% of new cancer cases are treated with radiation oncology each year. Our Radiation Oncology Division has grown significantly over the past few years through both de-novo development and strategic acquisitions. For example, through the acquisition of US Radiosurgery in 2011, we added eight stereotactic radiosurgery facilities to our existing portfolio of centers and has greatly expanded our pipeline of SRS projects. During 2012 we opened three de-novo SRS facilities, and as of December 31, 2012, we operated 29 radiation oncology centers (one in unconsolidated joint ventures), including 17 in dedicated SRS facilities.

We plan to continue to grow and expand our Radiation Oncology Division by fully integrating our spectrum of care offerings, with an emphasis on opening de-novo centers and driving industry-leading volume growth. We intend to find the best solution to address customer needs and become indispensible to our customers. We believe the opportunities that exist in the radiation therapy clinical service line remain strong, especially in the SRS segment. Relative to our sales strategy, we are creating metrics and pricing tools and performing extensive market assessments to drive appropriate investment decisions. Lastly, we are aligning the incentive plans of our business development team to the growth initiatives for de-novo openings that exhibit stronger returns on capital, as well as assessing appropriate support levels needed to drive the sales strategy.

In pursuit of our company-wide initiative to monitor performance of existing customers and centers more effectively, in 2012 we undertook a performance assessment of our Radiation Oncology Division, including its existing facilities and partnerships. As a result of this analysis, we developed specific action plans for each center based on the review. Action plans included initiatives to focus on driving volume growth through adding SBRT capability to select existing linear accelerator systems and increased marketing efforts at well-performing facilities. Additionally, we created specific action plans for improvement or divesture for underperforming sites with targeted dates of completion. We implemented these action plans effectively, and sold or closed 10 of our radiation oncology centers during 2012. We continue to be focused on driving volume and efficiency plans at our existing centers.

Drive a Culture of Organizational Efficiency

We have executed on a company-wide transformation project to take advantage of organizational efficiencies across the entire organization. These efforts have improved efficiency and quality of service while reducing costs and maximizing the internal and external customer service levels we provide. This initiative supports the Imaging and Radiation Oncology clinical service lines by establishing a framework for company-wide excellence and provides specific service level training to our support service functions. In addition, we have completed a corporate administrative restructuring and are assessing all functions of our business for productivity efficiencies. We have engaged consultants to assist in lean process improvements and are closely reviewing all administrative costs for savings opportunities. During 2011 and 2012 we achieved approximately $36 million in annualized savings company-wide by executing on the cost efficiency initiatives described, which exceeded the annualized savings goal announced in August 2011 of $20.0 million to $25.0 million.

We continue to invest significantly in leadership development, talent management and performance, training, incentives and recognition. Additionally, we have invested in our recruiting team to develop our recruiting organization, upgrade talent in key positions through active program management and develop recruiting scoreboards. We believe these investments are necessary to sustain and ensure our success in the long-term.

Most importantly, we are dedicated to the highest level of patient care standards and clinical quality. We strive to provide a variety of solutions designed to meet the needs of our clients by developing new surveying tools for both patients and clients. These surveying tools provide performance-driven data that enables us to improve levels of satisfaction for all of our clinical services. As a result of these efforts, we have achieved the highest levels of accreditation. We were the first national provider of shared-imaging services to be awarded accreditation by The Joint Commission on Accreditation of Healthcare Organizations, or JCAHO, in 1998. All of our sites and centers are currently accredited by The Joint Commission (formerly known as JCAHO) or certified by the American College of Radiology.

Contracts and Payment

Our typical MRI and PET/CT contract is exclusive, averages approximately three years in length for mobile services and five to 10 years in length for fixed-site imaging center arrangements, and often includes an automatic renewal provision. Most of our contracts require a fee for each scan we perform. With other contracts, we bill clients on a fixed-fee basis for a period of time, regardless of the number of scans performed. These fee levels are affected primarily by the type of imaging system provided, scan volume and the number of ancillary services provided. Our typical radiation oncology contract is exclusive, averages approximately 10 to 20 years in length and often includes an automatic renewal provision.

Wholesale payments under our contracts are due to us independent of our clients' receipt of retail reimbursement from third-party payors. We generated approximately 81% of our revenues for the year ended December 31, 2012 by providing these services to hospitals and other healthcare providers. To a lesser extent, we generate our revenues from direct billings to patients or their medical payors. We generated approximately 19% of our revenues for the year ended December 31, 2012 by providing services directly to patients or their medical payors. We typically reserve the right to reduce a client's number of service days or terminate an unprofitable contract.

Systems

As of December 31, 2012, we had 490 diagnostic imaging and radiation oncology systems, including 267 MRI systems, 119 PET or PET/CT systems, and 104 other systems, substantially all of which we own. We operated 128 fixed-site imaging centers (one in an unconsolidated joint venture), which are classified into three categories. The first category is hospital-based fixed-site imaging centers, which includes systems installed in hospitals or other buildings on hospital campuses, including modular buildings. The second category is physician-based fixed-site imaging centers, which includes systems installed inside medical groups' offices, most of which are owned by hospitals. The third category is free-standing fixed-site imaging centers, which includes systems installed in a medical office building, ambulatory surgical center, or other retail space. Of the consolidated fixed-site imaging centers, 85 were hospital-based fixed-site imaging centers, 23 were physician-based fixed-site imaging centers, and 19 were free-standing fixed-site imaging centers. Of the 128 fixed-site imaging centers we operated at December 31, 2012, 97 were MRI fixed-site imaging centers, 21 were PET/CT fixed-site imaging centers, ten were other modality fixed-site imaging centers, and one was an unconsolidated joint venture. We have made significant investments in our systems in an effort to ensure that we maintain the newest, most advanced imaging systems that meet our clients' needs. Moreover, because we can upgrade most of our current MRI and PET/CT systems, we believe we have reduced the potential for technological obsolescence. We also operated 29 radiation oncology centers and stereotactic radiosurgery facilities (including one radiation oncology center in an unconsolidated joint venture) at December 31, 2012.

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

Regional Structure / Segments

We divide our imaging operations into two geographic regions. None of our revenues for the years ended December 31, 2012, 2011 and 2010 were derived from business outside the United States. We believe we will continue to benefit from our regional managers' direct contact with and knowledge of the markets we serve, which allows us to address the specific needs of each local operating environment. Each region continues to market, manage and staff the operation of its imaging systems and is run as a separate profit center responsible for its own revenues, expenses and overhead. To complement this regional arrangement, we continue to have standardized contracts, operating policies and other procedures that we implement nationwide in an effort to ensure quality, consistency and efficiency across all regions. We run radiation oncology as a separate profit center responsible for its own revenues, expenses and overhead, and we manage it on a national basis. For the purposes of Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") 280, "Segment Reporting," we have two reportable segments, Imaging and Radiation Oncology, based on similar economic and other characteristics. See Note 17 of the Notes to the Consolidated Financial Statements for financial information about our segments.

System Management and Maintenance

We actively manage deployment of our imaging systems to increase their utilization through the coordinated transportation of our mobile systems using 150 power units, which are large trucks that pull the trailers, or coaches, that house and transport our mobile systems. We examine client requirements, route patterns, travel times, fuel costs and system availability in our deployment process. We currently schedule our shared-service MRI and PET/CT systems for as little as one-half day and up to seven days per week at any particular client, with an average usage of 1.5 days per week per client. Drivers typically move the systems at night and activate them upon arrival at each client location so that the systems are operational when our technologists arrive.

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

Sales and Marketing

As of December 31, 2012, our national sales and business development force and sales support staff consisted of 26 members. These employees identify and contact potential clients and encourage current customers to renew their contracts with us and expand their business with us. The sales force is organized nationally under leadership in each of the Imaging and Radiation Oncology Divisions. The Imaging Division is under the oversight of two senior vice presidents, one who focuses on driving new sales and one who leads the initiative for renewals of current customers. The Radiation Oncology Division is under the oversight of a senior vice president and regional management. Some of our executive officers and senior vice presidents also spend a portion of their time participating in contract negotiations. As of December 31, 2012, we also had 35 marketing representatives who are focused on increasing the number of scans or treatments performed with our systems by educating physicians and radiation oncologists about our new imaging and radiation oncology applications and service capabilities.

Competition

The markets for diagnostic imaging and radiation oncology services are highly fragmented and have few national service providers. We believe that the key competitive factors affecting our business include:

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

We are, and expect to continue to be, subject to competition in our targeted markets from businesses offering diagnostic imaging and radiation oncology services, including existing and developing technologies. Many companies are engaged in the shared-service and fixed-site imaging market, including two national competitors and many smaller regional competitors. These competitors include RadNet, Inc., Center for Diagnostic Imaging (which purchased InSight Health Services Corp. in 2012), Diagnostic Imaging Group, American Radiology Services and several smaller regional competitors, including Medquest, Inc., Shared Medical Services, Kings Medical Company Inc. and DMS Health Group. We also face numerous competitors in the radiation oncology market, including Radiation Therapy Services, Inc., Vantage Oncology, Inc., Oncure Medical Corp., US Oncology, Inc. (a subsidiary of McKesson Corporation since December 30, 2010) and many other smaller regional competitors. While we believe that we had a greater number of diagnostic imaging systems in operation and also had greater revenue from diagnostic imaging services during the year ended December 31, 2012 than our principal competitors, some of our competitors may now or in the future have access to greater resources than we do.

In addition to direct competition from other imaging and radiation oncology providers, we compete with independent imaging centers and referring physicians with diagnostic imaging systems in their own offices, as well as with original equipment manufacturers ("OEMs") that aggressively sell or lease imaging systems to healthcare providers for full-time installation. In recent years, we have seen an increase in direct sales by OEMs of systems to some of our clients. OEMs typically target our higher scan volume clients. These sales efforts by OEMs have resulted in an overcapacity of systems in the marketplace, especially for medical groups that add imaging capacity within their practice settings. This situation has caused an increase in the number of our higher scan volume clients deciding not to renew their contracts. We typically replace these higher volume scan clients with lower volume clients. Our MRI revenues decreased during the year ended December 31, 2012 compared to 2011. We believe that MRI revenues will continue to decline in future years.

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

Employees

As of December 31, 2012, we had 1,720 employees, of whom 1,344 were trained diagnostic imaging technologists, therapists, patient coordinators, other clinical and technical support staff or drivers. In addition, we use independent

contractor drivers for some long-haul and rural routes. We believe we have good relationships with our employees.

Seasonality

We experience seasonality in the revenues and margins generated for our services. First and fourth quarter revenues are typically lower than those from the second and third quarters.

Regulation

Our business is subject to extensive federal and state government regulation. This includes the federal Anti-Kickback Law and similar state anti-kickback laws, the Stark Law and similar state laws affecting physician referrals, the federal False Claims Act, the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009, or HITECH Act, and similar state laws addressing privacy and security, state unlawful practice of medicine and fee splitting laws and state CON laws. Although we believe that our operations materially comply with the laws governing our industry, it is possible that non-compliance with existing laws or the adoption of new laws or interpretations of existing laws could adversely affect our financial performance.

Fraud and Abuse Laws; Physician Referral Prohibitions

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

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

The Anti-Kickback Law is broad, and it prohibits many arrangements and practices that are lawful in businesses outside of the healthcare industry. Recognizing that the Anti-Kickback Law is broad and may technically prohibit many innocuous or beneficial arrangements within the healthcare industry, the U.S. Department of Health and Human Services, or DHHS, issued regulations in July 1991, which the DHHS has referred to as “safe harbors.” These safe harbor regulations set forth certain provisions that, if met in form and substance, will assure healthcare providers and other parties that they will not be prosecuted under the federal Anti-Kickback Law. Additional safe harbor provisions providing similar protections have been published intermittently since 1991. Our arrangements with physicians, physician practice groups, hospitals and other persons or entities who are in a position to refer may not fully meet the stringent criteria specified in the various safe harbors. Although full compliance with these provisions ensures against prosecution under the federal Anti-Kickback Law, the failure of a transaction or arrangement to fit within a specific safe harbor does not necessarily mean that the transaction or arrangement is illegal or that prosecution under the federal Anti-Kickback Law will be pursued. In addition, the Office of Inspector General of the DHHS, or OIG, issued a Special Advisory Bulletin on Contractual Joint Ventures in April 2003. The OIG Bulletin stated the DHHS's concerns regarding the legality of certain joint contractual arrangements between providers and suppliers of health care items or services. The OIG Bulletin identified characteristics of arrangements the OIG may consider suspect, and focused on arrangements in which a healthcare provider expands into a related service, through a joint contractual arrangement with an existing supplier of the related service, to service the healthcare provider's existing patient

population. The OIG noted that such arrangements may be suspect when the provider contracts out all or nearly all aspects of the new venture, including the management, to the existing supplier, and provides only an existing patient base. In the OIG Bulletin, the OIG asserted that the provider's return on its investment in such circumstances may be viewed as remuneration for the referral of the provider's federal health care program patients to the supplier, and thus may violate the Anti-Kickback Law.

Although some of our arrangements may not fall within a safe harbor, we believe that such business arrangements do not violate the Anti-Kickback Law because we are careful to structure them to reflect fair market value and ensure that the reasons underlying our decision to enter into a business arrangement comport with reasonable interpretations of the Anti-Kickback

Law. Even though we continuously strive to comply with the requirements of the Anti-Kickback Law, liability under the Anti-Kickback Law may still arise because of the intentions or actions of the parties with whom we do business. In addition, we may have Anti-Kickback Law liability based on arrangements established by the entities we have acquired if any of those arrangements involved an intention or actions to exchange remuneration for referrals covered by the Anti-Kickback Law. While we are not aware of any such intentions or actions, we have only limited knowledge regarding the intentions or actions underlying those arrangements. Conduct and business arrangements that do not fully satisfy one of these safe harbor provisions may result in increased scrutiny by government enforcement authorities such as the OIG.

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

In addition, the Ethics in Patient Referral Act of 1989, commonly referred to as the federal physician self-referral prohibition or Stark Law, prohibits physician referrals of Medicare and Medicaid patients for certain designated health services (including MRI and other diagnostic imaging services) to an entity if the physician or an immediate family member has any financial arrangement with the entity and no statutory or regulatory exception applies. The Stark Law also prohibits the entity from billing for any such prohibited referral. Initially, the Stark Law applied only to clinical laboratory services and regulations applicable to clinical laboratory services were issued in 1995. Earlier that same year, the Stark Law's self-referral prohibition expanded to additional goods and services, including MRI and other imaging services. In 1998, CMS (formerly known as the Health Care Financing Administration), published proposed rules for the remaining designated health services, including MRI and other imaging services, and in January 2001, CMS published the first phase of the final rule covering the designated health services. Phase one of the final rule became effective on January 4, 2002, except for a provision relating to certain physician payment arrangements, which became effective July 26, 2004. CMS released phase two of the Stark Law final rule as a final rule which became effective on July 26, 2004. On September 5, 2007, CMS released phase three of the Stark Law final rule which became effective on December 4, 2007. Finally, on August 19, 2008, CMS finalized additional changes to the Stark Law, which became effective on October 1, 2009.

A person who engages in a scheme to circumvent the Stark Law's referral prohibition may be fined for each such arrangement or scheme. In addition, any person who presents or causes to be presented a claim to the Medicare or Medicaid program in violation of the Stark Law is subject to civil monetary penalties per bill submission, an assessment of up to three times the amount claimed, and possible exclusion from participation in federal healthcare programs. Bills submitted in violation of the Stark Law may not be paid by Medicare or Medicaid, and any person collecting any amounts with respect to any such prohibited bill is obligated to refund such amounts.

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

We believe our operations comply with these federal and state physician self-referral prohibition laws. We do not believe we have established any arrangements or schemes involving any service of ours which would violate the Stark Law or the prohibition against schemes designed to circumvent the Stark Law, or any similar state law prohibitions. Because we have financial arrangements with physicians and possibly their immediate family members, and because we may not be aware of all the financial arrangements such physicians and their immediate family members may have with entities to which they refer patients, we rely on physicians and their immediate family members to avoid making prohibited referrals to us in violation of the Stark Law and similar state laws. If we receive a prohibited referral which is not permitted under an exception to the Stark Law and applicable state law, our submission of a bill for the referral could subject us to sanctions under the Stark Law and applicable state law. Any sanctions imposed on us under the Stark Law or any similar state laws could adversely affect our financial results and our ability to operate our business.

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, created federal statutes to prevent healthcare fraud and false statements relating to healthcare matters. The healthcare fraud statute prohibits knowingly and willfully executing a scheme to defraud any healthcare benefit program, including private payors. A violation of this statute is a felony and may result in fines, imprisonment or exclusion from government sponsored programs such as the Medicare and Medicaid programs. The false statements statute prohibits knowingly and willfully falsifying, concealing or covering up a material fact or making any materially false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare

benefits, items or services. A violation of this statute is a felony and may result in fines or imprisonment or exclusion from government sponsored programs.

Both federal and state government agencies are continuing heightened and coordinated civil and criminal enforcement efforts. As part of announced enforcement agency work plans, the federal government will continue to scrutinize, among other things, the billing practices of hospitals and other providers of healthcare services. For instance, as enacted by Congress on January 1, 2013, the American Taxpayer Relief Act of 2012, or ATRA, increases the amount of time DHHS may use to recover Medicare overpayments to providers from three to five years. The federal government also has increased funding to fight healthcare fraud, and it is coordinating its enforcement efforts among various agencies, such as the U.S. Department of Justice, or DOJ, the OIG, and state Medicaid fraud control units. Moreover, we expect there will continue to be federal and state laws and/or regulations, proposed and implemented, that could impact our operations and business. The extent to which future legislation or regulations, if any, relating to health care fraud abuse laws and/or enforcement, may be enacted or what effect such legislation or regulation would have on our business remains uncertain. We believe that the healthcare industry will continue to be subject to increased government scrutiny and investigations.

Federal False Claims Act

Another trend affecting the healthcare industry is the increased use of the federal False Claims Act and, in particular, actions under the False Claims Act's "whistleblower" provisions. Those provisions allow a private individual to bring actions on behalf of the government alleging that the defendant has defrauded the federal government. After the individual has initiated the lawsuit, the government must decide whether to intervene in the lawsuit and to become the primary prosecutor. If the government declines to join the lawsuit, then the individual may choose to pursue the case alone, in which case the individual's counsel will have primary control over the prosecution, although the government must be kept apprised of the progress of the lawsuit. Whether or not the federal government intervenes in the case, it will receive the majority of any recovery. If the litigation is successful, the individual is entitled to no less than 15%, but no more than 30%, of whatever amount the government recovers. The percentage of the individual's recovery varies, depending on whether the government intervened in the case and other factors. Recently, the number of suits brought against healthcare providers by private individuals has increased dramatically. In addition, various states are considering or have enacted laws modeled after the federal False Claims Act. Under the Deficit Reduction Act of 2005, or DRA, states are being encouraged to adopt false claims acts similar to the federal False Claims Act, which establish liability for submission of fraudulent claims to the State Medicaid program and contain whistleblower provisions. Even in instances when a whistleblower action is dismissed with no judgment or settlement, we may incur substantial legal fees and other costs relating to an investigation. Future actions under the False Claims Act may result in significant fines and legal fees, which would adversely affect our financial performance and our ability to operate our business.

When an entity is determined to have violated the federal False Claims Act, it may be liable for damages and civil penalties. Liability arises, primarily, when an entity knowingly submits a false claim for reimbursement to the federal government. Simple negligence should not give rise to liability, but submitting a claim with reckless disregard of its truth or falsity could result in substantial civil liability.

Although simple negligence should not give rise to liability, the government or a whistleblower may attempt and could succeed in imposing liability on us for a variety of previous or current failures, including for example:

- Failure to comply with the many technical billing requirements applicable to our Medicare and Medicaid business.
- Failure to comply with Medicare requirements concerning the circumstances in which a hospital, rather than we, must bill Medicare for diagnostic imaging services we provide to outpatients treated by the hospital.
- Failure of our hospital clients to accurately identify and report our reimbursable and allowable services to Medicare.
- Failure to comply with the Anti-Kickback Law or Stark Law.
- Failure to comply with the prohibition against billing for services ordered or supervised by a physician who is excluded from any federal healthcare programs, or the prohibition against employing or contracting with any person or entity excluded from any federal healthcare programs.
- Failure to comply with the Medicare physician supervision requirements for the services we provide, or the Medicare documentation requirements concerning such physician supervision.
- The past conduct of the companies we have acquired.

On May 20, 2009, President Obama signed into law the Fraud Enforcement and Recovery Act of 2009 (“FERA”), which greatly expanded the types of entities and conduct subject to the False Claims Act. Further, the PPACA requires Medicare providers, suppliers, and other entities to report and return any overpayment of Medicare or Medicaid funds within 60 days of identifying the overpayment or face potential False Claims Act liability. In February 2012, CMS proposed a rule enacting the 60-day reporting requirement that would also create a 10-year “lookback period,” requiring providers and suppliers to report

and return overpayments identified within 10 years of the date the overpayment was received. The proposed rule, if enacted, could require us to expand our recordkeeping, compliance and reporting processes to comply with the rule's requirements. We strive to ensure that we meet applicable billing requirements. However, the costs of defending claims under the False Claims Act, as well as sanctions imposed under the Act, could significantly affect our financial performance.

Health Insurance Portability and Accountability Act of 1996

In addition to creating the new federal statutes discussed above, HIPAA, as amended by the HITECH Act, also establishes uniform standards governing the conduct of certain electronic health care transactions and protecting the security and privacy of individually identifiable health information maintained or transmitted by certain covered entities, including health care providers, health plans and health care clearinghouses. As a covered entity, we must comply with the Standards for Privacy of Individually Identifiable Health Information, which restrict our use and disclosure of certain individually identifiable health information. We have been required to comply with the Privacy Standards since April 14, 2003. We must also comply with the Standards for Electronic Transactions, which establish standards for common health care transactions, such as claims information, plan eligibility, payment information and the use of electronic signatures. We have been required to comply with these standards since October 16, 2003. We must also comply with the Security Standards, which require us to implement security measures to protect the security and integrity of certain electronic health information. We have been required to comply with these standards since April 21, 2005. One other standard relevant to our use of medical information has been promulgated under HIPAA. CMS has published a final rule, which required us to adopt Unique Health Identifiers for use in filing and processing health care claims and other transactions by May 23, 2007. The American Recovery and Reinvestment Act of 2009, commonly referred to as the economic stimulus package signed into law on February 17, 2009, included the HITECH Act, which dramatically expanded, among other things, (1) the scope of HIPAA to apply directly to “business associates,” or independent contractors who receive or obtain protected health information (“PHI”) in connection with providing a service to the covered entity, (2) substantive security and privacy obligations, including new federal security breach notification requirements to affected individuals and DHHS and potentially media outlets, of breaches of unsecured PHI, (3) restrictions on marketing communications and a prohibition on covered entities or business associates from receiving remuneration in exchange for PHI, and (4) the civil and criminal penalties that may be imposed for HIPAA violations, increasing the annual cap in penalties from $25,000 to $1.5 million per year. We believe that we are in compliance with all of the applicable HIPAA and HITECH standards, rules and regulations. If we fail to comply with these standards, we could be subject to criminal penalties and civil sanctions.

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

Unlawful Practice of Medicine and Fee Splitting

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

Certificate-of-Need Laws

In some states, a CON or similar regulatory approval is required before the acquisition of high-cost capital items, including diagnostic imaging or radiation oncology systems or provision of diagnostic imaging or radiation oncology services by us or our clients. CON regulations may limit or preclude us from providing diagnostic imaging or radiation oncology services or systems. Revenue from states with CON regulations represented a substantial portion of our total revenue for the year ended December 31, 2012.

CON laws were enacted to contain rising healthcare costs, prevent the unnecessary duplication of health resources, and increase patient access for health services. In practice, CON laws have prevented hospitals and other providers who have been unable to obtain a CON from acquiring new machines or offering new services. Our current contracts will remain in effect even if the CON states in which we operate modify their programs. However, a significant increase in the number of states

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

Reimbursement

We derive most of our revenues directly from healthcare providers, primarily from acute care hospitals, with whom we contract to provide services to their patients. We generated approximately 81% of our revenues for the year ended December 31, 2012, by providing services to hospitals and other healthcare providers. Some of our revenues come from third-party payors, including government programs such as the Medicare and Medicaid programs, that we bill directly. In the year ended December 31, 2012, we derived 19% of our revenues from direct billings to patients and their third-party payors. Services for which we submit direct billings for Medicare and Medicaid patients are paid on a fee schedule basis, and patients are responsible for deductibles and coinsurance.

With respect to our retail business, for services for which we bill Medicare directly, we are paid under the Medicare Physician Fee Schedule, which is updated on an annual basis. Under the Medicare statutory formula, payments under the Physician Fee Schedule would have decreased for the past several years if Congress had failed to intervene. In the past, when the application of the statutory formula resulted in lower payment, Congress has passed interim legislation to prevent the reductions. For 2012, CMS projected a rate reduction of 27.4% from 2011 rates if Congress failed to intervene. On December 23, 2011, President Obama signed into law the Temporary Payroll Tax Cut Continuation Act of 2011, which replaced the Medicare physician payment cut that was scheduled to take place on January 1, 2012, with a 0% update for two months, thereby allowing for continuation of 2011 physician payment rates until February 29, 2012. The 0% update for physician payment rates was extended through December 31, 2012, by the Middle Class Tax Relief and Job Creation Act of 2012, which was signed into law on February 22, 2012. For 2013, CMS projected the formula would result in an aggregate reduction of 26.5% from 2012 payment rates. This reduction was delayed by the enactment of the ATRA on January 2, 2013, which adopted another 0% update to extend 2012 physician payment rates through December 31, 2013.

In its March 2012 Report to Congress, the Medicare Payment Advisory Commission (“MedPAC”), which makes recommendations to Congress on Medicare payment issues, again recommended that Congress repeal the current statutory formula to prevent significant future reductions to the Physician Fee Schedule. MedPAC recommended that Congress freeze current payment levels for primary care physicians and reduce annual payments by 5.9% for each of the next three years for all other physicians, followed by a freeze in those payment levels. There also have been a number of legislative initiatives to develop a permanent revision to the statutory formula. If Congress fails to continue the existing freeze or otherwise fails to revise the statutory formula for future years to prevent substantial reductions to physician payment levels, the resulting decrease in payment will adversely affect our revenues and results of operations.

Also with respect to our retail business, for services furnished on or after July 1, 2010, CMS began implementing a 50% reduction in reimbursement for multiple images on contiguous body parts, as mandated by the PPACA. Beginning January 1, 2011, CMS applied the same reduction to certain CT and CT angiography, MRI and MR angiography, and ultrasound services furnished to the same patient in the same session, regardless of the imaging modality, and not limited to contiguous body areas. CMS projected that this expanded policy would reduce payment for 20% more services than the prior multiple procedure payment reduction policy, and would primarily reduce payments for radiology services and to freestanding diagnostic imaging centers, such as our retail business. For 2012, CMS extended this policy to the physician reviews of these imaging services by implementing a 25% multiple procedure reduction to the professional payments to the specialties of radiology and interventional radiology. In addition, beginning in 2013, CMS will expand the 25% multiple-procedure reduction policy to certain other nuclear medicine and cardiovascular diagnostic procedures. At this time, we do not believe that these multiple procedure payment reductions will have a material effect on our future retail revenues.

Other recent legislative and regulatory updates to the Physician Fee Schedule included reduced payment rates for certain diagnostic services using equipment costing more than $1 million through revisions to usage assumptions from the previous 50% usage rate to a 90% usage rate. This change began in 2010 with a planned four-year phase-in period for MRI and CT scans, but not for radiation therapy and other therapeutic equipment. The PPACA superseded CMS's assumed usage rate for such equipment and, beginning on January 1, 2011, CMS instituted a 75% usage rate. Through

enactment of the ATRA, Congress increased the usage rate assumption from 75% to 90% for fee schedules to be developed for 2014 and subsequent years. In 2011, CMS expanded the list of services to which the higher equipment usage rate assumption applies to include certain diagnostic CTA and MRA procedures using similar CT and MRI scanners that cost more than $1 million. We currently estimate that the new usage assumptions for MRI and CT scans under the ATRA will not have a material adverse effect on our future retail revenues.

Also effective January 1, 2011, CMS made further adjustments to the Physician Fee Schedule so that specialties that have a higher proportion of the payment rate attributable to operating expenses such as equipment and supplies, which include radiation oncology, will experience an increase in aggregate payments. In addition, as a result of adjustments to codes identified to be misvalued, radiation oncology specialties and suppliers providing the technical component of diagnostic tests are among the entities that will experience decreases in aggregate payment. Some of these changes are being transitioned over time; for 2013, CMS projects additional aggregate payment reductions of 7% in radiation oncology, 3% in radiology, 3% in nuclear medicine and 7% for suppliers providing the technical component of diagnostic tests. A portion of the payment reduction to radiation oncology stems from revisions to the operating expenses and procedure time allotted to perform IMRT and SBRT. CMS is also undertaking a review of procedure times allotted to other radiation oncology treatments. At this time, we do not believe that these regulatory changes will have a material effect on our future retail revenues.

In addition to annual updates to the Medicare Physician Fee Schedule, as indicated above, CMS also publishes regulatory changes to the hospital outpatient prospective payment system ("HOPPS") on an annual basis. These payments are bundled amounts received by our hospital clients for hospital outpatient services related to PET scans, PET/CT scans and SRS treatments. Recent adjustments to the HOPPS payments for these procedures have not had a material adverse effect on our revenue and earnings in 2010, 2011 or 2012. Beginning on April 1, 2013, the ATRA requires CMS to reduce the payment associated with Cobalt 60-based SRS treatments to an amount equal to a less-expensive SRS treatment. At this time, we do not believe that this change will have a material adverse effect on our future revenues; however, we cannot predict the effect of future rate reductions on our future revenues or business.

Over the past few years, the growth rate of MRI industry wide scan volumes has slowed in part due to weak hospital volumes as reported by several investor-owned hospital companies, additional patient-related cost-sharing programs and an increasing trend of third-party payors intensifying their utilization management efforts, for example, through benefit managers who require prior authorizations to control the growth rate of imaging services generally. We expect that these trends will continue. Another recent initiative to potentially reduce utilization of certain imaging services is the Medicare Imaging Demonstration, which is a two-year demonstration project designed to collect data regarding physician use of advanced diagnostic imaging services. This information would be used to determine the appropriateness of services by developing medical specialty guidelines for advanced imaging procedures within three designated modalities (MRI, CT and nuclear medicine). On February 2, 2011, CMS announced that it selected five participants for the demonstration project. The data collection portion of the demonstration concluded on April 1, 2012, and the 18-month intervention portion of the demonstration then went into effect, during which time the appropriateness of a physician's order for diagnostic imaging services is considered at the time the order is entered into the decision support systems being tested. The demonstration is expected to conclude on September 30, 2013.

We cannot predict the full impact of the PPACA on our business. The reform law substantially changed the way health care is financed by both governmental and private insurers. Although certain provisions may negatively affect payment rates for certain imaging services, the PPACA also extended coverage to approximately 32 million previously uninsured people, which may result in an increase in the demand for our services. Other legislative changes have been proposed and adopted since the PPACA was enacted, which also may impact our business. On August 2, 2011, the President signed into law the Budget Control Act of 2011 ("BCA"), which, among other things, created the Joint Select Committee on Deficit Reduction to recommend proposals in spending reductions to Congress. The Joint Select Committee did not achieve its targeted deficit reduction of at least $1.2 trillion for the years 2013 through 2021, triggering the legislation's automatic reduction to several government programs. These reductions include aggregate reductions to Medicare payments to providers of up to 2% per fiscal year, which were scheduled to go into effect on January 2, 2013. The enactment of the ATRA delayed the imposition of the automatic cuts until March 1, 2013. On March 1, 2013, the President signed an executive order implementing the automatic budget reductions. Unless Congress acts to delay or mitigate the reductions, payments to Medicare providers for services furnished on or after April 1, 2013 will be reduced by up to 2% per fiscal year. The full effect of the PPACA, BCA and ATRA on our business is uncertain, and it is not clear whether other legislative changes will be adopted or how those changes would affect the demand for our services.

Payments to us by third-party payors depend substantially upon each payor's coverage and reimbursement policies. Third-party payors may impose limits on coverage or reimbursement for diagnostic imaging services, including

denying reimbursement for tests that do not follow recommended diagnostic procedures. Coverage policies also may be expanded to reflect emerging technologies. Because unfavorable coverage and reimbursement policies have and may continue to constrict the profit margins of the hospitals and clinics we bill directly, we have and may continue to need to lower our fees to retain existing clients and attract new ones. If coverage is limited or reimbursement rates are inadequate, a healthcare provider might find it financially unattractive to own diagnostic imaging or radiation oncology systems, yet beneficial to purchase our services. It is possible that third-party coverage and reimbursement policies will affect the need or prices for our services in the future, which could significantly affect our financial performance and our ability to conduct our business.

Environmental, Health and Safety Laws

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

How to Obtain Our SEC Filings

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

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

Executive Officers of the Registrant

Set forth below is information regarding our executive officers, including their principal occupations for the past five years and their ages as of March 15, 2013. There are no family relationships between any of our executive officers and any other executive officer or board member. Our board of directors elects our executive officers, who serve at the discretion of our board of directors.

| Name | Age | Present Position |
|---|---|---|
| Larry C. Buckelew | 59 | Interim Chief Executive Officer and Chairman of the Board of Directors |
| Michael J. Shea | 61 | Chief Operating Officer |
| Howard K. Aihara | 49 | Executive Vice President and Chief Financial Officer |
| Richard W. Johns | 55 | Executive Vice President, General Counsel and Secretary |
| Richard A. Jones | 49 | President, Alliance Imaging |
| Deborah Rodriquez | 50 | Executive Vice President of Human Resources |

Larry C. Buckelew became Chairman of the Board and Interim Chief Executive Officer in June 2012. He has previously served Alliance HealthCare Services since 2009 as a company director, including member of the Audit and Compensation Committees. Mr. Buckelew’s extensive background as a healthcare director and executive includes acting as President and Chief Executive Officer of Gambro Healthcare, Inc. from November 2000 through October 2005. During Mr. Buckelew’s tenure, Gambro had more than $2 billion in annual revenues, 13,000 employees, and was ultimately purchased for approximately $3 billion. Prior to joining Gambro, Mr. Buckelew served in numerous executive and management positions, including positions with American Hospital Supply Corporation, Baxter International, Inc., Sunrise Medical, Inc., Teleflex, Inc., and Surgical Services, Inc.

Michael J. Shea joined Alliance HealthCare Services as Chief Operating Officer in June, 2012. His healthcare industry business experience spans more than 30 years, including senior executive roles in both private and public companies ranging from successful start-ups to established industry leaders. From June 2008 to June 2012, Mr. Shea was senior vice president of operations at DaVita, Inc., a publicly held renal care company with more than $7 billion in revenues,

operating 1800 dialysis clinics, and serving over 850 hospitals. Mr. Shea was responsible for DaVita operations in California, Nevada, and Arizona as

well as being the senior executive in charge of DaVita's Hospital Services Group. Prior to DaVita, he was the senior vice president of business development and marketing at TeamHealth, a publicly held outsourced physician services company.

Howard K. Aihara has served as our Executive Vice President and Chief Financial Officer since December 2005. Mr. Aihara joined us in September 2000 as our Vice President and Corporate Controller. From 1997 until September 2000, he was vice president, finance, for UniMed Management Company, a physician practice management company in Burbank, California. From 1995 through 1997, he was executive director and corporate controller for AHI Healthcare Systems, Inc. of Downey, California. AHI was a publicly traded physician practice management company. Mr. Aihara began his career at Ernst & Young LLP and is a certified public accountant (inactive).

Richard W. Johns has served as our Executive Vice President, General Counsel and Secretary since February 1, 2012. Mr. Johns had a legal career spanning 30 years providing legal services to a variety of healthcare clients based in the United States and Europe. Before joining Alliance, he was General Counsel at LaVie Care Centers, a national long-term care company with revenues in excess of $1 billion annually and approximately 19,000 employees caring for 13,000 residents. Prior to his role with LaVie Care Centers, he served as a partner for over 10 years with the nationally recognized firm of Foley & Lardner, where he was instrumental in developing a national healthcare practice. Mr. Johns began his legal career working with various law firms in the Washington, D.C. area and holds a Juris Doctor degree from the University of Southern California.

Richard A. Jones was appointed to Executive Vice President of the Imaging Division in August 2011 and was promoted to President of the Imaging Division in June 2012. He has been with Alliance since 1996, originally serving as Regional Operations Manager, then Vice President of Business Development, then Vice President of Operations for the North zone, then Senior Vice President of the North zone, and then as Senior Vice President of Operations. Before joining Alliance, Mr. Jones held a number of leadership roles in hospitals and the commercial healthcare sector.

Deborah Rodriguez joined Alliance in June 2011 as Senior Vice President of Human Resources and was later promoted to Executive Vice President of Human Resources in 2012. Prior to her joining Alliance HealthCare Inc., Ms. Rodriguez was Director of Global Human Resources at IMI Severe Service (CCI), an engineering-to-order manufacturing company, from June of 2009 to June of 2011, and was Senior Director of Human Resources at Allergan Medical (the medical device division of Allergan, Inc.) from July 2007 to February 2009. Ms. Rodriguez brings over 22 years of human resources experience to this role, having held additional senior human resources leadership positions in other Fortune 100 companies like Johnson & Johnson and GE Capital, as well as CalOptima, a county organized health system. Ms. Rodriguez holds a master's degree in Human Resources Development from La Roche College.

## ITEM 1A. RISK FACTORS

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

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

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

### Risks Related to Government Regulation of Our Business

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

We derived approximately 19% of our 2012 revenues from direct billings to patients and third-party payors such as Medicare, Medicaid or private health insurance companies. Changes in the rates or methods of reimbursement for the services we provide could have a significant negative effect on those revenues. Moreover, our healthcare provider clients on whom we depend for the majority of our revenues generally rely on reimbursement from third-party payors. If we or our clients receive decreased reimbursements as a result of various governmental efforts to reduce healthcare costs as described in detail in Item 1, Business-Regulation and Reimbursement, these decreases could result in a reduced demand for our services or downward pricing pressures, which could have a material adverse effect on our financial position.

With respect to our retail business, for services for which we bill Medicare directly, we are paid under the Medicare Physician Fee Schedule, which is updated on an annual basis. Under the Medicare statutory formula, payments under the fee schedule would have decreased for the past several years if Congress had failed to intervene. In the past, when the application of the statutory formula resulted in lower payment, Congress has passed interim legislation to prevent the reductions in payments. If Congress fails to intervene as it has done in the past to prevent the implementation of payment reductions through either another temporary measure or a permanent revision to the statutory formula, the resulting decrease in payment will adversely affect our revenues and results of operations.

We cannot predict the individual and collective effect on our business of the changes described above, but they could negatively affect parts of our business or our entire operations, which could harm our financial performance and condition.

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

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

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

If our operations are found to be in violation of any of the laws and regulations to which we or our clients are subject, we may be subject to the applicable penalty associated with the violation, including civil and criminal penalties, damages, fines and the curtailment of our operations. Any penalties, damages, fines or curtailment of our operations, individually or in the aggregate, could adversely affect our ability to operate our business and our financial results. Our risk of being found in violation of these laws and regulations is increased by the fact that many of them have not been fully interpreted by the regulatory authorities or the courts, and their provisions are open to a variety of interpretations. Any action against us for violation of these laws or regulations, even if we successfully defend against it, could cause us to incur significant legal expenses and divert management's attention from the operation of our business. For a more detailed discussion of the various state and federal regulations to which we are subject, see Item 1, Business-Regulation, Reimbursement and Environmental, Health and Safety Laws.

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

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

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

Medicaid fraud and abuse or that imposes additional requirements or burdens on us.

A number of states in which our diagnostic imaging centers are located have adopted a form of anti-kickback law and/or Stark Law. The scope of these laws and the interpretations of them vary from state to state and are enforced by state courts and

regulatory authorities, each with broad discretion. A determination of liability under the laws described in this risk factor could result in fines and penalties and restrictions on our ability to operate in these jurisdictions.

In addition, under the DRA, states are encouraged to adopt false claims acts, similar to the federal False Claims Act, which establish liability for submission of fraudulent claims to the State Medicaid program and contain qui tam or whistleblower provisions. States enacting such false claims statutes will receive an increased percentage of any recovery from a State Medicaid judgment or settlement. Adoption of new false claims statutes in states where we operate may impose additional requirements or burdens on us.

Healthcare reform legislation and regulations could adversely affect our operations or limit the prices we can charge for our services, which would reduce our revenues and harm our operating results.

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

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

Some states require a CON or similar regulatory approval prior to the acquisition of high-cost capital items, including diagnostic imaging systems or provision of diagnostic imaging services by us or our clients. A majority of the 45 states in which we operate require a CON, and more states may adopt similar licensure frameworks in the future. In many cases, a limited number of these certificates are available in a given state. If we are unable to obtain the applicable certificate or approval or additional certificates or approvals necessary to expand our operations, these regulations may limit or preclude our operations in the relevant jurisdictions.

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

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

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

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

Recent healthcare reform laws, in particular the Patient Protection and Affordable Care Act ("PPACA"), substantially changed the way health care is financed by both governmental and private insurers. Although certain provisions may negatively affect payment rates for some imaging services, the PPACA also extended coverage to approximately 32 million previously uninsured people, which may result in an increase in the demand for our services. A number of states and other parties challenged the constitutionality of the individual mandate and aspects of Medicaid eligibility expansion under the PPACA. On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of the individual mandate, and invalidated requirements that states forfeit certain federal funding if they do not expand Medicaid coverage as prescribed by the PPACA.

In addition, other legislative changes have been proposed and adopted since the PPACA was enacted. On August 2, 2011, the President signed into law the Budget Control Act of 2011 ("BCA"), which, among other things, created the

Joint Select Committee on Deficit Reduction to recommend proposals in spending reductions to Congress. The Joint Select Committee did

not achieve its targeted deficit reduction of at least $1.2 trillion for the years 2013 through 2021, triggering the legislation's automatic reduction to several government programs. These reductions include aggregate reductions to Medicare payments to providers of up to 2% per fiscal year, which were scheduled to go into effect on January 2, 2013. The enactment of the American Taxpayer Relief Act of 2012 on January 2, 2013, delayed the imposition of these automatic cuts until March 1, 2013. On March 1, 2013, the President signed an executive order implementing the automatic reductions. Unless Congress acts to delay or mitigate the reductions, payments to Medicare providers for services furnished on or after April 1, 2013 will be reduced by up to 2% per fiscal year. The full effect on our business of the PPACA and BCA on our business is uncertain, and it is not clear whether other legislative changes will be adopted or how those changes would affect the demand for our services.

Other Risks Related to Our Business

Our MRI and PET/CT scan volumes were lower in 2012 than in 2011, and a continued decline in the volumes could have a material adverse effect on the demand for our services and/or our future revenues.

We believe the reductions we experienced in our 2012 MRI and PET/CT scan volumes resulted from high unemployment rates, the number of under-insured or uninsured patients, the reported decline in physician office visits, hospitals adding imaging services to enhance hospital profitability and other conditions arising from the global economic conditions described below. We believe that MRI and PET/CT scan revenues from our shared-service operations will continue to decline in future periods. If we are unable to arrest and reverse these declines, our financial performance and condition will suffer.

We experience competition from other medical diagnostic and radiation oncology companies and equipment manufacturers, and this competition could adversely affect our revenues and our business.

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

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

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

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

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

We may be unable to renew or maintain our client contracts, which would harm our business and financial results. When our clients' contracts with us expire, those clients may cease using our imaging services and purchase or lease their own imaging systems or use our competitors' imaging systems. During the year ended December 31, 2012, we experienced a decrease in the rate of contract terminations partially due to stepped up efforts to renew existing contracts. However, marketing,

sales and attractive financing alternatives offered by OEMs to our clients may impact our ability to renew or maintain client contracts. Additionally, some of our clients can exercise early termination clauses and otherwise discontinue service before maturity. As a result of these and other factors, our MRI revenues for 2012 declined compared to 2011 levels. If our clients do not renew or maintain their contracts as we expect, our business will suffer. It is not always possible to obtain replacement clients quickly. Historically, many replacement clients have been smaller facilities that have a lower number of scans and generate less revenue than the clients we lost. We also run the risk of being unable to renew or maintain our client contracts in our Radiation Oncology Division.

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

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

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

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

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

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

Natural disasters could adversely affect our business and operations.

Our corporate headquarters is located in California and we currently operate in various geographic regions across 45 states. Consequently, we are subject to varying risks for natural disaster, including hurricanes, blizzards, floods, earthquakes and tornados. Depending on its severity, a natural disaster could damage our facilities and systems or prevent potential patients from traveling to our centers. Damage to our equipment or any interruption in our business would adversely affect our financial condition and could result in the loss of the capital invested in the damaged facilities or systems or anticipated future cash flows from those facilities or imaging systems.

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

We are subject to risks arising from adverse changes in general domestic and global economic conditions, including recession or economic slowdown and disruption of credit markets. Recent global market and economic conditions have been unprecedented and challenging. Significant concerns have arisen regarding potential defaults by several European countries, including Greece, and the effects that those defaults may have on European and worldwide banking systems and economies. These conditions, combined with volatile oil prices, declining business and consumer

confidence, increased unemployment, increased tax rates and governmental budget deficits and debt levels have contributed to volatility of unprecedented levels in our business. We believe our MRI and PET/CT scan volumes were reduced during 2012 by high unemployment rates, the number of under-insured or uninsured patients, the reported decline in physician office visits, hospitals adding imaging services

to enhance hospital profitability and other conditions arising from the global economic conditions described above. We cannot quantify the effect these conditions might have on our future revenues or business, although we believe that MRI scans will continue to decline in 2013. If we are unable to arrest and reverse these declines, our financial performance and condition will suffer.

As a result of these market conditions, the cost and availability of credit has been and may continue to be adversely affected by illiquid credit markets and wider credit spreads. Concern about the stability of the markets generally and the strength of counterparties specifically has led many lenders and institutional investors to reduce, and in some cases cease to provide, funding to borrowers. Continued turbulence in the United States and international markets and economies may adversely affect our liquidity and financial condition and the liquidity and financial condition of our customers. If these market conditions continue, they may limit our ability to timely access the capital markets to meet liquidity needs, resulting in adverse effects on our financial condition and results of operations.

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

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

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

We operate in a competitive, capital intensive and high fixed-cost industry. The development of new technologies or refinements of existing ones might make our existing systems technologically or economically obsolete, or reduce the demand for our systems. Numerous companies currently manufacture MRI and PET/CT, radiation oncology and other diagnostic on demand imaging systems. Competition among manufacturers for a greater share of the MRI and PET/CT and other diagnostic imaging systems market has resulted in and likely will continue to result in technological advances in the speed and imaging capacity of these new systems, including the new ultra-high field MRI systems and 256-slice CT systems. Consequently, the obsolescence of our systems may be accelerated. In the future, to the extent we are unable to generate sufficient cash from our operations or obtain additional funds through bank financing or the issuance of equity or debt securities, we may be unable to maintain a competitive equipment base. In addition, advancing technology may enable hospitals, physicians or other service providers to perform procedures without the assistance of service providers such as ourselves. As a result, we may not be able to maintain our competitive position in our targeted regions or expand our business.

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

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

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

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

In response to recent press reports concerning the risk of significant, sometimes fatal, errors in radiation therapy, especially relating to linear radiation, accreditation of facilities and the establishment of a national error reporting database are under consideration. In addition, various trade organizations have called for quality improvement measures and the establishment of the nation's first central database for the reporting of errors involving linear particle accelerators and CT scanners. Federal legislation in these areas is under consideration and a Congressional hearing

was held in February 2010. We are not aware of any actions taken after the hearing. In addition, on September 29, 2010, California enacted a law that required hospitals and clinics to record radiation doses for CT scans, which became effective July 1, 2012, and to report any overdoses to patients, their doctors and the California Department of Public Health. Effective July 1, 2013, the new California law will

also require all facilities that furnish CT services to be accredited by an organization approved by CMS, the Medical Board of California or the California Department of Public Health. We cannot assure you that the cost of complying with any new regulations will not be substantive, that the negative publicity concerning these errors will not adversely affect our business, or that these types of errors will not occur with our services.

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

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

We depend upon our management team to a substantial extent. In particular, we depend upon Mr. Buckelew, our Interim Chief Executive Officer and Chairman of our Board of Directors and Mr. Shea, our Chief Operating Officer, for their skills, experience, knowledge of our company and industry contacts. We do not have key employee insurance policies covering any of our management team. The loss of Mr. Buckelew, Mr. Shea, or other members of our management team could have a material adverse effect on our business, results of operations or financial condition.

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

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

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

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

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

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

outside the coverage of our insurance. We may not be able to maintain insurance on acceptable terms, or at all. We could incur significant costs and the diversion of our management's attention to comply with current or future environmental, health and safety laws and regulations.

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

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

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

We may not be able to maintain the levels of operating efficiency that acquired companies have achieved or might achieve separately. Successful integration of each of their operations will depend upon our ability to manage those operations and to eliminate redundant and excess costs. Because of difficulties in combining operations, we may not be able to achieve the cost savings and other size-related benefits that we hoped to achieve after these acquisitions, which would harm our financial condition and operating results.

High fuel costs can harm our operations and financial performance.

Fuel costs constitute a significant portion of our mobile operating expenses, through diesel fuel for our tractor fleet and mileage reimbursement for our technologists. Historically, fuel costs have been subject to wide price fluctuations based on geopolitical issues and supply and demand. Fuel availability is also affected by demand for home heating oil, diesel, gasoline and other petroleum products, as well as overall economic conditions. Because of the effect of these events on the price and availability of fuel, we cannot predict the cost and future availability of fuel with any degree of certainty. In the event of a fuel supply shortage or further increases in fuel prices, we might be forced to curtail our scheduled mobile services. There have been significant increases in fuel costs recently, and continued high fuel costs or further increases will harm our financial condition and results of operations.

Insurance costs and claims expenses could adversely affect our earnings.

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

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

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

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

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

Risks Related to Our Governance and Stock Exchange Listing

Funds managed by Oaktree Capital Management, LLC and MTS Health Investors, LLC beneficially own the majority of our outstanding shares of common stock and are therefore able to exert significant influence over us, including with respect to change of control transactions.

As of December 31, 2012, funds managed by Oaktree Capital Management, LLC and MTS Health Investors, LLC (collectively, the "Investor Parties") beneficially owned approximately 51.0% of our outstanding shares of common stock. So long as they beneficially own at least 35% of our outstanding shares of common stock, the Investor Parties will have the right to designate three of the members of our board of directors. As a result of their ownership of our common stock and their right to designate three directors, the Investor Parties have the ability to exert significant influence on our management and operations, as well as control the outcome of matters requiring stockholder approval, including approving mergers, consolidations or sales of all or substantially all of our assets, election of directors and advisory votes, including advisory votes related to our executive pay practices and appointment of independent registered auditors. This concentration of ownership and voting power may have the effect of delaying or preventing a merger, consolidation, sale of assets or other similar transaction that involves a third party.

Because of the equity ownership of the Investor Parties, we are considered a "controlled company" for purposes of the NASDAQ listing requirements. As such, we are exempt from the requirement that the majority of our board of directors meet the standards of independence established by the NASDAQ and we are exempt from the requirement that we have a separate Compensation Committee comprised entirely of directors who meet those independence standards. Although we do not currently intend to rely upon the exemption available for controlled companies, we may choose to use the exemption at any time that we remain a controlled company. The NASDAQ independence standards are intended to ensure that directors who meet the independence standards are free of any conflicting interest with management that could influence their actions as directors. It is possible that the interests of the Investor Parties may in some circumstances conflict with our interests or the interests of our other stockholders.

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

The trading price of our common stock has fluctuated significantly in the past. During the period from January 1, 2010 through December 31, 2012, the trading price of our common stock fluctuated from a high of $29.90 per share to a low of $3.61 per share. The price of our common stock could also be subject to wide fluctuations in the future as a result of a number of other factors, including the following:

- changes in expectations as to future financial performance or buy/sell recommendations of securities analysts;
- our, or a competitor's, announcement of new products or services, or significant acquisitions, strategic partnerships, joint ventures or capital commitments; and
- the operating and stock price performance of other comparable companies.

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

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

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

In the future, we could become the subject of an unsolicited takeover attempt. Although an unsolicited takeover could be in the best interests of our stockholders, our organizational documents and the General Corporation Law of the State of Delaware both contain provisions that will impede the removal of directors and may discourage another party from making a proposal to acquire us. For example, the provisions:

- permit the board of directors to increase its own size and fill the resulting vacancies;
- provide for a board composed of three classes of directors with each class serving a staggered three-year term;

- authorize the issuance of additional shares of preferred stock in one or more series without a stockholder vote; and
- establish an advance notice procedure for stockholder proposals to be brought before an annual meeting of our stockholders, including proposed nominations of persons for election to the board of directors.

Moreover, these provisions can only be amended by the vote of 66 2/3% or more of our outstanding shares entitled to vote. Furthermore, we are subject to Section 203 of the Delaware General Corporation Law, which could have the effect of delaying or preventing a change in control.

Risks Related to Our Debt

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

We are highly leveraged. As of December 31, 2012, we had $558.6 million of outstanding debt, excluding letters of credit, and approximately $66.0 million was available for borrowing under our revolving credit facility. Our substantial debt could have important consequences for our stockholders. For example, it requires us to dedicate a substantial portion of our cash flow from operations to payments on our debt, thereby reducing the availability of our cash flow to fund working capital, capital expenditures and acquisitions and for other general corporate purposes. In addition, our debt could:

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

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

The indenture governing the notes and our credit agreement contain affirmative and negative covenants that restrict, among other things, our ability to:

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

In addition, we are required under our credit agreement to maintain specified financial ratios. On November 5, 2012 and September 27, 2011, we entered into amendments to our credit agreement pursuant to which we modified the financial covenants to provide us with greater flexibility. Under the amended credit agreement, we are required to maintain (a) a maximum ratio of consolidated total debt to Consolidated Adjusted Earnings Before Interest, Taxes, Depreciation and Amortization ("EBITDA"), as defined in the credit agreement, of 5.00 to 1.00 from July 1, 2012 through September 30, 2014, 4.75 to 1.00 from October 1, 2014 through September 30, 2015, 4.50 to 1.00 from October 1, 2015 through December 31, 2015, and 4.25 to 1.00 thereafter, and (b) a minimum ratio of Consolidated Adjusted EBITDA to consolidated interest expense of 2.25 to 1.00 through December 31, 2012, 2.50 to 1.00 from January 1, 2013 through December 31, 2014 and 2.75 to 1.00 thereafter. As of December 31, 2012, our ratio of consolidated total debt to Consolidated Adjusted EBITDA was 3.89 to 1.00 and our ratio of Consolidated Adjusted EBITDA to consolidated interest expense was 2.85 to 1.00. If we are not able to improve our financial ratios prior to the expiration of this amendment, or if our financial ratios continue to worsen, we may be in default under our credit agreement.

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

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

Our property and equipment, which make up a significant portion of our tangible assets, had a net book value of $208.6 million as of December 31, 2012 and $291.3 million as of December 31, 2011. The book value of these assets

should not be relied on as a measure of realizable value for such assets. The realizable value may be lower than net book value. The value of our assets in the event of liquidation will depend upon market and economic conditions, the availability of buyers and similar factors. A sale of these assets in a bankruptcy or similar proceeding would likely be made under duress, which would reduce the amounts recovered. Furthermore, such a sale could occur when other companies in our industry also are distressed,

which might increase the supply of similar assets and further reduce the amounts that recovered. Our goodwill and other intangible assets had a net book value of $183.4 million as of December 31, 2012 and $199.5 million as of December 31, 2011. These assets primarily consist of the excess of the acquisition cost over the fair market value of the net assets acquired in purchase transactions, customer contracts and costs to obtain certificates of need. The value of goodwill and other intangible assets will continue to depend significantly upon the success of our business as a going concern and the growth in future cash flows. As a result, in the event of a default under the agreements governing our material debt or any bankruptcy or dissolution, the realizable value of these assets will likely be substantially lower and may be insufficient to satisfy the claims of our creditors.

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

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

We and our subsidiaries may be able to incur substantial additional debt in the future. The terms of our new credit facility and the indenture governing the notes permit us or our subsidiaries to incur additional debt, subject to certain restrictions. Further, the credit facility and the indenture governing the notes allow our subsidiaries to incur debt, all of which would be structurally senior to the notes. In addition, as of December 31, 2012, our credit facility permitted additional borrowings of up to approximately $66.0 million under our revolving credit facility subject to the covenants contained in our credit facility, and all of those borrowings would be senior to the notes to the extent of the assets securing the new credit facility. If we add new debt to our or our subsidiaries' current debt levels, the risks discussed above could intensify.

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

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

Increases in interest rates could adversely affect our financial condition.

An increase in prevailing interest rates would have an effect on the interest rates charged on our variable rate debt, which rise and fall upon changes in interest rates. As of December 31, 2012, approximately $335.3 million of our debt was at variable interest rates. If prevailing interest rates or other factors result in higher interest rates, the increased interest expense would adversely affect our cash flow and our ability to service our debt. If interest rates are higher when our debt becomes due, we may be forced to borrow at the higher rates.

As a protection against rising interest rates, we may enter into agreements such as interest rate swaps, caps, floors and other interest rate exchange contracts. These agreements, however, carry the risks that the other parties to the agreements may not perform or that the agreements could be unenforceable. In the first quarter of 2010, we entered into three interest rate cap agreements to avoid unplanned volatility in the income statement due to changes in the London Interbank Offered Rate ("LIBOR") interest rate environment. These agreements, which mature in February 2014, have a total notional amount of $150.0 million and were designated as cash flow hedges of future cash interest payments associated with a portion of our variable rate bank debt. Under these arrangements, we have purchased a cap on LIBOR at 4.50%.

ITEM 1B. UNRESOLVED STAFF COMMENTS

Not applicable.

ITEM 2. PROPERTIES

We lease approximately 36,634 square feet of space in Newport Beach, California for our executive and principal administrative offices. We also lease 20,000 square feet of space in Canton, Ohio for our retail billing and scheduling operations. We have 15,900 square feet of space for a large regional office in Andover, Massachusetts, in addition to other small regional offices we lease throughout the country. We also lease a 11,200 square foot operations warehouse in Fontana, California and a 9,000 square foot operations warehouse in Childs, Pennsylvania, which are used for the Imaging Division.

ITEM 3. LEGAL PROCEEDINGS

From time to time, we are involved in routine litigation incidental to the conduct of our business. We believe that none of this litigation pending against us will have a material adverse effect on our business.

In connection with our acquisition of Medical Outsourcing Services, LLC (“MOS”) in the third quarter of 2008, we subsequently identified a Medicare billing practice related to a portion of MOS's retail billing operations that raised compliance issues under Medicare reimbursement guidelines. The practice was in place before the acquisition and was discontinued when we became aware of it. In accordance with our corporate compliance program, we entered into discussions with representatives of the federal government to advise them of the issue and seek guidance on appropriate next steps. In June 2010, we commenced arbitration proceedings against the former owners of MOS related to the Medicare billing matter, in addition to certain other indemnification issues. In the arbitration, we asserted claims of fraud and breach of representations and warranties.

On December 29, 2011, we received notice of an award by the arbitration panel, which awarded us $2.5 million in damages for breach of contract claims, plus prejudgment interest at 9% under New York law from July 29, 2008 (which interest continues to accrue until the award is paid in full); $0.3 million for two other indemnification claims; $1.5 million for attorneys' fees and expenses; and $0.1 million for arbitration expenses. The award also provides that approximately $1.3 million of a remaining indemnification cap created in connection with the acquisition is available for future indemnification claims, including with respect to the potential government claim discussed above, and must be satisfied by the former owners of MOS. On January 25, 2012, one of the former owners of MOS paid $0.7 million to us, and on February 17, 2012, the same owner released $0.6 million to us from amounts held in an indemnification escrow related to the acquisition. On January 25, 2012, we filed an action in the United States District Court for the Northern District of Illinois to confirm the award as a judgment against the other former owner of MOS that has refused to satisfy its obligations under the award

In the first quarter of 2013, the former owners of MOS paid $1.2 million which amount represented the remaining amount of the indemnification cap created in connection with the acquisition. This amount was in addition to $5.3 million we already recovered from the former owners of MOS in connection with the arbitration award against them. With these final payments totaling $1.2 million, the former owners of MOS have now fully satisfied their obligations to us under the arbitration award. Following receipt of the final payments from the former owners of MOS, we then entered into a settlement agreement to resolve the government's investigation of the Medicare billing practices engaged in by MOS prior to our acquisition. Under the terms of the settlement agreement, we paid $2.4 million to the government, which amount was paid primarily from the funds recovered in the arbitration from the former owners of MOS.

In June 2012, Pacific Coast Cardiology (“PCC”) d/b/a Pacific Coast Imaging, Emanuel Shaoulian, MD, Inc., and Michael M. Radin, MD, Inc. filed a lawsuit in California state court against the Company and other defendants. The complaint asserts a number of claims related to the Company's decision not to purchase PCC in 2010, and also separately seeks a determination regarding an amount the Company contends is owed to it by PCC pursuant to a previous contractual arrangement. Plaintiffs are seeking monetary and punitive damages. The Company intends to vigorously defend against the claims asserted in this lawsuit. The Company has not recorded an expense related to any potential damages in connection with this matter because any potential loss is not probable or reasonably estimable.

On November 9, 2012, U.S. Radiosurgery, LLC (“USR”) a subsidiary of Alliance Healthcare Services, Inc. (the “Company”), received a grand jury subpoena issued by the United States Attorney's Office for the Middle District of

Tennessee seeking documents related to USR and its financial relationships with physicians and other healthcare providers. The Company and USR are cooperating fully with the inquiry. The Company is currently unable to predict the timing or outcome of this matter, however, it is not unusual for such matters to continue for a considerable period of time. Responding to this matter will require management's attention and likely result in significant legal expense. To our knowledge, the federal government has not initiated any proceedings against us at this time.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS, AND ISSUER PURCHASES OF EQUITY SECURITIES

Beginning February 11, 2013, our common stock has been traded on the NASDAQ Global Market under the symbol "AIQ." Prior to February 11, 2013, our common stock was traded on the New York Stock Exchange ("NYSE"). The high and low sales prices as reported on the NYSE are set forth below for the respective time periods. As of March 14, 2013, there were 39 stockholders of record of our common stock and approximately 2,100 beneficial holders of our common stock.

The table below illustrates share prices that have been adjusted to reflect our 1-for-5 reverse stock split that occurred on December 26, 2012.

| | 2012 | | 2011 | |
|---|---|---|---|---|
| | High | Low | High | Low |
| First Quarter | $8.45 | $5.45 | $22.35 | $19.50 |
| Second Quarter | $7.70 | $4.25 | $23.70 | $18.20 |
| Third Quarter | $7.15 | $3.65 | $19.00 | $5.00 |
| Fourth Quarter | $7.60 | $5.80 | $6.80 | $4.65 |

We have never paid any cash dividends on our common stock and have no current plans to do so. We intend to retain available cash to operate our business, including capital expenditures, future acquisitions and debt repayment. Our credit facility and the indenture related to our notes restrict the payment of cash dividends on our common stock. In 2012, we withheld 23,832 shares from certain employees to pay taxes related to restricted tax awards that vested. These shares are included in treasury stock and have a weighted-average value of $6.26. In 2011, we withheld 28,572 shares from certain employees to pay taxes related to restricted stock awards that vested. These shares are included in treasury stock and have a weighted-average value of $6.10. See Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources.

SECURITIES AUTHORIZED FOR ISSUANCE UNDER EQUITY COMPENSATION PLANS

Our stockholders have previously approved all stock option plans under which our common stock is reserved for issuance. The following table provides summary information as of December 31, 2012 for all of our stock option plans:

| | Number of shares of Common Stock to be issued upon exercise of outstanding options | Weighted-average exercise price of outstanding options | Number of shares of Common Stock remaining available for future issuance (excluding shares reflected in column 1) |
|---|---|---|---|
| Stock option plans approved by shareholders | 767,496 | $18.65 | 577,143 |
| Stock option plans not approved by shareholders | — | — | — |
| | 767,496 | $18.65 | 577,143 |

STOCK PERFORMANCE GRAPH

The following graph sets forth the cumulative return on our common stock from December 31, 2007 through December 31, 2012, as compared to the cumulative return of the S&P 500 Index and the cumulative return of the S&P Healthcare Index. The graph assumes that $100 was invested on December 31, 2007 in each of (1) our common stock, (2) the S&P 500 Index and (3) the S&P Healthcare Index and that all dividends (if applicable) were reinvested.

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| | 12/31/2007 | 12/31/2008 | 12/31/2009 | 12/31/2010 | 12/31/2011 | 12/31/2012 |
|---|---|---|---|---|---|---|
| Alliance HealthCare Services, Inc. | 100.00 | 82.85 | 59.36 | 44.07 | 13.10 | 13.26 |
| S&P 500 | 100.00 | 61.51 | 75.94 | 85.65 | 85.65 | 97.13 |
| S&P Healthcare Index | 100.00 | 75.52 | 88.41 | 89.04 | 98.10 | 113.00 |

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

ITEM 6. SELECTED FINANCIAL DATA

The selected consolidated financial data shown below has been taken or derived from the audited consolidated financial statements of the Company and should be read in conjunction with Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations and our consolidated financial statements and related notes included in this Annual Report on Form 10-K (in thousands, except per share data).

| | Year Ended December 31, | | | | |
|---|---|---|---|---|---|
| | 2008 | 2009 | 2010 | 2011 | 2012 |
| Consolidated Statements of Operations Data: | | | | | |
| Revenues | $495,834 | $505,513 | $478,855 | $493,651 | $472,258 |
| Costs and expenses: | | | | | |
| Cost of revenues, excluding depreciation and amortization | 261,753 | 270,381 | 264,725 | 279,751 | 253,225 |
| Selling, general and administrative expenses | 62,728 | 67,579 | 67,110 | 77,140 | 76,022 |
| Transaction costs | — | 893 | 2,439 | 3,429 | 994 |
| Severance and related costs | 636 | 1,404 | 1,002 | 3,991 | 2,226 |
| Impairment charges | — | — | 42,095 | 167,792 | — |
| Depreciation expense | 87,728 | 94,918 | 92,321 | 89,974 | 79,333 |
| Amortization expense | 8,696 | 11,000 | 12,439 | 16,444 | 15,861 |
| Interest expense and other, net | 48,392 | 45,894 | 51,203 | 49,789 | 54,101 |
| Loss on extinguishment of debt | 61 | 14,600 | — | — | — |
| Other (income) and expense, net | (872) | (1,178) | (590) | 2,203 | 3,036 |
| Total costs and expenses | 469,122 | 505,491 | 532,744 | 690,513 | 484,798 |
| Income (loss) before income taxes, earnings from unconsolidated investees and noncontrolling interest | 26,712 | 22 | (53,889) | (196,862) | (12,540) |
| Income tax expense (benefit) | 11,764 | 308 | (20,799) | (38,242) | (6,710) |
| Earnings from unconsolidated investees | (4,605) | (3,831) | (4,327) | (3,516) | (4,667) |
| Net income (loss) | 19,553 | 3,545 | (28,763) | (155,104) | (1,163) |
| Less: Net income attributable to noncontrolling interest | (3,030) | (3,064) | (3,890) | (5,008) | (10,775) |
| Net income (loss) attributable to Alliance HealthCare Services, Inc. | $16,523 | $481 | $(32,653) | $(160,112) | $(11,938) |
| Earnings (loss) per common share attributable to Alliance HealthCare Services, Inc.: | | | | | |
| Basic (1) | $1.61 | $0.05 | $(3.09) | $(15.07) | $(1.12) |
| Diluted | $1.58 | $0.05 | $(3.09) | $(15.07) | $(1.12) |
| Weighted average number of shares of common stock and common stock equivalents: | | | | | |
| Basic (1) | 10,260 | 10,348 | 10,556 | 10,626 | 10,624 |
| Diluted | 10,432 | 10,431 | 10,556 | 10,626 | 10,624 |
| Consolidated Balance Sheet Data (at end of period): | | | | | |
| Cash and cash equivalents | $73,305 | $111,884 | $97,162 | $44,190 | $39,977 |
| Total assets | 883,723 | 887,836 | 816,201 | 663,094 | 560,141 |
| Long-term debt, including current maturities | 662,562 | 667,890 | 653,265 | 643,483 | 558,635 |
| Stockholders' equity (deficit) | 28,993 | 34,762 | 13,659 | (104,911) | (116,293) |

(1) Share and per share amounts have been retroactively adjusted to reflect our one-for-five reverse stock effective as of December 26, 2012.

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

### Overview

We are a leading national provider of advanced outpatient diagnostic imaging and radiation therapy services, based upon annual revenue and number of imaging systems deployed and radiation oncology centers operated. Our principal sources of revenue are derived from providing magnetic resonance imaging ("MRI"), positron emission tomography/computed tomography ("PET/CT") through our Imaging Division and radiation oncology services through our Radiation Oncology Division. Unless the context otherwise requires, the words "we," "us," "our," "Company" or "Alliance as used in this Quarterly Report on Form 10-Q refer to Alliance HealthCare Services, Inc. and our direct and indirect subsidiaries. We provide imaging and therapeutic services primarily to hospitals and other healthcare providers on a shared-service and full-time service basis. We also provide services through fixed-site imaging centers, primarily to hospitals or health systems. Our imaging services normally include the use of our imaging systems, technologists to operate the systems, equipment maintenance and upgrades and management of day-to-day shared-service and fixed-site diagnostic imaging operations. We also provide non scan-based services, which include only the use of our imaging systems under a short-term contract. We have leveraged our leadership in MRI and PET/CT to expand into radiation oncology, including stereotactic radiosurgery. We operate our radiation oncology business through our wholly owned subsidiary, Alliance Oncology, LLC, which we sometimes refer to as our Radiation Oncology Division. This division includes a wide range of services for cancer patients covering initial consultation, preparation for treatment, simulation of treatment, actual radiation oncology delivery, therapy management and follow-up care. Our services include the use of our linear accelerators or stereotactic radiosurgery systems, therapists to operate those systems, administrative staff, equipment maintenance and upgrades, and management of day-to-day operations.

MRI, PET/CT and radiation oncology services generated 42%, 33% and 18% of our revenue, respectively, for the year ended December 31, 2012 and 42%, 34% and 15% of our revenue, respectively, for the year ended December 31, 2011. Our remaining revenue was comprised of other modality diagnostic imaging services revenue, primarily computed tomography ("CT"), professional radiology services, and management contract revenue. We had 490 diagnostic imaging and radiation oncology systems, including 267 MRI systems and 119 positron emission tomography ("PET") or PET/CT systems and served over 1,000 clients in 45 states at December 31, 2012. We operated 128 fixed-site imaging centers (one in an unconsolidated joint venture), which constitute systems installed in hospitals or other medical buildings on or near hospital campuses, including modular buildings, systems installed inside medical groups' offices, parked mobile systems, and free-standing fixed-site imaging centers, which include systems installed in a medical office building, ambulatory surgical center, or other retail space at December 31, 2012. Of the 128 fixed-site imaging centers, 97 were MRI fixed-site imaging centers, 21 were PET or PET/CT fixed-site imaging centers, ten were other modality fixed-site imaging centers and one was in an unconsolidated joint venture. We also operated 29 radiation oncology centers and stereotactic radiosurgery facilities (including one radiation oncology center as an unconsolidated joint venture) at December 31, 2012.

We generated approximately 81% and 80% of our revenues for the year ended December 31, 2012 and 2011, respectively, by providing services to hospitals and other healthcare providers; we refer to those revenues as wholesale revenues. We typically generate our wholesale revenues from contracts that require our clients to pay us based on the number of scans we perform on patients on our clients' behalf, although some pay us a flat fee for a period of time regardless of the number of scans we perform. Wholesale payments are due to us independent of our clients' receipt of retail reimbursement from third-party payors, although receipt of reimbursement from third-party payors may affect demand for our services. We typically deliver our services for a set number of days per week through exclusive, long-term contracts with hospitals and other healthcare providers. The initial terms of these contracts average approximately three years in length for mobile services and approximately five to 10 years in length for fixed-site arrangements. These contracts often contain automatic renewal provisions and certain contracts have cancellation clauses if the hospital or other healthcare provider purchases its own system. We price our contracts based on the type of system used, the scan volume, and the number of ancillary services provided. Competitive pressures also affect our pricing.

We generated approximately 19% and 20% of our revenues for the year ended December 31, 2012 and 2011, respectively, by providing services directly to patients from our sites located at or near hospitals or other healthcare provider facilities; we refer to these revenues as retail revenues. We generate our revenue from these sites from direct billings to patients or their third-party payors, including Medicare, and we record this revenue net of contractual discounts and other arrangements for providing services at discounted prices. We typically receive a higher price per scan under retail billing than we do under wholesale billing.

Fixed-site imaging centers and radiation oncology centers can be structured as either wholesale or retail arrangements. Our contracts for radiation oncology services average approximately 8 to 15 years in length. We include revenues from these centers in either our wholesale or retail revenues.

Our revenues, whether for wholesale or retail arrangements, are dependent directly or indirectly on third-party payor reimbursement policies, including Medicare. Please see Item 1, Business-Reimbursement for a more detailed explanation of how we bill and receive payment for our services.

Over the past few years, the industry-wide growth rate of MRI scan volumes has slowed. This is in part due to weak hospital volumes, as reported by several investor-owned hospital companies, additional patient-related cost-sharing programs and an increasing trend of third-party payors intensifying their utilization management efforts, including, for example, through benefit managers who require preauthorizations, to control the growth rate of imaging services generally. We expect these trends to continue. In addition, we cannot predict the full extent of recent healthcare reform measures, including recent laws and regulations, on our financial performance and condition. Please see Item 1, Business-Regulation for a more detailed explanation of the applicable laws and regulations.

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

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

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

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

Results of Operations

The following table shows our consolidated statements of operations as a percentage of revenues for each of the years ended December 31:

| | 2010 | 2011 | 2012 |
|---|---|---|---|
| Revenues | 100.0 % | 100.0 % | 100.0 % |
| Costs and expenses: | | | |
| Cost of revenues, excluding depreciation and amortization | 55.3 | 56.7 | 53.6 |
| Selling, general and administrative expenses | 14.0 | 15.7 | 16.1 |
| Transaction costs | 0.5 | 0.7 | 0.2 |
| Severance and related costs | 0.2 | 0.8 | 0.5 |
| Impairment charges | 8.8 | 33.9 | — |
| Depreciation expense | 19.3 | 18.2 | 16.8 |
| Amortization expense | 2.6 | 3.3 | 3.4 |
| Interest expense and other, net | 10.7 | 10.1 | 11.5 |
| Other (income) and expense, net | (0.1) | 0.4 | 0.6 |
| Total costs and expenses | 111.3 | 139.8 | 102.7 |
| Loss before income taxes, earnings from unconsolidated investees and noncontrolling interest | (11.3) | (40.0) | (2.7) |
| Income tax benefit | (4.3) | (7.7) | (1.4) |
| Earnings from unconsolidated investees | (0.9) | (0.7) | (1.0) |
| Net loss | (6.0) | (31.4) | (0.2) |
| Less: Net loss attributable to noncontrolling interest, net of tax | (0.8) | (1.0) | (2.3) |
| Net loss attributable to Alliance HealthCare Services, Inc. | (6.8)% | (32.4)% | (2.5)% |

The table below provides MRI statistical information for the years ended December 31:

| | 2010 | 2011 | 2012 |
|---|---|---|---|
| MRI statistics | | | |
| Average number of total systems | 280.5 | 287.9 | 265.8 |
| Average number of scan-based systems | 237.8 | 243.0 | 222.7 |
| Scans per system per day (scan-based systems) | 8.25 | 8.06 | 8.46 |
| Total number of scan-based MRI scans | 505,640 | 500,430 | 494,739 |
| Price per scan | $384.05 | $368.42 | $359.50 |

The table below provides PET and PET/CT statistical information for each of the years ended December 31:

| | 2010 | 2011 | 2012 |
|---|---|---|---|
| PET and PET/CT statistics | | | |
| Average number of systems | 118.5 | 121.2 | 112.1 |
| Scans per system per day | 5.66 | 5.36 | 5.62 |
| Total number of PET/CT scans | 174,178 | 164,130 | 157,496 |
| Price per scan | $1,054 | $1,018 | $964 |

The table below provides Radiation oncology statistical information for each of the years ended December 31:

| | 2010 | 2011 | 2012 |
|---|---|---|---|
| Radiation oncology statistics | | | |
| Linac treatments | 78,894 | 92,876 | 83,013 |
| Cyberknife patients | 683 | 1,800 | 2,450 |

Following are the components of revenue (in millions) for each of the years ended December 31:

| | 2010 | 2011 | 2012 |
|---|---|---|---|
| Total MRI revenue | $214.6 | $205.7 | $196.1 |
| PET/CT revenue | 186.0 | 169.0 | 154.8 |
| Radiation oncology revenue | 44.4 | 75.2 | 83.2 |
| Other modalities and other revenue | 33.9 | 43.7 | 38.2 |
| Total | $478.9 | $493.6 | $472.3 |

| | Year ended December 31, | | |
|---|---|---|---|
| | 2010 | 2011 | 2012 |
| Total fixed-site imaging center revenue (in millions) | $117.1 | $123.4 | $121.5 |

Year Ended December 31, 2012 Compared to Year Ended December, 2011

Revenue decreased $21.4 million , or 4.3%, to $472.3 million in 2012 compared to $493.7 million in 2011 due to decreases in PET/CT revenues and MRI revenues of $29.4 million, partially offset by an increase in radiation oncology revenue of $8.0 million. Of the $29.4 million decrease, $10.7 million was due to Company-initiated termination of customer contracts.

PET/CT revenue in 2012 decreased $14.2 million, or 8.4%, compared to 2011 due to our increased efforts in identifying and eliminating unprofitable customers and a reduction in the average price per PET/CT scan, which decreased to $964 per scan in 2012 compared to $1,018 per scan in 2011. The decline in the average price per PET/CT scan was primarily due to reimbursement pressure and greater than expected competitive pricing pressure. The average number of PET/CT systems in service decreased to 112.1 systems in 2012 from 121.2 systems in 2011. Total PET/CT scan volumes decreased 4.0% to 157,496 scans in 2012 from 164,130 scans in 2011, primarily due to a decrease caused by the persistent high rate of unemployment and the related number of uninsured and under-insured patients. Scans per system per day increased 4.9% to 5.62 scans per system per day in 2012 from 5.36 scans per system per day in 2011.

MRI revenue decreased $9.6 million in 2012, or 4.7%, compared to 2011. Scan-based MRI revenue decreased $6.5 million in 2012, or 3.5%, compared to 2011, to $177.9 million in 2012 from $184.4 million in 2011. The decrease in scan-based MRI revenue was primarily due to our increased efforts in identifying and eliminating unprofitable customers and a reduction in the average price per MRI scan, which decreased to $359.50 per scan in 2012 from $368.42 per scan in 2011. The decline in the average price per MRI scan was primarily due to greater than expected competitive pricing pressure. The average number of scan-based systems in service decreased to 222.7 systems in 2012 from 243.0 systems in 2011. Average scans per system per day increased by 5.0% to 8.46 in 2012 from 8.06 in 2011 due to efficiency efforts deployed by our imaging division. Scan-based MRI scan volume decreased 1.1% to 494,739 scans in 2012 from 500,430 scans in 2011. We have increased our efforts to renew existing clients and add new MRI customers, which has had a positive impact on maintaining our scan volumes. Non scan-based MRI revenue decreased $3.1 million in 2012 compared to 2011. Included in the revenue totals above are fixed-site imaging center revenues, which decreased $4.3 million, or 3.7%, to $121.5 million in 2012 from $117.1 million in 2011.

Radiation oncology revenue increased $8.0 million, or 10.6%, to $83.2 million in 2012 compared to $75.2 million in 2011, primarily due to revenue related to the acquisition of USR and the opening of three de-novo SRS facilities. The year-over-year growth in revenue was partially offset by a reduction in revenue due to our divesting of ten radiation oncology centers since December 2011. The total impact to revenue from these closures is estimated to be $5.6 million. Other modalities and other revenue decreased $5.6 million, or 12.7%, to $38.2 million in 2012 compared to $43.7 million in 2011, primarily due to our increased efforts in identifying and eliminating unprofitable customers, partially offset by the acquisition of 24/7 Radiology, LLC (“24/7 RAD”) in April 2011.

At December 31 2012, we had 267 MRI systems and 119 PET and PET/CT systems, including 19 MRI systems and 9 PET/CT systems on operating leases as a result of our sale and lease transaction that occurred in the fourth quarter of 2012. We had 309 MRI systems and 128 PET and PET/CT systems at December 31, 2011. We operated 128 fixed-site imaging centers (including one unconsolidated investee) at December 31, 2012, compared to 133 fixed-site imaging centers (including two in unconsolidated investees) at December 31, 2011. We operated 29 radiation oncology centers (including one unconsolidated investee) at December 31, 2012, compared to 36 radiation oncology centers (including

three unconsolidated investees) at December 31, 2011.

Cost of revenues, excluding depreciation and amortization, decreased $26.5 million, or 9.5%, to $253.2 million in 2012 compared to $279.8 million in 2011. Compensation and related employee expenses decreased $12.5 million, or 10.3%, primarily as a result of a decrease in average employee headcount related to more efficient staffing of our operations.

Maintenance and related costs decreased $8.8 million, or 13.5%, due to a decrease in service costs related to the decrease in the number of MRI, PET/CT and radiation oncology systems in operation, and a reduction in service contract costs incurred on each asset. Renegotiating with service contract providers and medical supply vendors is one of our cost control initiatives. Medical supplies decreased $4.7 million, or 18.5%, primarily as a result of sourcing discounts on the radiopharmaceutical that is used as a component of PET and PET/CT scans. Expenses related to management contract services decreased $1.7 million, or 18.2%, primarily due to the canceling of management services contracts in 2012. Site fees decreased $1.0 million, or 12.7%, primarily due to fewer site locations related to location closures in 2012. Fuel expenses decreased $0.7 million, or 10.4%, primarily due to the decline in the average price per gallon of diesel fuel and a decrease in the number of miles driven to transport our mobile systems. These decreases to cost of revenues were partially offset by a $2.8 million increase in other expenses, mostly attributed to a $1.5 million increase in licenses, taxes and fees related to sales taxes. All other cost of revenues, excluding depreciation and amortization, increased $1.3 million or 3.0%. Cost of revenues, as a percentage of revenue, decreased to 53.6% in 2012 from 56.7% in 2011 as a result of the factors described above.

Selling, general and administrative expenses decreased $1.1 million, or 1.4%, to $76.0 million in 2012 compared to $77.1 million in 2011. The majority of this decrease is due to a decrease in non-cash stock-based compensation expense of $3.9 million, or 84.3%, from $4.6 million 2011 to $0.7 million in 2012 . The low level of expense in 2012 was mostly due to forfeitures of stock options and restricted stock granted to two of our former executive officers. The provision for doubtful accounts decreased $3.2 million, or 52.5%, during 2012 primarily due to continued strong collections in 2012. The provision for doubtful accounts as a percentage of revenue was 0.6% and 1.2% in 2012 and 2011, respectively. These decreases in selling, general and administrative expenses were partially offset by an increase in professional services expense of $1.1 million, or 9.2%, due to an increase in professional consulting fees mainly in support of our cost control initiatives and legal fees. Compensation and related employee expenses increased $4.3 million, or 10.4%, primarily as a result of investments in our sales force, executive team and oncology division. All other selling, general and administrative expenses increased $0.6 million, or 4.3%. Selling, general and administrative expenses as a percentage of revenue were 16.1% and 15.6% in 2012 and 2011, respectively.

Transaction costs decreased $2.4 million, or 71.0%, to $1.0 million in 2012 compared to $3.4 million in 2011 as there was no acquisition activity in 2012.

Severance and related costs decreased $1.8 million, or 44.2%, to $2.2 million in 2012 compared to $4.0 million in 2011, due the the organizational restructure and cost savings and efficiency initiative that was initiated in the third quarter of 2011.

Depreciation expense decreased $10.6 million, or 11.8%, to $79.3 million in 2012 compared to $90.0 million in 2011 due to our aging fleet of imaging assets, the disposition of 114 imaging systems and a decrease in capital expenditures compared to the prior year.

Amortization expense decreased $0.6 million, or 3.5%, to $15.9 million in 2012 compared to $16.4 million in 2011, primarily due to the impairment and write-off of intangible assets in 2011.

Interest expense and other, net increased $4.3 million, or 8.7%, to $54.1 million in 2012 compared to $49.8 million in 2011, primarily due to higher average interest rates in 2012 on our credit facility.

Income tax benefit was $6.7 million in 2012 compared to $38.2 million in 2011 resulting from a one-time non-recurring impairment charge of $155.7 million in the third quarter of 2011 related to the write-down of goodwill and other intangible assets. Our effective tax rates differed from the federal statutory rate principally as a result of state income taxes and permanent non-deductible tax items, including share-based payments, unrecognized tax benefits and other permanent differences.

Earnings from unconsolidated investees increased $1.2 million, or 32.7%, to $4.7 million in 2012 compared to $3.5 million in 2011.

Net income attributable to noncontrolling interest increased $5.8 million, or 115.2%, to $10.8 million in 2012 compared to $5.0 million in 2011, primarily due to a $2.1 million reduction of noncontrolling interest related to the goodwill impairment charges in 2011, partially offset by an increase related to the second quarter acquisition of USR in 2011.

Net loss attributable to Alliance HealthCare Services, Inc. was $11.9 million, or $($1.12) per share on a diluted basis, in 2012 compared to $160.1 million, or ($15.07) per share on a diluted basis, in 2011.

Year Ended December 31, 2011 Compared to Year Ended December 31, 2010

Revenue increased $14.8 million, or 3.1%, to $493.7 million in 2011 compared to $478.9 million in 2010 due to an increase in radiation oncology revenue and other modalities and other revenue, partially offset by a decrease in PET/CT revenues and MRI revenues. Radiation oncology revenue increased $30.8 million, or 69.2%, to $75.2 million in 2011 compared

to $44.4 million in 2010, primarily due to revenue related to the USR and Pine Bluff acquisitions and an increase in treatments performed in our core radiation oncology business. Other modalities and other revenue increased $9.9 million, or 29.1%, to $43.8 million in 2011 compared to $33.9 million in 2010, primarily due to the acquisitions of RAD 24/7 and 24/7 RAD.

PET/CT revenue in 2011 decreased $17.0 million, or 9.1%, compared to 2010. Total PET and PET/CT scan volumes decreased 5.8% to 164,130 scans in 2011 from 174,178 scans in 2010, primarily due to a decrease in client demand, the persistent high rate of unemployment and the number of uninsured and under-insured patients. Scans per system per day decreased 5.3%, to 5.36 scans per system per day in 2011 from 5.66 scans per system per day in 2010. The average price per PET and PET/CT scan decreased to $1,018 per scan in 2011 compared to $1,054 per scan in 2010. The decline in the average price per PET and PET/CT scan was primarily due to reimbursement pressures and greater than expected competitive pricing pressures. The average number of PET and PET/CT systems in service increased to 121.2 systems in 2011 from 118.5 systems in 2010.

MRI revenue decreased $8.9 million in 2011, or 4.1%. Scan-based MRI revenue decreased $9.8 million, or 5.1%, to $184.4 million in 2011 from $194.2 million in 2010. Scan-based MRI scan volume decreased 1.0% to 500,430 scans in 2011 from 505,640 scans in 2010, primarily due to a decrease in client demand, the persistent high rate of unemployment and the number of uninsured and under-insured patients. The average price per MRI scan decreased to $368.42 per scan in 2011 from $384.05 per scan in 2010. The decline in the average price per MRI scan is primarily due to greater than expected competitive pricing pressure. Average scans per system per day decreased by 2.3% to 8.06 in 2011 from 8.25 in 2010. The average number of scan-based systems in service increased to 243.0 systems in 2011 from 237.8 systems in 2010. Non scan-based MRI revenue increased $0.9 million in 2011 compared to 2010 primarily due to a small increase in the number of hospital construction projects and an increase in the number of equipment upgrades occurring in the hospital market, both of which affect the demand for our non scan-based MRI business. Included in the revenue totals above is fixed-site imaging center revenues, which increased $6.3 million, or 5.4%, to $123.4 million in 2011 from $117.1 million in 2010.

We had 309 MRI systems at December 31, 2011 compared to 302 MRI systems at December 31, 2010. We had 128 PET and PET/CT systems at December 31, 2011 and 2010. We operated 133 fixed-site imaging centers (including two in unconsolidated joint ventures) at December 31, 2011, compared to 132 fixed-site imaging centers (including three in unconsolidated joint ventures) at December 31, 2010. We operated 36 radiation oncology centers (including three in unconsolidated joint ventures) at December 31, 2011, compared to 27 radiation oncology centers (including two in unconsolidated joint ventures) at December 31, 2010.

Cost of revenues, excluding depreciation and amortization, increased $15.1 million, or 5.7%, to $279.8 million in 2011 compared to $264.7 million in 2010. Outside medical services increased $7.1 million, or 40.9%, primarily as a result of an increase in professional services related to the acquisitions of RAD 24/7 and 24/7 RAD, and an increase in professional services in our oncology division, including radiation oncologists and physics costs. Maintenance and related costs increased $4.7 million, or 7.7%, due to an increase in service costs related to an increase in the number of MRI and radiation oncology systems in operation, specifically CyberKnife equipment (which has a high average monthly service contract cost), and an increase in maintenance costs due to an aging imaging division fleet. Compensation and related employee expenses increased $4.1 million, or 3.5%, primarily as a result of an increase in headcount in our oncology division, primarily related to the acquisition of USR and oncology operational management, as well as an increase in headcount to support professional radiology interpretation services. Fuel expenses increased $0.9 million, or 16.4%, primarily due to an increase in the average price per gallon of diesel fuel. Site fees increased $0.9 million, or 12.5%, primarily due to an increase in the number of oncology sites related to the acquisition of USR. Medical supplies decreased $1.9 million, or 7.1%, primarily as a result of a decrease in the number of PET and PET/CT scans, which use a radiopharmaceutical as a component of the PET and PET/CT scan. Equipment rental costs decreased $0.4 million, or 33.1%, primarily due to a lower number of rental systems in use to support current clients as a result of improved system utilization. All other cost of revenues, excluding depreciation and amortization, decreased $0.3 million, or 1.1%. Cost of revenues, as a percentage of revenue, increased to 56.7% in 2011 from 55.3% in 2010 as a result of the factors described above and the nature of our high fixed cost operating expense.

Selling, general and administrative expenses increased $10.0 million, or 14.9%, to $77.1 million in 2011 compared to $67.1 million in 2010. The provision for doubtful accounts increased $4.6 million, or 350.1%, primarily due to specific reserves required on a small group of hospital customers during 2011 and the collection of aged accounts receivable during 2010. The provision for doubtful accounts as a percentage of revenue was 1.2% in 2011 compared to 0.3% of revenue in 2010. Professional services expenses increased $3.2 million, or 38.7%, due to an increase in legal and other professional fees related to the significant organizational restructure described previously. Compensation and related employee expenses increased $1.0 million, or 2.5%, primarily as a result of investments in the infrastructure of the oncology division (including the USR executive team) and professional radiology services. License, taxes and fees increased $0.5 million, or 251.8%, due to an increase in business license fees. Bank charges increased $0.5 million, or 40.7%, due to an increase in credit card charges related to payments received from wholesale customers. Office expenses increased $0.3 million, or 3.7%, due to an increase in

information technology expenses and other office expenses. Share-based payments decreased $0.9 million, or 16.3%, due to previously issued equity awards becoming fully vested. All other selling, general and administrative expenses increased $0.7 million, or 28.0%. Selling, general and administrative expenses as a percentage of revenue were 15.6% and 14.0% in 2011 and 2010, respectively.

Transaction costs increased $1.0 million, or 40.6%, to $3.4 million in 2011 compared to $2.4 million in 2010 due to increased acquisition activity, specifically for USR-related costs in 2011 and $0.7 million of deferred financing costs that were written off in 2011.

Severance and related costs increased $3.0 million, or 298.2%, to $4.0 million in 2011 compared to $1.0 million in 2010 as a result of a decrease in headcount related to the significant organizational restructure described previously.

We recorded non-cash impairment charges of $167.8 million in 2011 compared to $42.1 million in 2010 related to the write down of goodwill, other intangible assets and other assets under the provisions of ASC 350, "Intangibles-Goodwill and Other," ASC 360, "Property, Plant, and Equipment," and ASC 323, "Investments-Equity Method and Joint Ventures." We have been adversely affected by sustained high unemployment rates, a reported decline in physician office visits, uncertainty related to healthcare reform and other conditions in the United States arising from global economic conditions. Additionally, the development of new projects, specifically in the Radiation Oncology segment, has taken longer than expected as the hospital decision-making cycle has slowed, causing longer than expected negotiation periods and further delaying the regulatory approval cycle and construction timelines. These factors have had a sustained negative effect on our stock price and on the fair values of our Imaging and Radiation Oncology reporting units.

During 2011 and 2010, we concluded that the fair values of the Imaging reporting units and Radiation Oncology reporting unit, respectively, were less than their carrying values, and we performed Step 2 of the analysis to determine the amount of goodwill impairment. As a result, we recorded impairment charges of $154.3 million under ASC 350 related to goodwill in the Imaging segment in 2011 and $19.9 million under ASC 350 related to goodwill in the Radiation Oncology segment in 2010. In 2011, we recorded impairment charges of $0.8 million under ASC 350 related to certain CONs with indefinite lives. These charges were related to the Imaging segment. In 2010, we recorded impairment charges of $10.3 million under ASC 350 related to certain CONs with indefinite lives, $7.8 million of which was related to the Radiation Oncology segment and $2.6 million of which was related to the Imaging segment. In 2011, we recorded impairment charges of $12.7 million under ASC 360 related to certain long-lived assets and physician referral network intangible assets that were related to the Imaging segment. In 2010, we recorded impairment charges of $5.8 million under ASC 360 related to physician referral network intangible assets of which $0.3 million was related to the Radiation Oncology segment and $5.5 million was related to the Imaging segment. In 2010, we also recorded impairment charges of $6.1 million under ASC 323 related to an other-than-temporary decline in the fair value of investments in two joint ventures. For additional information, see Critical Accounting Policies-Goodwill and Long-Lived Assets below and Note 6 of the Notes to the Consolidated Financial Statements.

Depreciation expense decreased $2.3 million, or 2.5%, to $90.0 million in 2011 compared to $92.3 million in 2010.

Amortization expense increased by $4.0 million, or 32.2%, to $16.4 million in 2011 compared to $12.4 million in 2010, primarily due to the incremental amortization expense for intangible assets acquired in conjunction with our acquisitions in 2011.

Interest expense and other, net decreased $1.4 million, or 2.8%, to $49.8 million in 2011 compared to $51.2 million in 2010, primarily due to a $1.8 million expense from a non-cash fair value adjustment recorded in 2010 related to our interest rate swap agreements, partially offset by higher average interest rates in 2011 on our credit facility.

Income tax benefit was $38.2 million in 2011 compared to $20.8 million in 2010, resulting in effective tax rates of 19.3% and 38.9%, respectively. Our effective tax rate differed from the federal statutory rate principally as a result of state income taxes and permanent non-deductible tax items, including share-based payments, unrecognized tax benefits and other permanent differences, and for 2011, non-deductible goodwill impairment.

Earnings from unconsolidated investees decreased by $0.8 million, or 18.8%, to $3.5 million in 2011 compared to $4.3 million in 2010.

Net income attributable to noncontrolling interest increased $1.1 million, or 28.7%, to $5.0 million in 2011 compared to $3.9 million in 2010, primarily due to an increase in noncontrolling interest related to the acquisition of USR, partially offset by a $2.1 million reduction of noncontrolling interest related to the goodwill impairment charges.

Net loss attributable to Alliance HealthCare Services, Inc. was $160.1 million, or $(15.07) per share on a diluted basis, in 2011 compared to $32.7 million, or $(3.09) per share on a diluted basis, in 2010.

Liquidity and Capital Resources

Our primary source of liquidity is cash provided by operating activities. We generated $103.1 million and $93.5 million of cash flow from operating activities in 2012 and 2011, respectively. Our ability to generate cash flow is affected by numerous factors, including demand for MRI, PET/CT, other diagnostic imaging and radiation oncology services. Our ability to generate cash flow from operating activities is also dependent upon the collections of our accounts receivable. The provision for doubtful accounts decreased by $3.2 million in 2012 compared to 2011. Our number of days of revenue outstanding for our accounts receivable decreased to 49 days as of December 31, 2012 from 54 days as of December 31, 2011. We believe this number is comparable to other diagnostic imaging and radiation oncology providers. As of December 31, 2012, we had $66.0 million of available borrowings under our revolving line of credit, net of outstanding letters of credit.

We used cash of $0.6 million and $89.8 million for investing activities in 2012 and 2011, respectively. Investing activities in 2012 included $37.5 million from proceeds from sales of assets, and $2.5 million in cash provided by a decrease in cash in escrow. In connection to the $37.5 million from proceeds from sales of assets, $30.0 million is attributed to the sale of certain imaging assets, which were then leased from the purchasers, under competitive terms. The entire $30.0 million in proceeds from the sale and lease transactions was used to make a one-time payment to permanently reduce borrowings outstanding under the term loan facility.

While we had no acquisition activity in 2012, we may continue to use cash for acquisitions in the future. Other than acquisitions, our primary use of capital resources is to fund capital expenditures. We spend capital:

- to purchase new systems;
- to replace less advanced systems with new systems;
- to upgrade MRI, PET/CT and radiation oncology systems; and
- to upgrade our corporate infrastructure, primarily in information technology.

Capital expenditures totaled $37.6 million and $49.6 million in 2012 and 2011, respectively. During 2012, we purchased three MRI and one PET/CT systems, six other modality systems, and financed the purchase of one radiation oncology system. We traded-in or sold a total of 114 systems during 2012, including 64 MRI systems, 19 PET/CT, 8 CT systems, 8 radiation oncology systems, and 23 other modality systems. Of the MRI and PET/CT systems sold, 19 MRI systems and 9 PET/CT systems were involved in the sale-lease transaction discussed above. Our decision to purchase a new system is typically predicated on obtaining new or extending existing client contracts, which serve as the basis of demand for the new system. We expect to purchase additional systems in 2012 and finance substantially all of these purchases with our available cash, cash from operating activities and equipment leases. Based upon the client demand described above, which dictates the amount and type of equipment we purchase, we expect capital expenditures to total approximately $45.0 million to $55.0 million in 2013.

At December 31, 2012, we had cash and cash equivalents of $40.0 million. This available cash and cash equivalents are held in accounts managed by third-party financial institutions and consist of invested cash and cash in our operating accounts. The invested cash is invested in interest-bearing funds managed by third-party financial institutions. These funds invest in high-quality money market instruments, primarily direct obligations of the government of the United States. To date, we have experienced no loss or lack of access to our invested cash or cash equivalents; however, we cannot assure you that access to our invested cash and cash equivalents will not be affected by adverse conditions in the financial markets.

At December 31, 2012, we had $0.6 million in our accounts with third-party financial institutions that exceed the Federal Deposit Insurance Corporation (“FDIC”) insurance limits. While we monitor daily the cash balances in our operating accounts and adjust the cash balances as appropriate, these cash balances could be adversely affected if the underlying financial institutions fail or could be subject to other adverse conditions in the financial markets. To date, we have experienced no loss or lack of access to cash in our operating accounts.

We believe that, based on current levels of operations, our cash flow from operating activities, together with other available sources of liquidity, including borrowings available under our revolving line of credit, will be sufficient over the next one to two years to fund anticipated capital expenditures and potential acquisitions and make required payments of principal and interest on our debt and other contracts. As of December 31, 2012, we are in compliance with all covenants contained in our long-term debt agreements and expect that we will be in compliance with these covenants for the remainder of 2013.

On September 27, 2011, we entered into an amendment to our credit agreement. As part of the amendment, our quarterly amortization payments on the term loan facility were increased from $1.2 million to $3.0 million, and our annual excess cash flow sweep percentage was increased from 50% to 75%. The amendment also made other changes to the Credit Agreement, including revisions to the calculation of Consolidated Adjusted EBITDA and revisions to the covenants related to joint ventures, restricted payments and capital expenditures. In addition to other covenants, the New Credit Facility limits our and our subsidiaries' ability to declare dividends or redeem or repurchase capital stock, prepay, redeem or purchase debt, incur liens

and engage in sale-leaseback transactions, make loans and investments, incur additional indebtedness, amend or otherwise alter debt and other material agreements, make capital expenditures, engage in mergers, acquisitions and asset sales, transact with affiliates and alter the business conducted by us and our subsidiaries.

Additionally, we agreed to a decrease in the maximum amount of availability under our revolving credit facility from $120.0 million to $70.0 million and to an increase in margins on our borrowings under the credit facility. The margins under the revolving loans, which are based on our ratio of consolidated total debt to Consolidated Adjusted EBITDA, were increased to 3.75% to 4.25% on base rate loans and 4.75% to 5.25% on LIBOR loans. The margins under the term loans were increased to 4.25% on base rate loans and 5.25% on LIBOR loans. In addition, we will not be able to borrow under the revolving credit facility unless we are able to meet our ratio of consolidated total debt to Consolidated Adjusted EBITDA on a pro forma basis after giving effect to the new borrowings. During the year ended December 31, 2011, we wrote off $0.7 million of deferred financing costs related to the revolving credit facility.

In September 2011, in connection with the execution of the amendment, we paid down $25.0 million of the borrowings outstanding under the term loan facility and paid a fee to the consenting lenders of $6.0 million.

In October 2012, we reached an agreement with our lenders for a second amendment to our Credit Agreement. The second amendment further modified the existing financial covenants. Pursuant to the second amendment, we are now required to maintain a maximum ratio of consolidated total debt to Consolidated Adjusted EBITDA less minority interest expense of 5.00 to 1.00 through September 30, 2014, 4.75 to 1.00 from October 1, 2014 through September 30, 2015, 4.50 to 1.00 from October 1, 2015 through December 31, 2015 and 4.25 to 1.00 thereafter. The minimum ratio of Consolidated Adjusted EBITDA less minority interest expense to consolidated interest expense will remain unchanged at of 2.25 to 1.00 through December 31, 2012, 2.50 to 1.00 from January 1, 2013 through December 31, 2014 and 2.75 to 1.00 thereafter.

As of December 31, 2012, our ratio of consolidated total debt to Consolidated Adjusted EBITDA was 3.84 to 1.00 and our ratio of Consolidated Adjusted EBITDA to consolidated interest expense was 2.85 to 1.00.

In connection with the execution of the second amendment, we used $30.0 million in proceeds from the sale-lease transaction discussed above together with $44.5 million of our existing cash to make a total payment of $74.5 million to permanently reduce borrowings outstanding under the term loan facility. This prepayment made in connection with the amendment satisfies all future mandatory amortization payments under the terms of the Credit Agreement, which matures in June 2016.

We estimate that we will incur approximately $7.9 million of annual rent expense in connection with the sale and lease transaction, which will reduce future Consolidated Adjusted EBITDA. The Company estimates it will have a reduction in annual interest expense of approximately $5.4 million based on the current interest rate.

The indenture governing our outstanding 8% Notes due 2016 (the "8% Notes") contains covenants limiting our and most of our subsidiaries' ability to pay dividends and make other restricted payments, incur additional indebtedness or issue disqualified stock, create liens on our assets, merge, consolidate, or sell all or substantially all of our assets, and enter into transactions with affiliates, among others. As of December 31, 2012, we were in compliance with all covenants contained in the 8% Notes and expect to comply with these covenants in 2013. Our failure to comply with these covenants could permit the trustee under the indenture relating to the 8% Notes and the note holders to declare the principal amounts under the 8% Notes, together with accrued and unpaid interest, to be immediately due and payable. If the indebtedness under the 8% Notes, or any of our other indebtedness, is accelerated, and we are not able to refinance our debt, we could become subject to bankruptcy proceedings.

In the first quarter of 2010, we entered into one interest rate swap agreement (the “2010 Swap”) and three interest rate cap agreements (the “2010 Caps”) to avoid unplanned volatility in the income statement due to changes in the LIBOR interest rate environment. The 2010 Swap, which matured in January 2011, had a notional amount of $92.7 million. For the year ended December 31, 2011, we received net settlement amounts of $0.1 million on this swap agreement. The interest rate cap agreements, which mature in February 2014, have a total notional amount of $150.0 million and were designated as cash flow hedges of future cash interest payments associated with a portion of our variable rate bank debt. Under these arrangements, we have purchased a cap on LIBOR at 4.50%. We paid $1.5 million to enter into the caps, which is being amortized through interest expense over the life of the agreements. For the years ended December 31, 2012, 2011 and 2010, we paid no net settlement amounts on the 2010 Caps.

In the second quarter of 2011, we acquired two interest rate swap agreements (the “USR Swaps”) as part of the acquisition of USR. One of the USR Swaps, which matures in October 2015, has a notional amount of $3.0 million as of December 31, 2012. Under the terms of this agreement, we receive one-month LIBOR and pay a fixed rate of 5.71%. The net effect of the hedge is to record interest expense at a fixed rate of 8.71%, as the underlying debt incurred bears interest based on

one-month LIBOR plus 3.00%. The other USR Swap, which matures in April 2014, has a notional amount of $1.4 million as of December 31, 2012. Under the terms of this agreement, we receive one-month LIBOR and pay a fixed rate of 4.15%. The net effect of the hedge is to record interest expense at a fixed rate of 6.15%, as the underlying debt incurred bears interest based on one-month LIBOR plus 2.00%. As a result of the acquisition of USR, the USR Swaps were de-designated, hedge accounting was terminated and all further changes in the fair market value of these swaps are being recorded in interest expense and other, net. For the year ended December 31, 2012, we paid net settlement amounts of $0.1 million on these swap agreements.

During the first quarter of 2009, we entered into a diesel fuel swap agreement that had a notional quantity of 1,008,000 gallons, or 84,000 gallons per month, to hedge future cash payments associated with purchasing diesel fuel for our mobile fleet. Under the terms of this agreement, which matured in February 2010, we received the Department of Energy ("DOE") published monthly average price per gallon and paid a fixed rate of $2.63 per gallon. We designated this swap as a cash flow hedge of future cash flows associated with our diesel fuel payments. We recorded effective changes in the fair value of the swap through comprehensive income (loss) and reclassified gains or losses to fuel expense (included in cost of revenues, excluding depreciation and amortization) when the underlying fuel was purchased. Settlement amounts under this swap were not material for the year ended December 31, 2010. For the year ended December 31, 2010, amounts recognized in other (income) and expense with respect to this swap were not material.

During the first quarter of 2010, we entered into a diesel fuel swap agreement that had a notional quantity of 1,008,000 gallons, or 84,000 gallons per month, to hedge future cash payments associated with purchasing diesel fuel for our mobile fleet. Under the terms of this agreement, which matured in February 2011, we received the DOE published monthly average price per gallon and paid a fixed rate of $3.25 per gallon. We designated this swap as a cash flow hedge of future cash flows associated with our diesel fuel payments. We recorded effective changes in the fair value of the swap through comprehensive income (loss) and reclassified gains or losses to fuel expense (included in cost of revenues, excluding depreciation and amortization) when the underlying fuel was purchased. Settlement amounts under this swap were not material for the year ended December 31, 2011. For the year ended December 31, 2010, we paid net settlement amounts of $0.1 million on this swap agreement. For the years ended December 31, 2011 and 2010, amounts recognized in other (income) and expense, net with respect to this swap were not material.

During the second quarter of 2011, we entered into a diesel fuel swap agreement that has a notional quantity of 450,000 gallons, or 37,500 gallons per month, to hedge future cash payments associated with purchasing diesel fuel for our mobile fleet. Under the terms of this agreement, which matured in April 2012, we received the DOE published monthly average price per gallon and paid a fixed rate of $4.31 cents per gallon. We designated this swap as a cash flow hedge of future cash flows associated with our diesel fuel payments. We recorded effective changes in the fair value of the swap through comprehensive income (loss) and reclassied gains or losses to fuel expense (included in cost of revenues, excluding depreciation and amortization) when the underlying fuel was purchased. For the year ended December 31, 2011, we paid net settlement amounts of $0.1 million on this swap agreement. For the years ended December 31, 2012 and 2011, amounts recognized in other (income) and expense, net with respect to this swap were not material.

In fourth quarter of 2012, we entered into an interest rate swap agreement in connection with the financing of an equipment purchase to avoid unplanned volatility in income due to changes in the LIBOR interest rate environment. This swap agreement, which matures in November 2017, has a notional amount of $5.2 million as of December 31, 2012. Under the terms of this agreement, we receive one-month LIBOR and pay a fixed rate of 3.75%. The net effect of the hedge is to record interest expense at a fixed rate of 5.25%, as the underlying debt incurred bears interest based on one-month LIBOR plus 2.50%.

The maturities of our long-term debt, including interest, future payments under our operating leases and binding equipment purchase commitments as of December 31, 2012 are as follows:

| Contractual Obligations | 2013 | 2014 | 2015 | 2016 | 2017 | Thereafter | Total |
|---|---|---|---|---|---|---|---|
| New Term Loan | $24.7 | $24.7 | $24.7 | $352.8 | $— | $— | $426.9 |
| 8% Senior Notes | 15.2 | 15.2 | 15.2 | 203.9 | — | — | 249.5 |
| Equipment Loans | 13.5 | 9.3 | 6.1 | 4.4 | 1.7 | — | 35.0 |
| Operating Leases | 14.4 | 13.7 | 13.3 | 11.5 | 3.2 | 9.3 | 65.4 |
| Letters of Credit | 0.4 | — | — | — | — | — | 0.4 |
| Equipment Purchase Commitments | 9.2 | — | — | — | — | — | 9.2 |
| Total Contractual Obligation Payments | 77.4 | 62.9 | 59.3 | 572.6 | 4.9 | 9.3 | 786.4 |
| Less Amount Representing Interest | (1.5) | (0.8) | (0.4) | (0.2) | — | — | (2.9) |
| Future Contractual Obligations | $75.9 | $62.1 | $58.9 | $572.4 | $4.9 | $9.3 | $783.5 |

We have omitted our liability for unrecognized tax benefits of $0.4 million at December 31, 2012 from the above table because we cannot determine with certainty when this liability will be settled. Although we believe that it is reasonably possible that the amount of liability for unrecognized tax benefits will change in the next twelve months, we do not expect the change will have a material impact on our consolidated financial statements.

We believe that, based on current levels of operations, our cash flow from operating activities, together with other available sources of liquidity, including borrowings available under our revolving line of credit, will be sufficient over the next one to two years to fund anticipated capital expenditures and potential acquisitions and make required payments of principal and interest on our debt and other contracts. Under current tax law, we expect to utilize all of our federal net operating loss carryforwards ("NOLs") by approximately 2014, and therefore anticipate being in a tax paying position with respect to a portion of our taxable income in 2014, and for all taxable income generated beyond 2014. We may require or choose to obtain additional financing. Our ability to obtain additional financing will depend, among other things, on our financial condition and operating performance, as well as the condition of the capital markets at the time we seek financing. We cannot assure you that additional financing will be available to us on favorable terms when required, or at all. If we raise additional funds through the issuance of equity, equity-linked or debt securities, those securities may have rights, preferences or privileges senior to the rights of our common stock, and our stockholders may experience dilution. If we need to raise additional funds in the future and are unable to do so or obtain additional financing on acceptable terms in the future, we may have to limit planned activities or sell assets to obtain liquidity. We may also from time to time seek to repurchase, redeem, or retire our outstanding indebtedness through cash purchases and exchange offers in open market transactions, privately negotiated purchases or otherwise. Those repurchases, redemptions or retirements, if any, will depend on prevailing market conditions, our liquidity requirements and capital resources, contractual restrictions and other factors. The amounts involved may be material.

Off-Balance Sheet Arrangements

See Item 7A "Quantitative and Qualitative Disclosures about Market Risk."

We periodically enter into guarantees and other similar arrangements as part of transactions in the ordinary course of business. We describe these arrangements in Note 12 of the Notes to the Consolidated Financial Statements.

Critical Accounting Policies

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates. The significant accounting policies that we believe are the most critical to aid in fully understanding and evaluating our reported financial results include the following:

Revenue Recognition

We derive the majority of our revenue directly from healthcare providers, primarily for imaging and radiation oncology services. To a lesser extent, we generate revenues from direct billings to patients or their medical payors, and we record these revenues net of contractual discounts and other arrangements for providing services at less than

established patient billing rates. Revenues from direct patient billing amounted to approximately 19%, 20% and 20% of revenues in the years ended December 31, 2012, 2011 and 2010, respectively. We continuously monitor collections from direct patient billings and compare

these collections to revenue, net of contractual discounts, recorded at the time of service. While these contractual discounts have historically been within our expectations and the provisions established, an inability to accurately estimate contractual discounts in the future could have a material adverse effect on our operating results. Because the price is predetermined, we recognize all revenues when we deliver the imaging service and collectability is reasonably assured, which is based upon contract terms with healthcare providers and negotiated rates with third-party payors and patients.

Accounts Receivable

We provide shared and single-user diagnostic imaging and radiation oncology equipment and technical support services to the healthcare industry and directly to patients on an outpatient basis. Substantially all of our accounts receivable are due from hospitals, other healthcare providers and health insurance providers, including Medicare, located throughout the United States. Services are generally provided under long-term contracts with hospitals and other healthcare providers or directly to patients, and generally collateral is not required. We generally collect receivables within industry norms for third-party payors. We continuously monitor collections from our clients and maintain an allowance for estimated credit losses based upon any specific client collection issues that we have identified and our historical experience. Although those credit losses have historically been within our expectations and the provisions established, an inability to accurately estimate credit losses in the future could have a material adverse effect on our operating results.

Goodwill and Long-Lived Assets

ASC 350 requires that goodwill and intangible assets with indefinite useful lives not be amortized, but instead be tested for impairment at least annually. In accordance with ASC 350, we have elected to perform an annual impairment test in the fourth quarter for goodwill and intangible assets with indefinite lives, using financial information as of September 30, or more frequently if an event occurs or circumstances change that would more likely than not reduce the fair value of a reporting unit below its carrying amount. Those indicators include a sustained significant decline in our market capitalization or a significant decline in our expected future cash flows due to changes in company-specific factors or the broader business climate. The evaluation of such factors requires considerable judgment. Any adverse change in these factors could have a significant effect on the recoverability of goodwill and could have a material effect on our consolidated financial statements.

We allocate goodwill and intangible assets with indefinite lives to our three reporting units, which are aggregated into the Imaging and Radiation Oncology segments. Goodwill represented $56.5 million of our $560.1 million of total assets as of December 31, 2012 and $56.5 million of our $663.1 million of total assets as of December 31, 2011. Imaging segment goodwill totaled $41.7 million as of December 31, 2012 and 2011, and Radiation Oncology segment goodwill totaled $14.8 million as of December 31, 2012 and 2011.

We comply with periodic impairment test procedures, as described above. For each reporting unit, we first compare its estimated fair value with its net book value. If the estimated fair value exceeds its net book value, goodwill is deemed not to be impaired, and no further testing is necessary. If the net book value exceeds its estimated fair value, we then perform a second test to calculate the amount of impairment, if any. To determine the amount of any impairment, we determine the implied fair value of goodwill. Specifically, we determine the fair value of all of the assets and liabilities of the reporting unit, including any unrecognized intangible assets, in a hypothetical calculation that yields the implied fair value of goodwill. If the implied fair value of goodwill is less than the recorded goodwill, we record an impairment charge for the difference.

The fair value of a reporting unit is determined using a combination of income and market approaches. The following describes the valuation methodologies used in 2012, 2011 and 2010 to derive the estimated fair value of the reporting units. We use the average of the Discounted Cash Flow (“DCF”) method and the Guideline Public Company (“GPC”) method in assessing fair value for each reporting unit.

The DCF method involves an analysis of future cash flow projections for the subject reporting unit. Cash flows are discounted at a rate reflective of the perceived risks inherent in the projections. A terminal value, the estimated value of the entity at the end of the discrete forecast period, is calculated by dividing the terminal year net cash flow by an appropriate capitalization rate, which assumes constant growth into perpetuity.

Under the GPC method, the fair value of a business is estimated by comparing the subject company to similar companies with publicly traded ownership interests. From these guideline companies, valuation multiples are derived

and then applied to the appropriate operating statistics of the subject company to arrive at indications of value. We identified six guideline companies for use in our analysis of our reporting units. For purposes of this analysis, the guideline companies selected represented reasonably similar, but alternative investment opportunities to an investment in the reporting unit.

In 2012, we concluded that the fair value of each reporting unit exceeded its carrying value, indicating no goodwill or indefinite-lived intangible asset impairment was present.

With the decline in our market capitalization during the third quarter of 2011, we performed an interim impairment test in the third quarter as of September 30, 2011. Following the 2011 goodwill assessment, we concluded that the net book values of the Imaging reporting units exceeded their estimated fair values. Based on the results of the Step 2 test, we recorded an impairment charge of $154.3 million under ASC 350 related to goodwill in the Imaging segment. Through December 31, 2011, we have recognized a total of $174.2 million of goodwill impairment charges. We also recorded impairment charges of $0.8 million under ASC 350 related to certain CONs with indefinite lives that were related to the Imaging segment. We applied the income approach to value the CONs, using either an excess earnings method or a beneficial earnings method. Under the income approach, value is measured as the present worth of anticipated future net cash flows generated by the asset.

ASC 350 also requires intangible assets with definite useful lives to be amortized over their respective estimated useful lives to their estimated residual values and reviewed for impairment in accordance with ASC 360, “Property, Plant, and Equipment.” During the third quarter of 2011, we also deemed it appropriate to perform a valuation of certain definite useful lived intangible assets in accordance with ASC 360 as a result of the factors described above. Based on this valuation, we recorded impairment charges of $2.0 million related to certain physician referral network intangible assets, which were related to the Imaging segment. We applied the income approach to value the physician referral networks, utilizing the excess earnings method.

During the fourth quarter of 2011, we also evaluated the recoverability of the carrying amount of certain long-lived assets and recognized an impairment charge of $10.7 million to reduce these assets to their fair values. These assets represent a certain class of imaging-related equipment. We based the fair values of these assets on their anticipated disposal values.

Following the 2010 goodwill assessment, we concluded that the net book values of the Radiation Oncology reporting unit exceeded its estimated fair value. Based on the results of the Step 2 test, we recorded an impairment charge of $19.9 million under ASC 350 related to goodwill in the Radiation Oncology segment. Through December 31, 2010, we recognized a total of $19.9 million of goodwill impairment charges. We also recorded impairment charges of $10.3 million under ASC 350 related to certain CONs with indefinite lives, $7.8 million of which was related to the Radiation Oncology segment, and $2.5 million of which was related to the Imaging segment. We applied the income approach to value the CONs, using either an excess earnings method or a beneficial earnings method. Under the income approach, value is measured as the present worth of anticipated future net cash flows generated by the asset.

During the fourth quarter of 2010, based on the factors noted below, we also deemed it appropriate to perform a valuation of certain definite useful lived intangible assets in accordance with ASC 360. Based on this valuation, we recorded impairment charges of $5.8 million related to certain physician referral network intangible assets, $0.3 million of which was related to the Radiation Oncology segment, and $5.5 million of which was related to the Imaging segment. We applied the income approach to value the physician referral networks, utilizing the excess earnings method.

Also in 2010, we recorded impairment charges of $6.1 million under ASC 323, “Investments-Equity Method and Joint Ventures” related to an other-than-temporary decline in the fair value of investments in two joint ventures, due to triggering events that occurred in the fourth quarter during the annual budgeting process. We applied a combination of the DCF and GPC methods, as described above, and the guideline transaction method, for which a value indication is derived from the prices at which companies similar to the subject have been sold, to determine the fair value of these investments.

See Note 6 of the Notes to the Consolidated Financial Statements for further information.

The determination of fair value of our reporting units requires significant estimates and assumptions. These estimates and assumptions primarily include earnings and required capital projections, discount rates, terminal growth rates, and operating income for each reporting unit and the weighting assigned to the results of each of the valuation methods described above. Changes in certain assumptions could have a significant impact on the goodwill impairment assessment. We evaluated the significant assumptions used to determine the estimated fair values of each reporting unit, both individually and in the aggregate, and concluded they are reasonable. However, if weak market conditions continue for an extended period or the operating results of any of our reporting units decline substantially compared to projected results, we could determine that we need to record additional impairment charges.

Goodwill Impairment Test

The goodwill impairment test has two steps. Step 1 of the test identifies potential impairments at the reporting unit level. We divide our imaging operations into two geographic regions. Radiation oncology is run as a separate profit center responsible for its own revenue, expenses, and overhead, and is managed on a national basis. We have aggregated the results of our two imaging reporting units and radiation oncology reporting unit into two reportable segments, Imaging and Radiation Oncology. For purposes of goodwill impairment testing, we compare the estimated fair value of each of the two imaging reporting units

and the radiation oncology reporting unit to its net book value. If the estimated fair value of a reporting unit exceeds its net book value, there is no impairment of goodwill and Step 2 is unnecessary. However, if the net book value exceeds the estimated fair value, then Step 1 is failed, and Step 2 is performed to determine the amount of the potential impairment. Step 2 uses acquisition accounting guidance and requires the fair value calculation of all individual assets and liabilities of the reporting unit (excluding goodwill, but including any unrecognized intangible assets). The net fair value of assets less liabilities is then compared to the reporting unit's total estimated fair value as calculated in Step 1. The excess of fair value over the net asset value equals the implied fair value of goodwill. The implied fair value of goodwill is then compared to the carrying value of goodwill to determine the reporting unit's goodwill impairment. See Notes 6 and 7 to the Consolidated Financial Statements for more information.

Deferred Income Taxes

Deferred income tax assets and liabilities are determined based on the temporary differences between the financial reporting and tax bases of assets and liabilities, applying enacted statutory tax rates in effect for the year in which the differences are expected to reverse. Future income tax benefits are recognized only to the extent that the realization of such benefits is considered to be more likely than not. We regularly review our deferred income tax assets for recoverability and establish a valuation allowance based on historical taxable income, projected future taxable income and the expected timing of the reversals of existing temporary differences. If we are unable to generate sufficient future taxable income, or if there is a material change in the actual effective income tax rates or time period within which the underlying temporary differences become taxable or deductible, we could be required to significantly increase our valuation allowance, resulting in a substantial increase in our effective tax rate.

Recent Accounting Pronouncements

For a discussion of recent accounting pronouncements, please refer to Note 2 of the Notes to Condensed Consolidated Financial Statements.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We provide our services exclusively in the United States and receive payment for our services exclusively in United States dollars. As a result, our financial results are unlikely to be affected by factors such as changes in foreign currency exchange rates or weak economic conditions in foreign markets.

Our interest expense is sensitive to changes in the general level of interest rates in the United States, particularly because the majority of our indebtedness bears interest at variable rates. The recorded carrying amount of our long-term debt under our credit facility approximates fair value because those borrowings have variable rates that reflect currently available terms and conditions for similar debt. To decrease the risk associated with interest rate increases, we have entered into multiple interest rate swap and cap agreements for a portion of our variable rate debt. These swaps and caps are designated as cash flow hedges of variable future cash flows associated with our long-term debt.

For information about our swap activities since 2010, please see Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations-Liquidity and Capital Resources.

The swaps expose us to credit risk if the counterparties to the agreements do not or cannot meet their obligations. The notional amount is used to measure interest to be paid or received and does not represent the amount of exposure to credit loss. The loss would be limited to the amount that would have been received, if any, over the remaining life of the 2010 swaps. On a quarterly basis, the counterparties are evaluated for non-performance risk. See Note 11 of the Notes to the Consolidated Financial Statements for additional details.

Our interest income is sensitive to changes in the general level of interest rates in the United States, particularly because the majority of our investments are in cash equivalents. We maintain our cash equivalents in financial instruments with original maturities of 90 days or less. Cash and cash equivalents are invested in interest bearing funds managed by third party financial institutions. These funds invest in high-quality money market instruments, primarily direct obligations of the government of the United States. At December 31, 2012, we had cash and cash equivalents of $40.0 million, of which $0.6 million was held in accounts that are with third party financial institutions that exceed the FDIC insurance limits.

The recorded carrying amounts of cash and cash equivalents approximate fair value due to their short-term maturities.

The table below provides information about our financial instruments that are sensitive to changes in interest rates. For long-term debt obligations, the table presents principal cash flows and related weighted-average interest rates by expected (contractual) maturity dates. All amounts are in United States dollars.

| | Expected Maturity as of December 31, 2012 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2013 | 2014 | 2015 | 2016 | 2017 | Thereafter | Total | Fair Value | |
| | (dollars in millions) | | | | | | | | |
| Liabilities: | | | | | | | | | |
| Long-term debt: | | | | | | | | | |
| Fixed rate | $13.5 | $9.3 | $6.1 | $194.4 | $1.7 | $— | $224.9 | $206.9 | |
| Average interest rate | 7.65% | 7.76% | 7.85% | 7.25% | 1.90% | —% | 7.27% | 8.00% | % |
| Variable rate | $— | $— | $— | $340.4 | $— | $— | $340.4 | $340.4 | |
| Average interest rate | 7.25% | 7.25% | 7.25% | 7.25% | 7.25% | —% | 7.25% | 7.25% | % |

ITEM 8. FINANCIAL STATMENTS AND SUPPLEMENTARY DATA

ALLIANCE HEALTHCARE SERVICES, INC.
INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders of
Alliance HealthCare Services, Inc.
Newport Beach, California

We have audited the accompanying consolidated balance sheets of Alliance HealthCare Services, Inc. and subsidiaries (the "Company") as of December 31, 2012 and 2011, and the related consolidated statements of operations and comprehensive loss, cash flows, and stockholders' equity (deficit) for each of the three years in the period ended December 31, 2012. Our audits also included the consolidated financial statement schedule listed in the Index at Item 15. These consolidated financial statements and the consolidated financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements and the consolidated financial statement schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Alliance HealthCare Services, Inc. and subsidiaries as of December 31, 2012 and 2011, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2012, in conformity with accounting principles generally accepted in the United States of America. Also, in our opinion, such consolidated financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2012, based on the criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated March 15, 2013 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ Deloitte & Touche LLP
Costa Mesa, California
March 15, 2013

ALLIANCE HEALTHCARE SERVICES, INC.
CONSOLIDATED BALANCE SHEETS
(in thousands)

| | December 31, 2011 | 2012 |
|---|---|---|
| ASSETS | | |
| Current assets: | | |
| Cash and cash equivalents | $44,190 | $39,977 |
| Accounts receivable, net of allowance for doubtful accounts of $7,914 in 2011 and $5,317 in 2012 | 70,701 | 62,320 |
| Deferred income taxes | 10,086 | 17,364 |
| Prepaid expenses | 6,462 | 5,078 |
| Other receivables | 4,301 | 3,898 |
| Total current assets | 135,740 | 128,637 |
| Equipment, at cost | 954,337 | 827,162 |
| Less accumulated depreciation | (663,038) | (618,601) |
| Equipment, net | 291,299 | 208,561 |
| Goodwill | 56,493 | 56,493 |
| Other intangible assets, net | 143,024 | 126,931 |
| Deferred financing costs, net | 17,268 | 16,497 |
| Other assets | 19,270 | 23,022 |
| Total assets | $663,094 | $560,141 |
| LIABILITIES AND STOCKHOLDERS' DEFICIT | | |
| Current liabilities: | | |
| Accounts payable | $22,417 | $15,993 |
| Accrued compensation and related expenses | 18,204 | 22,481 |
| Accrued interest payable | 6,582 | 5,081 |
| Other accrued liabilities | 33,438 | 26,835 |
| Current portion of long-term debt | 24,923 | 13,145 |
| Total current liabilities | 105,564 | 83,535 |
| Long-term debt, net of current portion | 430,451 | 357,056 |
| Senior notes | 188,109 | 188,434 |
| Other liabilities | 879 | 4,314 |
| Deferred income taxes | 43,002 | 43,095 |
| Total liabilities | 768,005 | 676,434 |
| Commitments and contingencies (Note 12) | | |
| Stockholders' deficit: | | |
| Preferred stock, $0.01 par value; 200,000 shares authorized and no shares issued and outstanding | | |
| Common stock, $0.01 par value; 20,000,000 shares authorized; shares issued and outstanding - 10,663,868 at December 31, 2011 and 10,615,072 at December 31, 2012 | 527 | 524 |
| Less: treasury stock, at cost - 116,196 shares at December 31, 2011 and 140,028 December 31, 2012 | (2,729) | (2,877) |
| Additional paid-in capital | 20,269 | 21,507 |
| Accumulated comprehensive loss | (950) | (716) |
| Accumulated deficit | (171,288) | (183,226) |
| Total stockholders' deficit attributable to Alliance HealthCare Services, Inc. | (154,171) | (164,788) |
| Noncontrolling interest | 49,260 | 48,495 |
| Total stockholders' deficit | (104,911) | (116,293) |
| Total liabilities and stockholders' deficit | $663,094 | $560,141 |

See accompanying notes.

ALLIANCE HEALTHCARE SERVICES, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS
AND COMPREHENSIVE INCOME (LOSS)
(in thousands, except per share amounts)

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2010 | 2011 | 2012 |
| Revenues | $478,855 | $493,651 | $472,258 |
| Costs and expenses: | | | |
| Cost of revenues, excluding depreciation and amortization | 264,725 | 279,751 | 253,225 |
| Selling, general and administrative expenses | 67,110 | 77,140 | 76,022 |
| Transaction costs | 2,439 | 3,429 | 994 |
| Severance and related costs | 1,002 | 3,991 | 2,226 |
| Impairment charges | 42,095 | 167,792 | — |
| Depreciation expense | 92,321 | 89,974 | 79,333 |
| Amortization expense | 12,439 | 16,444 | 15,861 |
| Interest expense and other, net | 51,203 | 49,789 | 54,101 |
| Other (income) and expense, net | (590) | 2,203 | 3,036 |
| Total costs and expenses | 532,744 | 690,513 | 484,798 |
| Loss before income taxes, earnings from unconsolidated investees, and noncontrolling interest | (53,889) | (196,862) | (12,540) |
| Income tax benefit | (20,799) | (38,242) | (6,710) |
| Earnings from unconsolidated investees | (4,327) | (3,516) | (4,667) |
| Net loss | (28,763) | (155,104) | (1,163) |
| Less: Net income attributable to noncontrolling interest | (3,890) | (5,008) | (10,775) |
| Net loss attributable to Alliance HealthCare Services, Inc. | $(32,653) | $(160,112) | $(11,938) |
| Comprehensive loss, net of taxes: | | | |
| Net loss attributable to Alliance HealthCare Services, Inc. | $(32,653) | $(160,112) | $(11,938) |
| Unrealized gain (loss) on hedging transactions, net of taxes | 1,723 | (281) | (234) |
| Comprehensive loss, net of taxes: | $(30,930) | $(160,393) | $(12,172) |
| Loss per common share attributable to Alliance HealthCare Services, Inc.: | | | |
| Basic | $(3.09) | $(15.07) | $(1.12) |
| Diluted | $(3.09) | $(15.07) | $(1.12) |
| Weighted-average number of shares of common stock and common stock equivalents: | | | |
| Basic | 10,556 | 10,626 | 10,624 |
| Diluted | 10,556 | 10,626 | 10,624 |

See accompanying notes.

ALLIANCE HEALTHCARE SERVICES, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(in thousands)

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2010 | 2011 | 2012 |
| Operating activities: | | | |
| Net loss | $(28,763) | $(155,104) | $(1,163) |
| Adjustments to reconcile net loss income to net cash provided by operating activities: | | | |
| Provision for doubtful accounts | 1,343 | 6,046 | 2,871 |
| Share-based payment | 5,580 | 4,695 | 730 |
| Impairment charges | 42,095 | 167,792 | — |
| Depreciation and amortization | 104,760 | 106,418 | 95,194 |
| Amortization of deferred financing costs | 2,744 | 3,947 | 4,006 |
| Accretion of discount on long-term debt | 1,528 | 1,611 | 1,690 |
| Adjustment of derivatives to fair value | 186 | (113) | 46 |
| Distributions (less) more than undistributed earnings from investees | 1,223 | (450) | 41 |
| Deferred income taxes | (20,765) | (38,189) | (7,030) |
| Loss (gain) on sale of assets | (589) | 2,167 | 2,087 |
| Excess tax benefit from share-based payment arrangements | (32) | — | — |
| Changes in operating assets and liabilities, net of the effects of acquisitions: | | | |
| Accounts receivable | (538) | (8,489) | 5,510 |
| Prepaid expenses | (312) | 3,698 | 1,384 |
| Other receivables | 603 | (703) | 403 |
| Other assets | 228 | 988 | 896 |
| Accounts payable | (4,419) | 2,800 | (3,729) |
| Accrued compensation and related expenses | (315) | 645 | 4,277 |
| Accrued interest payable | 2,023 | 696 | (1,501) |
| Income taxes payable | (326) | (294) | (252) |
| Other accrued liabilities | (1,326) | (4,634) | (2,317) |
| Net cash provided by operating activities | 104,928 | 93,527 | 103,143 |
| Investing activities: | | | |
| Equipment purchases | (64,522) | (49,609) | (37,564) |
| (Increase) decrease in deposits on equipment | (2,163) | 5,878 | (2,968) |
| Acquisitions, net of cash received | (34,298) | (47,725) | — |
| Decrease in cash in escrow | 485 | 1,063 | 2,496 |
| Proceeds from sale of assets | 3,349 | 573 | 37,450 |
| Investment in unconsolidated joint ventures | (250) | — | — |
| Net cash used in investing activities | (97,399) | (89,820) | (586) |
| Financing activities: | | | |
| Principal payments on equipment debt | (6,904) | (12,207) | (13,566) |
| Proceeds from equipment debt | 358 | 1,885 | 6,526 |
| Principal payments on term loan facility | (4,600) | (31,450) | (83,515) |
| Principal payments on revolving loan facility | — | (25,000) | — |
| Proceeds from revolving loan facility | — | 25,000 | — |
| Principal payments on senior subordinated notes | (5,582) | — | — |
| Payments of debt issuance costs | (484) | (6,332) | (3,235) |

| | | | |
|---|---|---|---|
| Payments of contingent consideration | (355) | (1,626) | (1,797) |
| Noncontrolling interest in subsidiaries | (4,575) | (6,826) | (11,035) |
| Excess tax benefit from share-based payment arrangements | 32 | — | — |
| Proceeds from shared-based payment arrangements | 78 | 56 | — |
| Purchase of treasury stock | (219) | (179) | (148) |
| Net cash used in financing activities | (22,251) | (56,679) | (106,770) |
| Net decrease in cash and cash equivalents | (14,722) | (52,972) | (4,213) |
| Cash and cash equivalents, beginning of period | 111,884 | 97,162 | 44,190 |
| Cash and cash equivalents, end of period | $97,162 | $44,190 | $39,977 |
| | | | |
| Supplemental disclosure of cash flow information: | | | |
| Interest paid | $43,401 | $44,396 | $50,355 |
| Income taxes paid (received), net of refunds | $425 | $(2,708) | $760 |
| Supplemental disclosure of non-cash investing and financing activities: | | | |
| Net book value of assets exchanged | $1,602 | $315 | $5,434 |
| Capital lease obligations related to the purchase of equipment | $575 | $6,587 | $4,017 |
| Capital lease obligations transferred | $— | $(2,631) | $— |
| Comprehensive gain (loss) from hedging transactions, net of taxes | $1,723 | $(281) | $(234) |
| Equipment debt assumed in connection with acquisitions | $— | $25,973 | $— |
| Equipment purchases in accounts payable | $229 | $2,977 | $282 |
| Contingent consideration for acquisitions | $3,489 | $— | $(308) |
| Noncontrolling interest assumed (disposed) in connection with acquisitions (Note 2) | $5,036 | $39,610 | $(1,254) |

See accompanying notes.

ALLIANCE HEALTHCARE SERVICES, INC.
CONSOLIDATED STATMENTS OF STOCKHOLDERS' EQUITY
(in thousands)

| | Common Stock | | Treasury Stock | | Additional Paid-In Capital | Accumulated Comprehensive Income (Loss) | Retained Earnings (Accumulated Deficit) | Stockholders' Equity (Deficit) Attributable to Alliance HealthCare Services, Inc. | Non-contro Interest |
|---|---|---|---|---|---|---|---|---|---|
| | Shares | Amount | Shares | Amount | | | | | |
| Balance at January 1, 2010 | 10,405,003 | $516 | (77,340) | $(2,333) | $10,652 | $(2,392) | $21,477 | $27,920 | $6,842 |
| Exercise of common stock options | 250 | — | — | — | 68 | — | — | 68 | — |
| Issuance of common stock under directors' deferred compensation plan | 12,158 | 1 | — | — | — | — | — | 1 | — |
| Issuance of restricted stock | 178,580 | 9 | — | — | — | — | — | 9 | — |
| Issuance of common stock under stock bonus award | — | — | — | — | — | — | — | — | — |
| Purchase of treasury stock | — | (1) | (10,284) | (218) | — | — | — | (219) | — |
| Share-based payment | — | — | — | — | 5,580 | — | — | 5,580 | — |
| Share-based payment income tax detriment | — | — | — | — | (238) | — | — | (238) | — |
| Unrealized loss on hedging transaction, net of tax | — | — | — | — | — | 1,723 | — | 1,723 | — |
| Acquired noncontrolling interest | — | — | — | — | | — | — | — | 5,036 |
| Net contributions/(distributions) | — | — | — | — | — | — | — | — | (4,300) |
| Net (loss) income | — | — | — | — | — | — | (32,653) | (32,653) | 3,890 |
| Balance at December 31, 2010 | 10,595,991 | 525 | (87,624) | (2,551) | 16,062 | (669) | (11,176) | 2,191 | 11,468 |
| Exercise of common stock options | 2,480 | — | — | — | 53 | — | — | 53 | — |
| Issuance of common stock under directors' deferred compensation plan | 44,310 | 2 | — | — | — | — | — | 2 | — |
| Issuance of restricted stock | 21,087 | 1 | — | — | — | — | — | 1 | — |
| Purchase of treasury stock | — | (1) | (28,572) | (178) | — | — | — | (179) | — |
| Share-based payment | — | — | — | — | 4,695 | — | — | 4,695 | — |
| Share-based payment income tax detriment | — | — | — | — | (541) | — | — | (541) | — |
| Unrealized loss on hedging transaction, net of tax | — | — | — | — | — | (281) | — | (281) | — |
| Acquired noncontrolling interest | — | — | — | — | | — | — | — | 39,610 |
| Net contributions/(distributions) | — | — | — | — | — | — | — | — | (6,826) |
| Net (loss) income | — | — | — | — | — | — | (160,112) | (160,112) | 5,008 |
| | 10,663,868 | 527 | (116,196) | (2,729) | 20,269 | (950) | (171,288) | (154,171) | 49,260 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Balance at December 31, 2011 | | | | | | | | | |
| Forfeit of restricted stock | (106,340) | (4) | — | — | — | — | — | (4) | — |
| Issuance of restricted stock | 57,544 | 1 | — | — | — | — | — | 1 | — |
| Purchase of treasury stock | — | — | (23,832) | (148) | — | — | — | (148) | — |
| Share-based payment | — | — | — | — | 733 | — | — | 733 | — |
| Unrealized gain on hedging transaction, net of tax | — | — | — | — | — | 234 | — | 234 | — |
| Noncontrolling interest disposed in connection with acquisition | — | — | — | — | 505 | — | — | 505 | — |
| Net contributions (distributions) | — | — | — | — | — | — | — | — | (11,540) |
| Net (loss) income | — | — | — | — | — | — | (11,938) | (11,938) | 10,775 |
| Balance at December 31, 2012 | 10,615,072 | $524 | (140,028) | $(2,877) | $21,507 | $(716) | $(183,226) | $(164,788) | $48,495 |

See accompanying notes.

ALLIANCE HEALTHCARE SERVICES, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2012

(Dollars in thousands, except per share amounts)

1. Description of the Company and Basis of Financial Statement Presentation

Description of the Company Alliance HealthCare Services, Inc. and its subsidiaries (the "Company") provides diagnostic imaging services and therapeutic services primarily to hospitals and other healthcare providers on a shared-service and full-time service basis. The Company also provides services through fixed-sites, primarily to hospitals or health systems. The Company's services normally include the use of its systems, technologists, therapists and other clinical staff to operate the systems, equipment maintenance and upgrades and management of day-to-day shared-service and fixed-site diagnostic imaging and radiation oncology operations. The Company also offers ancillary services including marketing support, education, training and billing assistance. The Company operates entirely within the United States and is one of the largest providers of shared service and fixed-site magnetic resonance imaging ("MRI") and positron emission tomography/computed tomography ("PET/CT") services in the country. The Company also operates 29 radiation oncology centers at December 31, 2012. For the year ended December 31, 2012, MRI, PET/CT and radiation oncology services generated 42%, 33% and 18% of the Company's revenue, respectively.

Principles of Consolidation and Basis of Financial Statement Presentation The accompanying audited consolidated financial statements of the Company include the assets, liabilities, revenues and expenses of all majority-owned subsidiaries over which the Company exercises control. Intercompany transactions have been eliminated. The Company records noncontrolling interest related to its consolidated subsidiaries which are not wholly owned. Investments in non-consolidated investees over which it exercises significant influence but does not control are accounted for under the equity method. The consolidated financial statements have been prepared in accordance with generally accepted accounting principles ("GAAP") in the United States of America.

Reverse Stock Split On December 26, 2012, the Company executed a 1-for-5 reverse stock split. All share and per share information for all periods presented herein gives effect to the reverse stock split.

2. Summary of Significant Accounting Policies

Cash and Cash Equivalents The Company classifies short-term investments with original maturities of three months or less as cash equivalents.

Accounts Receivable The Company provides shared and single-user diagnostic imaging and radiation oncology equipment and technical support services to the healthcare industry and directly to patients on an outpatient basis. Substantially all of the Company's accounts receivables are due from hospitals, other healthcare providers and health insurance providers located throughout the United States. A substantial portion of the Company's services are provided pursuant to long-term contracts with hospitals and other healthcare providers or directly to patients. Accounts receivable generally are collected within industry norms for third-party payors. Estimated credit losses are provided for in the consolidated financial statements and losses experienced have been within management's expectations.

Concentration of Credit Risk Financial instruments which potentially subject the Company to a concentration of credit risk principally consist of cash, cash equivalents and trade receivables. The Company invests available cash in cash equivalents and money market securities of high-credit-quality financial institutions. The Company had cash and cash equivalents in the amount of $613 and $648 as of December 31, 2011 and 2012, respectively, in excess of federally insured limits. At December 31, 2011 and 2012, the Company's accounts receivable were primarily from clients in the healthcare industry and third-party payors. To reduce credit risk, the Company performs periodic credit evaluations of its clients, but does not generally require advance payments or collateral. Credit losses to clients in the healthcare industry have not been material. The provision for doubtful accounts was 0.3% of revenues in 2010, 1.2% of revenues in 2011 and 0.6% of revenues in 2012, respectively.

Equipment Equipment is stated at cost and is depreciated using the straight-line method over an initial estimated life of three to 10 years to an estimated residual value, between five and 10 percent of original cost. If the Company continues to operate the equipment beyond its initial estimated life, the residual value is then depreciated to a nominal salvage value over 1.5 to 3 years.

Routine maintenance and repairs are charged to expense as incurred. Major repairs and purchased software and hardware upgrades, which extend the life of or add value to the equipment, are capitalized and depreciated over the remaining useful life.

With the exception of a relatively small dollar amount of office furniture, office equipment, computer equipment, software and leasehold improvements, substantially all of the property owned by the Company relates to diagnostic imaging and radiation oncology equipment, power units and mobile trailers used in the business. The Company had $1,200 and $0 of equipment classified as held for sale as of December 31, 2011 and 2012, respectively.

Goodwill and Intangible Assets Accounting Standards Codification ("ASC") 350, "Intangibles-Goodwill and Other," requires that goodwill and intangible assets with indefinite useful lives not be amortized, but instead be tested for impairment at least annually. In accordance with ASC 350, the Company has selected to perform an annual impairment test in the fourth quarter for goodwill and intangible assets with indefinite lives, using financial information as of September 30, or more frequently if an event occurs or circumstances change that would more likely than not reduce the fair value of a reporting unit below its carrying amount. Such indicators include a sustained significant decline in our market capitalization or a significant decline in our expected future cash flows due to changes in company-specific factors or the broader business climate. The evaluation of such factors requires considerable judgment. Any adverse change in these factors could have a significant impact on the recoverability of goodwill and could have a material impact on the Company's consolidated financial statements.

Goodwill and intangible assets with indefinite lives are allocated to three reporting units, which are aggregated into the Imaging and Radiation Oncology segments. Goodwill represented $56,493 of our $663,094 and $560,141 of total assets as of December 31, 2011, and 2012, respectively. Imaging segment goodwill totaled $41,684 as of December 31, 2011 and 2012, and Radiation Oncology segment goodwill totaled $14,809 as of December 31, 2011 and 2012.

The Company complies with periodic impairment test procedures, as described above. For each reporting unit, the Company first compares its estimated fair value with its net book value. If the estimated fair value exceeds its net book value, goodwill is deemed not to be impaired, and no further testing is necessary. If the net book value exceeds its estimated fair value, the Company then performs a second test to calculate the amount of impairment, if any. To determine the amount of any impairment, the Company determines the implied fair value of goodwill. Specifically, the Company determines the fair value of all of the assets and liabilities of the reporting unit, including any unrecognized intangible assets, in a hypothetical calculation that yields the implied fair value of goodwill. If the implied fair value of goodwill is less than the recorded goodwill, the Company records an impairment charge for the difference.

The fair value of a reporting unit is determined using a combination of income and market approaches. The following describes the valuation methodologies used in 2010, 2011 and 2012 to derive the estimated fair value of the reporting units. The Company uses the average of the Discounted Cash Flow ("DCF") method and the Guideline Public Company ("GPC") method in assessing fair value for each reporting unit.

The DCF method involves an analysis of future cash flow projections for the subject reporting unit. Cash flows are discounted at a rate reflective of the perceived risks inherent in the projections. A terminal value, the estimated value of the entity at the end of the discrete forecast period, is calculated by dividing the terminal year net cash flow by an appropriate capitalization rate, which assumes constant growth into perpetuity.

Under the GPC method, the fair value of a business is estimated by comparing the subject company to similar companies with publicly traded ownership interests. From these guideline companies, valuation multiples are derived and then applied to the appropriate operating statistics of the subject company to arrive at indications of value. The Company identified six guideline companies for use in our analysis of our reporting units. For purposes of this analysis, the guideline companies selected represented reasonably similar, but alternative investment opportunities to an investment in the reporting unit.

ASC 350 also requires intangible assets with definite useful lives to be amortized over their respective estimated useful lives to their estimated residual values and reviewed for impairment in accordance with ASC 360, "Property, Plant, and Equipment." For additional information, see Note 6 of the Notes to the Consolidated Financial Statements.

Impairment of Long-Lived Assets The Company accounts for long-lived assets in accordance with the provisions of ASC 360. ASC 360 requires that long-lived assets be reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to undiscounted future net cash flows expected to be generated by the asset. If the carrying amount of an asset exceeds its estimated undiscounted future

cash flows, an impairment charge is recognized by the amount by which the carrying amount of the asset exceeds the fair value of the asset. Assets to be disposed of are reported at the lower of the carrying amount or fair value less costs to sell.

Revenue Recognition The majority of the Company's revenues are derived directly from healthcare providers and are primarily for imaging and radiation oncology services. To a lesser extent, revenues are generated from direct billings to third-party payors or patients which are recorded net of contractual discounts and other arrangements for providing services at less than established patient billing rates. Revenues from billings to third-party payors and patients amounted to approximately

20%, 21% and 19% of revenues for the years ended December 31, 2010, 2011 and 2012, respectively. No single customer accounted for more than 3% of consolidated revenues in each of the years ended December 31, 2010, 2011, and 2012. The Company recognizes revenue in accordance with ASC 600, "Revenue." As the price is predetermined, all revenues are recognized at the time the delivery of service has occurred and collectibility is reasonably assured which is based upon contract terms with healthcare providers and negotiated rates with third party payors and patients. The Company also records revenue from management services that it performs based upon management service contracts with predetermined pricing. Revenues from these services amounted to approximately 5%, 3% and 2% of total revenue for the three years ended December 31, 2010, 2011 and 2012, respectively. These revenues are recorded in the period in which the service is performed and collections of the billed amounts are reasonably assured in accordance with ASC 600.

Share-Based Payment ASC 718, "Compensation—Stock Compensation" requires that the fair value at the grant date resulting from all share-based payment transactions be recognized in the financial statements. Further, ASC 718 requires entities to apply a fair-value based measurement method in accounting for these transactions. This value is recorded over the vesting period. Under ASC 718, the Company records in its consolidated statements of operations (i) compensation cost for options granted, modified, repurchased or cancelled on or after January 1, 2006 under the provisions of ASC 718 and (ii) compensation cost for the unvested portion of options granted prior to January 1, 2006 over their remaining vesting periods using the amounts previously measured under ASC 718 for pro forma disclosure purposes.

Derivatives The Company accounts for derivative instruments and hedging activities in accordance with the provisions of ASC 815, "Derivatives and Hedging." On the date the Company enters into a derivative contract, management may designate the derivative as a hedge of the identified exposure. The Company formally documents all relationships between hedging instruments and hedged items, as well as the risk-management objective and strategy for undertaking various hedge transactions. In this documentation, the Company specifically identifies the firm commitment or forecasted transaction that has been designated as a hedged item and states how the hedging instrument is expected to hedge the risks related to the hedged item. The Company formally measures effectiveness of its hedging relationships, both at the hedge inception and on an ongoing basis, in accordance with its risk management policy. The Company would discontinue hedge accounting prospectively (i) if it is determined that the derivative is no longer effective in offsetting the change in the cash flows of a hedged item, (ii) when the derivative expires or is sold, terminated or exercised, (iii) because it is probable that the forecasted transaction will not occur, (iv) because a hedged firm commitment no longer meets the definition of a firm commitment, or (v) if management determines that designation of the derivative as a hedge instrument is no longer appropriate. The Company's derivatives are recorded on the balance sheet at their fair value. For derivatives accounted for as cash flow hedges, any unrealized gains or losses on fair value are included in comprehensive loss, net of tax, assuming perfect effectiveness. Any ineffectiveness is recognized in earnings.

Income Taxes The provision for income taxes is determined in accordance with ASC 740, "Income Taxes." Deferred tax assets and liabilities are determined based on the temporary differences between the financial reporting and tax bases of assets and liabilities, applying enacted statutory tax rates in effect for the year in which the differences are expected to reverse. Future income tax benefits are recognized only to the extent that the realization of such benefits is considered to be more likely than not. The Company regularly reviews its deferred tax assets for recoverability and establishes a valuation allowance, when it is more likely than not that such deferred tax assets will not be recoverable, based on historical taxable income, projected future taxable income, and the expected timing of the reversals of existing temporary differences.

Fair Values of Financial Instruments The carrying amount reported in the balance sheet for cash and cash equivalents approximates fair value based on the short-term maturity of these instruments. The carrying amounts reported in the balance sheet for accounts receivable and accounts payable approximate fair value based on the short-term nature of these accounts. The carrying amount reported in the balance sheet for long-term debt under the Company's New Credit Agreement (as discussed in Note 5 of the Notes to the Consolidated Financial Statements) approximates fair value, as these borrowings have variable rates that reflect currently available terms, credit spreads and conditions for similar debt. The fair value of the Company's senior subordinated notes, senior notes and its equipment loans was $169,227 and $206,895 compared to the carrying amount reported on the balance sheet of $227,963 and $224,939 as of

December 31, 2011 and 2012, respectively. The fair values of the Company's senior subordinated notes and senior notes at December 31, 2011 and 2012, were based upon the bond trading prices. The fair value of the equipment loans was estimated using discounted cash flow analyses, based on the Company's current borrowing rates for similar types of equipment loans.

Use of Estimates The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America 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.

Comprehensive Loss The Company reports comprehensive loss in accordance with ASC 220, "Comprehensive Income." For the years ended December 31, 2010, 2011 and 2012, the Company has entered into multiple interest rate swap agreements, interest rate cap agreements and fuel swap agreements, as discussed in Note 11 of the Notes to the Consolidated Financial Statements. Assuming perfect effectiveness, any unrealized gains and losses related to the swaps, collars and caps that qualify for cash flow hedge accounting are classified as a component of comprehensive loss, net of any tax. Any ineffectiveness is recognized in earnings.

Segment Reporting In accordance with ASC 280, "Segment Reporting," and based on the nature of the financial information that is received by the chief operating decision maker ("CODM"), the Company operates in two reportable segments, Imaging and Radiation Oncology, based on similar economic and other characteristics. In 2010, as discussed in Note 17 of the Notes to the Consolidated Financial Statements, the Radiation Oncology segment met the quantitative thresholds for separate reporting. Additionally, the Company does not consider its wholesale revenue and retail revenue sources to constitute separate operating segments as there is no discrete financial information that is provided to the CODM.

Recent Accounting Pronouncements Accounting Standards Update ("ASU") No. 2011-05, "Presentation of Comprehensive Income" ("ASU 2011-05"), improves the comparability, consistency, and transparency of financial reporting and increases the prominence of items reported in other comprehensive income by eliminating the option to present components of other comprehensive income as part of the statement of changes in stockholders' equity. The amendments in this standard require that all nonowner changes in stockholders' equity be presented either in a single continuous statement of comprehensive income or in two separate but consecutive statements. Under either method, adjustments must be displayed for items that are reclassified from other comprehensive income ("OCI") to net income, in both net income and OCI. The standard does not change the current option for presenting components of OCI gross or net of the effect of income taxes, provided that such tax effects are presented in the statement in which OCI is presented or disclosed in the notes to the financial statements. Additionally, the standard does not affect the calculation or reporting of earnings per share. The amendments in ASU 2011-05 are effective for fiscal years, and interim periods within those years, beginning after December 15, 2011 and are to be applied retrospectively, with early adoption permitted. The Company adopted the provisions of ASU 2011-05 on June 30, 2011. The adoption of ASU 2011-05 did not have a material impact on the Company's results of operations, cash flows, or financial position.

Fair Value of Financial Instruments ASU No. 2011-04, "Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in United States GAAP and IFRSs" ("ASU 2011-04"), amends the wording used to describe many of the requirements in United States GAAP for measuring fair value and disclosing information about fair value measurements. The amendments in ASU 2011-04 develop common fair value measurement and disclosure requirements in United States GAAP and IFRSs and improve their understandability. Some of the requirements clarify the FASB's intent about the application of existing fair value measurement requirements while other amendments change a particular principle or requirement for measuring fair value or for disclosing information about fair value measurements. The amendments in ASU 2011-04 are effective prospectively for interim and annual periods beginning after December 15, 2011, with no early adoption permitted. The Company adopted the provisions of ASU 2011-04 on January 1, 2012. The adoption of ASU 2011-04 did not have a material impact on the Company's results of operations, cash flows, or financial position.

Patient Service Revenue ASU No. 2011-07, "Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities" ("ASU 2011-07"), requires certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, those health care entities are required to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts. The amendments also require disclosures of patient service revenue (net of contractual allowances and discounts) as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. The amendments in ASU 2011-07 are effective for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2011. Early adoption is permitted. The Company adopted the provisions of ASU 2011-07 on January 1, 2012. The Company determined that the presentation and disclosure provisions of this update are not applicable, as the Company assesses each patient's ability to pay prior to rendering services and, as a result, the adoption of ASU 2011-07 did not have a

material impact on the Company's results of operations, cash flows, or financial position.

Goodwill Impairment ASU No. 2011-08, "Intangibles—Goodwill and Other (Topic 350): Testing Goodwill for Impairment" ("ASU 2011-08"), is intended to simplify how entities, both public and nonpublic, test goodwill for impairment. ASU 2011-08 permits an entity to first assess qualitative factors to determine whether it is "more likely than not" that the fair value of a reporting unit is less than its carrying amount as a basis for determining whether it is necessary to perform the two-step goodwill impairment test described in Topic 350. The more-likely-than-not threshold is defined as having a likelihood of more than 50%. ASU 2011-08 is effective for annual and interim goodwill impairment tests performed for fiscal years

beginning after December 15, 2011. Early adoption is permitted. The Company adopted the provisions of ASU 2011-08 on January 1, 2012. The adoption of ASU 2011-08 did not have a material impact on the Company's results of operations, cash flows, or financial position.

Similarly, on July 27, 2012, the FASB issued ASU 2012-02, "Testing Indefinite-Lived Intangible Assets for Impairment" ("ASU 2012-02"), which supplements Topic 350 by providing guidance for testing indefinite-lived intangible assets, other than goodwill, for impairment. Under ASU 2012-02, testing an indefinite-lived intangible asset for impairment allows the option of performing a qualitative assessment before calculating the fair value of the asset. If it is determined, on the basis of qualitative factors, that the fair value of the indefinite-lived intangible asset is not more likely than not (i.e., a likelihood of more than 50%) impaired, performance of the quantitative impairment test by determining the fair value of the asset is not required. In addition, ASU 2012-02 does not revise the requirement to test indefinite-lived intangible assets annually for impairment, and does not amend the requirement to test indefinite-lived intangible assets for impairment between annual tests if there is a change in events or circumstances. However, it does revise the examples of events and circumstances to be considered in interim periods. ASU 2012-02 is effective for annual and interim impairment tests performed for fiscal years beginning after September 15, 2012. The Company is assessing the impact that the adoption of ASU 2012-12 may have on its financial reporting for future periods.

3. Transactions

Acquisition of Radiology 24/7, LLC

In the second quarter of 2010, the Company purchased a majority of the outstanding membership interests of Radiology 24/7, LLC ("RAD 24/7"), a teleradiology services company that provides primarily final, subspecialty professional radiology interpretation services and outsourced staffing services for magnetic resonance imaging ("MRI"), position emission tomography/computed tomography ("PET/CT"), computed tomography ("CT"), mammography, X-Ray and other imaging modalities and also preliminary radiology interpretation services nationwide. The purchase price consisted of $8,860 in cash, $3,775 in contingent payments, and $659 in assumed liabilities. The Company financed this acquisition using internally generated funds. As a result of this acquisition, the Company recorded goodwill of $9,883 and acquired intangible assets of $8,000, of which $6,450 was assigned to customer relationships, which are being amortized over ten years, and $1,450 was assigned to trademarks, which are being amortized over seven years. The Company recorded the intangible assets at fair value at the acquisition date. All recorded goodwill and intangible assets are deductible for tax purposes and are being amortized over 15 years. The acquisition included $3,775 for contingent payments due upon the achievement of certain revenue targets over the two years following the acquisition date. The Company recorded all contingent payments at fair value at the acquisition date. The fair value of noncontrolling interest related to this transaction was $5,036 as of the acquisition date. The year ended December 31, 2010 included nine months of operations from this acquisition. During the year ended December 31, 2011, the Company recognized $101 as a reduction in expenses related to decreasing the estimated value of contingent consideration. During the year ended December 31, 2011, the Company paid $1,543 related to contingent consideration.

Acquisition of Diagnostic Health Center of Anchorage, LLC

Also in the second quarter of 2010, the Company purchased all of the outstanding membership interests of Diagnostic Health Center of Anchorage, LLC ("DHC"), a fixed-site imaging center located in Anchorage, Alaska. The center operates in a certificate of need ("CON") state and is a multi-modality imaging center that provides MRI, CT, digital mammography, X-Ray and other imaging services. The purchase price consisted of $13,737 in cash and $554 in assumed liabilities. The Company financed this acquisition using internally generated funds. As a result of this acquisition, the Company recorded goodwill of $3,764 and acquired intangible assets of $8,150, of which $6,400 was assigned to the physician referral network, which is being amortized over 10 years, and $1,750 was assigned to CONs held by DHC, which have indefinite useful lives and are not subject to amortization. The Company recorded the intangible assets at fair value at the acquisition date. All recorded goodwill and intangible assets are deductible for tax purposes and are being amortized over 15 years. The year ended December 31, 2010 included seven months of operations from this acquisition.

Acquisition of Arkansas Cancer Center, P.A. in Pine Bluff, Arkansas

In the third quarter of 2010, the Company purchased certain assets from Arkansas Cancer Center, P.A., located in Pine Bluff, Arkansas (“Pine Bluff”). This is the Company's third Arkansas-based radiation therapy facility. The purchase price consisted of $9,489 in cash, $427 in contingent payments and $6 in assumed liabilities. The Company financed this acquisition using internally generated funds. As a result of this acquisition, the Company recorded goodwill of $4,098