Alliance HealthCare Services, Inc
Form S-4
April 29, 2010
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As filed with the Securities and Exchange Commission on April 29, 2010

Registration No. 333-

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM S-4

REGISTRATION STATEMENT

UNDER

THE SECURITIES ACT OF 1933

ALLIANCE HEALTHCARE SERVICES, INC.

(Exact Name of Registrant as Specified in its Charter)

Delaware	**8071**	**33-0239910**
(State or Other Jurisdiction of Incorporation or Organization)	**(Primary Standard Industrial Classification Code Number)**	**(I.R.S. Employer Identification Number)**

100 Bayview Circle, Suite 400

Newport Beach, California 92660

(949) 242-5300

(Address, Including Zip Code, and Telephone Number, Including Area Code, of Registrant s Principal Executive Office)

Eli H. Glovinsky

Executive Vice President, General Counsel and Secretary

Alliance HealthCare Services, Inc.

100 Bayview Circle, Suite 400

Newport Beach, California 92660

(949) 242-5300

(Name, Address, Including Zip Code, and Telephone Number, Including Area Code, of Agent for Service)

Copy to:

Keith Benson, Esq.

Latham & Watkins LLP

505 Montgomery Street, Suite 2000

San Francisco, CA 94111

(415) 391-0600

Approximate date of commencement of proposed sale to the public: As soon as practicable after the effective date of this registration statement.

If the securities being registered on this Form are being offered in connection with the formation of a holding company and there is compliance with General Instruction G, check the following box. ¨

If this Form is filed to register additional securities for an offering pursuant to Rule 462(b) under the Securities Act, check the following box and list the Securities Act registration number of the earlier effective registration number for the same offering. ¨

If this Form is a post-effective amendment filed pursuant to Rule 462(d) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier, effective registration statement for the same offering. ¨

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated files, 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	x
Non-accelerated filer	¨ (Do not check if a smaller reporting company)	Smaller reporting company	¨

CALCULATION OF REGISTRATION FEE

Title of Each Class of Securities to be Registered	Amount to be Registered	Proposed Maximum Offering Price Per Note(1)	Proposed Maximum Aggregate Offering Price	Amount of Registration Fee
8% Series B Senior Notes due 2016	$190,000,000	100%	$190,000,000	$13,547

(1) Estimated solely for purposes of calculating the registration fee pursuant to Rule 457(f).

The Registrant hereby amends this registration statement on such date or dates as may be necessary to delay its effective date until Registrant shall file a further amendment which specifically states that this registration statement shall thereafter become effective in accordance with Section 8(a) of the Securities Act or until this registration statement shall become effective on such date as the SEC, acting pursuant to said Section 8(a), may determine.

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The information in this prospectus is not complete and may be changed. We may not exchange these securities until the registration statement filed with the Securities and Exchange Commission is effective. This prospectus is not an offer to sell these securities, and we are not soliciting offers to buy these securities, in any state where the offer or sale is not permitted.

SUBJECT TO COMPLETION, DATED APRIL 29, 2010

PRELIMINARY PROSPECTUS

ALLIANCE HEALTHCARE SERVICES, INC.

OFFER TO EXCHANGE

$190,000,000 principal amount of its

8.00% Series B Senior Notes due 2016

which have been registered under the Securities Act,

for any and all of its outstanding 8.00% Senior Notes due 2016

The exchange offer expires at 5:00 p.m., New York City time, on , 2010, unless extended.

We will exchange all outstanding notes that are validly tendered and not validly withdrawn for an equal principal amount of a new series of notes which are registered under the Securities Act.

The exchange offer is not subject to any conditions other than that it not violate applicable law or any applicable interpretation of the staff of the Securities and Exchange Commission.

You may withdraw tenders of outstanding notes at any time before the exchange offer expires.

The exchange of notes will not be a taxable event for U.S. federal income tax purposes.

We will not receive any proceeds from the exchange offer.

The terms of the new series of notes are substantially identical to the outstanding notes, except for transfer restrictions and registration rights relating to the outstanding notes.

You may tender outstanding notes only in denominations of $2,000 and integral multiples of $1,000 in excess thereof.

Our affiliates may not participate in the exchange offer.

Each broker-dealer that receives new notes for its own account pursuant to the exchange offer must acknowledge that it will deliver a prospectus in connection with any resale of such new notes. This prospectus, as it may be amended or supplemented from time to time, may be used by a broker-dealer in connection with resales of new notes received in exchange for outstanding notes where such outstanding notes were acquired by such broker-dealer as a result of market-making activities or other trading activities.

Please refer to Risk Factors beginning on page 10 of this prospectus for a description of the risks you should consider when evaluating this offer to exchange.

We are not making this exchange offer in any state where it is not permitted.

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

The date of this prospectus is , 2010.

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We have not authorized any dealer, salesperson or other people to give any information or to make any representations to you other than the information contained in this prospectus. You must not rely on any information or representations not contained in this prospectus unless we authorize it. This prospectus does not offer to sell or solicit an offer to buy any securities other than the registered notes to which it relates, nor does it offer to buy any of these notes in any jurisdiction to any person to whom it is unlawful to make such offer or solicitation in such jurisdiction.

The information contained in this prospectus is current only as of the date on the cover page of this prospectus, and may change after that date.

This prospectus incorporates important business and financial information about us that is not included in or delivered with this prospectus. This information is available without charge to you upon written or oral request. If you would like a copy of any of this information, please submit your request to Alliance HealthCare Services, Inc., 100 Bayview Circle, Suite 400, Newport Beach, California 92660, Attention: Investor Relations, or call (949) 242-5300 and ask to speak to Investor Relations. In addition, to obtain timely delivery of any information you request, you must submit your request no later than , 2010, which is five business days before the date the exchange offer expires.

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CAUTIONARY DISCLOSURE REGARDING FORWARD-LOOKING STATEMENTS

We have made statements under the captions Prospectus Summary, Risk Factors, Use of Proceeds, Management s Discussion and Analysis of Financial Condition and Results of Operations, Business and elsewhere in this prospectus and in the documents incorporated by reference herein that are forward-looking statements, within the meaning of the safe harbor provisions of the Private Securities Litigation Reform Act of 1995. The safe harbor provisions of the Private Securities Litigation Reform Act of 1995 do not apply to statements made in connection with this offer to exchange these outstanding notes pursuant to this prospectus. In some cases you can identify these statements by forward-looking words such as may , will , should , expect , plans , anticipate , believe , estimate , predict , seek , intend and continue or similar words. Fo may also 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.

We believe it is important to communicate our expectations to our investors. However, there may be events in the future that we are not able to accurately predict or that we do not fully control that could 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 counter-parties to our interest rate swap agreements fail to satisfy their obligations under these agreements;

our ability to obtain financing;

the effect of operating and financial restrictions in our debt agreements;

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 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 markets;

our ability to successfully integrate acquisitions; and

other factors discussed under Risk Factors.

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MARKET AND INDUSTRY DATA

This prospectus contains and incorporates 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 do not guarantee the accuracy and completeness of their information. Although we believe that the publications are reliable, we have not independently verified market industry data provided by third parties. Similarly, while we believe our management s estimates with respect to our industry are reliable, our estimates have not been verified by any independent sources, and we cannot assure you that they are accurate.

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PROSPECTUS SUMMARY

In this prospectus, unless we indicate otherwise, the words we, us, our, Alliance and the Company refer to Alliance HealthCare Services, Inc the issuer of the notes, and its subsidiaries. The following summary contains basic information about the Company and this offering. You should read this entire prospectus, including our financial statements, the notes to those financial statements and the other financial information included and incorporated by reference in this prospectus, carefully before making an investment decision. It likely does not contain all the information that is important to you. For a more complete understanding of this offering, we encourage you to read this entire document and the documents we have referred you to. Our fiscal year ends on December 31 of each year.

We will refer to the offering of the private notes as the private offering. Unless indicated otherwise, the term notes refers to both the private notes and the exchange notes.

Our Company

We are a leading national provider of outpatient diagnostic imaging services, based upon annual revenue and number of diagnostic imaging systems deployed, and a provider of radiation oncology services. Our principal sources of revenue are derived from magnetic resonance imaging (MRI) and positron emission tomography/computed tomography (PET/CT). 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 a growing number of fixed-site imaging centers, primarily to hospitals or health systems. Our 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 also leveraged our leadership in MRI and PET/CT to expand into radiation oncology. Our radiation oncology business includes a wide range of services for cancer patients covering initial consultation, preparation for treatment, simulation of treatment, radiation oncology delivery, therapy management and follow-up care. Our services include the use of our linear accelerators, therapists to operate such systems, administrative staff, equipment maintenance and upgrades, and management of day-to-day operations.

For the year ended December 31, 2009, MRI services and PET/CT services generated 47% and 40% of our revenue, respectively. The remaining revenue was comprised of radiation oncology revenue, and other modality diagnostic imaging services revenue, primarily computed tomography (CT), and management contract revenue. At December 31, 2009, our 507 diagnostic imaging and radiation oncology systems included 295 MRI systems and 126 PET or PET/CT systems, and served over 1,000 clients in 45 states. We operated 116 fixed-site imaging centers (three in unconsolidated joint ventures), which constitutes systems installed in hospitals or other medical buildings on hospital campuses, including modular buildings, systems installed inside medical groups offices, and free-standing fixed-site imaging centers, which include systems installed in a medical office building, ambulatory surgical center, or other retail space. We also operated 25 radiation oncology centers and stereotactic radiosurgery facilities (including two radiation oncology centers in unconsolidated joint ventures) as of December 31, 2009.

Approximately 80% of our revenues for the twelve month period ended December 31, 2009 were generated by providing services to hospitals and other healthcare providers, which we refer to as wholesale revenues. Our wholesale revenues are due to us independent of our clients receipt of reimbursement from third-party payors. For shared-service customers, 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 and many contain automatic renewal provisions. The initial terms of our contracts for our fixed-site imaging centers average approximately five to 10 years in length. Our contracts for radiation oncology services average approximately 10 to 20 years in length.

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Our clients, primarily small-to-mid-sized hospitals, contract with us to provide diagnostic imaging and radiation oncology systems and services in order to:

- take advantage of our extensive diagnostic imaging, radiation oncology and project management experience;
- avoid capital investment and financial risk associated with the purchase of their own systems;
- provide access to MRI, 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 systems and technology without direct capital expenditures;
- eliminate the need to recruit, train and manage qualified technologists, 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.

Our Competitive Strengths

We believe we benefit from the following competitive strengths:

- *Our position as 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, 2009, we had 295 MRI systems, 126 PET or PET/CT systems, and 86 other diagnostic imaging 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;
- *Our 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;
- *Our ability to provide 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 such authority. We believe that a comprehensive service solution is an important factor when potential clients select a diagnostic imaging or radiation oncology provider;
- *Our 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 30, 2009, no single client accounted for more than 2% of our revenue;

Our reduced reimbursement risk. For the year ended December 31, 2009, we generated approximately 80% of our revenues by billing hospitals and other healthcare providers, which we refer to as wholesale revenues, 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

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majority of the 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. With our wholesale model, our exposure to patient bad debt is minimized, as evidenced by our bad debt expense of only 0.5% of revenues for the year ended December 31, 2009. Further, short-term exposure to Medicare reimbursement cuts is limited as approximately 4% of our imaging revenues came from Medicare for the year ended December 31, 2009;

Our generation of stable and significant cash flows and maintenance of 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 the our revenues and (5) our economies of scale;

Our management experience. Our experienced management team, including our four senior executive officers who average approximately 20 years of industry experience; and

Our advanced MRI, PET/CT and radiation therapy 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 the entire system. Our radiation oncology services utilize the most advanced radiation oncology technology, including image guided radiation therapy (IGRT), intensity modulated radiation therapy (IMRT) and stereotactic radiosurgery systems.

Despite the competitive strengths discussed above, we face a number of challenges in growing our business. We currently have a substantial amount of indebtedness, which places financial and other limitations on our business. Our business is also subject to a number of other risks described in Risk Factors.

Our Services

We provide our outsourcing services on the following bases:

shared service;

full-time service; and

interim and rental services.

Our Strategy

Key components of our strategy include:

further expanding our presence in growth markets with fixed-site imaging and radiation oncology services;

improvement of our sales management and sales support infrastructure to improve the pace of new business;

improved operating efficiency, including reducing our cost structure and improving asset allocation;

focus on patient care and customer service; and

bolster our market positions through strategic acquisitions and de novo expansion activity.

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Our Sponsors

On April 16, 2007, OCM Principal Opportunities Fund IV, L.P., MTS Health Investors II, L.P., and affiliated funds (together, the Oaktree Parties), acquired approximately 49.7% of our outstanding shares of common stock from a fund controlled by an affiliate of Kohlberg Kravis Roberts & Co., L.P. (*KKR*). KKR no longer owns any shares of the Company. OCM Principal Opportunities Fund IV, L.P. is a commingled investment fund managed by Oaktree Capital Management, L.P. (*Oaktree*), a leading alternative asset manager that manages in excess of $67 billion in capital on behalf of institutional and high net worth investors in non-mainstream and alternative investment strategies, including high yield bonds, convertible securities, distressed debt, private equity, mezzanine, real estate, emerging market equities and Japanese equities. Oaktree is headquartered in Los Angeles, California and maintains offices in Beijing, Frankfurt, Hong Kong, London, New York, Paris, Seoul, Shanghai, Singapore, Stamford (Connecticut), Tokyo and, through fund affiliates, Amsterdam and Luxembourg.

MTS Health Investors, LLC (*MTS*), located in New York, New York, is a healthcare private equity firm that makes equity investments in the buyout, recapitalization or growth financing of healthcare operating companies. MTS focuses on businesses that operate in services sectors of the healthcare industry-managed care/health insurance, providers of healthcare services, distributors of medical products and pharmaceuticals, manufacturers of medical products and low-technology devices and providers of outsourced services to the healthcare industry.

We are a Delaware corporation with our principal executive offices located at 100 Bayview Circle, Suite 400, Newport Beach, California 92660. Our telephone number at that location is (949) 242-5300. Our website is located at *www.alliancehealthcareservices-us.com*. The information contained on our website is not a part of this prospectus.

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The Exchange Offer

The Exchange Offer	We are offering to exchange the exchange notes for the outstanding private notes that are properly tendered and accepted. You may tender outstanding private notes only in denominations of $2,000 and integral multiples of $1,000 in excess thereof. We will issue the exchange notes on or promptly after the exchange offer expires. As of the date of this prospectus, $190,000,000 aggregate principal amount of private notes are outstanding.
Expiration Date	The exchange offer will expire at 5:00 p.m., New York City time, on , 2010, (the 21st business day following commencement of the exchange offer) unless extended, in which case the expiration date will mean the latest date and time to which we extend the exchange offer.
Conditions to the Exchange Offer	The exchange offer is not subject to any condition other than that it not violate applicable law or any applicable interpretation of the staff of the Securities and Exchange Commission (the SEC). The exchange offer is not conditioned upon any minimum principal amount of private notes being tendered for exchange.
Procedures for Tendering Private Notes	If you wish to tender your private notes for exchange notes pursuant to the exchange offer: • You must comply with the Automated Tender Offer Program procedures of The Depository Trust Company (DTC); and • The Bank of New York Mellon Trust Company, N.A., the exchange agent, must receive timely confirmation of a book-entry transfer of the private notes into its account at DTC through DTC s Automated Tender Offer Program pursuant to the procedure for book-entry transfer described herein, along with a properly transmitted agent s message, before the expiration date. By tendering the private notes pursuant to the exchange offer, you will make the representations to us described under The Exchange Offer Procedures for Tendering.
Acceptance of the Private Notes and Delivery of the Exchange Notes	Subject to the satisfaction or waiver of the conditions to the exchange offer, we will accept for exchange any and all private notes which are validly tendered in the exchange offer and not withdrawn before 5:00 p.m., New York City time, on the expiration date.
Withdrawal Rights	You may withdraw the tender of your private notes at any time before 5:00 p.m., New York City time, on the expiration date, by complying with the procedures for withdrawal described in this prospectus under the heading The Exchange Offer Withdrawal of Tenders.

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Material U.S. Federal Income Tax Consequences	The exchange of notes will not be a taxable event for U.S. federal income tax purposes. For a discussion of the material U.S. federal income tax consequences relating to the notes, see Material U.S. Federal Income Tax Consequences.
Exchange Agent	The Bank of New York Mellon Trust Company, N.A., the trustee under the indenture governing the notes, is serving as the exchange agent (the Exchange Agent).
Consequences of Failure to Exchange	If you do not exchange your private notes for exchange notes, you will continue to be subject to the restrictions on transfer provided in the private notes and in the indenture governing the private notes. In general, the private notes may not be offered or sold, unless registered under the Securities Act of 1933, as amended (the Securities Act), except pursuant to an exemption from, or in a transaction not subject to, the Securities Act and applicable state securities laws. We do not currently plan to register the resale of any private notes under the Securities Act.
Registration Rights Agreement	You are entitled to exchange your private notes for exchange notes with substantially identical terms. This exchange offer satisfies this right. After the exchange offer is completed, you will no longer be entitled to any exchange or registration rights with respect to your private notes.

We explain the exchange offer in greater detail beginning on page 27.

The Exchange Notes

The summary below describes the principal terms of the exchange notes. Certain of the terms and conditions described below are subject to important limitations and exceptions. The Description of the Notes section of this prospectus contains a more detailed description of the terms and conditions of the exchange notes.

The form and terms of the exchange notes are the same as the form and terms of the private notes, except that the exchange notes will be registered under the Securities Act and, therefore, the exchange notes will not be subject to the transfer restrictions, registration rights and provisions providing for an increase in the interest rate applicable to the private notes. The exchange notes will evidence the same debt as the private notes and are governed by the same indenture as the private notes.

Issuer	Alliance HealthCare Services, Inc.
Securities Offered	$190,000,000 aggregate principal amount of 8% Series B Senior Notes due 2016.
Maturity	December 1, 2016.
Interest Rate	8% per year (calculated using a 360-day year).
Interest Payment Dates	June 1 and December 1 of each year, beginning on June 1, 2010.

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Ranking	The exchange notes are unsecured senior obligations of the Company, rank equally in right of payment to all of our existing and future senior indebtedness and senior in right of payment to all of our existing and future subordinated indebtedness. The exchange notes are effectively subordinated in right of payment to our secured indebtedness (including obligations under our credit facility) to the extent of the value securing such indebtedness, and all obligations of each of our existing and future subsidiaries. As of December 31, 2009, we had approximately $667.9 million of indebtedness, approximately $474.8 million of which was secured (excluding $4.5 million of undrawn letters of credit and up to $115.5 million of additional borrowing capacity under the New Revolving Credit Facility) and our subsidiaries had total liabilities, together with guarantees of indebtedness, of approximately $492.3 million (of which $460.0 million represents guarantees of indebtedness under the New Credit Facility). See Selected Consolidated Financial Data, Risk Factors Risks Related to Our Indebtedness.
Optional Redemption	We may redeem the exchange notes, in whole or in part, at any time on or after December 1, 2012 at the redemption prices listed under Description of the Notes Optional Redemption.

We may redeem some or all of the exchange notes at any time prior to December 1, 2012 at a price equal to 100% of the principal amount of the exchange notes plus a make-whole premium as set forth under Description of the Notes Optional Redemption.

Optional Redemption After Equity Offerings	We may redeem up to 35% of the outstanding exchange notes with money that we raise in one or more equity offerings at any time (which may be more than once) prior to December 1, 2012, at a redemption price of 108.0% of the principal amount of the exchange notes plus accrued and unpaid interest and liquidated damages, if any, as long as at least 65% of the aggregate principal amount of exchange notes issued remains outstanding afterwards. See Description of the Notes Optional Redemption.
Change of Control	If a change in control of the Company occurs, we must give holders of the exchange notes the opportunity to sell us their exchange notes at 101% of their face amount, plus accrued interest.

We might not be able to pay you the required price for exchange notes you present to us at the time of a change of control because:

- we might not have enough funds at that time; and
- the terms of our credit facility may prevent us from paying.

See Risk Factors Risks Related to the Notes We may not be able to repurchase notes upon a change of control, which would be an event of default under the indenture.

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Asset Sale Proceeds	If we or our subsidiaries engage in asset sales, we generally must either invest the net cash proceeds from such sales in our business within a period of time, prepay certain debt or make an offer to purchase a principal amount of the exchange notes equal to the excess net cash proceeds. The purchase price of the notes will be 100% of their principal amount, plus accrued interest.
Certain Indenture Provisions	The indenture governing the exchange notes contains covenants limiting our (and most or all of our subsidiaries) ability to: pay dividends or make certain other restricted payments or investments; incur additional indebtedness and issue disqualified stock; create liens on assets; merge, consolidate, or sell all or substantially all of our and our restricted subsidiaries assets; enter into certain transactions with affiliates; create restrictions on dividends or other payments by our restricted subsidiaries; and create guarantees of indebtedness by restricted subsidiaries. These covenants are subject to a number of important limitations and exceptions. See Description of the Notes Certain Covenants.
Use of Proceeds	We will not receive any cash proceeds from the exchange offer.

We explain the exchange notes in greater detail beginning on page 95.

Risk Factors

You should carefully consider all of the information in this prospectus. In particular, for a discussion of some specific factors that you should consider in evaluating an investment in the notes, see Risk Factors beginning on page 10 of this prospectus and Risk Factors beginning on page 23 of our Annual Report on Form 10-K for the year ended December 31, 2009, which is incorporated by reference herein.

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Summary Consolidated Financial Information

We derived the following summary historical consolidated financial information presented below from our financial statements. The following summary historical consolidated financial information with respect to each year in the three-year period ended December 31, 2009 are derived from our audited consolidated financial statements. The summary historical consolidated financial information provided below should be read in conjunction with Management s Discussion and Analysis of Financial Condition and Results of Operations and our consolidated financial statements and notes thereto included and incorporated by reference in this prospectus.

	Year Ended December 31,				
	2005	2006	2007	2008	2009
Consolidated Statements of Operations Data:					
Revenues	$ 430,788	$ 455,775	$ 444,919	$ 495,834	$ 505,513
Costs and expenses:					
Cost of revenues, excluding depreciation and amortization	226,294	244,254	235,471	261,753	270,381
Selling, general and administrative expenses	48,077	53,955	57,049	62,728	67,579
Transaction costs					893
Employment agreement costs	366				
Severances and related costs	826	745	682	636	1,404
Loss on extinguishment of debt				61	14,600
Depreciation expense	82,505	83,397	82,703	87,728	94,918
Amortization expense	3,954	4,933	5,195	8,696	11,000
Interest expense and other, net	34,203	41,078	42,362	48,392	45,894
Other (income) and expense, net	(399)	45	(579)	(872)	(1,178)
Total costs and expenses	395,826	428,407	422,883	469,122	505,491
Income before income taxes, earnings from unconsolidated investees and noncontrolling interest, net of tax	34,962	27,368	22,036	26,712	22
Income tax expense	14,758	12,032	11,644	11,764	308
Earnings from unconsolidated investees	(3,343)	(5,371)	(7,567)	(4,605)	(3,831)
Net income	23,547	20,707	17,959	19,553	3,545
Less: Net income attributable to noncontrolling interest, net of tax	(1,718)	(2,075)	(1,727)	(3,030)	(3,064)
Net income attributable to Alliance HealthCare Services, Inc.	$ 21,829	$ 18,632	$ 16,232	$ 16,523	$ 481
Consolidated Balance Sheet Data (at end of period):					
Cash and cash equivalents	$ 13,421	$ 16,440	$ 120,892	$ 73,305	$ 111,884
Total assets	675,342	664,526	849,807	883,723	887,836
Long-term debt, including current maturities	579,582	529,425	670,796	662,562	667,890
Stockholders (deficit) equity	(35,856)	(12,598)	8,079	28,993	34,762
Other Data:					
Cash flows provided by (used in):					
Operating activities	127,838	117,937	119,704	130,124	139,131
Investing activities	(134,437)	(63,520)	(142,515)	(151,324)	(60,452)
Financing activities	(701)	(51,398)	127,263	(26,387)	(40,100)
Capital expenditures	76,460	75,007	65,252	66,204	73,830

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RISK FACTORS

You should carefully consider the risk factors set forth below as well as the other information contained and incorporated by reference in this prospectus before making a decision to tender your private notes in the exchange offer. The risk factors set forth below are generally applicable to the private notes as well as the exchange notes. The risks described below are not the only risks that we face. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially and adversely affect our business operations. Any of the following risks could materially and adversely affect our business, financial condition or results of operations. In such case, you may lose all or part of your original investment.

Risks Related to Our Indebtedness

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

We are highly leveraged. As of December 31, 2009, we had $667.9 million of outstanding debt, excluding letters of credit, and approximately $115.5 million was available for borrowing under our credit facility. Our substantial indebtedness could have important consequences for our stockholders. For example, it could:

- require us to dedicate a substantial portion of our cash flow from operations to payments on our indebtedness, thereby reducing the availability of our cash flow to fund working capital, capital expenditures and acquisitions and for other general corporate purposes;
- 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; and
- limit our flexibility in planning for, or reacting to, changes in our business and our industry.

If there is a default under the agreements governing our material indebtedness, 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 $340.1 million as of December 31, 2009 and $357.2 million as of December 31, 2008. 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 such 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 could reduce the amounts that would be 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 therefore reduce the amounts that could be recovered. Our goodwill and other intangible assets had a net book value of $294.4 million as of December 31, 2009. 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 indebtedness or any bankruptcy or dissolution of our company, 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.

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

We and our subsidiaries may be able to incur substantial additional indebtedness in the future. The terms of our credit facility and the indenture governing the notes permit us or our subsidiaries to incur additional indebtedness, subject to certain restrictions. Further, our credit facility and the indenture governing the notes allow for the incurrence of indebtedness by our subsidiaries, all of which would be structurally senior to the notes. In addition, as of December 31, 2009, our credit facility permitted additional borrowings of up to approximately $115.5 million 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 our credit facility. If new debt is added 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 indebtedness or to refinance our indebtedness on acceptable terms, our financial condition would be materially harmed, our business may fail and you may lose all of your investment.

Our ability to make scheduled payments on or to refinance our obligations with respect to our debt will depend on our financial and operating performance, which will be affected by general economic, financial, competitive, business and other factors 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 impacted. 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.

We may not be able to finance future needs or adapt our business plan to changes because of restrictions placed on us by our credit facility, our notes, the indentures governing our notes and instruments governing our other indebtedness.

The indenture governing the notes and our credit facility contain affirmative and negative covenants which 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.

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 indebtedness under our 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 indebtedness then outstanding. If we are not able 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.

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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. At December 31, 2009, approximately $460.0 million of our debt was at variable interest rates.

Increases in interest rates would also impact the refinancing of our debt. If interest rates are higher when our debt becomes due, we may be forced to borrow at the higher 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. 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. We are required under the terms of our credit facility to enter into agreements such as interest rate swaps, caps, floors and other interest rate exchange contracts that would have the effect of fixing the rate of a specified percentage of our variable rate debt for periods to be determined.

Risks Related to 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 would result in a decline in our revenues and harm to our financial position.

We derive approximately 20% of our revenues from direct billings to patients and third-party payors such as Medicare, Medicaid or private health insurance companies, and changes in the rates or methods of reimbursement for the services we provide could have a significant negative impact 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 our clients receive decreased reimbursement, this could result in a reduced demand for our services or downward pricing pressures, which could have a material impact on our financial position.

From time to time, changes designed to contain healthcare costs have been implemented, some of which have resulted in decreased reimbursement rates for diagnostic imaging services that impact 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 failed to intervene. For example, for 2008, the fee schedule rates were to be reduced by approximately 10.1%. The Medicare, Medicaid and SCHIP Extension Act of 2007 eliminated the 10.1% reduction for 2008 and increased the annual payment rate update by 0.5%. This increase to the annual Medicare Physician Fee Schedule payment update was effective only for Medicare claims with dates of service between January 1, 2008 and June 30, 2008. Beginning July 1, 2008, under MIPPA, the 0.5% increase was continued for the rest of 2008. In addition, MIPPA established a 1.1% increase to the Medicare Physician Fee Schedule payment update for 2009. For 2010, CMS are projecting a rate reduction of 21.2% unless Congress intervenes again to avoid the payment reduction. On December 19, 2009, President Obama signed into law the Department of Defense Appropriations Act, 2010 (H.R. 3326) which includes a zero percent Medicare physician update through February 28, 2010. This was further extended through May 31, 2010 by the Temporary Extension Act of 2010 and the Continuing Extension Act of 2010, signed into law by President Obama on March 2, 2010 and April 15, 2010, respectively. If Congress fails to intervene to prevent the 21.2% rate reduction, the resulting decrease in payment will adversely impact our revenues and results of operations.

MIPPA also modified the methodology by which the budget neutrality formula was applied to the 2009 physician fee schedule payment rates, resulting in an overall reduction in payment rates for services performed by many specialties, including an estimated 3% reduction for radiation oncology and 1% reduction for nuclear medicine. The impact of the payment rates on specific companies depends on their service mix. We estimated slight decreases in rates for our radiation oncology business but cannot predict the full impact the rate reductions

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will have on our future revenues or business. Also with respect to MIPPA, the legislation requires all suppliers that provide the technical component of diagnostic MRI, PET/CT, CT and nuclear medicine to be accredited by an accreditation organization designated by CMS by January 1, 2012. On January 26, 2010, CMS initially approved the following designated accreditation organizations to accredit suppliers furnishing the technical component of all advanced imaging modalities (CT, nuclear medicine, PET and MRI) on or after January 1, 2010: The American College of Radiology (ACR), the Intersocietal Accreditation Commission (IAC) and The Joint Commission. All our facilities are accredited by The Joint Commission.

A number of other legislative changes impact our retail business. For example, the DRA imposed caps on Medicare payment rates for certain imaging services furnished in physicians offices and other non-hospital based settings. The caps impact MRI, PET/CT and certain imaging services performed in conjunction with radiation therapy, including certain IGRT services and diagnostic imaging services used to plan IMRT. Under the cap, payments for specified imaging services cannot exceed the hospital outpatient payment rates for those services. This change applies to services furnished on or after January 1, 2007. The limitation is applicable to the technical components of the diagnostic imaging services only, which is the payment we receive for the services for which we bill directly under the Medicare Physician Fee Schedule. CMS issues on an annual basis the HOPPS rates, which are used to develop the caps. If the technical component of the service established under the Physician Fee Schedule (without including geographic adjustments) exceeds the hospital outpatient payment amount for the service (also without including geographic adjustments), then the payment is to be reduced. In other words, in those instances where the technical component for the particular service is greater for the non-hospital site, the DRA directs that the hospital outpatient payment rate be substituted for the otherwise applicable Physician Fee Schedule payment rate. The implementation of this reimbursement reduction contained in the DRA had a significant effect on our financial condition and results of operations in 2007, whereas the changes in 2008 and 2009 have been limited.

The DRA also codified the reduction in reimbursement for multiple images on contiguous body parts, which was previously announced by CMS. The DRA mandated payment at 100% of the technical component of the higher priced imaging procedure and 50% for the technical component of each additional imaging procedure for multiple images of contiguous body parts within a family of codes performed in the same session. CMS announced that it would phase in this reimbursement reduction over a two-year period. Beginning in 2006, CMS implemented the initial 25% reduction for each additional imaging procedure on contiguous body parts. For services furnished on or after July 1, 2010, the recently enacted Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act (collectively, the PPACA), requires the full 50% reduction to be implemented as mandated by the DRA.

For HOPPS rates, effective January 1, 2009, CMS established three HOPPS imaging families according to modality one for ultrasound, one for CT and CTA, and one for MRI and MRA services. CMS then established five composite Ambulatory Payment Classifications, or APCs, based on these HOPPS imaging families, splitting the families for CT and CTA, and MRI and MRA, into two separate composite APCs each to reflect whether the procedures are performed with or without contrast. CMS will provide a single APC payment when two or more imaging procedures using the same imaging modality are reported on a single date of service. If a with and without contrast procedure are reported together, they are paid at the higher with contrast payment category. The implementation of this new payment methodology did not have a material impact on our consolidated financial position or results of operations.

Regulatory updates to payment rates for which we bill the Medicare program directly are published annually by CMS. For payments under the Physician Fee Schedule for calendar year 2010, CMS changed the way it calculates components of the Medicare Physician Fee Schedule. As part of the changes, CMS reduced payment rates for certain diagnostic services using equipment costing more than $1 million through revisions to usage assumptions from the current 50% usage rate to a 90% usage rate to be phased in over a four-year period. This change applied to MRI and CT scans, but not for radiation therapy and other therapeutic equipment. The PPACA supersedes CMS s regulatory changes and reduces the assumed usage rate for such equipment from CMS s 2010 rate of 90% to a rate of 75%, beginning on January 1, 2011. A decrease in utilization rate generally corresponds

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to an increase to the payment rate. In addition, the OIG has stated that for 2010, it intends to focus on, among other things, the practice expense components, including the equipment utilization rate, for certain imaging services reimbursed under Medicare Physician Fee Schedule to determine whether Medicare payment reflects the actual expenses incurred and whether the utilization rate reflects current industry practices.

Further with respect to its 2010 regulatory changes to the Medicare Physician Fee Schedule, in addition to the changes to the usage assumptions, CMS s changes to services primarily involving the technical component rather than the physician work component were adjusted downward. The reductions primarily impact radiology and other diagnostic tests, including the services we provide. Some of the changes to the Medicare Physician Fee Schedule are being transitioned over a four year period such that beginning in 2013, CMS will have fully implemented the revised payment rates. For the 2010 transitioned payment, CMS estimated that the impact of its changes (including the change in the usage assumption that has been superseded by PPACA) would result in a 1% reduction in radiation oncology, 5% reduction in radiology, 18% reduction in nuclear medicine and 12% reduction for all suppliers providing the technical component of diagnostic tests generally. These impacts are calculated prior to any application of the projected negative update factor of 21.2% related to MIPPA (which may be implemented in June 2010 unless Congress intervenes) and may impact our future revenues. The PPACA changes to the Medicare Physician Fee Schedule impact only the usage assumptions described above and therefore all other 2010 updates issued by CMS remain in place. If the CMS 2010 reimbursement rates had been in effect for full year 2009, we estimate that our annualized retail revenue related to MRI and radiation oncology would not have been materially impacted. At this time, we estimate that the new usage assumptions for MRI and CT scans under the PPACA, which is to take effect on January 1, 2011, will not have a material impact 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 HOPPS on an annual basis. These payments are the amounts received by our hospital clients for hospital outpatient services. For 2008, the national Medicare HOPPS payment rate for nonmyocardial PET and PET/CT scans was $1,057 per scan and the national payment rate for myocardial PET scans was $1,400 per scan. Effective January 1, 2008, CMS also bundled the PET and PET/CT payment for radiopharmaceuticals with the payment for the PET and PET/CT scan. In addition, CMS reduced the 2008 national Medicare HOPPS rate for MRI scans by approximately 3%. The 2008 national Medicare HOPPS payment rates for stereotactic radiosurgery treatment delivery services ranged from $1,057 to $8,055, depending on the level of service. For 2009, the payment rate for nonmyocardial PET and PET/CT scans is $1,037 per scan. For myocardial PET procedures, the 2009 payment rate is $1,157 per scan. For stereotactic radiosurgery treatment delivery services, the 2009 payment rates range from $952 to $7,642, depending on the level of service. On October 30, 2009, CMS released its 2010 national Medicare HOPPS payment rates, which went into effect January 1, 2010. For nonmyocardial PET and PET/CT, the 2010 payment rate is $1,037 per scan. For myocardial PET procedures, the 2010 payment rate is $1,433 per scan. For stereotactic radiosurgery treatment delivery services, the 2010 payment rates range from $963 to $7,344, depending on the level of service.

At this time, we cannot predict the impact the DRA and PET and PET/CT Medicare HOPPS rate reductions will have on our future revenues or business. In addition, we cannot predict the full extent of the PPACA on our business. The legislation substantially changes the way health care is financed by both governmental and private insurers and may negatively impact payment rates for certain imaging services. Nor can we predict at this time whether or the extent to which other proposed changes will be adopted, if any, or how these or future changes will affect the demand for our services. For example, President Obama s budget for fiscal year 2010 includes provisions that may require the use of radiology benefit managers to preauthorize certain imaging services. Future requirements limiting access to or payment for radiology or radiation oncology services may negatively impact our future revenues or business.

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We may 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. Our major diagnostic imaging competitors include RadNet, Inc., InSight Health Services Corp., Medquest, Inc., Medical Resources, Inc., Shared Medical Services, Kings Medical Company Inc. and DMS Health Group. Our major radiation oncology competitors include Radiation Therapy Services, Inc., Oncare Medical Corp., Vontage Oncology, Inc., and US Oncology, Inc. 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, or OEMs, that aggressively sell or lease imaging systems to healthcare providers for full-time installation. In recent years we have seen an increase in activity by OEMs sale of systems directly to a certain number of our clients. Typically, OEMs target our higher scan volume clients. This increase in activity by OEMs has resulted in overcapacity of systems in the marketplace, especially related to medical groups adding imaging capacity within their practice settings. This has caused an increase in the number of our higher scan volume clients deciding not to renew their contracts. We replace these higher volume scan clients typically with lower volume clients. Our MRI revenues decreased during the year ended December 31, 2009 compared to 2008 due to a decrease in demand. We believe that MRI revenues will continue to decline in future years.

There are many competitors in the imaging sector we find ourselves competing with to gain business. If we are unable to successfully compete, our client base would decline and our business and financial condition would be harmed.

Our revenues may fluctuate or be unpredictable and this may impact our financial results.

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

- variations in the rate at which clients renew their contracts;
- the extent to which our mobile shared-service clients become full-time clients;
- changes in the number of days of service we can offer with respect to a given diagnostic imaging system due to equipment malfunctions or the seasonal factors discussed below; and
- the mix of wholesale and retail billing for our services.

In addition, we experience seasonality in the sale of our services. For example, our revenues typically decline from our third fiscal quarter to our fourth fiscal quarter. First and fourth quarter revenues are typically lower than those from the second and third quarters. First quarter revenue can be affected primarily by inclement weather, the results of which are fewer patient scans during the period. Fourth quarter revenue is affected primarily by holiday and client and patient vacation schedules and inclement weather, the results of which are fewer patient scans during the period. As a result, our revenues may vary significantly from quarter to quarter, and our quarterly results may be below market expectations. We also experience fluctuations in revenues generated due to acquisition activity and 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.

Upon expiration of our clients contracts, we are subject to the risk that clients will 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, 2009, we continued to experience a high rate of contract terminations partially due to stepped up marketing, sales and attractive financing alternatives being offered by original equipment

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manufacturers to our clients. A portion of our clients can execute early termination clauses and discontinue service prior to maturity. As a result, our MRI revenues for 2009 declined compared to 2008 levels due to a decrease in demand and we believe that MRI revenues from our shared-service operations will continue to decline in future periods. If these contracts are not renewed, it could result in a significant negative impact on our business. It is not always possible to immediately obtain replacement clients, and historically many replacement clients have been smaller facilities which have a lower number of scans than lost clients.

Managed care organizations may prevent healthcare providers from using our services which would cause us to lose current and prospective clients.

Healthcare providers participating as providers under managed care plans may be required to refer diagnostic imaging tests to specific imaging service providers depending on the plan in which each covered patient is enrolled. These requirements currently inhibit healthcare providers from using our diagnostic imaging services in some cases. The proliferation of managed care may prevent an increasing number of healthcare providers from using our services in the future which would cause our revenues to decline.

We may be unable to effectively maintain our imaging and radiation oncology systems 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 operating costs include depreciation, salaries paid to technologists and other clinical staff, drivers, annual system maintenance costs, insurance and transportation costs. 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. Repairs of our equipment are performed for us by the equipment manufacturers. These manufacturers may not be able to perform repairs or supply needed parts in a timely manner. Thus, 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.

Our ability to maximize the utilization of our diagnostic imaging equipment may be adversely impacted by harsh weather conditions, which may affect our ability to generate revenue.

Harsh weather conditions can adversely impact 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 would experience a decrease in scan volume during that period. Our equipment utilization, scan volume or revenues could be adversely affected by similar conditions in the future.

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 with tighter credit conditions and recession in most major economies continuing into 2010. Continued concerns about the systemic impact of potential long-term and wide-spread recession, inflation, energy costs, geopolitical issues, the availability and cost of credit, the United States mortgage market and a declining real estate market in the United States have contributed to increased market volatility and diminished expectations for the United States economy. Added concerns fueled by the United States government financial assistance to certain companies and other federal government s interventions in the United States financial system has led to increased market uncertainty and instability in both United States

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and international capital and credit markets. 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. We believe our MRI and PET/CT scan volumes have been impacted during 2009 and will continue to be impacted in 2010 by rising unemployment rates, the number of under-insured or uninsured patients and other conditions arising from the global economic conditions described above. At this time, it is unclear what impact this might have on our future revenues or business.

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, and the ability of our customers, to timely replace maturing liabilities, and 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 customers because of their financial circumstances.

Some of our healthcare provider customers do not have significant financial resources, liquidity or access to capital. If these customers 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 customers 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 affect on the financial health of certain of our healthcare provider customers. 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.

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, subject to varying risks for natural disaster, including but not limited to, hurricanes, blizzards, floods, earthquakes and tornados. Depending upon their severity, these natural disasters 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.

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

We operate in a competitive, capital intensive and high fixed-cost industry. The development of new technologies or refinements of existing ones might make our existing systems technologically or economically obsolete, or reduce the need for our systems. MRI, PET and PET/CT, radiation oncology and other diagnostic imaging systems are currently manufactured by numerous companies. Competition among manufacturers for a greater share of the MRI, PET 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. Consequently, the obsolescence of our systems may be accelerated. Should new technological advances occur, we may not be able to acquire the new or improved systems. In the future, to the extent we are unable to generate

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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 diagnostic service providers to perform procedures without the assistance of diagnostic 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.

High fuel costs would harm our operations.

Fuel costs constitute a significant portion of our mobile operating expenses. 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, the cost and future availability of fuel cannot be predicted with any degree of certainty. In the event of a fuel supply shortage or further increases in fuel prices, a curtailment of scheduled mobile service could result. There have been significant increases in fuel costs and continued high fuel costs or further increases will harm our financial condition and results of operations.

Because a high percentage of our operating expenses are fixed, a relatively small decrease in revenues could have a significant negative impact 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. Such expenses include, but are not limited to, debt service and capital lease payments, rent and operating lease payments, salaries, maintenance, insurance and vehicle operation costs. As a result, a relatively small reduction in the prices we charge for our services or procedure volume 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 impact our business and financial results.

We may be subject to professional liability claims. Although there currently are no known hazards associated with any of our scanning or therapy delivery technologies directly related to the physical equipment when used properly, hazards may be discovered in the future. Furthermore, 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. There also is potential risk to patients treated with therapy equipment secondary to inadvertent or excessive over- or under exposure to radiation a topic on which the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health held a hearing on February 26, 2010. 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. However, 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.

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

We depend upon our management team to a substantial extent. In particular, we depend upon Mr. Viviano, our Chief Executive Officer and Chairman of our Board of Directors for his skills, experience and knowledge of our Company and industry contacts. We do not have key employee insurance policies covering any of our management team. The loss of Mr. Viviano 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. It is impossible to predict the availability of qualified field

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managers and sales persons or the compensation levels that will be required to hire 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 economically reasonable compensation levels could adversely affect our ability to operate and grow our business.

Loss of, and failure to attract, qualified employees, technologists and other clinical staff could limit our growth and negatively impact 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 and 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 positron emission tomography and positron emission tomography/computed tomography, or PET and 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.

Our PET and PET/CT services and some of our other imaging services require radioactive materials. While this radioactive material has a short half-life, meaning it quickly breaks down into inert, or non-radioactive substances, storage, 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, handling and disposal of these materials and waste products. In spite of our safety procedures for storing, 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. 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 in order 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. 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 acquired companies have achieved or might achieve separately. Successful integration of each of their operations will depend upon our ability to

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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.

Two of our stockholders and their affiliates beneficially own almost half of our outstanding shares of common stock and have the contractual right to designate members of our board of directors and board committees, and will therefore be able to exert significant influence over us, including with respect to change of control transactions.

As of December 31, 2009, funds managed by Oaktree Capital Management, LLC and MTS Health Investors, LLC (collectively the Oaktree Parties) beneficially owned approximately 47.1% of our outstanding shares of common stock. So long as they beneficially own at least 35% of our outstanding shares of common stock, the Oaktree Parties will have the right to designate three of the members of our board of directors.

As a result of the arrangements described above, the Oaktree Parties have the ability to exert significant influence on our management and operations, as well as matters requiring stockholder approval, including approving mergers, consolidations or sales of all or substantially all of our assets. In addition, beginning in April 2010, provisions of a standstill agreement we entered into with the Oaktree Parties limiting their ability to acquire more than 49.9% of our outstanding common stock will terminate. The interests of the Oaktree Parties may conflict with your interests.

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

The trading price of our common stock on the New York Stock Exchange has fluctuated significantly in the past. During the period from January 1, 2007 through December 31, 2009, the trading price of our common stock fluctuated from a high of $12.03 per share to a low of $4.84 per share. In the past, we have experienced a drop in stock price following an announcement of disappointing earnings or earnings guidance. Any such announcement in the future could lead to a similar drop in stock price. 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 U.S. securities markets 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 attempted takeover of our Company. Although an unsolicited takeover could be in the best interests of our stockholders, our organizational documents and the

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General Corporation Law of the State of Delaware both contain provisions that will impede the removal of directors and may discourage a third-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 Government Regulation of Our Business

The regulatory and political framework is uncertain and evolving.

Healthcare laws and regulations may change significantly in the future which could adversely affect our financial condition and results of operations. We continuously monitor these developments and modify our operations from time to time as the legislative and regulatory environment changes.

In March 2010, the President signed one of the most significant health care reform measures in decades. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act (collectively, the PPACA), substantially changes the way health care is financed by both governmental and private insurers, including several payment reforms that establish payments to hospitals and physicians based in part on quality measures, and may significantly impact our industry. The PPACA requires, among other things, payment rates for services using imaging equipment that costs over $1 million to be calculated using revised equipment usage assumptions and reduced payment rates for imaging services paid under the Medicare Part B fee schedule. The current 50% usage assumption rate would be replaced with a 75% usage rate for such equipment for services furnished on or after January 1, 2011. In addition, the PPACA changes the technical component discount on imaging of contiguous body parts during a single imaging session from 25% to 50%, as mandated by the DRA. We are unable to predict what effect the PPACA or other healthcare reform measures that may be adopted in the future will have on our business. The federal government will, however, have greater involvement in the healthcare industry than in prior years, and such greater involvement may adversely affect our financial condition and results of operations.

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, the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009, 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, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, 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 health care companies, as well as their executives and

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managers. These investigations relate to a wide variety of matters, including referral and billing practices. The Office of the Inspector General of the Department of Health and Human Services (DHHS) 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 Business Regulation, Business Reimbursement and Business 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. Further, the recently enacted 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 this statute or specific intent to violate it. 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. 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. In addition, effective January 1, 2010, as a component for satisfying the Stark exception for in-office ancillary services, the PPACA requires physicians who refer a patient for MRI, CT, PET and any other designated health service to inform the patient in writing at the time of the referral that the patient may obtain such services from a person other than the in-office provider, and provide the patient with a written list of suppliers who furnish such services in the area in which the patient resides. 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

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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 impact 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 example, the PPACA, which was signed into law in March 2010, contains provisions affecting Medicare payment for imaging services. At this time, we cannot predict what effect the PPACA or other healthcare reform measures that may be adopted in the future, if any, will have on the demand for our services or the revenue per procedure that we can collect.

Regulations published in November 2006 by CMS identify 14 supplier standards applicable to independent diagnostic testing facilities, or IDTFs, which include some of our facilities. CMS designed these standards to ensure that minimum quality standards are met to protect Medicare beneficiaries. If an IDTF fails to meet one or more of the standards at the time of enrollment or re-enrollment, then its application will be denied or the agency will revoke an IDTF s billing privileges. These standards went into effect on January 1, 2007, and IDTFs must meet these standards to obtain or retain enrollment in the Medicare program. CMS published additional regulatory provisions in November 2007 and November 2008 that revised the existing IDTF standards and also created several additional standards. These changes went into effect on January 1, 2008 and January 1, 2009, respectively. To the extent that CMS publishes interpretations of these standards that are more restrictive than the standards described in the agency s published rules, our business could be adversely impacted. At this time, we cannot predict the impact that these new standards will have on our business.

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

Some states require a certificate of need 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. Twenty-one of the 45 states in which we operate require a certificate of need 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 certificate of need may repeal existing certificate of need regulations or liberalize exemptions from the regulations. For example, Pennsylvania, Nebraska, New York, Ohio and Tennessee have liberalized exemptions from certificate of need programs. The repeal of certificate of need regulations in states in which we have obtained a certificate of need or a certificate of need exemption would lower barriers to entry for competition in those states and could adversely affect our business.

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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 that the imaging technologists that operate our computed tomography, single photon emission computed tomography and positron emission tomography systems be licensed or certified. Also, each of our retail sites must continue to meet various requirements in order 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.

Risks Related to the Notes

If you do not exchange your private notes pursuant to this exchange offer, you may not be able to sell your notes.

It may be difficult for you to sell private notes that are not exchanged in the exchange offer. Those private notes may not be offered or sold unless they are registered or there are exemptions from the registration requirements under the Securities Act and applicable state securities laws.

If you do not tender your private notes or if we do not accept some of your private notes, those notes will continue to be subject to the transfer and exchange restrictions in:

- the indenture;
- the legend on the private notes; and
- the offering memorandum relating to the private notes.

The restrictions on transfer of your private notes arise because we issued the private notes pursuant to an exemption from the registration requirements of the Securities Act and applicable state securities laws. In general, you may only offer or sell the private notes if they are registered under the Securities Act and applicable state securities laws, or offered and sold pursuant to an exemption from such requirements. We do not intend to register the private notes under the Securities Act. To the extent private notes are tendered and accepted in the exchange offer, the trading market, if any, for untendered private notes would be adversely affected.

We have restricted access to the cash flows and assets of our subsidiaries which may prevent us from making principal and interest payments on the notes.

Although a substantial portion of our business is conducted through our subsidiaries, none of our subsidiaries will have any obligation, contingent or otherwise, to make any funds available to us for payment of the principal of, and the interest on, the notes. Accordingly, our ability to pay the principal of, and the interest on, the notes is dependent upon the earnings of our subsidiaries and the distribution of funds from our subsidiaries. Furthermore, our subsidiaries will be permitted under the terms of the indenture to incur certain additional indebtedness that may require substantial interest payments. There can be no assurance that our operations, independent of our subsidiaries, will generate sufficient cash flow to support payment of principal of, and interest on, the notes, or that dividends, distributions or loans will be available from our subsidiaries to fund these payments.

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The notes are structurally subordinated to the liabilities of our subsidiaries.

None of our subsidiaries has guaranteed our obligations to make payments on the notes. In the event of a bankruptcy, liquidation or reorganization of any of our subsidiaries, their creditors will generally be entitled to payment of their claims from their assets before any assets are made available for a distribution to us for any purpose, including payments on the notes. As a result, the notes are structurally subordinated to the liabilities and guarantees of indebtedness of our subsidiaries, which totaled $492.3 million (of which $460.0 million represents guarantees of our credit facility) outstanding as of December 31, 2009. In the event of a bankruptcy, liquidation or reorganization of any of our subsidiaries, we and our creditors, including the holders of the notes, will have no right to proceed against the assets of our subsidiaries or to cause the liquidation or bankruptcy of these subsidiaries under bankruptcy laws.

Payment of principal and interest on the notes will be effectively subordinated to our secured debt to the extent of the value of the assets securing that debt.

The notes are effectively subordinated to claims of our secured creditors to the extent of the value of the assets securing such claims. As of December 31, 2009, we had $460.0 million of borrowings outstanding under our credit, approximately $4.5 million of letters of credit outstanding and approximately $115.5 million of additional borrowing capacity under our credit facility to which the notes are or would be effectively subordinated to the extent of the value of the assets securing our credit facility. Holders of our secured obligations, including obligations under our credit facility, will have claims that are prior to claims of the holders of the notes with respect to the assets securing those obligations. In the event of a liquidation, dissolution, reorganization, bankruptcy or any similar proceeding, our assets and those of our subsidiaries will be available to pay obligations on the notes and the note guarantees only after holders of our senior secured debt have been paid the value of the assets securing such obligations. Accordingly, there may not be sufficient funds remaining to pay amounts due on all or any of the notes.

We may not be able to repurchase notes upon a change of control, which would be an event of default under the indenture.

Upon the occurrence of specific kinds of change of control events, we will be required to offer to repurchase all of the outstanding notes. The terms of the notes may not protect you if we undergo a highly leveraged transaction, reorganization, restructuring, merger or similar transaction that may adversely affect you unless the transaction is included in the definition of a change of control. Our credit facility restricts us from repurchasing the notes without the approval of the lenders. In addition, it is possible that we will not have sufficient funds at the time of the change of control to make the required repurchase of notes or that other restrictions in our credit facility and the notes will not allow these repurchases. Our failure to repurchase the notes would constitute an event of default under the indenture which would in turn result in an event of default under our credit facility, in which case the lenders under our credit facility could cause all indebtedness under our credit facility to become due and payable.

An active trading market may not develop for the notes.

There is no existing trading market for the notes. We do not intend to apply for listing of the notes, on any securities exchange or for quotation on the Nasdaq National Market.

The liquidity of any market for the notes will depend on a number of factors, including:

- the number of holders of the notes;
- our performance;
- the market for similar securities;

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the interest of securities dealers in making a market in the notes; and

prevailing interest rates.

An active market for the notes may not develop and, if it develops, it may not continue.

If a bankruptcy petition were filed by or against us, you may receive a lesser amount for your claim than you would be entitled to receive under the indenture governing the notes.

If a bankruptcy petition were filed by or against us under the United States Bankruptcy Code after the issuance of the notes, the claim by any holder of the notes for the principal amount of the notes may be limited to an amount equal to the sum of:

The original issue price for the notes; and

that portion of the original issue discount that does not constitute unmatured interest for purposes of the United States Bankruptcy Code.

Any original issue discount that was not amortized as of the date of the bankruptcy filing would constitute unmatured interest. Accordingly, holders of the notes under these circumstances may receive a lesser amount than they would be entitled to under the terms of the indenture governing the notes, even if sufficient funds are available.

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THE EXCHANGE OFFER

Purpose of the Exchange Offer

We issued $190,000,000 of the private notes on November 19, 2009 to Deutsche Bank Securities Inc., Morgan Stanley & Co. Incorporated and Barclays Capital Inc, the initial purchasers, pursuant to a purchase agreement. The initial purchasers subsequently sold the private notes to qualified institutional buyers, as defined in Rule 144A under the Securities Act, in reliance on Rule 144A, and outside the United States under Regulation S of the Securities Act. As a condition to the sale of the private notes, we entered into a registration rights agreement with the initial purchasers on December 1, 2009. Pursuant to the registration rights agreement, we agreed that we would:

(1) file an exchange offer registration statement with the SEC on or prior to April 30, 2010;

(2) use our commercially reasonable efforts to have the exchange offer registration statement declared effective by the SEC on or prior to July 29, 2010;

(3) keep the exchange offer open for a period of not less than the minimum period required under applicable law, but in no event for less than 20 business days; and

(4) use our commercially reasonable efforts to consummate the exchange offer on the earliest practicable date after the exchange offer registration statement has become effective, but in no event later than August 28, 2010.

Upon the effectiveness of the exchange offer registration statement, we will offer the exchange notes in exchange for the private notes. A copy of the registration rights agreement is filed as an exhibit to the registration statement of which this prospectus forms a part.

Resale of the Exchange Notes

Based upon an interpretation by the staff of the SEC contained in no-action letters issued to third parties, we believe that you may exchange private notes for exchange notes in the ordinary course of business. For further information on the SEC s position, see *Exxon Capital Holdings Corporation*, available May 13, 1988, *Morgan Stanley & Co. Incorporated*, available June 5, 1991 and *Shearman & Sterling*, available July 2, 1993, and other interpretive letters to similar effect. You will be allowed to resell exchange notes to the public without further registration under the Securities Act and without delivering to purchasers of the exchange notes a prospectus that satisfies the requirements of Section 10 of the Securities Act so long as you do not participate, do not intend to participate, and have no arrangement with any person to participate, in a distribution of the exchange notes. However, the foregoing does not apply to you if you are: a broker-dealer who purchased the private notes directly from us to resell pursuant to Rule 144A or any other available exemption under the Securities Act; or you are an affiliate of ours within the meaning of Rule 405 under the Securities Act.

In addition, if you are a broker-dealer, or you acquire exchange notes in the exchange offer for the purpose of distributing or participating in the distribution of the exchange notes, you cannot rely on the position of the staff of the SEC contained in the no-action letters mentioned above and must comply with the registration and prospectus delivery requirements of the Securities Act in connection with any resale transaction, unless an exemption from registration is otherwise available.

Each broker-dealer that receives exchange notes for its own account in exchange for private notes, which the broker- dealer acquired as a result of market-making activities or other trading activities, must acknowledge that it will deliver a prospectus in connection with any resale of the exchange notes. By delivering a prospectus, a broker-dealer will not be deemed to admit that it is an underwriter within the meaning of the Securities Act. A broker-dealer may use this prospectus, as it may be amended or supplemented from time to time, in connection with resales of exchange notes received in exchange for private notes which the broker-dealer acquired as a result of market-making or other trading activities.

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Terms of the Exchange Offer

Upon the terms and subject to the conditions described in this prospectus, we will accept any and all private notes validly tendered and not withdrawn before the expiration date. We will issue $1,000 principal amount of exchange notes in exchange for each $1,000 principal amount of outstanding private notes surrendered pursuant to the exchange offer. You may tender private notes only in denominations of $2,000 and integral multiples of $1,000 in excess thereof.

The form and terms of the exchange notes are the same as the form and terms of the private notes except that:

- we will register the exchange notes under the Securities Act and, therefore, the exchange notes will not bear legends restricting their transfer; and
- holders of the exchange notes will not be entitled to any of the rights of holders of private notes under the registration rights agreement, which rights will generally terminate upon the completion of the exchange offer.

The exchange notes will evidence the same debt as the private notes and will be issued under the same indenture, so the exchange notes and the private notes will be treated as a single class of debt securities under the indenture.

As of the date of this prospectus, $190,000,000 in aggregate principal amount of the private notes are outstanding and registered in the name of Cede & Co., as nominee for The Depository Trust Company, or DTC. Only registered holders of the private notes, or their legal representative or attorney-in-fact, as reflected on the records of the trustee under the indenture, may participate in the exchange offer. We will not set a fixed record date for determining registered holders of the private notes entitled to participate in the exchange offer.

You do not have any appraisal or dissenters rights under the indenture in connection with the exchange offer. We intend to conduct the exchange offer in accordance with the provisions of the registration rights agreement and the applicable requirements of the Securities Act, the Securities Exchange Act of 1934, as amended (the Exchange Act), and the rules and regulations of the SEC.

We will be deemed to have accepted validly tendered private notes when, as and if we had given oral or written notice of acceptance to the Exchange Agent. The Exchange Agent will act as your agent for the purposes of receiving the exchange notes from us.

If you tender private notes in the exchange offer you will not be required to pay brokerage commissions or fees or transfer taxes with respect to the exchange of private notes pursuant to the exchange offer. We will pay all charges and expenses, other than the applicable taxes described below under Fees and Expenses, in connection with the exchange offer.

Expiration Date; Extensions; Amendments

The term expiration date will mean 5:00 p.m., New York City time on , 2010, unless we, in our sole discretion, extend the exchange offer, in which case the term expiration date will mean the latest date and time to which we extend the exchange offer.

To extend the exchange offer, we will notify the Exchange Agent and each registered holder of any extension in writing by a press release or other public announcement before 9:00 a.m., New York City time, on the next business day after the previously scheduled expiration date. The notice of extension will disclose the aggregate principal amount of the private notes that have been tendered as of the date of such notice.

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We reserve the right, in our reasonable discretion:

- to delay accepting any private notes due to an extension of the exchange offer; or
- if any conditions listed below under Conditions are not satisfied, to terminate the exchange offer

in each case by giving written notice of the delay, extension or termination to the Exchange Agent and by press release or public announcement.

We will follow any delay in acceptance, extension or termination as promptly as practicable by written notice to the registered holders by a press release or other public announcement. If we amend the exchange offer in a manner we determine constitutes a material change, we will promptly disclose the amendment in a prospectus supplement that we will distribute to the registered holders. We will also extend the exchange offer for a period of five to ten business days, depending upon the significance of the amendment and the manner of disclosure, if the exchange offer would otherwise expire during the five to ten business day period.

Interest on the Exchange Notes

The exchange notes will bear interest at the same rate and on the same terms as the private notes. Consequently, the exchange notes will bear interest at a rate equal to 8.00% per annum (calculated using a 360-day year). Interest will be payable semi-annually on each June 1 and December 1.

You will receive interest on , 2010 from the date of initial issuance of the exchange notes, plus an amount equal to the accrued interest on the private notes from , to the date of exchange. We will deem the right to receive any interest accrued on the private notes waived by you if we accept your private notes for exchange.

Procedures for Tendering

If you are a DTC, Euroclear or Clearstream participant that has private notes which are credited to your DTC, Euroclear or Clearstream account by book-entry and which are held of record by DTC s nominee, you may tender your private notes by book-entry transfer as if you were the record holder. Because of this, references herein to registered or record holders include DTC, Euroclear and Clearstream participants with private notes credited to their accounts. If you are not a DTC, Euroclear or Clearstream participant, you may tender your private notes by book-entry transfer by contacting your broker, dealer or other nominee or by opening an account with a DTC, Euroclear or Clearstream participant, as the case may be.

To tender private notes in the exchange offer, you must:

- comply with DTC s Automated Tender Offer Program (ATOP) procedures described below; and
- the Exchange Agent must receive a timely confirmation of a book-entry transfer of the private notes into its account at DTC through ATOP pursuant to the procedure for book-entry transfer described below, along with a properly transmitted agent s message, before the expiration date.

Participants in DTC s ATOP program must electronically transmit their acceptance of the exchange by causing DTC to transfer the private notes to the Exchange Agent in accordance with DTC s ATOP procedures for transfer. DTC will then send an agent s message to the Exchange Agent. With respect to the exchange of the private notes, the term agent s message means a message transmitted by DTC, received by the Exchange Agent and forming part of the book-entry confirmation, which states that:

- DTC has received an express acknowledgment from a participant in its ATOP that is tendering private notes that are the subject of the book-entry confirmation;

the participant has received and agrees to be bound by the terms and subject to the conditions set forth in this prospectus; and

the Company may enforce the agreement against such participant.

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Participants in Euroclear s or Clearstream s book-entry transfer facility system must electronically transmit their acceptance of the exchange to Euroclear or Clearstream. The receipt of such electronic acceptance instruction by Euroclear or Clearstream will be acknowledged in accordance with the standard practices of such book-entry transfer facility and will result in the blocking of such private notes in that book-entry transfer facility. By blocking such private notes in the relevant book-entry transfer facility, each holder of private notes will be deemed to consent to have the relevant book-entry transfer facility provide details concerning such holder s identity to the Exchange Agent. The receipt of an electronic instruction by Euroclear or Clearstream shall mean:

- Euroclear or Clearstream, as applicable, has received an express acknowledgment from a participant in Euroclear or Clearstream, as the case may be, that such participant is tendering private notes that are the subject of the book-entry confirmation;
- the participant has received and agrees to be bound by the terms and subject to the conditions set forth in this prospectus; and
- the Company may enforce the agreement against such participant.

Your tender, if not properly withdrawn before the expiration date, will constitute an agreement between you and us in accordance with the terms and subject to the conditions described in this prospectus.

DTC, Euroclear and Clearstream are collectively referred to herein as the book-entry transfer facilities and, individually as a book-entry transfer facility.

We will determine in our sole discretion all questions as to the validity, form, eligibility, including time of receipt, acceptance and withdrawal of tendered private notes, which determination will be final and binding. We reserve the absolute right to reject any and all private notes not properly tendered or any private notes our acceptance of which would, in the opinion of our counsel, be unlawful. We also reserve the right to waive any defects, irregularities or conditions of tender as to particular private notes. Our interpretation of the terms and conditions of the exchange offer will be final and binding on all parties. Unless waived, you must cure any defects or irregularities in connection with tenders of private notes within the time we determine. Although we intend to notify you of defects or irregularities with respect to tenders of private notes, neither we, the Exchange Agent nor any other person will incur any liability for failure to give you that notification. Unless waived, we will not deem tenders of private notes to have been made until you cure the defects or irregularities.

While we have no present plan to acquire any private notes that are not tendered in the exchange offer or to file a registration statement to permit resales of any private notes that are not tendered in the exchange offer, we reserve the right in our sole discretion to purchase or make offers for any private notes that remain outstanding after the expiration date. We also reserve the right to terminate the exchange offer, as described below under Conditions, and, to the extent permitted by applicable law, purchase private notes in the open market, in privately negotiated transactions or otherwise. The terms of any of those purchases or offers could differ from the terms of the exchange offer.

If you wish to tender private notes in exchange for exchange notes in the exchange offer, we will require you to represent that:

- the private notes are, at the time of acceptance, and will continue to be, until exchanged in this offer, held by you;
- you acknowledge that all authority conferred or agreed to be conferred pursuant to these representations, warranties and undertakings and every obligation of yours shall be binding upon your successors, assigns, heirs, executors, administrators, trustees in bankruptcy and legal representatives and shall not be affected by, and shall survive, your death or incapacity (if an individual) or dissolution (if an entity);

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you will, upon request, execute and deliver any documents deemed by the Company or the Exchange Agent to be necessary or desirable to complete the exchange of the private notes that are the subject of the electronic acceptance instruction;

you have full power and authority to tender, exchange, assign and transfer the private notes that are the subject of the electronic acceptance instruction and that when such notes are accepted for exchange by the Company, the notes will be transferred by you with full title guarantee free from all liens, restrictions, charges and encumbrances and not subject to any adverse claim or right, together with all rights attached thereto;

you are not an affiliate of ours;

you will acquire any exchange notes in the ordinary course of your business;

you satisfy specific requirements of your state s security regulations;

you do not have an arrangement or understanding with any person to participate in the distribution of the exchange notes;

neither you nor any person or entity receiving the related exchange notes is an affiliate of Alliance HealthCare Services, Inc. as that term is defined under Rule 405 of the Securities Act; and

you are not acting on behalf of any person or entity who could not truthfully make these statements at the time of completion of the exchange offer, you are not engaged in, and do not intend to engage in, a distribution of the exchange notes.

You will be deemed to make such representations by tendering private notes in the exchange offer. In addition, in connection with the resale of exchange notes, any participating broker-dealer who acquired the private notes for its own account as a result of market-making or other trading activities acknowledges that it must deliver a prospectus meeting the requirements of the Securities Act. The SEC has taken the position that participating broker-dealers may fulfill their prospectus delivery requirements with respect to the exchange notes, other than a resale of an unsold allotment from the original sale of the notes, with this prospectus.

Return of Notes

If we do not accept any tendered private notes for any reason described in the terms and conditions of the exchange offer or if you withdraw or submit private notes for a greater principal amount than you desire to exchange, we will return the unaccepted, withdrawn or non-exchanged notes without expense to you as promptly as practicable by crediting the private notes to your account maintained with DTC as promptly as practicable.

Book Entry Transfer

The Exchange Agent will make a request to establish an account with respect to the private notes at DTC for purposes of the exchange offer within two business days after the date of this prospectus, and any financial institution that is a participant in DTC s system may make book-entry delivery of private notes by causing DTC to transfer the private notes into the Exchange Agent s account at DTC in accordance with DTC s procedures for transfer.

In all cases, we will issue exchange notes for private notes that we have accepted for exchange under the exchange offer only after the Exchange Agent timely receives:

a confirmation of book-entry transfer of your private notes into the Exchange Agent s account at DTC; and

a properly transmitted agent s message.

If we do not accept any tendered private notes for any reason set forth in the terms of the exchange offer, we will credit the non-exchanged private notes to your account maintained at DTC.

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Withdrawal of Tenders

Except as otherwise provided in this prospectus, you may withdraw tenders of private notes at any time before 5:00 p.m., New York City time, on the expiration date.

To withdraw a tender of private notes in the exchange offer, the holder must cause to be transmitted to the Exchange Agent an agent s message, on or before 5:00 p.m., New York City time, on the expiration date. In addition, the Exchange Agent must receive a timely confirmation of book-entry transfer of the private notes out of the Exchange Agent s account at DTC under the procedure for book-entry transfer described herein, on or before 5:00 p.m., New York City time, on the expiration date.

We will determine in our sole discretion all questions as to the validity, form and eligibility of the notices, and our determination will be final and binding on all parties. We will not deem any properly withdrawn private notes to have been validly tendered for purposes of the exchange offer, and we will not issue exchange notes with respect to those private notes, unless you validly retender the withdrawn private notes. You may retender properly withdrawn private notes by following the procedures described above under Procedures for Tendering at any time before 5:00 p.m., New York City time, on the expiration date.

Conditions

Notwithstanding any other term of the exchange offer, we will not be required to accept for exchange, or exchange the exchange notes for, any private notes, and may terminate the exchange offer as provided in this prospectus before the acceptance of the private notes, if, in our reasonable judgment, the exchange offer violates applicable law, rules or regulations or an applicable interpretation of the staff of the SEC.

If we determine in our reasonable discretion that any of these conditions are not satisfied, we may

- refuse to accept any private notes and return all tendered private notes to you;
- extend the exchange offer and retain all private notes tendered before the exchange offer expires, subject, however, to your rights to withdraw the private notes; or
- waive the unsatisfied conditions with respect to the exchange offer and accept all properly tendered private notes that have not been withdrawn.

If the waiver constitutes a material change to the exchange offer, we will promptly disclose the waiver by means of a prospectus supplement that we will distribute to the registered holders of the private notes, and we will extend the exchange offer for a period of five to 10 business days, depending upon the significance of the waiver and the manner of disclosure to the registered holders, if the exchange offer would otherwise expire during the five to 10 business day period.

Termination of Rights

All of your rights under the registration rights agreement will terminate upon consummation of the exchange offer except with respect to our continuing obligations:

- to indemnify you and parties related to you against liabilities, including liabilities under the Securities Act; and
- to provide, upon your request, the information required by Rule 144A(d)(4) under the Securities Act to permit resales of the notes pursuant to Rule 144A.

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Shelf Registration

If:

(1) we are not permitted to consummate the exchange offer because the exchange offer is not permitted by applicable law or applicable interpretation of the Staff of the SEC; or

(2) any holder of transfer restricted securities notifies us within twenty (20) business days following consummation of the exchange offer that:

(A) the holder is not permitted by law or SEC policy to participate in the exchange offer,

(B) the holder is not permitted to resell the exchange notes acquired by it in the exchange offer to the public without delivering a prospectus and this prospectus is not available for resales by the holder, or

(C) the holder is a broker-dealer and holds notes acquired directly from us or any of our affiliates,

we will file with the SEC a shelf registration statement to cover resales of the private notes by the holders thereof who satisfy certain conditions relating to the provision of information in connection with the shelf registration statement.

For purposes of the preceding, transfer restricted securities means each private note until:

(1) the date on which such note has been exchanged by a person other than a broker-dealer for an exchange note in the exchange offer and entitled to be resold to the public by the holder thereof without complying with the prospectus delivery requirements of the Securities Act;

(2) following the exchange by a broker-dealer in the exchange offer of a private note for an exchange note, the date on which such exchange note is sold to a purchaser who receives from such broker-dealer on or prior to the date of such sale a copy of the prospectus contained in the exchange offer registration statement;

(3) the date on which such private note has been registered under the Securities Act and disposed of in accordance with the shelf registration statement; or

(4) the date on which such private note is distributed to the public pursuant to Rule 144 under the Securities Act.

Liquidated Damages

If:

(1) we fail to file any of the registration statements required by the registration rights agreement on or before the date specified for such filing;

(2) any of such registration statements is not declared effective by the SEC on or prior to the date specified for such effectiveness;

(3) the exchange offer has not been consummated on or prior to the date specified for such consummation; or

(4) the shelf registration statement or the exchange offer registration statement is declared effective but ceases to be effective or fails to be usable for its intended purpose without being succeeded within two (2) business days by a post-effective amendment to such registration statement that cures such failure and that is itself declared effective within two (2) business days of filing such post-effective amendment to such registration statement (each such event referred to in clauses (1) through (4) above, a registration default);

then we will pay to each holder of the transfer restricted securities affected thereby liquidated damages. Liquidated damages shall accrue at an annual rate of 0.25% of the aggregate principal amount of transfer

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restricted securities on the date of such registration default, payable in cash semi-annually in arrears on each interest payment date, commencing on the date of such registration default. All accrued liquidated damages will be paid to the holders entitled thereto, in the manner provided for the payment of interest in the indenture, on each interest payment date, as more fully set forth in the indenture and the notes. Notwithstanding the fact that any securities for which liquidated damages are due cease to be transfer restricted securities, all obligations of the Company to pay liquidated damages with respect to securities shall survive until such time as such obligations with respect to such securities shall have been satisfied in full.

Exchange Agent

We have appointed The Bank of New York Mellon Trust Company, N.A. as Exchange Agent for the exchange offer. You should direct questions and requests for assistance and requests for additional copies of this prospectus to the Exchange Agent addressed as follows:

The Bank of New York Mellon

Corporate Trust Operations

Reorganization Unit

101 Barclay Street 7 East

New York, N.Y. 10286

Attn: Mrs. Diane Amoroso

Telephone: (212)-815-2742

Fax: (212)-298-1915

Delivery to an address other than the one stated above or transmission via a facsimile number other than the one stated above will not constitute a valid delivery.

Fees and Expenses

We will bear the expenses of soliciting tenders. We are making the principal solicitation by mail; however, our officers and regular employees may make additional solicitations by facsimile, telephone or in person.

We have not retained any dealer manager in connection with the exchange offer and will not make any payments to brokers, dealers or others soliciting acceptances of the exchange offer. We will, however, pay the Exchange Agent reasonable and customary fees for its services and will reimburse it for its reasonable out-of-pocket expenses.

We will pay the cash expenses incurred in connection with the exchange offer which we estimate to be approximately $250,000. These expenses include registration fees, fees and expenses of the Exchange Agent and the trustee, accounting and legal fees and printing costs, among others.

We will pay all transfer taxes, if any, applicable to the exchange of notes pursuant to the exchange offer. If, however, a transfer tax is imposed for any reason other than the exchange of the private notes pursuant to the exchange offer, then you must pay the amount of the transfer taxes.

Consequence of Failures to Exchange

Participation in the exchange offer is voluntary. We urge you to consult your financial and tax advisors in making your decisions on what action to take. Private notes that are not exchanged for exchange notes pursuant to the exchange offer will remain restricted securities. Accordingly, those private notes may be resold only:

to a person whom the seller reasonably believes is a qualified institutional buyer in a transaction meeting the requirements of Rule 144A;

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in a transaction meeting the requirements of Rule 144 under the Securities Act;

outside the United States to a foreign person in a transaction meeting the requirements of Rule 903 or 904 of Regulation S under the Securities Act;

in accordance with another exemption from the registration requirements of the Securities Act and based upon an opinion of counsel if we so request;

to us; or

pursuant to an effective registration statement.

In each case, the private notes may be resold only in accordance with any applicable securities laws of any state of the United States or any other applicable jurisdiction.

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USE OF PROCEEDS

The exchange offer is intended to satisfy an obligation under the registration rights agreement. We will not receive any cash proceeds from the exchange offer.

CAPITALIZATION

The following table sets forth our cash and cash equivalents and capitalization as of December 31, 2009. You should read this table together with Management s Discussion and Analysis of Financial Condition and Results of Operations, Selected Consolidated Financial Data and our financial statements and the related notes included elsewhere or incorporated by reference in this prospectus.

	As of December 31, 2009 Actual (in thousands)
Cash and cash equivalents	$ 111,884
Long-term debt, including current portion:	
New credit facility(1)	$ 460,000
Revolving credit facility(2)	
8% senior notes due 2016 offered in the private offering(3)	190,000
7 1/4% senior subordinated notes due 2012(4)	5,582
Equipment debt	23,878
Total long-term debt	679,460
Stockholders equity:	
Preferred stock, $0.01 par value: 1,000,000 shares authorized and no shares issued and outstanding	
Common stock, $0.01 par value: 100,000,000 shares authorized, 51,865,133 shares issued and outstanding, actual and as adjusted	516
Less: treasury stock, at cost 386,703 shares	(2,333)
Additional paid-in capital	10,652
Accumulated comprehensive loss	(2,392)
Retained Earnings	21,477
Total stockholders equity attributable to Alliance HealthCare Services, Inc.	27,920
Noncontrolling interest	6,842
Total stockholders equity	34,762
Total capitalization	$ 714,222

(1) Excludes the effect of approximately $9.1 million of original issue discount.
(2) We have up to $120.0 million available for borrowing under the New Revolving Credit Facility, which is undrawn as of the December 31, 2009, except to support undrawn letters of credit of $4.5 million.
(3) Excludes the effect of approximately $2.5 million of original issue discount. The notes offered hereby replace the private notes in the same amount.
(4) Balance was redeemed at par, together with accrued interest to the redemption date, in January 2010.

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SELECTED CONSOLIDATED 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 Management s Discussion and Analysis of Financial Condition and Results of Operations and our consolidated financial statements and related notes included elsewhere herein or incorporated by reference in this prospectus herein (in thousands, except per share data).

	Year Ended December 31,				
	2005	2006	2007	2008	2009
Consolidated Statements of Operations Data:					
Revenues	$ 430,788	$ 455,775	$ 444,919	$ 495,834	$ 505,513
Costs and expenses:					
Cost of revenues, excluding depreciation and amortization	226,294	244,254	235,471	261,753	270,381
Selling, general and administrative expenses	48,077	53,955	57,049	62,728	67,579
Transaction costs					893
Employment agreement costs	366				
Severances and related costs	826	745	682	636	1,404
Loss on extinguishment of debt				61	14,600
Depreciation expense	82,505	83,397	82,703	87,728	94,918
Amortization expense	3,954	4,933	5,195	8,696	11,000
Interest expense and other, net	34,203	41,078	42,362	48,392	45,894
Other (income) and expense, net	(399)	45	(579)	(872)	(1,178)
Total costs and expenses	395,826	428,407	422,883	469,122	505,491
Income before income taxes, earnings from unconsolidated investees and noncontrolling interest, net of tax	34,962	27,368	22,036	26,712	22
Income tax expense	14,758	12,032	11,644	11,764	308
Earnings from unconsolidated investees	(3,343)	(5,371)	(7,567)	(4,605)	(3,831)
Net income	23,547	20,707	17,959	19,553	3,545
Less: Net income attributable to noncontrolling interest, net of tax	(1,718)	(2,075)	(1,727)	(3,030)	(3,064)
Net income attributable to Alliance HealthCare Services, Inc.	$ 21,829	$ 18,632	$ 16,232	$ 16,523	$ 481
Ratio of earnings to fixed charges(1)	2.0x	1.8x	1.6x	1.6x	1.1x
Consolidated Balance Sheet Data (at end of period):					
Cash and cash equivalents	$ 13,421	$ 16,440	$ 120,892	$ 73,305	$ 111,884
Total assets	675,342	664,526	849,807	883,723	887,836
Long-term debt, including current maturities	579,582	529,425	670,796	662,562	667,890
Stockholders (deficit) equity	(35,856)	(12,598)	8,079	28,993	34,762

(1) The ratio of earnings to fixed charges is computed by dividing earnings by fixed charges. For purposes of calculating the ratio of earnings to fixed charges, earnings are defined as income before income taxes, plus noncontrolling interest, plus distributions from unconsolidated investees, plus fixed charges, less income from equity investments. Fixed charges are the sum of interest on all indebtedness, amortization of debt issuance costs, and estimated interest on rental expense.

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MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following Management s Discussion and Analysis of Financial Condition and Results of Operations contains forward-looking statements that involve risks and uncertainties. Our actual results could differ materially from those anticipated in these forward-looking statements as a result of certain factors, including those set forth under the headings Cautionary Disclosure Regarding Forward-Looking Statements and Risk Factors and elsewhere in this prospectus. The following discussion should be read in conjunction with our consolidated financial statements and related notes thereto incorporated by reference in this prospectus.

Overview

We are a leading national provider of outpatient diagnostic imaging services, based upon annual revenue and number of diagnostic imaging systems deployed, and are a provider of radiation oncology services. Our principal sources of revenue are derived from magnetic resonance imaging (MRI) and positron emission tomography/computed tomography (PET/CT). 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 a growing number of fixed-site imaging centers, primarily to hospitals or health systems. Our 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 includes only the use of our imaging systems under a short-term contract. We have also leveraged our leadership in MRI and PET/CT to expand into radiation oncology. Our radiation oncology business is operated through our wholly-owned subsidiary, Alliance Oncology, LLC (AO), and 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, therapists to operate such systems, administrative staff, equipment maintenance and upgrades, and management of day-to-day operations. We also provide stereotactic radiation oncology services through our wholly-owned subsidiary, Alliance Radiosurgery, LLC.

MRI and PET/CT services generated 47% and 40% of our revenue, respectively, for the year ended December 31, 2009, 54% and 34% of our revenue, respectively, for the year ended December 31, 2008 and 60% and 31% of our revenue, respectively, for the year ended December 31, 2007. Our remaining revenue was comprised of radiation oncology revenue and other modality diagnostic imaging services revenue, primarily computed tomography (CT) and management contract revenue. We had 507 diagnostic imaging and radiation oncology systems, including 295 MRI systems and 126 positron emission tomography (PET) or PET/CT systems and served over 1,000 clients in 45 states at December 31, 2009. We operated 116 fixed-site imaging centers (three in unconsolidated joint ventures), which constitutes systems installed in hospitals or other medical buildings on or near hospital campuses, including modular buildings, systems installed inside medical groups offices, and free-standing fixed-site imaging centers, which includes systems installed in a medical office building, ambulatory surgical center, or other retail space at December 31, 2009. Of the 116 fixed-site imaging centers, 91 were MRI fixed-site imaging centers, 16 were PET or PET/CT fixed-site imaging centers, six were other modality fixed-site imaging centers and three were in unconsolidated joint ventures. We also operated 25 radiation oncology centers and stereotactic radiosurgery facilities (including two radiation oncology centers in unconsolidated joint ventures) at December 31, 2009.

Approximately 80%, 79% and 89% of our revenues for the years ended December 31, 2009, 2008 and 2007, respectively, were generated by providing services to hospitals and other healthcare providers, which we refer to as wholesale revenues. Our wholesale revenues are typically generated 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

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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 their own system. We price our contracts based on the type of system used, the scan volume, and the number of ancillary services provided. Pricing is also affected by competitive pressures.

Approximately 20%, 21% and 11% of our revenues for the years ended December 31, 2009, 2008 and 2007, respectively, were generated by providing services directly to patients from our sites located at or near hospitals or other healthcare provider facilities, which we refer to as retail revenue. Our revenue from these sites is generated from direct billings to patients or their third-party payors, including Medicare, which are recorded net of contractual discounts and other arrangements for providing services at discounted prices. We typically charge 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 10 to 20 years in length. Revenues from these centers are included in either our wholesale or retail revenues.

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 failed to intervene. For example, for 2008, the fee schedule rates were to be reduced by approximately 10.1%. The Medicare, Medicaid and SCHIP Extension Act of 2007 eliminated the 10.1% reduction for 2008 and increased the annual payment rate update by 0.5%. This increase to the annual Medicare Physician Fee Schedule payment update was effective only for Medicare claims with dates of service between January 1, 2008 and June 30, 2008. Beginning July 1, 2008, under the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), the 0.5% increase was continued for the rest of 2008. In addition, MIPPA established a 1.1% increase to the Medicare Physician Fee Schedule payment update for 2009. For 2010, the Centers for Medicare and Medicaid Services (CMS) are projecting a rate reduction of 21.2% unless Congress intervenes again to avoid the payment reduction. On December 19, 2009, President Obama signed into law the Department of Defense Appropriations Act, 2010 (H.R. 3326) which includes a zero percent Medicare physician update through February 28, 2010. This was further extended through May 31, 2010 by the Temporary Extension Act of 2010 and the Continuing Extension Act of 2010, signed into law by President Obama on March 2, 2010 and April 15, 2010, respectively. If Congress fails to intervene to prevent the 21.2% rate reduction, the resulting decrease in payment will adversely impact our revenues and results of operations.

MIPPA also modified the methodology by which the budget neutrality formula was applied to the 2009 physician fee schedule payment rates, resulting in an overall reduction in payment rates for services performed by many specialties, including an estimated 3% reduction for radiation oncology and 1% reduction for nuclear medicine. The impact of the payment rates on specific companies depends on their service mix. We estimated decreases in rates for our radiation oncology business, but cannot predict the full impact the rate reductions will have on our future revenues or business. Also with respect to MIPPA, the legislation requires all suppliers that provide the technical component of diagnostic MRI, PET/CT, CT, and nuclear medicine to be accredited by an accreditation organization designated by CMS by January 1, 2012. On January 26, 2010, CMS initially approved the following designated accreditation organizations to accredit suppliers furnishing the technical component of all advanced imaging modalities (CT, nuclear medicine, PET and MRI) on or after January 1, 2010: The American College of Radiology (ACR), the Intersocietal Accreditation Commission (IAC) and The Joint Commission. All our facilities are accredited by The Joint Commission.

A number of other legislative changes impact our retail business. For example, the Deficit Reduction Act of 2005 (DRA) imposed caps on Medicare payment rates for certain imaging services furnished in physician s offices and other non-hospital based settings. The caps impact MRI, PET/CT and certain imaging services performed in conjunction with radiation therapy, including certain image guided radiation therapy (IGRT)

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services and diagnostic imaging services used to plan intensity modulated radiation therapy (IMRT). Under the cap, payments for specified imaging services cannot exceed the hospital outpatient payment rates for those services. This change applies to services furnished on or after January 1, 2007. The limitation is applicable to the technical components of the diagnostic imaging services only, which is the payment we receive for the services for which we bill directly under the Medicare Physician Fee Schedule. CMS issues on an annual basis the hospital outpatient prospective payment (HOPPS) rates, which are used to develop the caps. If the technical component of the service established under the Physician Fee Schedule (without including geographic adjustments) exceeds the hospital outpatient payment amount for the service (also without including geographic adjustments), then the payment is to be reduced. In other words, in those instances where the technical component for the particular service is greater for the non-hospital site, the DRA directs that the hospital outpatient payment rate be substituted for the otherwise applicable Physician Fee Schedule payment rate. The implementation of this reimbursement reduction contained in the DRA had a significant effect on our financial condition and results of operations in 2007, whereas the changes in 2008 and 2009 have been limited.

The DRA also codified the reduction in reimbursement for multiple images on contiguous body parts, which was previously announced by CMS. The DRA mandated payment at 100% of the technical component of the higher priced imaging procedure and 50% for the technical component of each additional imaging procedure for multiple images of contiguous body parts within a family of codes performed in the same session. CMS announced that it would phase in this reimbursement reduction over a two-year period. Beginning in 2006, CMS implemented the initial 25% reduction for each additional imaging procedure on contiguous body parts. For services furnished on or after July 1, 2010, the recently enacted Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act (collectively, the PPACA), requires the full 50% reduction to be implemented as mandated by the DRA.

Regulatory updates to payment rates for which we bill the Medicare program directly are published annually by CMS. For payments under the Physician Fee Schedule for calendar year 2010, CMS changed the way it calculates components of the Medicare Physician Fee Schedule. As part of the changes, CMS reduced payment rates for certain diagnostic services using equipment costing more than $1 million through revisions to usage assumptions from the current 50% usage rate to a 90% usage rate to be phased in over a four-year period. This change applied to MRI and CT scans, but not for radiation therapy and other therapeutic equipment. The PPACA supersedes CMS s regulatory changes and reduces the assumed usage rate for such equipment from CMS s 2010 rate of 90% to a rate of 75%, beginning on January 1, 2011. A decrease in utilization rate generally corresponds to an increase to the payment rate. In addition, the OIG has stated that for 2010, it intends to focus on, among other things, the practice expense components, including the equipment utilization rate, for certain imaging services reimbursed under Medicare Physician Fee Schedule to determine whether Medicare payment reflects the actual expenses incurred and whether the utilization rate reflects current industry practices.

Further with respect to its 2010 regulatory changes to the Medicare Physician Fee Schedule, in addition to the changes to the usage assumptions, CMS s changes to services primarily involving the technical component rather than the physician work component were adjusted downward. The reductions primarily impact radiology and other diagnostic tests, including the services we provide. Some of the changes to the Medicare Physician Fee Schedule are being transitioned over a four year period such that beginning in 2013, CMS will have fully implemented the revised payment rates. For the 2010 transitioned payment, CMS estimated that the impact of its changes (including the change in the usage assumption that has been superseded by PPACA) would result in a 1% reduction in radiation oncology, 5% reduction in radiology, 18% reduction in nuclear medicine and 12% reduction for all suppliers providing the technical component of diagnostic tests generally. These impacts are calculated prior to any application of the projected negative update factor of 21.2% related to MIPPA (which may be implemented in June 2010 unless Congress intervenes) and may impact our future revenues. The PPACA changes to the Medicare Physician Fee Schedule impact only the usage assumptions described above and therefore all other 2010 updates issued by CMS remain in place. If the CMS 2010 reimbursement rates had been in effect for full year 2009, we estimate that our annualized retail revenue related to MRI and radiation oncology would not have been materially impacted. At this time, we estimate that the new usage assumptions for MRI and

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CT scans under the PPACA, which is to take effect on January 1, 2011, will not have a material impact 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 HOPPS on an annual basis. These payments are the amounts received by our hospital clients for hospital outpatient services. For 2008, the national Medicare HOPPS payment rate for nonmyocardial PET and PET/CT scans was $1,057 per scan and the national payment rate for myocardial PET scans was $1,400 per scan. Effective January 1, 2008, CMS also bundled the PET and PET/CT payment for radiopharmaceuticals with the payment for the PET and PET/CT scan. In addition, CMS reduced the 2008 national Medicare HOPPS rate for MRI scans by approximately 3%. The 2008 national Medicare HOPPS payment rates for stereotactic radiosurgery treatment delivery services ranged from $1,057 to $8,055, depending on the level of service. For 2009, the payment rate for nonmyocardial PET and PET/CT scans is $1,037 per scan. For myocardial PET procedures, the 2009 payment rate is $1,157 per scan. For stereotactic radiosurgery treatment delivery services, the 2009 payment rates range from $952 to $7,642, depending on the level of service. On October 30, 2009, CMS released its 2010 national Medicare HOPPS payment rates, which went into effect January 1, 2010. For nonmyocardial PET and PET/CT, the 2010 payment rate is $1,037 per scan. For myocardial PET procedures, the 2010 payment rate is $1,433 per scan. For stereotactic radiosurgery treatment delivery services, the 2010 payment rates range from $963 to $7,344, depending on the level of service.

Combined, the DRA and PET and PET/CT Medicare HOPPS rate reductions negatively impacted our 2007 revenue by a total of approximately $14 million. For 2008 and 2009, however, the DRA and the net Medicare rate reductions in HOPPS did not have a material negative effect on revenue and earnings. At this time, however, we cannot predict the impact the rate reductions will have on our future revenues or business.

Furthermore, with respect to the final Medicare Physician Fee Schedule Rule for calendar year 2009, CMS announced additional performance standards for suppliers of mobile diagnostic services. The final rule requires suppliers of mobile diagnostic services under certain circumstances to enroll in Medicare and bill directly for these services, regardless of where they are performed. An exception was made for services provided to hospital patients under arrangement with that hospital. In those circumstances, the mobile diagnostic facility would be required to enroll in Medicare, but the hospital would bill for the services. On December 15, 2008, CMS issued additional guidance that companies that lease or contract with a Medicare-enrolled provider or supplier to provide only diagnostic testing equipment and/or non-physician personnel are not required to enroll in Medicare. The agency nonetheless indicated that it is continuing to evaluate such arrangements. The new policies have not significantly impacted our 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, a growing number of medical groups adding imaging capacity within their practice setting and additional patient-related cost-sharing programs. In addition, there is an increasing trend of third-party payors intensifying their utilization management efforts, for example through benefit managers who require preauthorizations, to control the growth rate of imaging services generally. We expect that these trends will continue throughout 2010. In addition, we cannot predict the full extent of the PPACA on our business. The legislation substantially changes the way health care is financed by both governmental and private insurers and may negatively impact payment rates for certain imaging services. Nor can we predict at this time whether or the extent to which other proposed changes will be adopted, if any, or how these or future changes will affect the demand for our services.

We have experienced and continue to experience an increase in the competitive climate in the MRI industry, resulting in an increase in activity by original equipment manufacturers, or OEMs, selling systems directly to certain of our clients. Typically, OEMs target our higher scan volume clients. This increase in activity by OEMs has resulted in overcapacity of systems in the marketplace. This has caused an increase in the number of our higher scan volume clients deciding not to renew their contracts. We replace these higher volume clients typically with lower volume clients. Our non-scan based MRI business has been impacted by a decline in the

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number of hospital construction projects, driven by a decrease in new MRI systems being added by hospitals in their facilities and a decrease in the number of equipment upgrades occurring in the hospital market. Our MRI revenues decreased in 2009 compared to 2008 due to the factors described above, and we believe that MRI revenues will continue to decline in future years.

Recent global market and economic conditions have been unprecedented and challenging with tighter credit conditions and recession in most major economies continuing into 2010. Continued concerns about the systemic impact of potential long-term and wide-spread recession, inflation, energy costs, geopolitical issues, the availability and cost of credit, the United States mortgage market and a declining real estate market in the United States have contributed to increased market volatility and diminished expectations for the United States economy. Added concerns fueled by the United States government financial assistance to certain companies and other federal government s interventions in the United States financial system has led to increased market uncertainty and instability in both United States and international capital and credit markets. 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. We believe our MRI and PET/CT scan volumes have been impacted during 2009 and will continue to be impacted in 2010 by rising unemployment rates, the number of under-insured or uninsured patients and other conditions arising from the global economic conditions described above. At this time, it is unclear what impact this might have on our future revenues or business.

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.

The principal components of our cost of revenues are compensation paid to technologists and drivers, system maintenance costs, medical supplies, system transportation and technologists travel costs. Because a majority of these expenses are fixed, increased revenues as a result of higher scan volumes per system significantly improves our margins while lower scan 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 therapeutic services.

Seasonality

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

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Kohlberg Kravis Roberts & Co Acquisition and Disposition

On November 2, 1999, Viewer Holdings L.L.C., an affiliate of Kohlberg Kravis Roberts & Co (KKR), acquired approximately 92% of Alliance in a recapitalization merger. Viewer is owned by two investment funds sponsored by KKR. The KKR acquisition consisted of a recapitalization merger in 1999 in which a wholly-owned subsidiary of Viewer was merged with and into Alliance. Upon the consummation of the KKR acquisition, Viewer owned approximately 92% of Alliance.

On November 27, 2006, affiliates of KKR sold 9.2 million shares of our common stock in an underwritten secondary public offering. Following completion of the offering, KKR beneficially owned approximately 52% of our outstanding shares of common stock. We did not sell any shares and did not receive any proceeds from the sale of shares in the public offering.

On April 16, 2007, funds managed by Oaktree Capital Management, LLC (Oaktree) and MTS Health Investors, LLC (MTS) purchased approximately 24.5 million shares of our common stock from KKR. Upon completion of the transaction, Oaktree and MTS owned in the aggregate approximately 49.7% of the outstanding shares of our common stock. Subsequently, KKR sold its remaining shares on the open market. At December 31, 2009, Oaktree and MTS owned in the aggregate approximately 47.1% of the outstanding shares of common stock of the Company.

Recent Transactions

Effective October 1, 2007, we purchased the assets of Diagnostic Radiology Systems, Inc., a mobile provider of MRI and PET/CT, with operations in a certificate of need state. The purchase price consisted of $8.6 million in cash and transaction costs. The acquisition was financed using internally generated funds. As a result of this acquisition, we recorded goodwill of $2.1 million and acquired intangible assets of $2.2 million, of which $1.5 million was assigned to customer contracts, which is amortized over eight years, $0.5 million was assigned to the non-compete agreement, which was amortized over one year, and $0.2 million was assigned to certificates of needs, which have indefinite useful lives and are not subject to amortization. The intangible assets were recorded at fair value at the acquisition date. All recorded goodwill and intangible assets are capitalized for tax purposes and amortized over 15 years. The preliminary values above were subject to adjustment for up to one year after the close of the transaction due to additional information that could result in changes in the original valuation of assets acquired and liabilities assumed. During the year ended December 31, 2008, the adjustments to goodwill as a result of changes in the original valuation of assets acquired and liabilities assumed were not material. The year ended December 31, 2007 included three months of operations from this acquisition. We have not included pro forma information as this acquisition did not have a material impact on our consolidated financial position or results of operations.

Effective November 2, 2007, we purchased the assets of eight radiation oncology centers in Alabama, Arkansas, Mississippi, and Missouri from Bethesda Resources, Inc., a wholly-owned subsidiary of Sonix, Inc. (the Bethesda transaction). Many of these centers are sole community providers and are located on or near hospital campuses. Several of these radiation oncology centers operate under certificates of need. The purchase price consisted of $36.5 million in cash and $0.8 million in assumed liabilities and transaction costs. The acquisition was financed using internally generated funds and capital leases. As a result of this acquisition, we recorded goodwill of $4.2 million and acquired intangible assets of $31.2 million, of which $2.2 million was assigned to the physician referral network, which is amortized over seven years and $29.0 million was assigned to certificates of need, which have indefinite useful lives and are not subject to amortization. The intangible assets were recorded at fair value at the acquisition date. All recorded goodwill and intangible assets are capitalized for tax purposes and amortized over 15 years. During the year ended December 31, 2008, we decreased goodwill by $0.1 million as a result of changes in the original valuation of assets acquired and liabilities assumed. The year ended December 31, 2007 included approximately two months of operations from this acquisition. We have not included pro forma information as this acquisition did not have a material impact on our consolidated financial position or results of operations.

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Effective November 5, 2007, we purchased all of the outstanding shares of the New England Health Enterprises Business Trust and all of the outstanding membership interests of New England Imaging Management, LLC, a fixed-site provider of MRI and CT, collectively referred to as New England Health Enterprises, or NEHE. NEHE operated seven fixed-site imaging centers and one mobile MRI system in Maine and Massachusetts. The purchase price consisted of $44.6 million in cash, $2.3 million in cash which is being held in an escrow account, and $4.6 million in assumed liabilities and transaction costs. The acquisition was financed using internally generated funds, borrowings under an Acquisition Credit Facility and capital leases. We recorded total goodwill of $19.3 million, which includes $10.9 million of goodwill related to deferred tax liabilities recorded for basis differences in intangible assets as a result of the acquisition. None of the goodwill recorded is deductible for tax purposes. We acquired intangible assets of $29.0 million, of which $15.7 million was assigned to the physician referral network, which is amortized over 15 years, $3.8 million was assigned to the non-compete agreement, which is amortized over five years, and $9.5 million was assigned to certificates of need held by NEHE, which have indefinite useful lives and are not subject to amortization. These assets were recorded at fair value at the acquisition date. At the date of acquisition, the acquisition included $2.3 million for a contingent payment which was being held in an escrow account, pending the resolution of claims for indemnification and contingent consideration based on certain performance target requirements, which were resolved over the one to three years following the acquisition date. During the year ended December 31, 2009, these contingencies were resolved and we recorded a decrease to goodwill of $0.6 million. We received $2.9 million from escrow during 2009. All contingencies have been resolved and all escrow amounts have been distributed as of December 31, 2009. The year ended December 31, 2007 included approximately two months of operations from this acquisition. We have not included pro forma information as this acquisition did not have a material impact on our consolidated financial position or results of operations.

On December 4, 2007, we issued an additional $150 million of our 7 1/4% Senior Subordinated Notes due 2012 (the new 7 1/4% Notes) in a transaction exempt from the registration requirements of the Securities Act of 1933, as amended. The new 7 1/4% Notes were issued at a discount of 8.5%, which was being amortized to interest expense through the maturity date of the notes. The new 7 1/4% Notes have terms that were substantially identical to our original 7 1/4% Notes, but were issued under a new indenture and are therefore a separate series of notes. We used a portion of the net proceeds from the issuance of the new 7 1/4% Notes to repay and terminate an Acquisition Credit Facility entered into to finance the NEHE acquisition (as described in Note 9 of the Notes to Consolidated Financial Statements in our Annual Report on Form 10-K for the year ended December 31, 2008). The remaining net proceeds were used for general corporate purposes, including acquisitions. The 7 1/4% Notes were substantially redeemed in December 2009, in conjunction with our Refinance Transaction, as discussed below. At December 31, 2009, $5.6 million of the 7 1/ 4% Notes were outstanding. The remaining balance of the 7 1/4% Notes was redeemed at par in January 2010.

In the first quarter of 2008, we purchased six CyberKnife® robotic radiosurgery facilities from Accuray, Inc (the CyberKnife transaction). The radiosurgery systems are currently providing radiosurgery services at hospitals located in California, Maryland, New Jersey and Tennessee. The purchase price totaled $10.3 million in cash and $0.7 million in transaction costs. The acquisition was financed using proceeds from the issuance of the new 7 1/4% Notes in December 2007. As a result of this acquisition, we recorded acquired intangible assets of $1.5 million, which was assigned to customer contracts and will be amortized over seven years. The intangible assets were recorded at fair value at the acquisition date. All recorded intangible assets are capitalized for tax purposes and amortized over 15 years. The year ended December 31, 2008 included approximately nine months of operations from this acquisition. We have not included pro forma information as this acquisition did not have a material impact on our consolidated financial position or results of operations.

In the third quarter of 2008, we purchased all of the outstanding membership interests of Medical Outsourcing Services, LLC (MOS), a mobile provider of PET/CT, based in Naperville, Illinois. MOS currently operates in nine states, including, Illinois, Indiana, Iowa, Michigan, Missouri, New Jersey, Ohio, Pennsylvania, and Wisconsin. The purchase price consisted of $17.3 million in cash, $2.5 million in cash which is being held in an escrow account, and $4.6 million in assumed liabilities and transaction costs. We financed this acquisition

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using internally generated funds and proceeds from the issuance of the new 7 1/4% Notes in December 2007. As a result of this acquisition, we recorded goodwill of $3.3 million and acquired intangible assets of $12.5 million, of which $3.9 million was assigned to the physician referral network, which is amortized over five years, $6.1 million was assigned to customer relationships, which is amortized over 10 years and $2.5 million was assigned to a non-compete agreement, which is amortized over three years. The intangible assets were recorded at fair value at the acquisition date. All recorded goodwill and intangible assets are capitalized for tax purposes and amortized over 15 years. The acquisition included $2.5 million for a contingent payment which is being held in an escrow account, pending the resolution of claims for indemnification, which is expected to be resolved over the three years following the acquisition date. When the contingencies are resolved and consideration is distributable from the escrow account, we will record the fair value of the consideration as additional purchase price to goodwill. During the year ended December 31, 2009, we increased goodwill by $0.1 million as a result of changes in the original valuation of assets acquired and liabilities assumed. The year ended December 31, 2008 included six months of operations from this acquisition. We have not included pro forma information as this acquisition did not have a material impact on our consolidated financial position or results of operations. Please also see further discussion in Note 12 of the Notes to the Consolidated Financial Statements in our Annual Report on Form 10-K for the year ended December 31, 2009.

In the third quarter of 2008, we purchased all of the outstanding membership interests of RAMIC Des Moines, LLC (RAMIC), a single modality center providing MRI services in West Des Moines, Iowa. The purchase price consisted of $7.2 million in cash, $0.6 million in cash which is being held in an escrow account, and $0.1 million in assumed liabilities and transaction costs. We financed this acquisition using internally generated funds and proceeds from the issuance of the new 7 1 /4% Notes in December 2007. As a result of this acquisition, we recorded goodwill of $2.9 million and acquired intangible assets of $2.6 million, of which $1.8 million was assigned to the physician referral network, which is amortized over five years and $0.8 million was assigned to certificates of need held by RAMIC, which have indefinite useful lives and are not subject to amortization. The intangible assets were recorded at fair value at the acquisition date. All recorded goodwill and intangible assets are capitalized for tax purposes and amortized over 15 years. The acquisition included $0.6 million for a contingent payment which was being held in an escrow account, pending the resolution of claims for indemnification. All contingencies have been resolved and all escrow amounts have been distributed as of December 31, 2009. During the year ended December 31, 2009, $0.6 million was released from escrow, which was recorded to goodwill as additional purchase price. The year ended December 31, 2008 included approximately five months of operations from this acquisition. We have not included pro forma information as this acquisition did not have a material impact on our consolidated financial position or results of operations.

In the fourth quarter of 2008, we purchased all of the outstanding membership interests of Shared PET Imaging, LLC (SPI), a mobile and fixed-site provider of PET and PET/CT, based in Canton, Ohio. SPI serves approximately 90 clients in thirteen states, including Ohio, Michigan, Indiana, Illinois, Florida, Pennsylvania, New York, Tennessee and South Carolina. The purchase price consisted of $34.1 million in cash, $2.0 million in cash which is being held in an escrow account, and $9.1 million in assumed liabilities and transaction costs. We financed this acquisition using internally generated funds and proceeds from the issuance of the new 7 1/4% Notes in December 2007. As a result of this acquisition, we recorded goodwill of $6.9 million and acquired intangible assets of $9.4 million, of which $0.5 million was assigned to the physician referral network, which is amortized over five years, $5.4 million was assigned to customer relationships, which is amortized over 13 years, $3.2 million was assigned to a non-compete agreement, which is amortized over three years, and $0.3 million was assigned to certificates of need held by SPI, which have indefinite useful lives and are not subject to amortization. The intangible assets were recorded at fair value at the acquisition date. All recorded goodwill and intangible assets are capitalized for tax purposes and amortized over 15 years. The acquisition included $2.0 million for a contingent payment which is being held in an escrow account, pending the resolution of claims for indemnification, which will be resolved over the 18 months following the acquisition date. When the contingencies are resolved and consideration is distributable from the escrow account, we will record the fair value of the consideration as additional purchase price to goodwill. During the year ended December 31, 2009, we increased goodwill by $0.4 million as a result of changes in the original valuation of assets acquired and

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liabilities assumed. The year ended December 31, 2008 included one month of operations from this acquisition. We have not included pro forma information as this acquisition did not have a material impact on our consolidated financial position or results of operations.

Also in the fourth quarter of 2008, we purchased the remaining 20% minority interest in AO. The total purchase price was $6.5 million, which consisted entirely of cash. We financed this acquisition using internally generated funds. As a result of this acquisition, we recorded goodwill of $4.5 million. All recorded goodwill is capitalized for tax purposes and amortized over 15 years.

During December 2009, we entered into and completed various debt related transactions in order to expand our borrowing capacity and extend the maturity of our debt (the Refinance Transaction). In order to accomplish this, we retired substantially all of our $300.0 million 7 1/4% senior subordinated notes due 2012 (the 7 1/4% Notes) through a cash tender offer (the Tender Offer) and repaid the balance of $351.6 million on our existing Tranche C1 term loan facility (the Old Term Loan). In conjunction with the Refinance Transaction we also entered into a new senior secured credit agreement (the New Credit Facility), comprised of a $460.0 million term loan (the New Term Loan) maturing June 2016 and a $120.0 million revolving facility (the New Revolving Credit Facility) maturing December 2014. Borrowings under the New Term Loan were issued at 98.0% of par, with the discount to par being amortized to interest expense and other, net through the maturity date of the loan. We also issued $190.0 million of 8% senior notes due 2016 (the 8% Notes) in a transaction that was exempt from the registration requirements of the Securities Act of 1933, as amended. The 8% Notes were issued at 98.69% of par, with the discount to par being amortized to interest expense and other, net through the maturity date of the notes. Borrowings under our credit facility bear interest through maturity at a variable rate based upon, at our option, either London InterBank Offered Rate (LIBOR) or the base rate (which is the highest of the administrative agent s prime rate, one-half of 1.00% in excess of the overnight federal funds rate, and 1.00% in excess of the one-month LIBOR rate), plus in each case, an applicable margin. With respect to the New Term Loan, the applicable margin for LIBOR loans is 3.50% per annum, and with respect to the New Revolving Credit Facility, the applicable margin for LIBOR loans ranges, based on the applicable leverage ratio, from 3.25% to 3.75% per annum, in each case, with a LIBOR floor of 2.00%. With respect to the New Term Loan, the applicable margin for base rate loans is 2.50% per annum, and with respect to the New Revolving Credit Facility, the applicable margin for base rate loans ranges, based on the applicable leverage ratio, from 2.25% to 2.75% per annum. We used the proceeds from these transactions and existing cash to complete the Tender Offer and purchase $294.4 million of the 7 1/4% Notes at a purchase price equal to 100.125% of the principal amount, together with the accrued interest to the purchase date. We also used the proceeds from these transactions to pay off the Old Term Loan and redeem the remaining $5.6 million of 7 1/4% notes in January 2010 at a redemption price equal to 100.0% of the principal amount, together with accrued interest to the redemption date. We incurred a loss on extinguishment of debt of $14.6 million related to the Refinance Transaction, which represents the tender premium and consent payment to redeem the 7 1/4% Notes, write-off of unamortized debt issuance costs related to the retired debt, and other fees and expenses.

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Results of Operations

The table below shows the components in our consolidated statements of operations as a percentage of revenues:

	Year Ended December 31,		
	2007	2008	2009
Revenues	100.0%	100.0%	100.0%
Costs and expenses:			
Cost of revenues, excluding depreciation and amortization	52.9	52.8	53.5
Selling, general and administrative expenses	12.8	12.6	13.4
Transaction costs			0.2
Severance and related costs	0.1	0.1	0.2
Depreciation expense	18.6	17.7	18.7
Amortization expense	1.2	1.7	2.2
Interest expense and other, net	9.5	9.8	9.1
Loss on extinguishment of debt		0.1	2.9
Other (income) and expense, net	(0.1)	(0.2)	(0.2)
Total costs and expenses	95.0	94.6	100.0
Income before income taxes and earnings from unconsolidated investees	5.0	5.4	
Income tax expense	2.6	2.4	0.1
Earnings from unconsolidated investees	(1.7)	(0.9)	(0.8)
Net income	4.1	3.9	0.7
Less: Net income attributable to noncontrolling interest, net of tax	(0.4)	(0.6)	(0.6)
Net income attributable to Alliance HealthCare Services, Inc.	3.7%	3.3%	0.1%

As noted previously, we have seen a continued decrease in our scan-based MRI revenues and we believe that scan-based MRI revenues from our shared- service operations will continue to decline in future years. The table below provides MRI statistical information for each of the years ended December 31:

	Year Ended December 31,		
	2007	2008	2009
MRI statistics			
Average number of total systems	307.9	303.7	280.1
Average number of scan-based systems	252.8	254.1	241.0
Scans per system per day (scan-based systems)	9.29	9.18	8.82
Total number of scan-based MRI scans	645,711	630,875	567,624
Price per scan	$ 364.78	$ 380.54	$ 383.58

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Over the past three years we have seen an increase in PET and PET/CT revenues. The table below provides PET and PET/CT revenue statistical information for each of the years ended December 31:

	Year Ended December 31,		
	2007	2008	2009
PET and PET/CT statistics			
Average number of scan-based systems	72.3	86.8	116.2
Scans per system per day	6.30	6.13	5.97
Total number of PET and PET/CT scans	115,870	141,513	180,824
Price per scan	$ 1,195	$ 1,178	1,098

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

	Year Ended December 31,		
	2007	2008	2009
Total MRI revenue	$ 265.3	$ 269.4	$ 238.5
PET/CT revenue	139.7	167.7	201.5
Radiation oncology, other modalities and other revenue	39.9	58.7	65.5
Total	$ 444.9	$ 495.8	$ 505.5

	Year Ended December 31,		
	2007	2008	2009
Total fixed-site imaging center revenue (in millions)	$ 78.1	$ 102.7	$ 113.1

Year Ended December 31, 2009 Compared to Year Ended December 31, 2008

Revenue increased $9.7 million, or 2.0%, to $505.5 million in 2009 compared to $495.8 million in 2008 due to an increase in PET/CT revenues, radiation oncology, other modalities and other revenue, partially offset by a decrease in MRI revenues. PET/CT revenue in 2009 increased $33.8 million, or 20.2%, compared to 2008. Total PET and PET/CT scan volumes increased 27.8% to 180,824 scans in 2009 from 141,513 scans in 2008, primarily as a result of the acquisition of SPI in the fourth quarter of 2008, the acquisition of MOS in the third quarter of 2008 and growth in our core PET business. The average number of PET and PET/CT systems in service increased to 116.2 systems in 2009 from 86.8 systems in 2008. These PET and PET/CT increases were partially offset by a 6.8% decline in the average price per PET and PET/CT scan, to $1,098 per scan in 2009 compared to $1,178 per scan in 2008. The decline in the average price per PET and PET/CT scan was primarily related to the SPI acquisition, which was largely wholesale in nature and had a lower average price per scan on acquired customer contracts, as well as normal levels of pricing pressure from our wholesale customers. Scans per system per day also decreased 2.6%, to 5.97 scans per system per day in 2009 from 6.13 scans per system per day in 2008. Radiation oncology, other modalities and other revenue increased $6.8 million, or 11.3%, to $65.5 million in 2009 compared to $58.7 million in 2008 primarily due to an increase in the number of radiation oncology centers on operation. MRI revenue decreased $30.9 million in 2009, or 11.4%. Scan-based MRI revenue decreased $22.4 million in 2009, or 9.3%, to $217.7 million in 2009 from $240.1 million in 2008. Scan-based MRI scan volume decreased 10.0% to 567,624 scans in 2009 from 630,875 scans in 2008, primarily due to a decrease in client demand. Scan-based systems in service decreased to 241.0 systems in 2009 from 251.4 systems in 2008. Average scans per system per day also decreased by 3.9% to 8.82 in 2009 from 9.18 in 2008. These decreases were partially offset by an increase in the average price per MRI scan. The average price per MRI scan increased to $383.58 per scan in 2009 from $380.54 per scan in 2008. Non-scan based MRI revenue decreased

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$8.5 million in 2009 compared to 2008 primarily due to a decline in the number of hospital construction projects and a decrease in the number of equipment upgrades occurring in the hospital market, both of which impact the demand for our non-scan based MRI business. Included in the revenue totals above is fixed-site imaging center revenues, which increased $10.4 million, or 10.1%, to $113.1 million in 2009 from $102.7 million in 2008.

We had 295 MRI systems at December 31, 2009 compared to 301 MRI systems at December 31, 2008. We had 126 PET and PET/CT systems at December 31, 2009 compared to 114 PET and PET/CT systems at December 31, 2008. We operated 116 fixed site imaging centers (including three in unconsolidated joint ventures) at December 31, 2009, compared to 105 fixed site imaging centers (including four in unconsolidated joint ventures) at December 31, 2008. We operated 25 radiation oncology centers (including two in unconsolidated joint ventures) at December 31, 2009, compared to 21 radiation oncology centers (including two in unconsolidated joint ventures) at December 31, 2008.

Cost of revenues, excluding depreciation and amortization, increased $8.6 million, or 3.3%, to $270.4 million in 2009 compared to $261.8 million in 2008. Medical supplies increased $5.8 million, or 24.6%, primarily as a result of an increase in the number of PET and PET/CT scans, which use a radiopharmaceutical as a component of the PET and PET/CT scan. Maintenance and related costs increased $5.7 million, or 10.6%, due to an increase in service costs related to an increase in the number of PET/CT systems in operation and the addition of radiation oncology systems. Compensation and related employee expenses increased $2.2 million, or 1.8%, primarily as a result of an increase in average headcount related to acquisitions completed in the second half of 2008. Fuel expenses decreased $2.7 million, or 34.0%, primarily due to a decrease in the average price per gallon of diesel fuel costs. Equipment rental costs decreased $2.2 million, or 43.8%, 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 $0.2 million, or 0.7%. Cost of revenues, as a percentage of revenue, increased to 53.5% in 2009 from 52.8% in 2008 as a result of the factors described above.

Selling, general and administrative expenses increased $4.9 million, or 7.7%, to $67.6 million in 2009 compared to $62.7 million in 2008. Compensation and related employee expenses increased $4.2 million, or 11.7%, as a result investments in the infrastructure of the oncology division and an increase in average headcount related to acquisitions completed in the second half of 2008. Office expenses increased $0.8 million, or 14.6%, due to an increase in information technology expenses and other office expenses. Professional services expenses increased $0.8 million, or 9.4%, due to an increase in legal and other professional fees. Share-based payment increased $0.7 million, or 14.0%, due to new equity awards granted in 2009. The provision for doubtful accounts decreased $1.9 million, or 44.3%, primarily due to the collections of aged wholesale receivables and a reduction in bad debt related to our retail receivables. The provision for doubtful accounts, as a percentage of revenue, was 0.5% of revenue in 2009 compared to 0.9% in 2008. All other selling, general and administrative expenses increased $0.3 million, or 6.5%. Selling, general and administrative expenses as a percentage of revenue were 13.4% and 12.7% in 2009 and 2008, respectively.

Transaction costs were $0.9 million due to acquisition-related costs, which are now required to be expensed.

We recorded severance and related costs of $1.4 million in 2009 compared to $0.6 million in 2008.

Depreciation expense increased $7.2 million, or 8.2%, to $94.9 million in 2009 compared to $87.7 million in 2008 as a result of fixed assets acquired in connection with our acquisitions in the second half of 2008.

Amortization expense increased by $2.3 million, or 26.5%, to $11.0 million in 2009 compared to $8.7 million in 2008, primarily due to the incremental amortization expense for intangible assets acquired in conjunction with our acquisitions in the second half of 2008.

Interest expense and other, net, decreased $2.5 million, or 5.2%, to $45.9 million in 2009 compared to $48.4 million in 2008. This decrease was primarily due to lower average rates on our credit facility.

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We recorded a loss on extinguishment of debt of $14.6 million in 2009 related to the Refinance Transaction, compared to $0.1 million in 2008.

Income tax expense was $0.3 million and $11.8 million in 2009 and 2008, respectively, resulting in effective tax rates of 39.0% and 41.6% in 2009 and 2008, respectively. Our effective tax rates were higher than the federal statutory rates principally as a result of various permanent non-deductible tax items, including share-based payments, unrecognized tax benefits and other permanent differences.

Earnings from unconsolidated investees decreased by $0.8 million, or 16.8%, to $3.8 million in 2009 compared to $4.6 million in 2008 due to a decrease in earnings from our unconsolidated investees.

Net income attributable to noncontrolling interest increased $0.1 million, or 1.1%, to $3.1 million in 2009 compared to $3.0 million in 2008, due to an increase in earnings from our consolidated subsidiaries.

Net income attributable to Alliance HealthCare Services, Inc. was $0.5 million, or $0.01 per share on a diluted basis, in 2009 compared to $16.5 million, or $0.32 per share on a diluted basis, in 2008.

Year Ended December 31, 2008 Compared to Year Ended December 31, 2007

Revenue increased $50.9 million, or 11.4%, to $495.8 million in 2008 compared to $444.9 million in 2007 due to an increase in PET/CT revenues, radiation oncology, other modalities and other revenue, and MRI revenues. PET/CT revenue in 2008 increased $28.0 million, or 20.0%, compared to 2007. Total PET and PET/CT scan volumes increased 22.1% to 141,513 scans in 2008 from 115,870 scans in 2007, primarily as a result of the acquisition of MOS in the third quarter of 2008, growth in our core PET business, and the acquisition of SPI in the fourth quarter of 2008. The average number of PET and PET/CT systems in service increased to 86.8 systems in 2008 from 72.3 systems in 2007. These PET and PET/CT increases were partially offset by a 1.4% decline in the average price per PET and PET/CT scan, to $1,178 per scan in 2008 compared to $1,195 per scan in 2007. Scans per system per day also decreased 2.7%, to 6.13 scans per system per day in 2008 from 6.30 scans per system per day in 2007. Radiation oncology, other modalities and other revenue increased $18.8 million, or 47.1%, to $58.7 million in 2008 compared to $39.9 million in 2007 primarily due to an increase in radiation oncology revenue generated by the Bethesda transaction and the CyberKnife transaction. MRI revenue increased $4.1 million in 2008, or 1.5%. Scan-based MRI revenue increased $4.5 million in 2008, or 1.9%, to $240.1 million in 2008 from $235.6 million in 2007. This increase is primarily a result of the acquisition of NEHE, which generates retail revenue, which resulted in an increase in the average price per MRI scan from $380.54 per scan in 2008 compared to $364.78 per scan in 2007. Scan-based systems in service increased to 254.1 systems in 2008 from 252.8 systems in 2007. These increases were partially offset by a 2.3% decrease in our scan-based MRI scan volume. Scan-based MRI scan volume decreased to 630,875 scans in 2008 from 645,711 scans in 2007, primarily due to a decrease in client demand. Average scans per system per day also decreased by 1.2% to 9.18 in 2008 from 9.29 in 2007. Non-scan based MRI revenue decreased $0.4 million in 2008 compared to 2007. Included in the revenue totals above is fixed-site imaging center revenues, which increased $24.6 million, or 31.5%, to $102.7 million in 2008 from $78.1 million in 2007.

We had 301 MRI systems at December 31, 2008 compared to 310 MRI systems at December 31, 2007. We had 114 PET and PET/CT systems at December 31, 2008 compared to 79 PET and PET/CT systems at December 31, 2007. We operated 105 fixed site imaging centers (including four in unconsolidated joint ventures) at December 31, 2008, compared to 88 fixed site imaging centers (including five in unconsolidated joint ventures) at December 31, 2007. We operated 21 radiation oncology centers (including two in unconsolidated joint ventures), compared to 12 radiation oncology centers (including two in unconsolidated joint ventures) at December 31, 2007.

Cost of revenues, excluding depreciation and amortization, increased $26.3 million, or 11.2%, to $261.8 million in 2008 compared to $235.5 million in 2007. Compensation and related employee expenses

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increased $10.6 million, or 9.4%, primarily as a result of an increase in average headcount related to acquisitions completed in the fourth quarter of 2007 and the last half of 2008. Medical supplies increased $4.6 million, or 24.1%, primarily as a result of an increase in the number of PET and PET/CT scans, which use a radiopharmaceutical as a component of the PET and PET/CT scan. Maintenance and related costs increased $4.2 million, or 8.5%, due to an increase in service costs related to the addition of radiation oncology systems and an increase in the number of PET/CT systems in operation. Fuel expenses increased $1.8 million, or 30.5%, primarily due to an increase in the average price per gallon of diesel fuel costs. Site fees increased $1.8 million, or 42.4%, primarily as a result of an increase in the average number of retail fixed-site imaging centers in operation. Outside medical services increased $0.9 million, or 10.3%, primarily as a result of an increase in radiologist service costs associated with the NEHE acquisition. License, taxes and other fees increased $0.7 million, or 15.9%, primarily due to an increase in property taxes related to an increase in PET/CT and radiation oncology systems in use. Equipment rental costs increased $0.5 million, or 11.7%, primarily due to an increase in the number of rental PET/CT systems in use related to the MOS acquisition. Marketing costs increased $0.2 million, or 49.5%, as a result of increased marketing campaigns. All other cost of revenues, excluding depreciation and amortization, increased $1.0 million, or 3.8%. Cost of revenues, as a percentage of revenue, decreased to 52.8% in 2008 from 52.9% in 2007 as a result of the factors described above, offset by a decrease in total fixed costs as a percentage of revenue, due to an increase in revenue.

Selling, general and administrative expenses increased $5.7 million, or 10.0%, to $62.7 million in 2008 compared to $57.0 million in 2007. Compensation and related employee expenses increased $2.8 million, or 8.5%, primarily as a result of an increase in average headcount related to acquisitions completed in the fourth quarter of 2007 and the last half of 2008. Share-based payment increased $1.4 million, or 36.7%, in 2008 from 2007 due to new equity awards granted in 2008. The provision for doubtful accounts increased $0.3 million, or 6.7%, due to an increase in the provision for doubtful accounts related to increased retail revenue generated from acquisitions completed in the fourth quarter of 2007 and third quarter of 2008. The provision for doubtful accounts, as a percentage of revenue, was 0.9% in both 2008 and 2007. All other selling, general and administrative expenses increased $1.2 million, or 7.5%. Selling, general and administrative expenses as a percentage of revenue were 12.7% and 12.8% in 2008 and 2007, respectively.

We recorded severance and related costs of $0.6 million in 2008 and $0.7 million in 2007.

Depreciation expense increased $5.0 million, or 6.1%, to $87.7 million in 2008 compared to $82.7 million in 2007 as a result of fixed assets acquired in connection with our acquisitions in the fourth quarter of 2007 and 2008.

Amortization expense increased by $3.5 million, or 67.4%, to $8.7 million in 2008 compared to $5.2 million in 2007, primarily due to the incremental amortization expense for intangible assets acquired in conjunction with our acquisitions in the fourth quarter of 2007 and the last half of 2008.

Interest expense and other, net, increased $6.0 million, or 14.2%, to $48.4 million in 2008 compared to $42.4 million in 2007. This increase was primarily related to incremental interest expense associated with the $150.0 million 7 1/4% Senior Subordinated Note offering completed in the fourth quarter of 2007 and a $2.4 million non-cash fair value adjustment related to our interest rate swap agreement with LCPI, partially offset by lower interest rates.

Income tax expense was $11.8 million and $11.6 million in 2008 and 2007, respectively, resulting in effective tax rates of 41.6% and 41.8% in 2008 and 2007, respectively. Our effective tax rates were higher than the federal statutory rates principally as a result of state income taxes and various permanent non-deductible tax items, including share-based payments, unrecognized tax benefits and other permanent differences.

Earnings from unconsolidated investees decreased by $3.0 million, or 39.1%, to $4.6 million in 2008 compared to $7.6 million in 2007, primarily due to a $2.0 million gain on sale from a sale/leaseback transaction in one of our unconsolidated investees, as well as a $0.5 million gain on the sale of real estate during 2007.

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Net income attributable to noncontrolling interest increased $1.3 million, or 75.5%, to $3.0 million in 2008 compared to $1.7 million in 2007, due to an increase in earnings from our consolidated subsidiaries.

Net income attributable to Alliance HealthCare Services, Inc. was $16.5 million, or $0.32 per share on a diluted basis, in 2008 compared to $16.2 million, or $0.31 per share on a diluted basis, in 2007.

Liquidity and Capital Resources

Our primary source of liquidity is cash provided by operating activities. We generated $139.1 million and $130.1 million of cash flow from operating activities in 2009 and 2008, 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 $1.9 million for the year ended December 31, 2009 compared to the year ended December 31, 2008. Our number of days of revenue outstanding for our accounts receivable was 48 days and 49 days as of December 31, 2009 and 2008, respectively, which we believe is favorable compared to other diagnostic imaging and radiation oncology providers.

We used cash of $60.5 million and $151.3 million for investing activities in 2009 and 2008, respectively. Investing activities in 2009 and 2008 includes cash used for acquisitions of $0.8 million and $75.2 million, respectively. Investing activities in 2009 include $2.9 million provided by a decrease in cash in escrow, while investing activities in 2008 include $5.1 million in cash used by an increase in cash in escrow. We expect to continue to use cash for acquisitions in the future. Other than acquisitions, our primary use of capital resources is to fund capital expenditures. We incur capital expenditures for the purposes of:

- purchasing new systems;
- replacing less advanced systems with new systems; and
- providing upgrades of our MRI, PET and PET/CT, and radiation oncology systems and upgrading our corporate infrastructure for future growth.

Capital expenditures totaled $73.8 million and $66.2 million for the years ended December 31, 2009 and 2008, respectively. During 2009 we purchased 22 MRI systems and 16 PET/CT systems. We traded-in or sold a total of 55 systems during 2009. 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 2010 and finance substantially all of these purchases with our available cash, cash from operating activities, our revolving line of credit, and equipment leases. Based upon the client demand described above, which dictates the type of equipment purchased, we expect cash capital expenditures to total approximately $65 to $75 million in 2010.

At December 31, 2009, we had cash and cash equivalents of $111.9 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 can provide no assurances that access to our invested cash and cash equivalents will not be impacted by adverse conditions in the financial markets.

At December 31, 2009, we had $106.9 million in our accounts that are with third party financial institutions which 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

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impacted 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.

In connection with the 1999 acquisition of Alliance by an affiliate of KKR, we entered into a $616.0 million credit agreement consisting of a $131.0 million Tranche A Term Loan Facility, a $150.0 million Tranche B Term Facility, a $185.0 million Tranche C Term Loan Facility and a Revolving Loan Facility. On June 11, 2002, we entered into a second amendment to the credit agreement and completed a $286.0 million refinancing of our Tranche B and C term loan facility. Under the terms of the amended term loan facility, we received proceeds of $286.0 million from a new Tranche C term loan facility, and used the entire amount of the proceeds to retire $145.5 million and $140.5 million owed under Tranche B and C of our existing term loan facility, respectively. The new Tranche C borrowing rate was decreased to LIBOR plus 2.375%.

In December 2004, we entered into a third amendment to our credit agreement which revised our Tranche C term loan facility (Old Term Loan) resulting in incremental borrowings of $154.0 million and decreased the maximum amount of availability under our existing revolving loan facility from $150.0 million to $70.0 million. We applied the proceeds from the amendment to retirement of $256.4 million of our $260.0 million 10 3/8% Senior Subordinated Notes due 2011 (the 10 3/8% Notes) through a cash tender offer (the 2004 Tender Offer , as described in Note 9 of the Notes to Consolidated Financial Statements in our Annual Report on Form 10-K for the year ended December 31, 2009). The amended Old Term Loan borrowing rate decreased to LIBOR plus 2.250%. On December 19, 2005 we entered into a fourth amendment to our Credit Agreement which revised our maximum consolidated leverage ratio covenant to a level not to exceed 4.00 to 1.00 as of the last day of any fiscal quarter until the expiration of the agreement. Prior to the fourth amendment, our maximum consolidated leverage ratio covenant was 3.75 to 1.00 as of the last day of any fiscal quarter beginning March 31, 2006 to the expiration of the agreement. The fourth amendment also required us to maintain a maximum consolidated senior leverage ratio covenant at a level not to exceed 3.00 to 1.00 as of the last day of any fiscal quarter. The amendment increased the Old Term Loan LIBOR margin from an annual rate of 2.250% to 2.500%. In connection with the amendment, we incurred an amendment fee of $0.6 million.

In December 2004, we completed the 2004 Tender Offer and redeemed $256.4 million of our outstanding 10 3/8% Notes. During 2008, we paid the remaining balance of $3.5 million related to the 10 3/8% Notes, which had an original balance of $260.0 million. In 2008, we used cash flow from operating activities to pay down $15.0 million under the Old Term Loan.

In December 2009, we entered into a new senior secured credit agreement (the New Credit Facility), comprised of a $460.0 million term loan (the New Term Loan) maturing June 2016 and a $120.0 million revolving facility (the New Revolving Credit Facility) maturing December 2014. Borrowings under the New Term Loan were issued at 98.0% of par, with the discount to par being amortized to interest expense and other, net through the maturity date of the loan. We used the proceeds from the New Term Loan to retire $351.6 million of our Old Term Loan. Borrowings under the New Credit Facility bear interest through maturity at a variable rate based upon, at our option, either London InterBank Offered Rate (LIBOR) or the base rate (which is the highest of the administrative agent s prime rate, one-half of 1.00% in excess of the overnight federal funds rate, and 1.00% in excess of the one-month LIBOR rate), plus in each case, an applicable margin. With respect to the New Term Loan, the applicable margin for LIBOR loans is 3.50% per annum, and with respect to the New Revolving Credit Facility, the applicable margin for LIBOR loans ranges, based on the applicable leverage ratio, from 3.25% to 3.75% per annum, in each case, with a LIBOR floor of 2.00%. With respect to the New Term Loan, the applicable margin for base rate loans is 2.50% per annum, and with respect to the New Revolving Credit Facility, the applicable margin for base rate loans ranges, based on the applicable leverage ratio, from 2.25% to 2.75% per annum.

At December 31, 2009, we did not have any borrowings outstanding under the New Revolving Credit Facility. As of December 31, 2009, we had $115.5 million of available borrowings under our New Revolving Credit Facility. In addition to other covenants, the New Credit Facility places limits on our and our subsidiaries

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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. The New Credit Facility also contains financial covenants requiring us to maintain (i) a maximum ratio of consolidated total debt to consolidated adjusted EBITDA that ranges from 4.75 to 1.00 to 4.00 to 1.00 and (ii) a minimum ratio of consolidated adjusted EBITDA to consolidated interest expense of 2.75 to 1.00. Within 180 days after the closing date of the New Credit Facility, which occurred December 1, 2009, we are required to enter into agreements such as interest rate swaps, caps, floors and other interest rate exchange contracts that would have the effect of fixing a specified percentage of our variable rate debt for periods to be determined.

As of December 31, 2009, we are in compliance with all covenants contained in our New Credit Facility and expect that we will be in compliance with these covenants in 2010. However, if we are unable to generate sufficient Consolidated Adjusted EBITDA, as defined in our credit agreement, or manage our indebtedness to sufficient levels, we could be out of compliance with our maximum consolidated leverage ratio and maximum consolidated senior leverage ratio. Our failure to comply with these covenants could permit the lenders under the credit agreement to declare all amounts borrowed under the agreement, together with accrued interest and fees, to be immediately due and payable. If the indebtedness under the New Credit Facility is accelerated, we may not have sufficient assets to repay amounts due under the credit facility. If we are not able to refinance our debt, we could become subject to bankruptcy proceedings.

In December 2004, we issued $150.0 million of our 7 1/4% Senior Subordinated Notes due 2012 (the original 7¼% Notes) in a transaction exempt from the registration requirements of the Securities Act of 1933, as amended, and applied the proceeds to repayment of a portion of our 10 3/8% Notes. The original 7 1/4% Notes were subsequently registered. On December 4, 2007, we issued an additional $150.0 million of our 7 1/4% Senior Subordinated Notes due 2012 (the new 7¼% Notes) in a transaction exempt from the registration requirements of the Securities Act. The new 7 1/4% Notes were subsequently registered. The new 7 1/4% Notes were issued at a discount of 8.5%, which was being amortized to interest expense through the maturity date of the notes. The new 7 1/4% Notes have terms that were substantially identical to our original 7 1/4% Notes, but were issued under a new indenture and are therefore a separate series of notes. We used a portion of the net proceeds from the issuance of the new 7 1/4% Notes to repay and terminate an Acquisition Credit Facility we entered into the previous month to finance the NEHE acquisition (as described in Note 9 to the Notes to Consolidated Financial Statements in our Annual Report on Form 10-K for the year ended December 31, 2009). The remaining net proceeds were used for general corporate purposes, including acquisitions. The original 7 1/4 % Notes and the new 7 1/4% Notes are collectively referred to as the 7¼% Notes.

In December 2009, we issued $190.0 million of 8.0% senior notes due 2016 (the 8% Notes) in a transaction that was exempt from the registration requirements of the Securities Act of 1933, as amended. The 8% Notes were issued at 98.690% of par, with the discount to par being amortized to interest expense and other, net through the maturity date of the notes. We used the proceeds from this transaction, the New Term Loan and existing cash to complete a Tender Offer and purchase $294.4 million of the 7 1/4% Notes at a purchase price equal to 100.125% of the principal amount, together with the accrued interest to the redemption date. We also used the proceeds from these transactions to redeem the remaining $5.6 million of 7 1/4% notes in January 2010 at a redemption price equal to 100.0% of the principal amount, together with accrued interest to the redemption date.

The indenture governing 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. The 8% Notes are unsecured senior obligations and are equal in right of payment to all existing and future senior debt, and rank senior in right of payment to all of our existing and future subordinated debt. The 8% Notes are effectively subordinated in right of payment to all of our existing and

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future secured indebtedness, including indebtedness under our New Credit Facility, to the extent of assets securing such indebtedness, and are effectively subordinated in right of payment to all obligations of our subsidiaries. As of December 31, 2009, we were in compliance with all covenants contained in the 8% Notes and forecast that we will be in compliance with these covenants in 2010. 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.

During 2004, we entered into interest rate swap agreements, with notional amounts of $56.8 million, $46.8 million and $48.4 million to manage the future cash interest payments associated with a portion of our variable rate bank debt. These agreements matured during 2007. We recorded changes in the fair value of the swaps through interest expense.

In the first quarter of 2005, we entered into multiple interest rate collar agreements for our variable rate bank debt. The total underlying notional amount of the debt was $178.0 million. Under these arrangements we purchased a cap on the interest rate of 4.00% and sold a floor of 2.25%. We paid a net purchase price of $1.5 million for these collars. These agreements were two and three years in length and matured at various dates between January 2007 and January 2008. We designated these collars as cash flow hedges of variable future cash flows associated with our long-term debt and recorded changes in the fair value of the collars through comprehensive income during the period these instruments were designated as hedges.

During the first quarter of 2008, we entered into two interest rate swap agreements with notional amounts of $92.7 million each, to hedge future cash interest payments associated with a portion of our variable rate bank debt (the 2008 swaps). Under the terms of these agreements, we receive three-month LIBOR and pay a fixed rate of 3.15%. The net effect of the hedges is to record interest expense at a fixed rate of 5.65%, as the debt incurred interest based on three-month LIBOR plus 2.50%. These agreements are three years in length and mature in 2011. See below for additional information regarding the 2008 swaps. As discussed below, we elected to terminate and replace one of the 2008 swaps in the first quarter of 2009.

On September 15, 2008, LHI filed for bankruptcy protection under Chapter 11 of the United States Bankruptcy Code. On October 6, 2008, LCPI filed for bankruptcy protection under Chapter 11 of the United States Bankruptcy Code. One of our 2008 swaps with a notional amount of $92.7 million, which expires January 31, 2011, is with LCPI (the Lehman Swap). As of September 12, 2008 hedge accounting was terminated and all further changes in the fair market value of the Lehman Swap are being recorded in interest expense and other. Comprehensive income (loss) related to effective unrealized gains or losses on the fair value of the Lehman Swap through September 12, 2008 remain in accumulated comprehensive income (loss) on the balance sheet and will be amortized into interest expense and other as the underlying interest payments are recognized in earnings. The Lehman Swap was valued using the income approach with observable Level 2 market expectations at the measurement date and standard valuation techniques to convert future amounts to a single discounted present amount. The fair market value of the Lehman Swap at September 30, 2008 was an asset of $0.7 million, which was adjusted to zero as collectability was deemed uncertain due to the LHI bankruptcy filing. We included the write down of the asset in interest expense and other for the year ended December 31, 2008.

During the first quarter of 2009, we replaced the Lehman Swap with an interest rate swap agreement which has a notional amount of $92.7 million (the 2009 Swap Replacement) and has been designated as a cash flow hedge of variable future cash flows associated with a portion of our long term debt. Under the terms of this agreement, which matures in January 2011, we receive three-month LIBOR and pay a fixed rate of 3.15%. The net effect of the hedges is to record interest expense at a fixed rate of 5.65%, as the debt incurs interest based on three-month LIBOR plus 2.50%.

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Additionally, during the first quarter of 2009, we entered into an interest rate swap agreement which had a notional amount of $56.8 million to hedge future cash interest payments associated with a portion of our variable rate bank debt (the New 2009 Swap). Under the terms of this agreement, which was to mature in November 2011, we received three-month LIBOR and paid a fixed rate of 2.07%. The net effect of the hedge was to record interest expense at a fixed rate of 4.57%, as the debt incurred interest based on three-month LIBOR plus 2.50%.

We elected to terminate one of the 2008 swaps and the New 2009 Swap in December 2009 in connection with entering into the Refinance Transaction on December 1, 2009. As a result of the Refinance Transaction, we de-designated the 2008 swap, the 2009 Swap Replacement and the New 2009 Swap and hedge accounting was terminated and all further changes in the fair market value of the terminated swaps are being recorded in interest expense and other. Comprehensive income (loss) related to effective unrealized gains or losses on the fair value of the terminated swaps through September 30, 2009 remain in accumulated comprehensive income (loss) on the balance sheet and will be amortized into interest expense and other as the underlying interest payments are recognized in earnings. The terminated swaps were valued using the income approach with observable Level 2 market expectations at the measurement date and standard valuation techniques to convert future amounts to a single discounted present amount.

The maturities of our long-term debt, including interest, future payments under our operating leases and binding equipment purchase commitments as of December 31, 2009 are as follows:

Contractual Obligations	2010	2011	2012	2013	2014	Thereafter	Total
				(in millions)			
New Term Loan	$ 30.0	$ 29.7	$ 29.4	$ 29.1	$ 28.9	$ 470.9	$ 618.0
8% Senior Notes	15.2	15.2	15.2	15.2	15.2	220.5	296.5
7 1/4% Senior Subordinated Notes	0.4	0.4	6.0				6.8
Equipment Loans	8.1	5.9	4.7	4.2	3.3	1.6	27.8
Operating Leases	4.5	3.1	2.6	1.5	1.4	3.4	16.5
Letters of Credit	4.5						4.5
Equipment Purchase Commitments	18.8						18.8
Total Contractual Obligation Payments	81.5	54.3	57.9	50.0	48.8	696.4	988.9
Less Amount Representing Interest	(42.4)	(41.7)	(41.1)	(40.2)	(39.7)	(64.5)	(269.6)
Present Value of Future Contractual Obligations	$ 39.1	$ 12.6	$ 16.8	$ 9.8	$ 9.1	$ 631.9	$ 719.3

The remaining $5.6 million of 7 1/4% notes were redeemed in January 2010 at a redemption price equal to 100.0% of the principal amount, together with accrued interest to the redemption date.

Our liability for unrecognized tax benefits of $1,329 at December 31, 2009 has been omitted from the above table because we cannot determine with certainty when this liability will be settled. It is reasonably possible that the amount of liability for unrecognized tax benefits will change in the next twelve months; however, 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. Under current tax law, we expect to utilize all of our net operating loss carryforwards (NOLs) by 2010, and therefore anticipate being in a tax paying position with respect to a portion of our income in 2010. However, legislation is currently pending which may extend the federal bonus depreciation deduction through December 31, 2010. If extended, we may have NOL carryforwards into 2011. 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

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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, it is possible we would have to limit planned activities or sell assets to obtain liquidity.

Off-Balance Sheet Arrangements

As of December 31, 2009, we were a party to interest rate swap agreements related to $92.7 million of outstanding principal on our variable rate debt. See Quantitative and Qualitative Disclosures about Market Risk below.

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 which we believe are the most critical to aid in fully understanding and evaluating our reported financial results include the following:

Revenue Recognition

The majority of our revenues is derived directly from healthcare providers and is primarily for imaging services. To a lesser extent, revenues are generated from direct billings to patients or their medical payors which are recorded 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 11%, 21% and 20% of revenues in the years ended December 31, 2007, 2008 and 2009, 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 such 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 impact on our operating results. As the price is predetermined, all revenues are recognized at the time the delivery of imaging service has occurred 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 located throughout the United States. Services are generally provided pursuant to long-term contracts with hospitals and other healthcare providers or directly to patients, and generally collateral is not required. Receivables generally are collected 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. While such 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 impact on our operating results.

Goodwill and Long-Lived Assets

ASC 350, Intangibles Goodwill and Other (formerly SFAS No. 142, Goodwill and Other Intangible Assets) requires that goodwill and intangible assets with indefinite useful lives not be amortized, but instead be

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tested for impairment at least annually. In accordance with ASC 350, we have selected to perform an annual impairment test for goodwill and intangible assets with indefinite lives based on the financial information as of September 30, or more frequently when an event occurs or circumstances change to indicate an impairment of these assets has possibly occurred. Goodwill and intangible assets with indefinite lives are allocated to our various reporting units, which are our geographical regions. ASC 350 requires us to compare the fair value of the reporting unit to its carrying amount on an annual basis to determine if there is potential impairment. If the fair value of the reporting unit is less than its carrying value, an impairment loss is recorded to the extent that the implied fair value of the goodwill and intangible assets with indefinite lives within the reporting unit are less than the carrying value. The fair value of the reporting unit is determined based on discounted cash flows, market multiples or appraised values as appropriate. We comply with periodic impairment test procedures. In 2007, 2008 and 2009 we concluded that the fair value of each reporting unit exceeds its carrying value, indicating no goodwill or intangible asset impairment was present. No triggering events occurred during the fourth quarters of 2007, 2008 and 2009 which required an additional impairment test as of December 31, 2007, 2008 or 2009. 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 (formerly SFAS No. 144, Accounting for the Impairment or Disposal of Long-Lived Assets). In 2007, 2008 and 2009 we concluded that no impairment was present in our intangible assets with definite useful lives.

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

FASB ASC 805, Business Combinations (formerly SFAS 141(R)) significantly changes the accounting for business combinations. Under ASC 805, an acquiring entity is required to recognize all the assets acquired and liabilities assumed in a transaction at the acquisition-date fair value with limited exceptions. ASC 805 changes the accounting treatment for certain specific items, including:

- Acquisition costs will be generally expensed as incurred;
- Noncontrolling interests (formerly known as minority interests see ASC 810 discussion below) will generally be valued at fair value at the acquisition date;
- Restructuring costs associated with a business combination will generally be expensed subsequent to the acquisition date; and
- Changes in deferred tax asset valuation allowances and income tax uncertainties after the acquisition date generally will affect income tax expense.

ASC 805 also includes a substantial number of new disclosure requirements. ASC 805 applies prospectively to business combinations for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after December 15, 2008. Earlier adoption is prohibited. The Company adopted ASC 805 on January 1, 2009. The adoption of ASC 805 did not have a material impact on the Company s results of

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operations, cash flows or financial position for the year ended December 31, 2009, except for the presentation of transaction costs as a line in the statements of operations.

FASB ASC 805 (formerly FSP No. FAS 141(R)-1, Accounting for Assets Acquired and Liabilities Assumed in a Business Combination That Arise from Contingencies) is effective for contingent assets or contingent liabilities acquired in business combinations for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after December 15, 2008. The adoption of this standard did not have a material impact on the Company s results of operations, cash flows or financial position for the year ended December 31, 2009.

FASB ASC 810, Consolidation (formerly SFAS 160) establishes new accounting and reporting standards for the noncontrolling interest in a subsidiary and for the deconsolidation of a subsidiary. Specifically, this statement requires the recognition of a noncontrolling interest (minority interest) as equity in the consolidated financial statements and separate from the parent s equity. The amount of net income attributable to the noncontrolling interest is included in consolidated net income on the face of the income statement. ASC 810 clarifies that changes in a parent s ownership interest in a subsidiary that do not result in deconsolidation are equity transactions if the parent retains its controlling financial interest. In addition, this statement requires that a parent recognize a gain or loss in net income when a subsidiary is deconsolidated. Such gain or loss will be measured using the fair value of the noncontrolling equity investment on the deconsolidation date. ASC 810 also includes expanded disclosure requirements regarding the interests of the parent and its noncontrolling interest. The Company adopted ASC 810 on January 1, 2009. The adoption of ASC 810 did not have a material impact on the Company s results of operations, cash flows or financial position for the year ended December 31, 2009; however, there may be an impact on future transactions. The adoption of ASC 810 changed the presentation of noncontrolling interest to a component of stockholders equity, rather than a liability, at December 31, 2009, and the corresponding amount as of December 31, 2008 was reclassified. In addition, ASC 810 required the presentation of net income attributable to noncontrolling interest, rather than minority interest expense, for the years ended December 31, 2007, 2008 and 2009. In conformity with the current year presentation under ASC 810, the Company has reclassified Noncontrolling interest in subsidiaries from the operating section to the financing section of the Statement of Cash Flows for the years ended December 31, 2007 and 2008.

FASB ASC 815, Derivatives and Hedging (formerly SFAS No. 161, Disclosure about Derivative Instruments and Hedging Activities An Amendment of FASB Statement No. 133) enhances the current guidance on disclosure requirements for derivative instruments and hedging activities. This statement requires that objectives for using derivative instruments be disclosed in terms of underlying risk and accounting designation. Specifically, ASC 815 requires disclosure about (a) how and why an entity uses derivative instruments, (b) how derivative instruments and related hedged items are accounted for under ASC 815 and its related interpretations, and (c) how derivative instruments and related hedged items affect an entity s financial position, financial performance, and cash flow. This statement requires qualitative disclosure about the objectives and strategies for using derivatives in terms of the risks that the entity is intending to manage, quantitative disclosures about fair value amounts of gains and losses on derivative instruments in a tabular format, and disclosures about credit-risk-related contingent features in derivative agreements to provide information on potential effect on an entity s liquidity from using derivatives. The derivative instruments shall be distinguished between those used for risk management purposes and those used for other purposes. ASC 815 is effective for fiscal years, and interim periods within those fiscal years, beginning after November 15, 2008, with early application encouraged. The Company adopted the provisions of ASC 815 on January 1, 2009. The adoption of ASC 815 did not have a material impact on the Company s results of operations, cash flows or financial position for the year ended December 31, 2009.

FASB ASC 260, Earnings Per Share (formerly FSP 03-6-1) addresses whether instruments granted in share-based payment transactions are participating securities prior to vesting and therefore need to be included in the earnings allocation in calculating earnings per share under the two-class method described in ASC 260. ASC 260 requires companies to treat unvested share-based payment awards that have non-forfeitable rights to

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dividend or dividend equivalents as a separate class of securities in calculating earnings per share. ASC 260 is effective for fiscal years beginning after December 15, 2008 and is to be applied retrospectively. The Company adopted the provisions of ASC 260 on January 1, 2009. The Company granted and expects to continue to grant restricted stock awards to its officers and non-employee directors that contain non-forfeitable rights to dividend and dividend equivalents. Such awards are considered participating securities under ASC 260. As such, the Company is required to include these awards in the calculation of the Company s basic earnings per share and will need to calculate basic earnings per share using the two-class method. Restricted stock awards have previously been included in the Company s dilutive earnings per share calculation using the treasury stock method. The two-class method of computing earnings per share is an earnings allocation formula that determines earnings per share for each class of common stock and participating security according to dividends declared (or accumulated) and participation rights in undistributed earnings. The Company has historically not paid and does not expect to pay dividends in the foreseeable future; however, the Company must still allocate undistributed earnings between common shareholders and participating securities based on the contractual rights of each security, as if all the earnings for the period have been distributed. Since the adoption of ASC 260 was applied retrospectively, the earnings per share for prior periods was recalculated to conform to the current year presentation. The weighted-average number of shares used in the basic earnings per share calculation for the years ended December 31, 2007 and 2008 have been recalculated using the two-class method to conform to the current year presentation.

FASB ASC 825, Financial Instruments (formerly FSP No. FAS 107-1 and Accounting Principles Board (APB) Opinion No. 28-1, Interim Disclosures about Fair Value of Financial Instruments) requires disclosures about the fair value of financial instruments in interim financial statements as well as in annual financial statements. ASC 825 is effective for periods ending after June 15, 2009. The Company adopted ASC 825 during the interim period ended June 30, 2009.

FASB ASC 855, Subsequent Events (formerly SFAS No. 165, Subsequent Events) enhances the current guidance on accounting and disclosure requirements for subsequent events. This statement requires the disclosure of the date through which an entity has evaluated subsequent events and the basis for that date, that is, whether that date represents the date the financial statements were issued or were available to be issued. ASC 855 is effective for interim periods and annual financial periods ending after June 15, 2009. The adoption of ASC 855 did not have a material impact on the Company s results of operations, cash flows or financial position for the year ended December 31, 2009.

Accounting Standards Update (ASU) No. 2009-17 (ASU 2009-17) (formerly SFAS No. 167, Amendments to FASB Interpretation No. 46 (R)) enhances the current guidance on disclosure requirements for companies with financial interest in a variable interest entity. ASU 2009-17 replaces the quantitative-based risks and rewards calculation for determining which enterprise, if any, has a controlling financial interest in a variable interest entity with an approach focused on identifying which enterprise has the power to direct the activities of a variable interest entity that most significantly impact the entity s economic performance and (a) the obligation to absorb losses of the entity or (b) the right to receive benefits from the entity. ASU 2009-17 requires an additional reconsideration event when determining whether an entity is a variable interest entity when any changes in facts and circumstances occur such that the holders of the equity investment at risk, as a group, lose the power from voting rights or similar rights of those investments to direct the activities of the entity that most significantly impact the entity s economic performance. It also requires ongoing assessments of whether an enterprise is the primary beneficiary of a variable interest entity. ASU 2009-17 requires additional disclosures about an enterprise s involvement in variable interest entities. ASU 2009-17 is effective for fiscal years beginning after November 15, 2009, with early application prohibited. The Company adopted the provisions of ASU 2009-17 on January 1, 2010. The adoption of ASU 2009-17 did not have a material impact on the Company s results of operations, cash flows or financial position.

FASB ASC 105, Generally Accepted Accounting Principles [formerly SFAS No. 168, The FASB Accounting Standards Codification and the Hierarchy of Generally Accepted Accounting Principles] is the

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single source of authoritative GAAP in the United States. The previous GAAP hierarchy consisted of four levels of authoritative accounting and reporting guidance levels. The ASC eliminated this hierarchy and replaced the previous GAAP with just two levels of literature: authoritative and non-authoritative. The ASC was effective as of July 1, 2009.

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 has interest rates which are variable. The recorded carrying amount of our long-term debt under our New Credit Facility approximates fair value as these 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 collar agreements for a portion of our variable rate debt. These swaps and collars are designated as cash flow hedges of variable future cash flows associated with our long-term debt. Within 180 days after the closing date of the New Credit Facility, which occurred December 1, 2009, we are required to enter into agreements such as interest rate swaps, caps, floors and other interest rate exchange contracts that would have the effect of fixing a specified percentage of our variable rate debt for periods to be determined.

During 2004 we entered into interest rate swap agreements which had notional amounts of $56.8 million, $46.8 million and $48.4 million. Under the terms of these agreements, we received three-month LIBOR and paid a fixed rate of 3.15%, 3.89%, and 3.69%, respectively. The net effect was to record interest expense at fixed rates of 5.65%, 6.39% and 6.19% respectively, as the debt incurred interest based on three-month LIBOR plus 2.50%. For the year ended December 31, 2007, we received a net settlement amount of $1.2 million. The swap agreements matured during the second and fourth quarters of 2007.

During 2005 we entered into multiple interest rate collar agreements which had an aggregate notional amount of $178.0 million. Under the terms of these agreements, we purchased a cap on the interest rate of 4.00% and sold a floor of 2.25%. For the years ended December 31, 2008 and 2007, we received a net settlement amount of $0.3 and $2.0 million, respectively, on these collar agreements. The collar agreements matured at various dates between January 2007 and January 2008.

During the first quarter of 2008, we entered into two interest rate swap agreements with notional amounts of $92.7 million each, to hedge future cash interest payments associated with a portion of our variable rate bank debt (the 2008 swaps). Under the terms of these agreements, we receive three-month LIBOR and pay a fixed rate of 3.15%. The net effect of the hedges is to record interest expense at a fixed rate of 5.65%, as the underlying debt incurred interest based on three-month LIBOR plus 2.50%.For the years ended December 31, 2009 and 2008, we paid net settlement amounts of $1.5 million and $0.2 million, respectively, on these swap agreements. The 2008 swaps are three years in length and mature in 2011. See below for additional information regarding the 2008 swaps. As discussed below, we elected to terminate and replace one of the 2008 swaps in the first quarter of 2009.

The collar agreements and the 2008 swaps have been designated as cash flow hedges of variable future cash flows associated with our long-term debt. In accordance with ASC 815 (formerly SFAS 133, Accounting for Derivative Instruments and Hedging Activities), the collars and the 2008 swaps are, and will be, recorded at fair value. On a quarterly basis, the fair value of the collars and swaps will be determined based on quoted market prices and, assuming perfect effectiveness, the difference between the fair value and the book value of the collars will be recognized in comprehensive income, a component of shareholders equity. On a quarterly basis, the fair value of the 2008 swaps will be determined based on the income approach using observable Level 2 inputs under

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ASC 825 (formerly SFAS No. 157, Fair Value Measurements (SFAS 157)). The fair market value of the 2008 swaps will be recorded on the balance sheet as assets or liabilities with all effective changes deferred in comprehensive income. Any ineffectiveness of the collars and 2008 swaps is required to be recognized in earnings. The collars outstanding at December 31, 2007 matured during January 2008, and all counterparty obligations were met.

On September 15, 2008, LHI filed for bankruptcy protection under Chapter 11 of the United States Bankruptcy Code. On October 6, 2008, LCPI filed for bankruptcy protection under Chapter 11 of the United States Bankruptcy Code. One of our 2008 swaps with a notional amount of $92.7 million, which expires January 31, 2011, is with LCPI (the Lehman Swap). As of September 12, 2008 hedge accounting was terminated and all further changes in the fair market value of the Lehman Swap are being recorded in interest expense and other. Comprehensive income (loss) related to effective unrealized gains or losses on the fair value of the Lehman Swap through September 12, 2008 remain in accumulated comprehensive income (loss) on the balance sheet and will be amortized into interest expense and other as the underlying interest payments are recognized in earnings. The Lehman Swap was valued using the income approach with observable Level 2 market expectations at the measurement date and standard valuation techniques to convert future amounts to a single discounted present amount. The fair market value of the Lehman Swap at September 30, 2008 was an asset of $0.7 million, which was adjusted to zero as collectability was deemed uncertain due to the LHI bankruptcy filing. We included the write down of the asset in interest expense and other for the year ended December 31, 2008. For the last three quarters of 2008, we included $2.4 million in interest expense and other, net related to the fair value adjustment for this swap as we did not expect LCPI to fulfill their obligations under the swap agreement. As a result, we terminated the Lehman Swap in February 2009. We paid $2.2 million for the remaining fair market value of the swap at the date of termination.

During the first quarter of 2009, we replaced the Lehman Swap with an interest rate swap agreement which has a notional amount of $92.7 million (the 2009 Swap Replacement) and has been designated as a cash flow hedge of variable future cash flows associated with a portion of our long term debt. Under the terms of this agreement, which matures in January 2011, we receive three-month LIBOR and pay a fixed rate of 3.15%. The net effect of the hedge is to record interest expense at a fixed rate of 5.65%, as the debt incurs interest based on three-month LIBOR plus 2.50%. We received $2.2 million in cash based on the terms of the agreement. For the year ended December 31, 2009, we paid a net settlement amount of $1.5 million on this swap agreement.

Additionally, during the first quarter of 2009, we entered into an interest rate swap agreement which has a notional amount of $56.8 million, to hedge future cash interest payments associated with a portion of the our variable rate bank debt (the New 2009 Swap). Under the terms of this agreement, which was to mature in November 2011, we received three-month LIBOR and paid a fixed rate of 2.07%. The net effect of the hedge was to record interest expense at a fixed rate of 4.57%, as the debt incurred interest based on three-month LIBOR plus 2.50%. For the year ended December 31, 2009, we paid net a settlement amount of $0.5 million on this swap agreement.

We elected to terminate one of the 2008 swaps and the New 2009 Swap in December 2009 in connection with entering into the Refinance Transaction on December 1, 2009. As a result of the Refinance Transaction, we de-designated the 2008 swap, the 2009 Swap Replacement and the New 2009 Swap and hedge accounting was terminated and all further changes in the fair market value of the terminated swaps are being recorded in interest expense and other. We paid $3.3 million and $1.4 million for the remaining fair market value of the 2008 swap and the New 2009 Swap, respectively, at the date of termination. Comprehensive income (loss) related to effective unrealized gains or losses on the fair value of the terminated swaps through September 30, 2009 remain in accumulated comprehensive income (loss) on the balance sheet and will be amortized into interest expense and other as the underlying interest payments are recognized in earnings. The terminated swaps were valued using the income approach with observable Level 2 market expectations at the measurement date and standard valuation techniques to convert future amounts to a single discounted present amount.

In the first quarter of 2010, we entered into one interest rate swap agreement (the 2010 Swap) and three interest rate cap agreements in order to avoid unplanned volatility in the income statement due to changes in the

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LIBOR interest rate environment. The 2010 Swap, which matures in January 2011, has a notional amount of $92,719 and synthetically unwinds the effects of remaining 2008 Swap. The interest rate cap agreements, which mature in February 2014, have a total notional amount of $150,000 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.

Also during the first quarter of 2009, we entered into a diesel fuel swap agreement which has a notional quantity of 1,008,000 gallons, or 84,000 gallons per month, to hedge future cash payments associated with our purchases of diesel fuel for the mobile fleet. Under the terms of this agreement, which matures in February 2010, we receive the Department of Energy published monthly average price per gallon and pay a fixed rate of $2.63 per gallon. For the year ended December 31, 2009, we paid a net settlement amount of $0.1 million on this swap agreement. For the year ended December 31, 2009, amounts recognized in other (income) and expense were not material.

During the first quarter of 2010, we entered into a diesel fuel swap agreement which has 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 matures in February 2011, we receive the Department of Energy published monthly average price per gallon and pays a fixed rate of three dollars and twenty-five cents per gallon. We designated this swap as a cash flow hedge of future cash flows associated with our diesel fuel payments. We record effective changes in the fair value of the swap through comprehensive income (loss) and reclassify gains or losses to fuel expense (included in cost of revenues, excluding depreciation and amortization) when the underlying fuel is purchased.

The swaps expose us to credit risk in the event that 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 2008 swaps. On a quarterly basis, the counterparties are evaluated for non-performance risk. Additionally, the credit crisis could have an impact on our other interest rate swap agreement if that counterparty files for bankruptcy or is otherwise unable to perform its obligations. See Note 11 to the Consolidated Financial Statements in our Annual Report on Form 10-K for the year ended December 31, 2009 for additional details. The collars outstanding at December 31, 2007 matured during January 2008, and all counterparty obligations were met.

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, 2009, we had cash and cash equivalents of $111.9 million, of which $106.9 million was held in accounts that are with third party financial institutions which exceed the FDIC insurance limits. At December 31, 2008, we had cash and cash equivalents of $73.3 million, of which $68.7 million was held in accounts that are with third party financial institutions which exceed the FDIC insurance limits. We held investments in marketable securities during 2007, which consisted primarily of investment grade auction rate securities and debt securities, all classified as available-for-sale with original maturities greater than 90 days. We did not have any marketable securities at December 31, 2007, 2008 and 2009.

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

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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, 2009							
	2010	2011	2012	2013	2014	Thereafter	Total	Fair Value
	(dollars in millions)							
Liabilities:								
Long-term debt:								
Fixed rate	$ 12.3	$ 4.9	$ 4.0	$ 3.8	$ 3.1	$ 191.4	$ 219.5	$ 206.2
Average interest rate	6.83%	6.86%	7.15%	7.51%	7.70%	5.65%	5.85%	7.98%
Variable rate	$ 4.6	$ 4.6	$ 4.6	$ 4.6	$ 4.6	$ 437.0	$ 460.0	$ 460.0
Average interest rate	5.53%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%

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BUSINESS

General

We are a leading national provider of outpatient diagnostic imaging services, based upon annual revenue and number of diagnostic imaging systems deployed, and a provider of radiation oncology services. Our principal sources of revenue are derived from magnetic resonance imaging (MRI) and positron emission tomography/computed tomography (PET/CT). Unless the context otherwise requires, the words we us, our, Company or Alliance as used in this 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 a growing number of fixed-site imaging centers, primarily to hospitals or health systems. Our 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 also leveraged our leadership in MRI and PET/CT to expand into radiation oncology. Our radiation oncology business is operated through our wholly-owned subsidiary, Alliance Oncology, LLC, and includes a wide range of services for cancer patients covering initial consultation, preparation for treatment, simulation of treatment, radiation oncology delivery, therapy management and follow-up care. Our services include the use of our linear accelerators, therapists to operate such systems, administrative staff, equipment maintenance and upgrades, and management of day-to-day operations. We also provide stereotactic radiation oncology services through our wholly-owned subsidiary, Alliance Radiosurgery, LLC.

MRI and PET/CT services generated 47% and 40% of our revenue, respectively, for the year ended December 31, 2009, 54% and 34% of our revenue, respectively, for the year ended December 31, 2008 and 60% and 31% of our revenue, respectively, for the year ended December 31, 2007. The remaining revenue was comprised of radiation oncology revenue, and other modality diagnostic imaging services revenue, primarily computed tomography (CT), and management contract revenue. We had 507 diagnostic imaging and radiation oncology systems, including 295 MRI systems and 126 positron emission tomography (PET) or PET/CT systems, and served over 1,000 clients in 45 states at December 31, 2009. We operated 116 fixed-site imaging centers (three in unconsolidated joint ventures), which constitutes systems installed in hospitals or other medical buildings on or near hospital campuses, including modular buildings, systems installed inside medical groups offices, and free-standing fixed-site imaging centers, which includes systems installed in a medical office building, ambulatory surgical center, or other retail space at December 31, 2009. Of the 116 fixed-site imaging centers, 91 were MRI fixed-site imaging centers, 16 were PET or PET/CT fixed-site imaging centers, six were other modality fixed-site imaging centers and three were in unconsolidated joint ventures. We also operated 25 radiation oncology centers and stereotactic radiosurgery facilities (including two radiation oncology centers in unconsolidated joint ventures) at December 31, 2009.

Approximately 80%, 79% and 89% of our revenues for the years ended December 31, 2009, 2008 and 2007, respectively, were generated by providing services to hospitals and other healthcare providers, which we refer to as wholesale revenues. Our wholesale revenues are typically generated 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 their own system. We price our contracts based on the type of system used, the scan volume, and the number of ancillary services provided. Pricing is also affected by competitive pressures.

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Approximately 20%, 21% and 11% of our revenues for the years ended December 31, 2009, 2008 and 2007, respectively, were generated by providing services directly to patients from our sites located at or near hospitals or other healthcare provider facilities, which we refer to as retail revenue. Our revenue from these sites is generated from direct billings to patients or their third-party payors, including Medicare, which are recorded net of contractual discounts and other arrangements for providing services at discounted prices. We typically charge 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 10 to 20 years in length. Revenues from these centers are included in either our wholesale or retail revenues.

Our clients, primarily small-to-mid-sized hospitals, contract with us to provide diagnostic imaging and radiation oncology systems and services in order 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 as Alliance Imaging, Inc. On February 17, 2009, we changed our name to Alliance HealthCare Services, Inc.

Significant 2009 Corporate Events

During December 2009, we entered into and completed various debt related transactions in order to expand our borrowing capacity and extend the maturity of our debt (the Refinance Transaction). In order to accomplish this, we retired substantially all of our $300.0 million 7¼% senior subordinated notes due 2012 (the 7¼% Notes) through a cash tender offer (the Tender Offer) and repaid the balance of $351.6 million on our existing Tranche C1 term loan facility (the Old Term Loan). In conjunction with the Refinance Transaction we also entered into a new senior secured credit agreement (the New Credit Facility), comprised of a $460.0 million term loan (the New Term Loan) maturing June 2016 and a $120.0 million revolving facility (the New Revolving Credit Facility) maturing December 2014. Borrowings under the New Term Loan were issued at 98.0% of par, with the discount to par being amortized to interest expense and other, net through the maturity date of the loan. We also issued $190.0 million of 8% senior notes due 2016 (the 8% Notes) in a transaction that was exempt from the registration requirements of the Securities Act of 1933, as amended. The 8% Notes were issued at 98.69% of par, with the discount to par being amortized to interest expense and other, net through the maturity date of the notes. Borrowings under the New Credit Facility bear interest through maturity at a variable rate based upon, at our option, either London InterBank Offered Rate (LIBOR) or the base rate (which is the highest of the administrative agent s prime rate, one-half of 1.00% in excess of the overnight federal funds rate, and 1.00% in excess of the one-month LIBOR rate), plus in each case, an applicable margin. With respect to the New Term Loan, the applicable margin for LIBOR loans is 3.50% per annum, and with respect to the New Revolving Credit Facility, the applicable margin for LIBOR loans ranges, based on the applicable leverage ratio, from 3.25% to

3.75% per annum, in each case, with a LIBOR floor of 2.00%. With respect to the New Term Loan, the applicable margin for base rate loans is 2.50% per annum, and with respect to the New Revolving

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Credit Facility, the applicable margin for base rate loans ranges, based on the applicable leverage ratio, from 2.25% to 2.75% per annum. We used the proceeds from these transactions and existing cash to complete the Tender Offer and purchase $294.4 million of the 7 1/4% Notes at a purchase price equal to 100.125% of the principal amount, together with the accrued interest to the purchase date. We also used the proceeds from these transactions to pay off the Old Term Loan and redeem the remaining $5.6 million of 7 1/4% notes in January 2010 at a redemption price equal to 100.0% of the principal amount, together with accrued interest to the redemption date. We incurred a loss on extinguishment of debt of $14.6 million related to the Refinance Transaction, which represents the tender premium and consent payment to redeem the 7 1/4% Notes, write-off of unamortized debt issuance costs related to the retired debt, and other fees and expenses.

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 (RO) is the practice of delivering radiation therapy by radiation oncologists. The market of RO 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 for evaluating 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. Conditions that can be detected by MRI include multiple sclerosis, tumors, strokes, infections, and injuries to the spine, joints, ligaments, and tendons. Unlike x-rays and computed tomography, 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 1.5 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 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.

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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 (RO) is the practice of delivering radiation therapy by radiation oncologists. RO uses ionizing radiation to treat cancer. In general this radiation is delivered over a period of many days to many weeks. Ionizing radiation damages a cell s DNA that the body then has to repair. Cancer cells are less able to repair the damage than are normal cells. Over the time period during which the radiation is delivered, the cancer cells become more and more damaged while normal cells are able to recover. Eventually, the cancer cells are unable to reproduce and are destroyed while the normal tissue survives.

We estimate that approximately 60% of all new cancer patients are treated with some form of radiation therapy each year. 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. The radiation can be delivered by a number of different technologies including linear accelerators and radioactive isotopes.

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Our radiation oncology business offers the following treatment options:

Conventional beam therapy (CBT). CBT is a very basic form of radiation therapy delivered by a linear accelerator. It is the simplest form to plan and deliver and is typically reserved for use in patients where 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 basic technology used in most practices supplanted by IMRT and IGRT when the specific case requires it.

Intensity modulated radiation therapy (IMRT). IMRT entails the use of hundreds to thousands of beams of radiation delivered by a linear accelerator whose intensity is adjusted individually in order to allow the radiation that is delivered to conform as closely as possible to the three dimensional shape of the tumor. It requires extremely sophisticated and time consuming treatment planning in order to determine what beams should be used and what their intensities should be, and extensive treatment quality assurance in order 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 at the time of each treatment delivery in order 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 IMRT and SRS.

Stereotactic radiosurgery (SRS). Originally developed for intracranial applications but now being used in a range of extracranial applications such as spine, lung, liver, prostate, and others, SRS delivers a very high dose of radiation in anywhere from 1 - 5 treatments as opposed to the 20 - 40 treatments used for 3D-CRT and IMRT. SRS needs to be as precisely planned for and delivered as possible since, because of the reduced number of treatments and the very high dose, it will destroy all cells, cancer and normal alike, that reside within the targeted volume. SRS is delivered with a range of advanced technologies such as the Cyberknife and the GammaKnife.

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 in the tumor through needles, with the seeds permanently left in place, gradually treating the cancer over time.

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 that deliver a much higher dose of radiation over a much shorter period of time. These seeds are inserted and removed several times over 24 - 48 hours through needles that are left in place for the entire course of care.

Imaging and Radiation Oncology Settings

Diagnostic imaging services and radiation oncology services are typically provided in one of the following settings:

Hospitals and clinics. Imaging and/or radiation oncology systems are located in and owned and operated by 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 imaging centers. Imaging and/or radiation oncology 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

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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.

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 the imaging service provider is paid directly by that hospital or clinic instead of by a third-party payor.

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, 2009, we had 295 MRI systems, 126 PET or PET/CT systems, and 86 other diagnostic imaging 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 such 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, 2009, no single client accounted for more than 2% of our revenue.

Reduced reimbursement risk

For the year ended December 31, 2009, we generated approximately 80% of our revenues by billing hospitals and other healthcare providers, which we refer to as wholesale revenues, 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. With our wholesale model, our exposure to patient bad debt is minimized, as

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evidenced by our bad debt expense of only 0.5% of revenues for the year ended December 31, 2009. Further, short-term exposure to Medicare reimbursement cuts is limited as approximately 4% of our imaging revenues came directly from Medicare for the year ended December 31, 2009.

Stable and significant cash flow generation

We have generated stable and 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 the 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 utilize the most advanced radiation oncology technology, including IGRT, IMRT and SRS.

Our Services

We provide our outsourcing services on the following bases:

Shared Service. We offered 59% of our systems on a part-time basis. These systems are located in mobile trailers which are transported 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 averages approximately three years in length. None of our radiation oncology services are offered on a part-time basis.

Full-Time Service. We offered 31% 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. Full-time service systems are provided 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. All of our radiation oncology services are offered on a full-time, long-term basis.

Interim and Rental Services. We offered 10% of our systems to clients on an unstaffed basis. These systems are located in mobile trailers which are transported 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. All of our stereotactic radiation oncology services are offered on an unstaffed basis.

Our Strategy

Key components of our strategy include:

Further expand our presence in growth markets. We will continue to operate our mobile, shared-service MRI business to maximize efficiency, clinical excellence and cash flow. However, we are also focused on

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diversifying and growing our business through the identification of additional services or new technologies which can be deployed on behalf of our hospital and healthcare clients, including:

PET/CT. We are one of the largest national PET/CT providers in the United States. In 2008, we added 22 PET and PET/CT systems to our fleet through the acquisition of MOS and SPI and in 2009 we added 12 PET/CT systems to our fleet. At December 31, 2009 we had 110 mobile systems and 16 fixed-site systems. Modest industry growth in the PET and PET/CT market provides opportunities for us. We anticipate potential for growth through increases in Medicare-approved procedures and greater physician acceptance of PET procedures.

Fixed-Site Imaging Centers. Our fixed-site imaging center contracts generally last for five to 10 years. From January 1, 2003, we have opened or acquired 118 fixed-site imaging centers and increased fixed-site revenues by 218%. We plan to continue to profitably grow our fixed-site imaging center business line through an aggressive, but disciplined growth strategy focused on partnerships with hospitals and fact-based, analytical screening processes. On November 5, 2007, we completed the New England Health Enterprises (NEHE) acquisition, adding seven fixed-site imaging centers in Maine and Massachusetts.

Radiation Oncology. Radiation oncology is an established, growing form of treatment that can exhibit strong operating margins and a strong return on investment. RO represents a significant opportunity for us, as PET/CT technology is increasingly used for the early detection of cancer and approximately 60% of new cancer cases are treated with RO each year. On November 2, 2007, we completed the Bethesda acquisition, adding eight radiation oncology centers in Alabama, Mississippi, and Missouri. In March 2008, we acquired six CyberKnife® robotic radiosurgery facilities from Accuray, Inc., which are providing radiosurgery services at hospitals located in California, Maryland, New Jersey and Tennessee. As of December 31, 2009, we operate 25 radiation oncology centers (two in unconsolidated joint ventures). The growth in RO as a part of our business mix is supported by strong demand from hospitals for assistance in upgrading to the latest RO technology (IGRT and IMRT), the increasing incidence of cancer, our PET/CT capabilities and the growing use of PET/CT scans.

Improvement of our Sales Force. We are focused on continuing to improve our sales management and sales support infrastructure to increase the pace of new business. 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. The ability of our sales force to effectively cross-sell mobile and fixed-site MRI, mobile and fixed-site PET/CT and radiation oncology will provide us with future growth and margin enhancement. Some of our sales force initiatives include new training programs, marketing campaigns and account coverage models. We also have designed our commission and incentive programs for our sales managers to align them with our Company s initiatives.

Improve Operating Efficiency. We are focused on continuing to reduce our cost structure and improve asset allocation. During 2009, we decreased the number of our business regions from four to three while continuing to standardize certain policies and procedures nationwide. In doing so, we believe we will continue to benefit from our regional managers direct contact and knowledge of markets we serve, while ensuring quality, consistency and efficiency across all regions. Other initiatives include developing new vendor relationships and actively managing our mobile systems to increase their utilization through improved route efficiency.

Focus on Patient Care and Customer Service. We are dedicated to the highest level of patient care standards and clinical performance improvement. We strive to provide a variety of solutions designed to meet the needs of our customers by developing new surveying tools for both patients and customers. These surveying tools provide performance-driven data to improve levels of satisfaction for all of our products.

As a result of our 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

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Healthcare Organizations, or JCAHO, in 1998. All of our sites and centers are accredited by The Joint Commission (formerly known as JCAHO) or certified by the American College of Radiology. We have also restructured our marketing function so that our marketing teams are regionally based, enabling us to better understand our patient and customer needs, and thereby improving our service to them.

Selectively Pursue Acquisitions. We intend to manage our market positions by selectively pursuing strategic acquisitions. Changes in the rates or methods of third-party reimbursement for diagnostic imaging services could severely impact our smaller competitors and result in a unique buying opportunity for us. We are particularly focused on acquiring radiation oncology centers, PET/CT providers, both mobile and fixed, and fixed-site imaging providers in Certificate of Need, or CON, regulated states. In some states, a CON or similar regulatory approval is required prior to the acquisition of diagnostic imaging or radiation oncology systems or services, resulting in a barrier to entry for competitors without a CON. In November 2007, we completed the Bethesda Acquisition, adding eight radiation oncology centers, many of which are in CON states, and the NEHE Acquisition, adding seven fixed-site imaging centers located in CON states. In March 2008, we acquired six CyberKnife® robotic radiosurgery facilities from Accuray, Inc., which are providing radiosurgery services at hospitals located in California, Maryland, New Jersey and Tennessee. Also in 2008, we added 22 PET and PET/CT systems to our fleet through the acquisitions of MOS and SPI.

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, clients are billed 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. Approximately 80% of our revenues for the year ended December 31, 2009 were generated by providing these services to hospitals and other healthcare providers. To a lesser extent, our revenues are generated from direct billings to patients or their medical payors. Approximately 20% of our revenues for the year ended December 31, 2009 were generated 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, 2009, we had 507 diagnostic imaging and radiation oncology systems, including 295 MRI systems, 126 PET or PET/CT systems, and 86 other systems, substantially all of which we own. We operated 116 fixed-site imaging centers (three in unconsolidated joint ventures), 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, 70 were hospital-based fixed-site imaging centers, 24 were physician- based fixed-site imaging centers, and 19 were free-standing fixed-site imaging centers. Of the 116 fixed-site imaging centers we operated at December 31, 2009, 91 were MRI fixed-site imaging centers, 16 were PET or PET/CT fixed-site imaging centers, six were other modality fixed-site imaging centers, and three were in unconsolidated joint ventures. 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

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upgrade most of our current MRI and PET/CT systems, we believe we have reduced the potential for technological obsolescence.

We purchase our imaging systems from major medical equipment manufacturers, primarily General Electric Medical Systems, Siemens Medical Systems and Philips Medical Systems. Generally, we contract with clients for new or expanded services prior to ordering new imaging systems in order to reduce 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

We divide our operations into three geographic regions. We have a local presence in each region, none of which accounts for more than 42% of our revenues. None of our revenues for the years ended December 31, 2009, 2008 and 2007 was 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 and radiation oncology 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, which are implemented nationwide in an effort to ensure quality, consistency and efficiency across all regions. For the purposes of Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 280, Segment Reporting (formerly Statement of Financial Accounting Standards (SFAS) No. 131, Disclosures About Segments of an Enterprise and Related Information, (SFAS 131)) the results of our three geographic regions represent one reportable segment.

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 184 power units. We examine client requirements, route patterns, travel times, fuel costs and system availability in our deployment process. Our shared-service MRI and PET/CT systems are currently scheduled for as little as one-half day and up to seven days per week at any particular client, with an average usage of 1.6 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 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, 2009, our national sales and business development force and sales support staff consisted of 33 members who identify and contact potential clients. We also had 32 marketing representatives, as of that date, 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. The sales force is organized regionally under the oversight of regional vice presidents and senior management. Furthermore, certain of our executive officers and regional vice presidents also spend a portion of their time participating in contract negotiations.

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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. There are many companies engaged in the shared service and fixed-site imaging market, including two national competitors and many smaller regional competitors. These competitors include RadNet, Inc., InSight Health Services Corp., and several smaller regional competitors, including Medquest, Inc., Medical Resources, Inc., Shared Medical Services, Kings Medical Company Inc. and DMS Health Group. While we believe that we had a greater number of diagnostic imaging systems in operation at December 31, 2009 than our principal competitors and also had greater revenue from diagnostic imaging services during the year ended December 31, 2009 than they did, some of our competitors may now or in the future have access to greater resources than we do. We compete with other mobile providers, independent imaging centers, physicians, hospitals and other healthcare providers that have their own diagnostic imaging systems, and original equipment manufacturers that sell or lease imaging systems to healthcare providers for mobile or full-time use. There are many competitors in the radiation oncology market as well, including Radiation Therapy Services, Inc., Oncure Medical Corp., Vantage Oncology, Inc., and US Oncology, Inc., and many other smaller regional competitors. Throughout our entire business, we may also experience greater competition in states that currently have certificates of need laws should these laws be repealed, thereby reducing barriers to entry in that state.

Employees

As of December 31, 2009, we had 1,956 employees, of whom 1,413 were trained diagnostic imaging technologists, patient coordinators, drivers or other technical support staff. The drivers in a portion of one of our regions, approximately 26 employees, are represented by the Teamsters union as their collective bargaining agent. We believe we have good relationships with our employees, based on the annual Team Member survey, which indicates Team Member satisfaction.

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 certificate of need laws. Although we believe that our operations materially comply with the laws

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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, the recently enacted 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 this statute or specific intent to violate it. 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 lack of uniform interpretation of the Anti-Kickback Law makes compliance with the law difficult. 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 issued regulations in July of 1991, which the Department has referred to as safe harbors. These safe harbor regulations set forth certain provisions which, 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 Department of Health and Human Services, or OIG, issued a Special Advisory Bulletin on Contractual Joint Ventures in April 2003. The OIG Bulletin stated the Department 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 health care provider expands into a related service, through a joint contractual arrangement with an existing supplier of the related service, to service the health care 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. However, 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 of 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 comment period on March 23, 2004, with an effective date of July 26, 2004. On September 5, 2007, CMS released phase three of the Stark Law final rule which became effective on December 4, 2007. Further, on August 19, 2008, CMS finalized additional changes to the Stark Law which became effective on October 1, 2009. Finally, effective January 1, 2010, as a component for satisfying the Stark exception for in-office ancillary services, the PPACA requires physicians who refer a patient for MRI, CT, PET and any other designated health service to inform the patient in writing at the time of the referral that the patient may obtain such services from a person other than the in-office provider, and provide the patient with a written list of suppliers who furnish such services in the area in which the patient resides.

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.

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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, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009, or HITECH Act, created new 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. 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, the U.S. Department of Health and Human Services Office of Inspector General, and state Medicaid fraud control units. The trend towards increased funding is also seen most recently in the PPACA and President Obama s budget for fiscal year 2011. 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

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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.

Further, 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 FCA. 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 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. While the government intended this legislation to reduce administrative expenses and burdens for the health care industry, our compliance with this law may entail significant and costly changes for us. The American Recovery and

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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 also now 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 standards, rules and regulations, as amended by the HITECH Act. 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 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 certificate of need or similar regulatory approval is required prior to the acquisition of high-cost capital items, including diagnostic imaging systems or provision of diagnostic imaging services by us or our clients. Certificate of need regulations may limit or preclude us from providing diagnostic imaging services or systems. Revenue from states with certificate of need regulations represented greater than 50% of our total revenue for the year ended December 31, 2009.

Certificate of need laws were enacted to contain rising healthcare costs, prevent the unnecessary duplication of health resources, and increase patient access for health services. In practice, certificate of need laws have prevented hospitals and other providers who have been unable to obtain a certificate of need from acquiring new machines or offering new services. Our current contracts will remain in effect even if the certificate of need states in which we operate modify their certificate of need programs. However, a significant increase in the number of states regulating our business through certificate of need or similar programs could adversely affect us. Conversely, repeal of existing certificate of need regulations in jurisdictions where we have obtained a certificate of need, or certificate of need exemption, also could adversely affect us by allowing competitors to enter our markets. Certificate of need 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. Approximately 80% of our revenues for the year ended December 31, 2009 were generated by providing services to hospitals and other healthcare providers. Some of

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our revenues come from third-party payors, including government programs such as the Medicare and Medicaid programs, to whom we directly bill. In the year ended December 31, 2009, we derived 20% 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 typically are processed by contractors and paid on a fee schedule basis, and patients are responsible for deductibles and coinsurance.

Our revenues, whether from providers who bill third-party payors directly or from our own direct billings, are impacted by Medicare laws and regulations. Many payors model their reimbursement structure using Medicare s policies. The Medicare payment policies vary depending on the site of service. As a result of federal cost-containment legislation currently in effect, Medicare generally pays for hospital inpatient services under a prospective payment system. For acute hospital services, the prospective payment is generally based on the assignment to a classification upon a patient s discharge, known as Medicare severity diagnosis related groups (MS-DRGs). The MS-DRG payments are pre-determined payment amounts for inpatient services. The DRG payment amount generally covers all inpatient operating costs regardless of the number of conditions treated or services furnished or the length of the patient s stay.

For hospital outpatient services, Medicare payment generally is based on the hospital outpatient prospective payment system (HOPPS), under which services and items furnished in most hospital outpatient departments are categorized into Ambulatory Payment Classifications (APCs). Certain new procedures are classified under new technology APCs, which, unlike clinical APCs, are classifications based solely on hospital costs. After a two to three year period, the procedure classified under the new technology APC is assigned to a clinical APC. Under HOPPS, hospitals are paid based on procedures performed and items furnished during a patient visit. In addition to clinical and new technology APCs, certain of these items and services are paid on a fee schedule, and for certain drugs biologics, and devices, hospitals may be reimbursed pass-through amounts. In addition, because Medicare reimburses a hospital for all services rendered to a Medicare patient (both inpatient and outpatient), a free-standing facility cannot be separately reimbursed for an MRI scan or other procedure performed on the hospital patient. Many state Medicaid programs have adopted similar payment policies. When our diagnostic or radiation oncology services are provided to a hospital patient, the hospital is responsible for Medicare billing.

For those hospitals and other providers with which we contract, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), changed the way Medicare payments are made in many significant ways. For example, the MMA revised the methodology used to calculate payments for certain drugs, including radiopharmaceutical agents, which were paid as pass-throughs, or additional payment amounts under HOPPS. This change resulted in reduced payments to hospitals for diagnostic scans utilizing radiopharmaceuticals; however, this change did not have a material effect on pricing of our PET contracts with hospitals or our financial performance.

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 failed to intervene. For example, for 2008, the fee schedule rates were to be reduced by approximately 10.1%. The Medicare, Medicaid and SCHIP Extension Act of 2007 eliminated the 10.1% reduction for 2008 and increased the annual payment rate update by 0.5%. This increase to the annual Medicare Physician Fee Schedule payment update was effective only for Medicare claims with dates of service between January 1, 2008 and June 30, 2008. Beginning July 1, 2008, under the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), the 0.5% increase was continued for the rest of 2008. In addition, MIPPA established a 1.1% increase to the Medicare Physician Fee Schedule payment update for 2009. For 2010, the Centers for Medicare and Medicaid Services (CMS) are projecting a rate reduction of 21.2% unless Congress intervenes again to avoid the payment reduction. Federal legislative proposals have been introduced to prevent the rate reduction. On December 19, 2009, President Obama signed into law the Department of Defense Appropriations Act, 2010 (H.R. 3326) which includes a zero percent Medicare physician update through February 28, 2010. This was further extended through May 31, 2010 by the Temporary Extension Act of 2010 and the Continuing Extension Act of 2010, signed into law by President

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Obama on March 2, 2010 and April 15, 2010, respectively. If Congress fails to intervene to prevent the 21.2% rate reduction, the resulting decrease in payment will adversely impact our revenues and results of operations.

MIPPA also modified the methodology by which the budget neutrality formula was applied to the 2009 physician fee schedule payment rates, resulting in an overall reduction in payment rates for services performed by many specialties, including an estimated 3% reduction for radiation oncology and 1% reduction for nuclear medicine. The impact of the payment rates on specific companies depends on their service mix. This resulted in decreases in rates for our radiation oncology business, but we cannot predict the full impact the rate reductions will have on our future revenues or business. Also with respect to MIPPA, the legislation requires all suppliers that provide the technical component of diagnostic MRI, PET/CT, CT, and nuclear medicine to be accredited by an accreditation organization designated by CMS by January 1, 2012. On January 26, 2010, CMS initially approved the following designated accreditation organizations to accredit suppliers furnishing the technical component of all advanced imaging modalities (CT, nuclear medicine, PET and MRI) on or after January 1, 2010: The American College of Radiology (ACR), the Intersocietal Accreditation Commission (IAC) and The Joint Commission. All our facilities are accredited by The Joint Commission.

A number of other legislative changes impact our retail business. For example, the Deficit Reduction Act of 2005 (DRA) imposed caps on Medicare payment rates for certain imaging services furnished in physician s offices and other non-hospital based settings. The caps impact MRI, PET/CT and certain imaging services performed in conjunction with radiation therapy, including certain IGRT services and diagnostic imaging services used to plan IMRT. Under the cap, payments for specified imaging services cannot exceed the hospital outpatient payment rates for those services. This change applies to services furnished on or after January 1, 2007. The limitation is applicable to the technical components of the diagnostic imaging services only, which is the payment we receive for the services for which we bill directly under the Medicare Physician Fee Schedule. CMS issues on an annual basis the hospital outpatient prospective payment (HOPPS) rates, which are used to develop the caps. If the technical component of the service established under the Physician Fee Schedule (without including geographic adjustments) exceeds the hospital outpatient payment amount for the service (also without including geographic adjustments), then the payment is to be reduced. In other words, in those instances where the technical component for the particular service is greater for the non-hospital site, the DRA directs that the hospital outpatient payment rate be substituted for the otherwise applicable Physician Fee Schedule payment rate. The implementation of this reimbursement reduction contained in the DRA had a significant effect on our financial condition and results of operations in 2007, whereas the changes in 2008 and 2009 have been limited.

The DRA also codified the reduction in reimbursement for multiple images on contiguous body parts, which was previously announced by CMS. The DRA mandated payment at 100% of the technical component of the higher priced imaging procedure and 50% for the technical component of each additional imaging procedure for multiple images of contiguous body parts within a family of codes performed in the same session. CMS announced that it would phase in this reimbursement reduction over a two-year period. Beginning in 2006, CMS implemented the initial 25% reduction for each additional imaging procedure on contiguous body parts. For services furnished on or after July 1, 2010, the recently enacted PPACA requires the full 50% reduction to be implemented as mandated by the DRA.

Regulatory updates to payment rates for which we bill the Medicare program directly are published annually by CMS. For payments under the Physician Fee Schedule for calendar year 2010, CMS changed the way it calculates components of the Medicare Physician Fee Schedule. As part of the changes, CMS reduced payment rates for certain diagnostic services using equipment costing more than $1 million through revisions to usage assumptions from the current 50% usage rate to a 90% usage rate to be phased in over a four-year period. This change applied to MRI and CT scans, but not for radiation therapy and other therapeutic equipment. The PPACA supersedes CMS s regulatory changes and reduces the assumed usage rate for such equipment from CMS s 2010 rate of 90% to a rate of 75%, beginning on January 1, 2011. A decrease in utilization rate generally corresponds to an increase to the payment rate. In addition, the OIG has stated that for 2010, it intends to focus on, among other things, the practice expense components, including the equipment utilization rate, for certain imaging

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services reimbursed under Medicare Physician Fee Schedule to determine whether Medicare payment reflects the actual expenses incurred and whether the utilization rate reflects current industry practices.

Further with respect to its 2010 regulatory changes to the Medicare Physician Fee Schedule, in addition to the changes to the usage assumptions, CMS s changes to services primarily involving the technical component rather than the physician work component were adjusted downward. The reductions primarily impact radiology and other diagnostic tests, including the services we provide. Some of the changes to the Medicare Physician Fee Schedule are being transitioned over a four year period such that beginning in 2013, CMS will have fully implemented the revised payment rates. For the 2010 transitioned payment, CMS estimated that the impact of its changes (including the change in the usage assumption that has been superseded by PPACA) would result in a 1% reduction in radiation oncology, 5% reduction in radiology, 18% reduction in nuclear medicine and 12% reduction for all suppliers providing the technical component of diagnostic tests generally. These impacts are calculated prior to any application of the projected negative update factor of 21.2% related to MIPPA (which may be implemented in June 2010 unless Congress intervenes) and may impact our future revenues. The PPACA changes to the Medicare Physician Fee Schedule impact only the usage assumptions described above and therefore all other 2010 updates issued by CMS remain in place. If the CMS 2010 reimbursement rates had been in effect for full year 2009, we estimate that our annualized retail revenue related to MRI and radiation oncology would not have been materially impacted. At this time, we estimate that the new usage assumptions for MRI and CT scans under the PPACA, which is to take effect on January 1, 2011, will not have a material impact on our future retail revenues.

In addition to annual updates to the Medical Physician Fee Schedule, as indicated above, CMS also publishes regulatory changes to the HOPPS on an annual basis. These payments are the amounts received by our hospital clients for hospital outpatient services. For 2008, the national Medicare HOPPS payment rate for nonmyocardial PET and PET/CT scans was $1,057 per scan and the national payment rate for myocardial PET scans was $1,400 per scan. Effective January 1, 2008, CMS also bundled the PET and PET/CT payment for radiopharmaceuticals with the payment for the PET and PET/CT scan. In addition, CMS reduced the 2008 national Medicare HOPPS rate for MRI scans by approximately 3%. The 2008 national Medicare HOPPS payment rates for stereotactic radiosurgery treatment delivery services ranged from $1,057 to $8,055, depending on the level of service. For 2009, the payment rate for nonmyocardial PET and PET/CT scans is $1,037 per scan. For myocardial PET procedures, the 2009 payment rate is $1,157 per scan. For stereotactic radiosurgery treatment delivery services, the 2009 payment rates range from $952 to $7,642, depending on the level of service. On October 30, 2009, CMS released its 2010 national Medicare HOPPS payment rates, which went into effect January 1, 2010. For nonmyocardial PET and PET/CT, the 2010 payment rate is $1,037 per scan. For myocardial PET procedures, the 2010 payment rate is $1,433 per scan. For stereotactic radiosurgery treatment delivery services, the 2010 payment rates range from $963 to $7,344, depending on the level of service.

Combined, the DRA and PET and PET/CT Medicare HOPPS rate reductions negatively impacted our 2007 revenue by a total of approximately $14 million. For 2008 and 2009, however, the DRA and the net Medicare rate reductions in HOPPS did not have a material negative effect on revenue and earnings. At this time, however, we cannot predict the impact the rate reductions will have on our future revenues or business.

Furthermore, CMS announced additional performance standards for suppliers of mobile diagnostic services. The final rule requires suppliers of mobile diagnostic services under certain circumstances to enroll in Medicare and bill directly for these services, regardless of where they are performed. An exception was made for services provided to hospital patients under arrangement with that hospital. In those circumstances, the mobile diagnostic facility would be required to enroll in Medicare, but the hospital would bill for the services. On December 15, 2008, CMS issued additional guidance that companies that lease or contract with a Medicare-enrolled provider or supplier to provide only diagnostic testing equipment and/or non-physician personnel are not required to enroll in Medicare. The agency nonetheless indicated that it is continuing to evaluate such arrangements. The new policies have not significantly impacted our business.

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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, a growing number of medical groups adding imaging capacity within their practice setting and additional patient-related cost-sharing programs. In addition, there is an increasing trend of third-party payors intensifying their utilization management efforts, for example through benefit managers who require preauthorizations to control the growth rate of imaging services generally. We expect that these trends will continue throughout 2010. In addition, we cannot predict the full extent of the PPACA on our business. The legislation substantially changes the way health care is financed by both governmental and private insurers and may negatively impact payment rates for certain imaging services. Nor can we predict at this time whether or the extent to which other proposed changes will be adopted, if any, or how these or future changes will 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, however, 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 price 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 in order 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.

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 operations. We have 15,900 square feet of space for a large regional office in Andover, Massachusetts, in addition to other small regional offices throughout the country. We also lease a 15,600 square foot operations warehouse in Orange, California and a 9,000 square foot operations warehouse in Childs, Pennsylvania.

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 MOS, LLC in the third quarter of 2008, we subsequently identified a Medicare billing practice related to a portion of MOS, LLC s retail billing operations that raised compliance

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issues under Medicare reimbursement guidelines. The practice was in place prior to the acquisition and was discontinued when we became aware of it. In accordance with our corporate compliance program, we have entered into discussions with representatives of the federal government to advise them of the issue and seek guidance on appropriate next steps. The discussions are ongoing and no resolution has yet been reached. Although the government may seek repayment and penalties relating to the billing practice, we do not expect that such repayment and penalties, if imposed on us, would have a material impact on our results of operations, cash flows or financial position because we believe the amounts we would owe will be substantially or fully off-set by recoveries under the indemnification provisions of the MOS, LLC acquisition purchase agreement.

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MANAGEMENT

Executive Officers and Directors

Set forth below is information regarding our executive officers and directors, including their principal occupations for the past five years and their ages as of April 16, 2010. There are no family relationships between any of our executive officers and any other executive officer or board member. Our executive officers are elected by our board of directors and serve at the discretion of our board of directors.

Name	Age	Position
Paul S. Viviano	57	Chairman of the Board of Directors and Chief Executive Officer
Michael F. Frisch	52	President, Alliance Imaging
Richard J. Hall	56	President, Alliance Oncology
Howard K. Aihara	46	Executive Vice President and Chief Financial Officer
Eli H. Glovinsky	49	Executive Vice President, General Counsel and Secretary
Christopher J. Joyce	46	Executive Vice President, Mergers & Acquisitions
Nicholas A. Poan	32	Senior Vice President, Corporate Finance, and Chief Accounting Officer
Aaron A. Bendikson	36	Director
Larry C. Buckelew	56	Director
Neil F. Dimick	60	Director
Michael P. Harmon	41	Director
Curtis S. Lane	52	Director
Edward L. Samek	72	Director

Paul S. Viviano joined Alliance HealthCare Services in January 2003 and serves as the Company s chairman of the board and chief executive officer. Prior to joining Alliance, from 2000 to 2002, Mr. Viviano was president and chief executive officer of USC University Hospital and USC/Norris Comprehensive Cancer Center. He was a member of the St. Joseph Health System from 1987 to 2000 and served as its executive vice president and chief operating officer from 1995 to 2000. From 1994 to 1995, Mr. Viviano was the Southern California regional president and chief executive officer; from 1992 to 1994 the chief executive officer for St. Joseph Hospital; and from 1987 to 1992 the chief executive officer for St. Jude Hospital. Mr. Viviano has held executive management positions in the healthcare services industry for more than 30 years, including 24 years in executive positions with hospitals and hospital systems. He currently serves on the board of a major nonprofit healthcare institution. Mr. Viviano has held the chairman and chief executive officer position and served on the Board at Alliance for more than seven years, providing him extensive experience with the Company s industry, business, operations and development. Given the importance of hospital service business models to the Company s operations and planning, and Mr. Viviano s substantial experience with the Company and the hospital industry, the Board determined that Mr. Viviano is well-suited to be a director of the Company. Mr. Viviano currently serves as the Chairman of the Finance Committee.

Michael F. Frisch has served as president, Alliance Imaging since November 2008, our executive vice president and chief operating officer since January 5, 2007, our senior vice president, southeast region, since September 2004, and our regional vice president, mid-atlantic region from November 2002 to August 2004. From January 1999 through October 2002, Mr. Frisch served as senior vice president-regional operations of American Dental Partners, a dental practice management company.

Richard J. Hall has served as president, Alliance Oncology since November 2008. Mr. Hall s health care background includes more than 25 years experience in both the public and private sectors, including approximately four years as senior vice president of business development and marketing for US Oncology, the nation s largest oncology services provider. Mr. Hall began his career with American Hospital Supply and has also held senior leadership positions with General Medical Corporation, McKesson Corporation, PatientKeeper® and BrightStar Healthcare®.

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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.

Eli H. Glovinsky has served as our executive vice president, secretary and general counsel since February 2007. Prior to joining Alliance, Mr. Glovinsky served as corporate vice president and chief legal counsel at Premier Inc., a voluntary alliance of hospitals and health systems, representing approximately 1,500 hospitals and 20,000 other health care providers. From 1997 to 2003 Mr. Glovinsky served as Premier s vice president and associate general counsel. Mr. Glovinsky began his career as an associate at the law firm of Konowieki & Rank.

Christopher J. Joyce has served as our executive vice president, mergers and acquisitions since January 1, 2008. He joined us in October 2004 as interim regional vice president of one of our regions and was appointed senior vice president of business development in May 2005. Mr. Joyce held the position of senior vice president, general counsel and secretary from February 2006 through February 2007, and then served as senior vice president of one of our regions until December 2007. Prior to joining Alliance, Mr. Joyce served as chief executive officer of Medical Resources, Inc., a publicly-traded fixed-site imaging center operator with 60 centers in nine states. He joined Medical Resources as its senior vice president and general counsel in May 1998 after leaving Alliance Entertainment Corp., a publicly-traded music distribution enterprise where he served as executive vice president of business affairs and general counsel. Mr. Joyce began his career in 1988 as a corporate associate at the law firm of Willkie Farr & Gallagher.

Nicholas A. Poan has served as our senior vice president, corporate finance since October 2006, and our corporate controller and chief accounting officer since December 2005. Previous to these roles, Mr. Poan served as our director of accounting, assistant controller and as part of our accounting management team since May 2003. Prior to joining us, Mr. Poan worked at Deloitte & Touche LLP from September 2000 through May 2003 and is a certified public accountant.

Aaron A. Bendikson is a senior vice president at Oaktree Capital Management, L.P. where he focuses on executing and sourcing leveraged/management buyouts, expansion capital investments and corporate restructurings. He dedicates a significant portion of his time to the Healthcare and Industrial sectors. Mr. Bendikson currently serves as a director of Tekni-Plex, Inc. and Jackson Square Aviation, LLC. Prior to joining Oaktree in 2005, Mr. Bendikson served as a Principal with Soros Fund Management s private equity affiliate. Before joining Soros in 1999, Mr. Bendikson was an investment banker within J.P. Morgan & Co. s Mergers & Acquisitions department. He received an M.B.A. from Harvard Business School and a B.A. degree cum laude in Economics and History from the University of California at Los Angeles, where he was elected to Phi Beta Kappa. In determining that Mr. Bendikson should continue to serve as a director, the Board noted that Mr. Bendikson s substantial private equity and banking experience is called upon to assist the Company in its ongoing operations, particularly with respect to the Company s debt structure and insurance programs, and that Mr. Bendikson also has significant background and experience in the healthcare services industry. Mr. Bendikson s experience and background provides him with a firm understanding of the Company s industry, business and operations. Pursuant to a Governance and Standstill Agreement, Oaktree and MTS currently collectively have the right to designate three persons to our Board of Directors, and Mr. Bendikson is one of those designees.

Larry C. Buckelew is a retired healthcare executive who serves as an advisor to healthcare companies and private investors. Mr. Buckelew served as president and chief executive officer of Gambro Healthcare, Inc. from November 2000 through October 2005. From April 2000 to November 2000 he served as president of Gambro Healthcare/USA. Mr. Buckelew began his career with American Hospital Supply Corporation (AHSC) in 1975 and served as an executive with AHSC and later Baxter International, Inc. following their merger in November

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1985. He has also held executive and management positions with Sunrise Medical, Inc., Teleflex, Inc. and Surgical Services, Inc. Mr. Buckelew currently serves as a director of Welch Allyn Medical and LaVie Care Centers. In determining that Mr. Buckelew should continue to serve as a director, the Board noted that Mr. Buckelew has substantial experience in the healthcare services and products industry, having served in executive positions with several large healthcare services providers and medical products companies throughout most of his career, that he also serves on the boards of two healthcare services companies, and that Mr. Buckelew s background and experience provide him with a firm understanding of the Company s industry, business and operations. Mr. Buckelew currently serves as a member of Alliance s Audit Committee and Compensation Committee.

Neil F. Dimick is a healthcare consultant and private investor, and has been a director since November 2002. Mr. Dimick served as executive vice president and chief financial officer of AmerisourceBergen Corporation from August 2001 through April 2002. From 1992 through August 2001 he served as senior executive vice president and chief financial officer of Bergen Brunswig Corporation. Mr. Dimick began his career as a corporate auditor with Deloitte & Touche in 1973 where he held the position of partner for eight years. Mr. Dimick is also a director of WebMD Corporation, Resources Connection, Inc., Thoratec Corporation and Mylan Laboratories, Inc. Mr. Dimick has substantial experience in the healthcare services industry and is an audit committee financial expert , serving as a director and member of the audit committee of several publicly-traded healthcare companies. This experience along with his chief financial officer and public accounting background is often called upon, particularly in connection with accounting and finance-related issues. Mr. Dimick has served as a member of the Alliance Board for more than seven years, providing him with significant background and experience concerning the Company and its development. The Board concluded that Mr. Dimick should continue to serve as a director because he is very knowledgeable about the Company s industry, business and operations due to his extensive work experience in the healthcare services industry and his long tenure as a member of the Board. Mr. Dimick currently serves as the Chairman of our Audit Committee and as a member of our Finance Committee and Nominating and Corporate Governance Committee.

Michael P. Harmon has been a director since April 2007. Mr. Harmon is a Managing Director with the Principal Group of Oaktree Capital Management L.P., a registered investment advisor and affiliate of Oaktree Group, where he has been responsible for sourcing, evaluating and managing private equity investments since 1997. Prior to this, Mr. Harmon held positions in the Corporate Recovery Consulting group of Price Waterhouse and the Distressed Credits group at Society Corporation. Mr. Harmon currently serves as a director of Novis Pharmaceuticals, LLC, Senior Home Care and Wright Line. Mr. Harmon was instrumental in evaluating and overseeing Oaktree s decision to invest in the Company in 2007. In determining that Mr. Harmon should continue to serve as a director, the Board noted that he has substantial experience in the healthcare services industry, serving on the boards of several healthcare services companies, that he also has significant experience in the private equity industry, and that Mr. Harmon s broad healthcare and business experience assists the Company in considering all significant aspects of the Company s business and operations. Mr. Harmon currently serves as Chairman of our Compensation Committee and as a member of our Nominating and Corporate Governance Committee and Finance Committee. Pursuant to a Governance and Standstill Agreement, Oaktree and MTS currently collectively have the right to designate three persons to our Board of Directors, and Mr. Harmon is one of those designees.

Curtis S. Lane has been a director since April 2007. Mr. Lane founded MTS Health Investors, LLC. In March 2000. Prior to MTS, Mr. Lane was a partner at Evercore Partners. From 1985 to 1998 he was at Bear Stearns & Co. Inc., where he was a Senior Managing Director responsible for healthcare investment banking. He presently serves as a director of Novis Pharmaceuticals, LLC, Senior Home Care, Inc. and Surgical Care Affiliates, LLC. Mr. Lane has substantial experience in the private equity and banking industry as well as broad experience in the healthcare services industry. Through MTS, he has worked with Oaktree in analyzing and participating in numerous healthcare services transactions. He serves on the boards of several healthcare services companies and nonprofit healthcare institutions. In determining that Mr. Lane should continue to serve as a director, the Board noted that his background and experience assists the Company in considering all significant

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aspects of the Company s business and operations and that Mr. Lane is very knowledgeable about the Company s industry, business and operations. Mr. Lane currently serves as a member of our Nominating and Corporate Governance Committee and Compensation Committee. Pursuant to a Governance and Standstill Agreement, Oaktree and MTS currently collectively have the right to designate three persons to our Board of Directors, and Mr. Lane is one of those designees.

Edward L. Samek has been a director since October 2001. Mr. Samek served as vice chairman of MedQuist, Inc. from 1998 to 2000 and as chairman and chief executive officer of The MRC Group and predecessor companies from 1982 to 1998 when it was acquired by MedQuist. Previously he served as President of Hudson Pharmaceutical Corporation and Childcraft Education Corp. He has also held executive and management positions with Procter & Gamble, Johnson & Johnson and Avon Products, Inc. Currently an independent consultant and investor, Mr. Samek serves as a director of Caremedic Systems, Inc., Veritext, LLC, the Jackson Laboratory and Water Jel. Mr. Samek has extensive background and experience in the healthcare services industry and currently serves on the boards of several healthcare companies. In addition, he is the Company s longest serving director, having joined the Board in 2001. In determining that Mr. Samek should continue to serve as a director, the Board noted that Mr. Samek s background and experience is called upon in considering all significant aspects of the Company s business and operations, particulary with respect to matters of business strategy, and that Mr. Samek has substantial experience concerning the Company s development and is very knowledgeable regarding the Company s industry, business and operations. Mr. Samek currently serves as the Chairman of our Nominating and Corporate Governance Committee and as a member of our Compensation Committee and Audit Committee.

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CERTAIN RELATIONSHIPS AND RELATED PARTY TRANSACTIONS

Review and Approval of Related Party Transactions

All relationships and transactions in which we are a participant and involving our directors, executive officers, nominees for directors, stockholders beneficially owning more than 5% of our outstanding shares, or in which any of their respective immediate family members are participants are reviewed by an independent body of the Board of Directors, such as the independent and disinterested members of the Board. As set forth in the Audit Committee charter, the members of the Audit Committee, all of whom are independent directors, also discuss with management and the independent auditor any related-party transactions brought to the Audit Committee s attention which could reasonably be expected to have a material impact on our financial statements.

In the course of their review and approval or ratification of a disclosable related party transaction, the independent and disinterested members of the Board may consider:

- the nature of the related person s interest in the transaction;
- the material terms of the transaction, including, without limitation, the amount and type of transaction;
- the importance of the transaction to the related person;
- the importance of the transaction to the company;
- whether the transaction would impair the judgment of a director or executive officer to act in the best interest of the company; and
- any other matters the Audit Committee or such independent and disinterested members of the Board deems appropriate.

Related Party Transactions

We believe that we have executed all of the transactions set forth below on terms no less favorable to us than we could have obtained from unaffiliated third parties. It is our intention to ensure that all future transactions between us and our officers, directors and principal stockholders and their affiliates, are on terms no less favorable to us than those that we could obtain from unaffiliated third parties.

We formed a special committee of independent and disinterested directors to consider various matters in connection with the sale of shares by Viewer Holdings LLC (an entity managed by an affiliate of KKR) of 49% of our outstanding shares of Common Stock in April 2007 to Oaktree, MTS and their affiliates, or the purchasers. We incurred expenses of between one and two million dollars in connection with the sale, $1.25 million of which was reimbursed to us by the purchasers. In connection with their share purchase, the purchasers negotiated a Governance and Standstill Agreement with the special committee. For so long as the purchasers beneficially own an aggregate of at least 35% of our outstanding shares of Common Stock, they shall have the right to designate three persons to our Board. In the event that the purchasers beneficially own less than 35% but at least 25% of our outstanding Common Stock, they shall have the right to designate two persons to our Board. If the purchasers beneficially own less than 25% but at least 15%, they shall have the right to designate only one person to our Board. The purchasers agreed that they would not obtain beneficial ownership of greater than 49.9% of our outstanding shares of Common Stock, or publicly announce or disclose any such intention, plan or arrangement, for a period of three years after closing. Viewer also assigned to the purchasers registration rights under its registration rights agreement with us. The standstill provisions of this agreement (but not the board designation rights) terminated in April 2010, and the purchasers have the ability to increase their beneficial ownership beyond the 49.9% limit. Also, the various management rights obtained by the purchasers under the agreement terminated in April 2010, including the right to designate members of the committees of our Board and the right to consult with management on various business issues concerning our operations, properties and financial conditions, in the event that the purchasers do not have a representative on our Board.

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PRINCIPAL STOCKHOLDERS

The following table sets forth certain information regarding beneficial ownership of the Common Stock as of April 16, 2010, (i) by each person who is known by us to own beneficially more than 5% of our Common Stock; (ii) by each of our directors; (iii) by each of our named executive officers (including former officers); and (iv) by all of our executive officers and directors as a group.

Name	Common Stock Owned Beneficially(1)	Percentage of Shares Beneficially Owned
Oaktree Capital Management, L.P.(2)	22,421,505	42.5%
MTS Health Investors L.L.C.(3)	2,080,000	3.9%
FMR LLC(4)	3,041,440	5.8%
Paul S. Viviano(5)	1,946,844	3.6%
Michael F. Frisch(6)	368,627	*
Howard K. Aihara(7)	347,500	*
Eli H. Glovinsky(8)	192,500	*
Richard J. Hall	150,000	*
Curtis S. Lane(3)	2,080,000	3.9%
Michael P. Harmon(2)	22,421,505	42.5%
Larry C. Buckelew	20,432	*
Neil F. Dimick	38,969	*
Edward L. Samek	33,411	*
All Present Executive Officers and Directors (12 persons)(9)	27,277,760	49.8%

* Less than 1%

(1) Except as otherwise indicated, the persons named in the table have sole voting and investment power with respect to the shares of Common Stock shown as beneficially owned by them. Beneficial ownership as reported in the above table has been determined in accordance with Rule 13d-3 under the Securities Exchange Act of 1934, as amended. The percentages are based upon 52,756,264 shares outstanding as of April 16, 2010, except for certain parties who hold options that are presently exercisable or exercisable within 60 days of April 16, 2010. The percentages f or those parties who hold options that are presently exercisable or exercisable within 60 days of April 16, 2010 are based upon the sum of 52,756,264 shares outstanding plus the number of shares subject to options that are presently exercisable or exercisable within 60 days of April 16, 2010 held by them, as indicated in the following notes.

(2) Oaktree Capital Management, L.P. is a limited partnership ultimately controlled by Oaktree Capital Group Holdings GP, LLC. Oaktree Capital Group Holdings GP, LLC is a limited liability company managed by Messrs. Stephen A. Kaplan, Howard S. Marks, Bruce A. Karsh, Kevin Clayton, John B. Frank, Larry W. Keele, David M. Kirchheimer, Richard Masson, and Sheldon M. Stone. Stephen A. Kaplan resigned as member of the Company s Board of Directors effective May 23, 2008. Mr. Kaplan disclaims that he is the beneficial owner of any shares beneficially owned by Oaktree Capital Management, L.P. Michael P. Harmon is a member of our Board of Directors and also an executive of Oaktree. Mr. Harmon is currently the Chairman of our Compensation Committee and a member of our Nominating and Corporate Governance Committee and Finance Committee. Mr. Harmon disclaims that he is the beneficial owner of any shares beneficially owned by Oaktree Capital Management. L.P. The address of Oaktree Capital Group Holdings GP, LLC, Oaktree Capital Management, L.P. and Mr. Harmon is: c/o Oaktree Capital Management L.P., 333 South Grand Avenue, 28th Floor, Los Angeles, CA 90071.

(3) MTS Health Investors L.L.C. is a limited liability company, the senior managing members of which are Messrs. Curtis S. Lane and Oliver T. Moses. Mr. Lane is currently a member of our Board of Directors and he is also a member of our Nominating and Corporate Governance Committee and Compensation Committee. Mr. Lane may be deemed to share beneficial ownership of any shares beneficially owned by MTS Health Investors L.L.C. Mr. Lane disclaims such beneficial ownership. The address of MTS Health

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Investors L.L.C. and Mr. Lane is: c/o MTS Health Investors L.L.C., 623 Fifth Avenue, New York, NY 10022.

(4) Based upon information contained in a Schedule 13G, which was filed with the U.S. Securities and Exchange Commission on February 16, 2010. FMR LLC has sole voting power with respect to 603,140 shares and sole dispositive power with respect to 3,041,440 shares. The address of FMR LLC is 82 Devonshire Street, Boston, MA 02109. Fidelity Management & Research Company (Fidelity), a wholly-owned subsidiary of FMR LLC and an investment advisor registered under Section 203 of the Investment Advisers Act of 1940, is the beneficial owner of 1,742,300 shares as a result of acting as investment adviser to various investment companies registered under Section 8 of the Investment Company Act of 1940. Edward C. Johnson III, Chairman of FMR LLC, and FMR LLC, through its control of Fidelity, and the funds each has sole dispositive power with respect to 1,742,300 shares owned by the funds. The address of Fidelity is 82 Devonshire Street, Boston, MA 02109. Pyramis Global Advisors Trust Company (PGATC), an indirect wholly-owned subsidiary of FMR LLC and a bank as defined in Section 3(a)(6) of the Securities Exchange Act of 1934, is the beneficial owner of 1,299,140 shares as a result of its serving as investment manager of institutional accounts owning such shares. Edward C. Johnson III and FMR LLC, through its control of PGATC, each has sole dispositive power with respect to 1,299,140 shares and sole voting power with respect to 599,140 shares owned by the institutional accounts managed by PGATC. The address of PGATC is 900 Salem Street, Smithfield, RI 02917.

(5) This amount includes 1,372,500 shares issuable upon exercise of stock options that are currently exercisable or exercisable within 60 days.

(6) This amount includes 201,250 shares issuable upon exercise of stock options that are currently exercisable or exercisable within 60 days.

(7) This amount includes 197,500 shares issuable upon exercise of stock options that are currently exercisable or exercisable within 60 days.

(8) This amount includes 117,500 shares issuable upon exercise of stock options that are currently exercisable or exercisable within 60 days.

(9) This amount includes 1,993,000 shares issuable upon exercise of stock options that are currently exercisable or exercisable within 60 days. This amount also includes 5,558 phantom shares issuable upon retirement, separation from the Board of Directors or the occurrence of a change of control.

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DESCRIPTION OF CREDIT FACILITY

The following summary of our credit facility does not purport to be complete and is qualified in its entirety by reference to the agreements described, including the definitions of certain capitalized terms used in this section, copies of which are available upon request.

General

In December 2009, we entered into a new senior secured credit facility agreement with Deutsche Bank Securities Inc., Barclays Capital, the investment banking division of Barclays Bank PLC, and Morgan Stanley Senior Funding, Inc., as lead arrangers, Deutsche Bank Trust Company Americas, as administrative agent, and certain other lenders, for $580.0 million in financing, consisting of (i) a $460.0 million, six and one half-year term loan facility and (ii) a $120.0 million, five-year revolving loan facility, including a $10.0 million, swing line subfacility and a $20.0 million sublimit for letters of credit. The credit facility includes uncommitted incremental loan facilities for up to $150.0 million in additional principal amount of revolving or term loans, subject to receipt of lender commitments and the satisfaction of certain conditions.

We are required to pay a commitment fee equal to 0.50% per annum on the undrawn portion available under the revolving loan facility and variable per annum fees in respect of outstanding letters of credit.

Prepayments

Loans are required to be prepaid with:

- 100% of the net proceeds of all non-ordinary course asset sales or other dispositions of property by us and our subsidiaries (other than unrestricted subsidiaries and certain non-wholly owned subsidiaries) in excess of $2.5 million for any transaction or series of related transactions which we have not reinvested in our business within one year after receipt of the proceeds, subject to limited exceptions;

- 50% of annual excess cash flow, which percentage may be reduced subject to our attaining certain leverage ratios;

- 100% of the net proceeds from issuances of debt by us and our subsidiaries (other than unrestricted subsidiaries), subject to certain exceptions;

- 100% of net proceeds from insurance recovery and condemnation events of us and our subsidiaries (other than unrestricted subsidiaries and certain non-wholly owned subsidiaries), subject to certain reinvestment rights and thresholds; and

- the amount by which the outstanding amounts under the revolving facility exceed the total amount committed under the revolving facility.

Interest

Borrowings under the credit facility bear interest through maturity at a variable rate based upon, at our option, either LIBOR of the base rate (which is the highest of the administrative agent s prime rate, one-half of 1.00% in excess of the overnight federal funds rate, and 1.00% in excess of the one-month LIBOR rate), plus in each case, an applicable margin. With respect to the term loan facilities, the applicable margin for LIBOR loans is 3.50% per annum, and with respect to the revolving loan facilities, the applicable margin for LIBOR loans ranges, based on the applicable leverage ratio, from 3.25% to 3.75% per annum, in each case with a LIBOR floor of 2.00%. With respect to the term loan facilities, the applicable margin for base rate loans is 2.50% per annum, and with respect to the revolving loan facilities, the applicable margin for base rate loans ranges, based on the applicable leverage ratio, from 2.25% to 2.75% per annum.

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Guarantees and Collateral

The obligations under the credit facility are guaranteed by substantially all of our direct and indirect domestic subsidiaries. The obligations under the credit facility and the guarantees are secured by a lien on substantially all of our tangible and intangible property, and by a pledge of (a) all of the shares of stock, partnership interests and limited liability company interests of our direct and indirect domestic subsidiaries, of which we now own or later acquire more than a 50% interest, except for certain specified subsidiaries and subsidiaries which own assets or have annual revenues of less than $100,000 individually and $1,000,000 collectively and (b) up to 65% of the total outstanding shares of voting stock of any material foreign subsidiaries.

Covenants

In addition to certain customary covenants, the credit facility restricts, among other things, our ability 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 we conduct.

Financial Covenants

The credit facility contains financial covenants requiring us to maintain (i) a maximum ratio of consolidated total debt to consolidated adjusted EBITDA that ranges from 4.75 to 1.00 to 4.00 to 1.00 and (ii) a minimum ratio of consolidated adjusted EBITDA to consolidated interest expense of 2.75 to 1.00. For the quarter ending December 31, 2009, the credit facility required a maximum leverage ratio of not more than 4.75 to 1.00. Our failure to comply with these covenants could permit the lenders under the credit facility to declare all amounts borrowed under the agreement, together with accrued interest and fees, to be immediately due and payable.

Events of Default

In addition to certain customary events of default, events of default under the credit facility include our failure to pay principal or interest when due, our material breach of any representation or warranty contained in the loan documents, covenant defaults, events of bankruptcy and a change of control.

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DESCRIPTION OF THE NOTES

General

Alliance issued the private notes, and will issue the exchange notes, pursuant to an indenture between Alliance and The Bank of New York Mellon Trust Company, N.A., as trustee. Upon the issuance of these exchange notes or the effectiveness of the shelf registration statement, the indenture will be subject to and governed by the Trust Indenture Act of 1939, as amended. The terms of the exchange notes include those stated in the indenture and those made part of the indenture by reference to the Trust Indenture Act. The exchange notes are subject to all such terms, and holders of exchange notes are referred to the indenture and the Trust Indenture Act for a statement thereof. The following summarizes the material provisions of the indenture and is qualified in its entirety by reference to the provisions of the indenture, including the definitions therein of certain terms used below. The definitions of certain terms used in the following summary are set forth below under Certain Definitions. For purposes of this summary, the term *Alliance* refers only to Alliance HealthCare Services, Inc. and not to any of its Subsidiaries, and the term notes refers to both the private notes and the exchange notes.

The notes are:

- senior unsecured obligations of Alliance;
- *pari passu* in right of payment to all existing and future senior Indebtedness of Alliance;
- senior in right of payment to all future subordinated Indebtedness of Alliance;
- effectively subordinated to all existing and future secured Indebtedness of Alliance, including the Credit Facilities, to the extent of the value of the assets securing such Indebtedness; and
- effectively subordinated to all Indebtedness and other obligations (including trade payables) of Alliance s Subsidiaries.

As of December 31, 2009, we had $667.9 million of Indebtedness, approximately $474.8 million of which was secured (excluding $4.5 million of undrawn letters of credit and $115.5 million of available undrawn revolving credit commitments). As of December 31, 2009, our Subsidiaries had approximately $492.3 million of Indebtedness and other liabilities (of which $460.0 million represents guarantees of Indebtedness under the Credit Facility). Any right of Alliance to receive assets of any of its Subsidiaries upon the latter s liquidation or reorganization (and the consequent right of the holders of the notes to participate in those assets) is effectively subordinated to the claims of that Subsidiary s creditors. Also, a portion of the operations of Alliance is conducted through its Subsidiaries. Therefore, Alliance is partially dependent upon the cash flows of its Subsidiaries to meet its obligations, including obligations under the notes. The indenture permits Alliance and its Subsidiaries to incur additional indebtedness, including secured Indebtedness, subject to certain limitations. See Risk Factors Risks Related to Our Indebtedness and Risk Factors Risks Related to the Notes.

Under certain circumstances, Alliance will be able to designate Subsidiaries as Unrestricted Subsidiaries. Unrestricted Subsidiaries will not be subject to any of the restrictive covenants set forth in the indenture.

Principal, Maturity and Interest

We will issue an aggregate principal amount of $190 million of exchange notes in the exchange offer. The exchange notes will mature on December 1, 2016. The indenture provides for the issuance of additional notes having identical terms and conditions to the notes, subject to compliance with the covenants contained in the indenture, including the provisions set forth under Certain Covenants Limitation on Incurrence of Indebtedness and Issuance of Disqualified Stock. Interest on the exchange notes will accrue at the rate of 8.00% per annum and will be payable semi-annually in arrears on June 1 and December 1 of each year. Alliance will make each interest payment to the holders of record on the immediately preceding May 15 and November 15. You will receive interest on from the date of initial issuance of the exchange notes,

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plus an amount equal to the accrued interest on the private notes from , to the date of exchange. Interest will be computed on the basis of a 360-day year comprised of twelve 30-day months. Principal of, premium, if any, and interest on the notes is payable at the office or agency of Alliance maintained for such purpose or, at the option of Alliance, payment of interest may be made by check mailed to the holders of the notes at their respective addresses set forth in the register of holders of notes; *provided* that all payments of principal, premium, if any, liquidated damages, if any, and interest with respect to notes the holders of which have given wire transfer instructions to Alliance will be required to be made by wire transfer of immediately available funds to the accounts specified by the holders thereof. Until otherwise designated by Alliance, Alliance s office or agency will be the office of the trustee maintained for such purpose. The exchange notes will be issued in denominations of $2,000 and integral multiples of $1,000 in excess thereof.

Transfer and Exchange

A holder may transfer or exchange notes in accordance with the indenture. The registrar and the trustee may require a holder to furnish appropriate endorsements and transfer documents in connection with a transfer of notes. Holders will be required to pay all taxes due on transfer. Alliance is not required to transfer or exchange any note selected for redemption.

Mandatory Redemption

Except as set forth below under Repurchase at the Option of Holders, Alliance is not required to make mandatory redemption or sinking fund payments with respect to the notes.

Optional Redemption

Except as described below, the notes will not be redeemable at Alliance s option prior to December 1, 2012. From and after December 1, 2012, the notes will be subject to redemption at any time at the option of Alliance, in whole or in part, upon not less than 30 nor more than 60 days notice, at the redemption prices (expressed as percentages of principal amount) set forth below, plus accrued and unpaid interest and liquidated damages, if any, thereon to the applicable redemption date, if redeemed during the twelve-month period beginning on December 1 of each of the years indicated below:

Year	Redemption Price
2012	104.00%
2013	102.00%
2014 and thereafter	100.00%

In addition, at any time or from time to time, on or prior to December 1, 2012, Alliance may, at its option, redeem up to 35% of the aggregate principal amount of notes issued under the indenture at a redemption price equal to 108.00% of the aggregate principal amount thereof, plus accrued and unpaid interest and liquidated damages, if any, thereon to the redemption date, with the net cash proceeds of one or more Equity Offerings; *provided* that at least 65% of the aggregate principal amount of notes issued under the indenture remains outstanding immediately after the occurrence of each such redemption; *provided further* that each such redemption occurs within 60 days of the date of closing of each such Equity Offering. The trustee shall select the notes to be purchased in the manner described under Repurchase at the Option of Holders Selection and Notice.

In addition, at any time prior to December 1, 2012, Alliance may redeem all or a part of the notes, upon not less than 30 nor more than 60 days prior notice mailed by first-class mail to the registered address of each holder of notes or otherwise delivered in accordance with the procedures of DTC, at a redemption price equal to 100% of the principal amount of the Notes redeemed plus the Applicable Premium as of, and accrued and unpaid interest and liquidated damages, if any, to the date of redemption (the *Redemption Date*), subject to the rights of the holders of record on the relevant record date to receive interest due on the relevant interest payment date.

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Applicable Premium means, with respect to any note on any redemption date, the greater of (i) 1.0% of the principal amount of such note or (ii) the excess of (A) the present value at such redemption date of (1) the redemption price of such note at December 1, 2012 (such redemption price being set forth in the table above) plus (2) all required interest payments due on such note through December 1, 2012 (excluding accrued but unpaid interest and liquidated damages, if any), computed using a discount rate equal to the Treasury Rate on such redemption date plus 50 basis points over (B) the principal amount of such note.

Treasury Rate means, as of any redemption date, the yield to maturity as of such redemption date of United States Treasury securities with a constant maturity (as compiled and published in the most recent Federal Reserve Statistical Release H.15(519) that has become publicly available at least two business days prior to the redemption date (or, if such statistical release is no longer published, any publicly available source of similar market data)) most nearly equal to the period from the redemption date to December 1, 2012; *provided, however*, that if the period from the redemption date to December 1, 2012 is less than one year, the weekly average yield on actually traded United States Treasury securities adjusted to a constant maturity of one year shall be used.

Repurchase at the Option of Holders

Change of Control

The indenture provides that, upon the occurrence of a Change of Control, unless Alliance has elected to redeem the notes in connection with such Change of Control, Alliance will make an offer to purchase all or any part (equal to $2,000 or an integral multiple of $1,000 in excess thereof) of the notes pursuant to the offer described below (the *Change of Control Offer*) at a price in cash (the *Change of Control Payment*) equal to 101% of the aggregate principal amount thereof plus accrued and unpaid interest and liquidated damages, if any, to the date of purchase. The indenture provides that within 30 days following any Change of Control, Alliance will mail a notice to each holder of notes issued under the indenture, with a copy to the trustee, with the following information:

(a) a Change of Control Offer is being made pursuant to the covenant entitled Offer to Repurchase Upon Change of Control, and that all notes properly tendered pursuant to such Change of Control Offer will be accepted for payment;

(b) the purchase price and the purchase date, which will be no earlier than 30 days nor later than 60 days from the date such notice is mailed, except as may be otherwise required by applicable law (the *Change of Control Payment Date*);

(c) any note not properly tendered will remain outstanding and continue to accrue interest;

(d) unless Alliance defaults in the payment of the Change of Control Payment, all notes accepted for payment pursuant to the Change of Control Offer will cease to accrue interest on the Change of Control Payment Date;

(e) holders of notes electing to have any notes purchased pursuant to a Change of Control Offer will be required to surrender the notes, with the form entitled Option of Holder to Elect Purchase on the reverse of the notes completed, to the paying agent specified in the notice at the address specified in the notice prior to the close of business on the third business day preceding the Change of Control Payment Date;

(f) holders of notes will be entitled to withdraw their tendered notes and their election to require Alliance to purchase such notes; *provided* that the paying agent receives, not later than the close of business on the last day of the offer period (as defined in the indenture), a telegram, telex, facsimile transmission or letter setting forth the name of the holder, the principal amount of notes tendered for purchase, and a statement that such holder is withdrawing his tendered notes and his election to have such notes purchased; and

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(g) that holders whose notes are being purchased only in part will be issued new notes equal in principal amount to the unpurchased portion of the notes surrendered, which unpurchased portion must be equal to $2,000 in principal amount or an integral multiple of $1,000 in excess thereof.

Alliance will comply with the requirements of Rule 14e-1 under the Exchange Act and any other securities laws and regulations thereunder to the extent such laws or regulations are applicable in connection with the repurchase of the notes pursuant to a Change of Control Offer. To the extent that the provisions of any securities laws or regulations conflict with the provisions of the indenture, Alliance will comply with the applicable securities laws and regulations and shall not be deemed to have breached its obligations described in the indenture by virtue thereof.

The indenture provides that on the Change of Control Payment Date, Alliance will, to the extent permitted by law,

(1) accept for payment all notes or portions thereof properly tendered pursuant to the Change of Control Offer,

(2) deposit with the paying agent an amount equal to the aggregate Change of Control Payment in respect of all notes or portions thereof so tendered and

(3) deliver, or cause to be delivered, to the trustee for cancellation the notes so accepted, together with an Officers Certificate stating that such notes or portions thereof have been tendered to and purchased by Alliance.

The indenture provides that the paying agent will promptly mail to each holder of notes the Change of Control Payment for such notes, and the trustee will promptly authenticate and mail (or cause to be transferred by book entry) to each holder a new note equal in principal amount to any unpurchased portion of the notes surrendered, if any; *provided* that each such new note will be in a principal amount of $2,000 or an integral multiple of $1,000 in excess thereof. Alliance will publicly announce the results of the Change of Control Offer on or as soon as practicable after the Change of Control Payment Date.

Alliance will not be required to make a Change of Control Offer upon a Change of Control if a third party makes the Change of Control Offer in the manner, at the times and otherwise in compliance with the requirements set forth in the indenture and purchases all notes validly tendered and not withdrawn under such Change of Control Offer.

A Change of Control Offer may be made in advance of a Change of Control, and conditioned upon such Change of Control, if a definitive agreement is in place for the Change of Control at the time of the making of the Change of Control Offer. The notes repurchased by Alliance pursuant to a Change of Control Offer will have the status of notes issued but not outstanding or will be retired and canceled at the option of Alliance. Notes purchased by a third party pursuant to the preceding paragraph will have the status of notes issued and outstanding.

The Credit Facility prohibits, and future credit agreements or other agreements to which Alliance becomes a party may prohibit, Alliance from purchasing any notes as a result of a Change of Control and/or provide that certain change of control events with respect to Alliance would constitute a default thereunder. In the event a Change of Control occurs at a time when Alliance is prohibited from pur