LIFEPOINT HEALTH, INC.
Form 10-K
February 17, 2017

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One) 2

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2016

or

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from to

Commission file number: 000-51251

LifePoint Health, Inc.

(Exact Name of Registrant as Specified in its Charter)

Delaware	20-1538254
(State or Other Jurisdiction of	(I.R.S. Employer
Incorporation or Organization)	Identification No.)
330 Seven Springs Way	
Brentwood, Tennessee	37027
(Address Of Principal Executive Offices)	(Zip Code)

(615) 920-7000

(Registrant's Telephone Number, Including Area Code)

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

Title of Each Class	Name of Exchange on Which Registered
Common Stock, par value $.01 per share	NASDAQ Global Select Market

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

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

Yes No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.

Yes No

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).

Yes No

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

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

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

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

The aggregate market value of the shares of registrant's Common Stock held by non-affiliates as of June 30, 2016, was approximately $1.7 billion.

As of February 10, 2017, the number of outstanding shares of the registrant's Common Stock was 39,943,956.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive proxy statement for its 2017 annual meeting of stockholders are incorporated by reference into Part III of this report.

LifePoint Health, Inc.

TABLE OF CONTENTS

PART I		
Item 1.	Business	1
Item 1A.	Risk Factors	27
Item 1B.	Unresolved Staff Comments	38
Item 2.	Properties	39
Item 3.	Legal Proceedings	41
Item 4.	Mine Safety Disclosures	42
PART II		
Item 5.	Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	43
Item 6.	Selected Financial Data	46
Item 7.	Management's Discussion and Analysis of Financial Condition and Results of Operations	47
Item 7A.	Quantitative and Qualitative Disclosures About Market Risk	82
Item 8.	Financial Statements and Supplementary Data	82
Item 9.	Changes in and Disagreements with Accountants on Accounting and Financial Disclosure	82
Item 9A.	Controls and Procedures	82
Item 9B.	Other Information	82
PART III		
Item 10.	Directors, Executive Officers and Corporate Governance	83
Item 11.	Executive Compensation	83
Item 12.	Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	84
Item 13.	Certain Relationships and Related Transactions, and Director Independence	84
Item 14.	Principal Accountant Fees and Services	84
PART IV		
Item 15.	Exhibits, Financial Statement Schedules	85
Item 16.	Form 10-K Summary	88
SIGNATURES		89
Exhibit Index		90

i

TABLE OF CONTENTS

PART I

Item 1. Business.

Overview of Our Company

LifePoint Health, Inc. a Delaware corporation, acting through its subsidiaries, owns and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. Unless the context otherwise requires, LifePoint Health, Inc. and its subsidiaries are referred to herein as “LifePoint,” the “Company,” “we,” “our” or “us.” At December 31, 2016, on a consolidated basis, we operated 72 hospital campuses in 22 states throughout the United States (“U.S.”), having a total of 9,424 licensed beds. We generate revenues by providing a broad range of general and specialized healthcare services to patients through a network of hospitals and outpatient facilities. We generated $6,364.0 million, $5,214.3 million and $4,483.1 million in revenues during the years ended December 31, 2016, 2015 and 2014, respectively.

Our hospitals typically provide the range of medical and surgical services commonly available in hospitals in non-urban markets. These services include general surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care, rehabilitation services, pediatric services, and, in some of our hospitals, specialized services such as open-heart surgery, skilled nursing, psychiatric care and neuro-surgery. In many markets, we also provide outpatient services such as same-day surgery, laboratory, x-ray, respiratory therapy, imaging, sports medicine and lithotripsy. The services provided at any specific hospital depend on factors such as community need for the service, whether physicians necessary to operate the service line safely are members of the medical staff of that hospital, whether the service might be supported by community residents, and any contractual or certificate of need restrictions that exist. Like most hospitals located in non-urban markets, our hospitals do not engage in extensive medical research and medical education programs. However, a number of our hospitals have affiliations with medical schools, including the clinical rotation of medical and pharmacy students, and two of our hospitals own and operate schools of nursing and other allied health professions.

We seek to fulfill our mission of Making Communities Healthier® by striving to (1) improve the quality and types of healthcare services available in our communities; (2) provide physicians with a positive environment in which to practice medicine, with access to necessary equipment and resources; (3) develop and provide a positive work environment for employees; (4) expand each hospital’s role as a community asset; and (5) improve each hospital’s financial performance. We expect our hospitals to be the place where patients choose to come for care, where physicians want to practice medicine and where employees want to work.

Business Strategy

Opportunities in Existing Markets

We believe that growth opportunities remain in our existing markets. Growth at our facilities is dependent in part on how successful our hospitals are in their efforts to recruit physicians to their respective medical staffs, whether those physicians are active members of their respective medical staffs over a long period of time and whether and to what extent members of our hospitals' medical staffs admit patients to our hospitals or utilize our outpatient service lines.

We also believe that growth at our hospitals is dependent in part on the quality of care provided in our facilities, adding new service lines in our existing markets and investing in new technologies desired by physicians and patients. The quality of healthcare services provided at our hospitals is an increasingly important factor to patients when deciding where to seek care, to physicians when deciding where to practice and to governmental and private third party payors when determining the reimbursement that is paid to our hospitals. We recognize that, in virtually every case, the Centers for Medicare and Medicaid Services ("CMS") core measure scores and other quality measures ascribed to our hospitals, such as Hospital Consumer Assessment of Healthcare Providers & Systems ("HCAHPS") scores, 30-day readmission rates, patient falls and adverse drug events, are impacted by the practice decisions of the physicians on our hospital medical staffs. As a result, we have implemented strategies to educate and partner with medical staff members to improve scores at our hospitals, especially those that are below our average or below management's expectation. We are committed to further improving our hospitals' quality scores through targeted strategies, including increased education and engagement campaigns, clinical decision support tools, subject matter expert facilitation and hospital-specific action plans.

TABLE OF CONTENTS

Additionally, in most of our markets, a significant portion of patients who require services available at acute care hospitals leave our markets to receive such care. We believe this presents an opportunity for growth, and we are working with the hospitals in communities where this phenomenon exists to implement new strategies or enhance existing strategies to attract patients. We regularly conduct operating reviews of our hospitals to identify new service lines that allow residents of our communities to receive healthcare services closer to home. When such needed service lines are determined, we focus on recruiting the physicians necessary to operate such service lines appropriately. For example, our hospitals have responded to physician interest in requests for hospitalists by introducing or strengthening hospitalist programs where appropriate. Our hospitals have taken other steps to allow more community residents to receive appropriate care close to home, such as structured efforts to solicit input from medical staff members and to respond promptly to legitimate unmet physician needs for necessary equipment or trained support staff.

While responsibly managing our operating expenses, we have also made significant, targeted investments in our facilities to add new technologies, modernize facilities and expand the services available. These investments should assist in our efforts to attract and retain physicians, to offset outmigration of patients and to make our facilities more desirable to our employees and potential patients.

Opportunities in New Markets

We believe that strategic acquisitions and partnerships can supplement our efforts to achieve organic growth in our existing markets, and in recent years, newly acquired hospitals have accounted for the majority of our growth. We continue to focus on strategic growth through acquisition and integration of well-positioned facilities in growing areas of the U.S. where valuations are attractive and we can identify opportunities for improved operating and financial performance through our management and strategic initiatives. We are also focused on developing strategic partnerships with not-for-profit healthcare providers to achieve growth in new regions. We believe that such opportunities remain strong as community hospitals continue to see the benefits of scale and the additional resources available through partnerships with large organizations such as ours. We believe that the additional regulatory burdens imposed by healthcare reform initiatives are also causing healthcare providers to pursue strategic acquisitions and partnerships.

We formed Duke LifePoint Healthcare, a joint venture between LifePoint and a wholly-controlled affiliate of Duke University Health System, Inc. (“Duke”), with a mission to own and operate community hospitals as well as improve the delivery of healthcare services. We own a controlling interest in Duke LifePoint Healthcare. We believe this partnership, which combines our operational resources and experience with Duke’s expertise in the development of clinical services and quality systems, further strengthens our ability to acquire well-positioned hospitals. Since its formation in 2011 and through December 31, 2016, we have completed the acquisition of 14 acute care hospitals and ancillary facilities through Duke LifePoint Healthcare, including, effective January 1, 2016, Frye Regional Medical Center, a 355 bed acute care hospital located in Hickory, North Carolina and Central Carolina Hospital, a 137 bed acute care hospital located in Sanford, North Carolina.

We entered into a joint venture agreement with Norton Healthcare, Inc. to form the Regional Health Network of Kentucky and Southern Indiana (“RHN”), the purpose of which is to own and operate hospitals in non-urban communities in Kentucky and Southern Indiana. Since its formation in 2012 and through December 31, 2016, we have completed the acquisition of two acute care hospitals through RHN.

Effective January 1, 2017, we entered into a joint venture agreement with a wholly-owned subsidiary of LHC Group, Inc. (“LHC”) to form In-Home Healthcare Partnership (“IHHP”), the purpose of which is to own and operate our home health agencies and hospices and certain of LHC’s home health agencies and hospices located near our

hospitals. Effective January 1, 2017, ownership and management of 11 of our home health agencies and 6 of our hospices were transferred to IHHP. Additional home health agencies and hospices owned by LifePoint and LHC are planned to be transitioned to IHHP during 2017 and later years, subject to regulatory approvals and customary closing conditions.

In addition to acquisitions and other growth through our joint ventures and partnerships, we continue to make other strategic acquisitions on an opportunistic basis, including the following additional facilities during the year ended December 31, 2016:

- St. Francis Hospital, a 376 bed acute care hospital located in Columbus, Georgia, effective January 1, 2016; and
- Providence Hospitals, comprised of Providence Hospital (Downtown), a 258 bed acute care hospital, and Providence Hospital Northeast, a 74 bed acute care hospital, each located in Columbia, South Carolina effective February 1, 2016.

Cost Management

We strive to improve our operating performance by making our revenue cycle processes more efficient, making an even higher level of purchases through our group purchasing organization, operating more efficiently and effectively, and working to appropriately standardize our policies, procedures and practices across all of our affiliated facilities.

As part of our ongoing efforts to further manage costs and improve the results of our revenue cycle, we have partnered with a third party to provide certain nonclinical business functions, including payroll processing, supply chain management and revenue cycle functions. We believe this model is the most cost effective and efficient approach to managing these nonclinical business functions across multi-facility enterprises.

Additionally, in connection with our efforts to responsibly manage purchasing costs, we participate along with other healthcare companies in a group purchasing organization, HealthTrust Purchasing Group, which makes certain national supply and equipment contracts available to our facilities. We owned an approximate 5.9% equity interest in this group purchasing organization at December 31, 2016.

Operations

We seek to operate our facilities in a manner that positions them to compete effectively and to further our mission of Making Communities Healthier®. The operating strategies of our facilities are determined largely by local leadership and are tailored to each of their respective communities. Generally, our overall operating strategy is to: (1) expand the breadth of services offered at our hospitals in an effort to attract community patients that might otherwise leave their community for healthcare; (2) recruit, attract and retain physicians interested in practicing in the communities where our hospitals are primarily located; (3) recruit, retain and develop hospital executives and staff interested in working and living in the communities where our hospitals are primarily located; (4) negotiate favorable, facility-specific contracts with managed care and other private third-party payors; and (5) efficiently leverage resources across all of our hospitals.

As of December 31, 2016, with the exception of Bluegrass Community Hospital (“Bluegrass”), Meyersdale Medical Center (“Meyersdale”) and Miners Medical Center (“Miners”), all of our hospitals are accredited by the Joint Commission. With such accreditation, our hospitals are deemed to meet the Medicare Conditions of Participation and are, therefore, eligible to participate in government-sponsored provider programs, such as the Medicare and Medicaid programs. Bluegrass, Meyersdale and Miners participate in the Medicare program by otherwise meeting the Medicare Conditions of Participation.

Services Provided and Peer Review

The range of services that can be offered at any of our hospitals depends significantly on the efforts, abilities and experience of the physicians on the medical staffs of our hospitals, most of whom have no long-term contractual

relationship with us. Under state laws and other licensing standards, hospital medical staffs are generally self-governing organizations subject to ultimate oversight by a hospital's local governing board. Our hospitals are staffed by licensed physicians who have been admitted to the medical staffs of individual hospitals, and in many cases, credentialed (or authorized) to provide specialized services by the medical executive (or other comparable) committees of the hospitals and the local governing boards. The medical executive or other applicable committees are generally comprised of physicians on a hospital's medical staff, and the boards generally include members of a hospital's medical staff as well as community leaders. In addition to medical staff credentialing decisions, these boards establish policies concerning medical, professional and ethical practices, monitor these practices, and are responsible for reviewing these practices in order to determine that they conform to established standards of proper and appropriate medical care. Although we maintain quality assurance programs to support and monitor quality of care standards and to meet accreditation and regulatory requirements, decisions about whether physicians can practice at our hospitals, the scope of each such physician's practice, the oversight of the quality of the care being provided by such physicians, and physician disciplinary or corrective actions are made or are the responsibility of the medical executive, peer review, quality assurance, utilization review, and other related medical staff committees and the local governing boards at each hospital. As a result, our ability to address quality of care and performance concerns relating to non-employed physicians may be limited. We also monitor patient care evaluations and other quality of care assessment activities on a regular basis.

Members of the medical staffs of our hospitals are free to serve on the medical staffs of hospitals not owned or operated by LifePoint. Members of our medical staffs are free to terminate their affiliation with our hospitals or admit their patients to competing hospitals at any time. Although, where permitted by law, we own a number of physician practices and employ a number of physicians, the majority of the physicians who practice at our facilities are not our employees. It is essential to our ongoing business that we attract and retain skilled employees and an appropriate number of quality physicians and other healthcare professionals in all specialties on our medical staffs.

In our markets, physician recruitment and retention are affected by a shortage of physicians in certain sought-after specialties, the difficulties that physicians are experiencing in obtaining affordable malpractice insurance or finding insurers willing to provide such insurance, and the challenges that can be associated with practicing medicine in small groups or independently.

TABLE OF CONTENTS

Availability of Information

Our website is www.lifepointhealth.net. We make available free of charge on this website under "Investor Relations — SEC Filings" our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and amendments to those reports filed or furnished as soon as reasonably practicable after we electronically file such materials with, or furnish them to, the U.S. Securities and Exchange Commission ("SEC").

Sources of Revenue

Our facilities receive payment for patient services from the federal government primarily under the Medicare program, state governments under their respective Medicaid programs, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and other private insurers, as well as directly from patients ("self-pay").

Our revenues by payor and approximate percentages of revenues during the years specified below were as follows (in millions):

	2016		2015		2014	
	Amount	Ratio	Amount	Ratio	Amount	Ratio
Medicare	$ 2,372.4	37.3 %	$ 1,894.9	36.3 %	$ 1,627.6	36.3 %
Medicaid	922.5	14.5	855.2	16.4	619.8	13.8
HMOs, PPOs and other private insurers	3,015.0	47.3	2,393.5	45.9	2,210.5	49.3
Self-pay	832.8	13.1	749.0	14.4	744.9	16.6
Other	130.9	2.1	121.8	2.3	98.1	2.2
Revenues before provision for doubtful accounts	7,273.6	114.3	6,014.4	115.3	5,300.9	118.2
Provision for doubtful accounts	(909.6)	(14.3)	(800.1)	(15.3)	(817.8)	(18.2)
Revenues	$ 6,364.0	100.0 %	$ 5,214.3	100.0 %	$ 4,483.1	100.0 %

Certain changes have been made to the classification of our historical sources of revenues. Primarily, we changed the classification of revenues related to our managed Medicare programs from HMOs, PPOs and other private insurers to Medicare for each of the periods presented above. This change had no impact on our historical results of operations.

Patients generally are not responsible for any difference between customary hospital charges and amounts reimbursed for the services under Medicare, Medicaid, private insurance plans, HMOs or PPOs, but are responsible for services not covered by these plans and for patient responsibility amounts due in connection with the exclusion, deductible or co-payment features of their coverage. The amounts of exclusions, deductibles and co-payments for which our patients are responsible generally have been increasing each year as employers have been shifting a higher percentage of healthcare costs to employees. Beginning in 2014, our self-pay revenues began to decrease due largely to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which

primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate. This shift partially offset trends our facilities have experienced in recent years, including increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments. The trend toward decreasing self-pay revenues may be impacted if the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act") is repealed, replaced or modified, will be gradual and may not offset scheduled decreases in reimbursement.

TABLE OF CONTENTS

Medicare

Our revenues from Medicare were approximately $2,372.4 million, or 37.3% of total revenues for the year ended December 31, 2016. Medicare provides hospital and medical insurance benefits, regardless of income, to persons age 65 and over, some disabled persons and persons with end-stage renal disease. All of our hospitals are currently certified as providers of Medicare services. Amounts received under the Medicare program are often significantly less than the hospital's customary charges for the services provided. Since 2003, Congress and CMS have made several sweeping changes to the Medicare program and its reimbursement methodologies, such as the implementation of the prescription drug benefit that was created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "MMA") and the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act"). Additionally, the Middle Class Tax Relief and Job Creation Act of 2012 and the American Taxpayer Relief Act of 2012 ("ATRA") required reductions in Medicare payments, and the Budget Control Act of 2011 ("BCA") imposed a 2% reduction in Medicare spending which began on April 1, 2013. The Bipartisan Budget Act of 2015 ("BBA"), which provides $80 billion in discretionary spending sequestration relief for federal fiscal years ("FFYs") 2016 and 2017, extends the 2% reduction in Medicare spending, which was imposed by the BCA, through FFY 2025 and, effective January 1, 2017, reduces Medicare payments to certain off-campus hospital outpatient departments that were not billing the Medicare program for covered outpatient services prior to November 2, 2015. Furthermore, reductions in Medicare reimbursement could result from changes to, or the repeal of, the Affordable Care Act, or as a result of the enactment of Medicare reform, deficit reduction, or other legislation.

Medicare Inpatient Prospective Payment System

Under the Medicare program, hospitals are reimbursed for the costs of acute care inpatient stays under an inpatient prospective payment system ("IPPS"). Under the IPPS, our hospitals are paid a prospectively determined amount for each hospital discharge that is based on the patient's diagnosis. Specifically, each discharge is assigned to a Medicare severity diagnosis related group ("MS-DRG"), which groups patients that have similar clinical conditions and that are expected to require a similar amount of hospital resources. Each MS-DRG is, in turn, assigned a relative weight that is prospectively set and that reflects the average amount of resources, as determined on a national basis, that are needed to treat a patient with that particular diagnosis, compared to the amount of hospital resources that are needed to treat the average Medicare inpatient stay. The IPPS payment for each discharge is based on two national base payment rates or standardized amounts, one that covers hospital operating expenses and another that covers hospital capital expenses. The base MS-DRG payment rate for operating expenses has two components, a labor share and a non-labor share. Although the labor share is adjusted by a wage index to reflect geographical differences in the cost of labor, the base MS-DRG payment rate does not consider the actual costs incurred by an individual hospital in providing a particular inpatient service. In addition to IPPS reimbursement, Medicare also makes supplemental payments known as outlier payments to compensate hospitals for cases involving extraordinarily high costs.

The base MS-DRG operating expense payment rate that is used by the Medicare program in the IPPS is adjusted by an update factor each FFY, which begin on October 1 (for example, FFY 2017 began on October 1, 2016). The index used to adjust the base MS-DRG payment rate, which is known as the "hospital market basket index," gives consideration to the inflation experienced by hospitals in purchasing goods and services. For FFYs 2017, 2016 and 2015, the hospital market basket index increased 2.7%, 2.4% and 2.9%, respectively. Generally, however, the

percentage increase in the MS-DRG payment rate has been lower than the projected increase in the cost of goods and services purchased by hospitals. In addition, as mandated by the Affordable Care Act, the hospital market basket increases for FFYs 2017, 2016 and 2015 were reduced by CMS by 0.75%, 0.20% and 0.20%, respectively. As also mandated by the Affordable Care Act, the market basket increase is reduced by a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide productivity. For FFYs 2017, 2016 and 2015, the productivity adjustment equated to a 0.3%, 0.5% and 0.5% reduction in the market basket increase, respectively.

The MMA required all acute care hospitals to participate in CMS's Hospital Inpatient Quality Reporting Program (the "IQR Program") in order to receive the full hospital market basket update. Beginning in FFY 2015, hospitals that do not participate in the IQR Program receive a one-fourth reduction in their IPPS annual payment update for the applicable FFY. Our hospitals reported all quality measures required by CMS related to the IQR Program and will receive the full market basket update through FFY 2017. In addition, hospitals that are not meaningful electronic health record ("EHR") users are also subject to an additional 75% reduction of the hospital market basket increase.

TABLE OF CONTENTS

On October 1, 2007, CMS replaced the previously existing 538 diagnosis related groups with 745 MS-DRGs. The MS-DRGs are intended to more accurately reflect the cost of providing inpatient services and eliminate any incentives that hospitals may have to only treat the healthiest and most profitable patients. ATRA, which was enacted on January 1, 2013, required CMS to recoup $11 billion from IPPS payments in FFYs 2014 through 2017 to offset an additional increase in aggregate payments to hospitals that Congress believes occurred from FFY 2008 through 2013 solely as the result of the transition to the MS-DRG system that had not otherwise been recaptured. In FFYs 2014, 2015 and 2016, CMS applied (0.8%) adjustments as part of the recovery process required by ATRA, and it applied a (1.5%) adjustment in FFY 2017 to recover the remaining outstanding amount. CMS had previously indicated that the reductions required by ATRA would be fully restored in FFY 2018. However, under the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”), those reductions will be restored in 0.5% increments over a six year period from FFY 2018 through FFY 2023, which will result in a cumulative 3.0% increase in rates, which is less than the 3.9% reduction that was imposed by CMS in FFYs 2014 through 2017. In addition, the 21st Century Cures Act (the “Cures Act”) further reduces the restoration for FFY 2018 from 0.5% to 0.4588%.

In addition to the documentation and coding adjustments required by ATRA, CMS reduced IPPS payment rates by 0.2% in FFY 2014 to offset the expected net increase in inpatient encounters resulting from the implementation of the “Two- Midnight Rule,” which is discussed in more detail below. A number of federal lawsuits have been filed challenging the Two-Midnight Rule primarily on the grounds that the implementation of the rule, as well as the payment reduction associated with the Rule, violated the Administrative Procedures Act. In the IPPS final rule for FFY 2017, CMS permanently removed the payment adjustment, and its effects for FFYs 2014 through FFY 2017, by increasing payments for FFY 2017 by approximately 0.8%.

The following tables list our historical Medicare MS-DRG and capital payments for the years presented (in millions):

	Medicare MS-DRG Payments	Medicare Capital Payments
2016	$ 765.1	$ 58.3
2015	$ 631.0	$ 47.1
2014	$ 585.5	$ 45.9

Hospitals may also qualify for Medicare disproportionate share hospital (“DSH”) payments, if they treat a high percentage of low-income patients. The adjustment is generally based on the hospital’s disproportionate patient percentage (“DPP”), which is equal to the sum of the percentage of Medicare inpatient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI), and the percentage of total inpatient days attributable to patients eligible for Medicaid but not Medicare Part A. Hospitals whose DPP meets or exceeds a specified threshold amount are eligible for a DSH payment adjustment. The Affordable Care Act requires Medicare

DSH payments to providers to be reduced by 75% beginning in FFY 2014, subject to adjustment if the Affordable Care Act does not decrease uncompensated care to the extent anticipated. The amount that is withheld will be reduced by the percentage change in uninsured individuals under the age of 65, and then paid as additional payments to DSH hospitals based on the amount of uncompensated care provided by each hospital relative to the amount of uncompensated care provided by all hospitals receiving DSH payments during the applicable time period. The IPPS final rule for FFY 2017 established the uncompensated care amount which will be distributed to qualifying hospitals in FFY 2017 at approximately $6.0 billion, down from $6.4 billion in FFY 2016. Medicare DSH payments received in the aggregate by our hospitals for 2016, 2015 and 2014 were approximately $66.2 million, $66.4 million and $73.5 million, respectively.

"Two-Midnight Rule"

In the Medicare program's IPPS final rule for FFY 2014, CMS issued the Two-Midnight Rule, which revised CMS's longstanding guidance to hospitals and physicians relating to when hospital inpatient admissions are deemed to be reasonable and necessary for payment under Medicare Part A. The Rule originally provided, in addition to services that are designated as inpatient-only, surgical procedures, diagnostic tests and other treatments are generally only appropriate for inpatient hospital admission and payment under Medicare Part A when the physician (i) expects the beneficiary to require a stay that crosses at least two midnights and (ii) admits the beneficiary to the hospital based upon that expectation.

While the IPPS final rule for FFY 2014 became effective on October 1, 2013, CMS initially indicated that it would not permit recovery auditor contractors ("RACs") and other Medicare review contractors to review inpatient admissions of one midnight or less that began between October 1, 2013 and December 31, 2013. CMS subsequently extended that delay to inpatient admissions that occurred on or prior to September 30, 2014. CMS did, however, instruct Medicare Administrative Contractors ("MACs") to review, on a pre-payment basis, a small sample (approximately 10 – 25) of inpatient hospital claims relating to admissions that spanned less than two midnights after admission in order to determine each hospital's compliance with the new inpatient admission and medical review criteria.

On April 1, 2014, the Protecting Access to Medicare Act of 2014 ("PAMA") was enacted into law. Among other things, PAMA prohibited CMS from allowing RACs to conduct inpatient hospital patient status reviews on claims with dates of admission through March 31, 2015, but it permitted CMS to continue to allow MACs to review, on a pre-payment basis, a small sample of inpatient hospital claims relating to admissions that spanned less than two midnights in order to determine hospital compliance with the new inpatient admission and medical review criteria. MACRA extended the prohibition on RAC inpatient hospital patient status reviews on claims with dates of admission through September 30, 2015.

On July 8, 2015, as part of the Medicare hospital outpatient prospective payment system ("OPPS") proposed rule for calendar year ("CY") 2016, CMS, announced changes in how it would educate providers about and enforce the Two-Midnight Rule. In the proposed rule, CMS stated that effective as of October 1, 2015, Beneficiary and Family Centered Care Quality Improvement Organization contractors ("BFCC-QIOs") would assume responsibility for conducting initial patient status reviews of providers to determine the appropriateness of Medicare Part A payment for short stay inpatient hospital claims. Under the new strategy, RAC reviews of short inpatient stays would be limited to hospitals that have been referred to the RAC by a BFCC-QIO as exhibiting consistent non-compliance with Medicare payment policies, including high denial rates and consistently failing to adhere to the Two-Midnight Rule or failing to improve their performance after BFCC-QIO educational intervention. On August 12, 2015, CMS announced that it was extending a partial enforcement delay of the Two-Midnight Rule and that it would not approve RACs to conduct patient status reviews for dates of admission of October 1, 2015 through December 31, 2015.

On October 30, 2015, as part of the OPPS final rule for CY 2016, CMS released modifications to the Two-Midnight Rule. Under the final rule, for stays that are expected to last less than two midnights, an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician if the documentation in the medical record supports the admitting physician's determination that an inpatient admission was necessary. The admitting physician's determination would be subject to medical review, and CMS indicated that despite the modification, its expectation would continue to be that inpatient stays under 24 hours would rarely qualify for an exception to the two-midnight benchmark. The final rule did not change the standard for stays that are expected to be two midnights or longer, and, as a result, those stays would still generally be considered appropriate for Medicare Part A payment. In the final rule, CMS also announced that BFCC-QIOs and RACs would conduct patient status reviews in accordance with the policy changes set forth in the OPPS final rule for CY 2016 beginning on January 1, 2016, and that any reviews conducted by BFCC-QIOs from October 1, 2015 through December 31, 2015, would be conducted based on the Medicare payment rules in effect during that period of time.

On May 4, 2016, CMS temporarily suspended performance by the BFCC-QIOs of initial patient status reviews to determine the appropriateness of Part A payments for short stay inpatient hospital claims. CMS implemented the temporary suspension after becoming aware of inconsistencies in the BFCC-QIOs' application of the Two-Midnight Rule. CMS lifted the temporary suspension effective as of September 12, 2016 after the BFCC-QIOs had completed retraining on the Two-Midnight Rule, re-reviewed all claims that they had denied in connection with the Two-Midnight Rule medical review process since October 2015, and performed any provider outreach and education that was required. We cannot predict whether CMS will make any additional changes or modifications to the Two-Midnight Rule or its Two-Midnight Rule enforcement policies or the impact that the review of inpatient

admissions of one midnight or less by BFCC-QIOs, RACs or other Medicare review contractors will have on our business and results of operations. We also cannot predict whether the pending federal court challenges to the Two-Midnight Rule will be successful. In addition, legislation has previously been introduced in Congress that, among other things, would generally prohibit Medicare review contractors from denying claims due to the length of a patient's stay or a determination that services could have been provided in an outpatient setting and require CMS to develop a new payment methodology for services that are provided during short inpatient hospital stays. We cannot predict whether the legislation that has been introduced in Congress, or any other similar legislation, will be adopted or, if adopted, the amount of reimbursement that would be paid under any alternative payment methodology that is developed by CMS.

Medicare Hospital Outpatient Prospective Payment System

The Balanced Budget Refinement Act of 1999 ("BBRA") established a prospective payment system for outpatient hospital services that commenced on August 1, 2000. Under OPPS, hospital outpatient services are classified into groups called ambulatory payment classifications ("APCs"). Services in each APC are clinically similar and are similar in terms of the resources they require. Depending on the services provided, a hospital may be paid for more than one APC for an encounter. CMS establishes a payment rate for each APC by multiplying the scaled relative weight for the APC by a conversion factor. The payment rate is further adjusted to reflect geographic wage differences. The APC conversion factors for CYs 2017, 2016 and 2015 were $75.001, $73.725 and $74.144, respectively, after the inclusion of the reductions (1.05% for CY 2017 and 0.7% for both CYs 2016 and 2015), that were required by the Affordable Care Act. APC classifications and payment rates are reviewed and adjusted on an annual basis, and, historically, the rate of increase in payments for hospital outpatient services has been higher than the rate of increase in payments for inpatient services. To receive the full increase, hospitals must satisfy the reporting requirements of the Hospital Outpatient Quality Data Reporting Program (the "HOPQDRP"). Hospitals that do not satisfy the reporting requirements of the HOPQDRP are subject to a reduction of 2.0% in their annual payment update under the OPPS. Our hospitals reported all quality measures required by CMS for HOPQDRP and will receive the full market basket update through CY 2017.

TABLE OF CONTENTS

Effective as of January 1, 2017, Section 603 of the BBA limits OPPS reimbursement for items and services that are furnished by certain off-campus outpatient provider-based departments (“off-campus PBDs”) of hospitals. CMS included several provisions implementing Section 603 in the OPPS final rule for CY 2017. Under the final rule, CMS will continue to make OPPS payments to off-campus PBDs that were billing Medicare as hospital departments under the OPPS prior to November 2, 2015 (“grandfathered PBDs”). However, grandfathered PBDs will generally not be able to relocate, and CMS has indicated that it intends to monitor service line growth at grandfathered PBDs and that it may adopt limitations on the expansion of such service lines in the future. In addition to grandfathered PBDs, CMS will also continue to reimburse all items and services that are furnished in a “dedicated emergency department” of a hospital, as such term is defined for the purposes of the Emergency Medical Treatment and Active Labor Act, regardless of whether the items and services are emergency items and services, and all items and services that are furnished in off-campus PBDs that are located within 250 yards of a remote location of a hospital, which is a facility that is either created or acquired by a hospital for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the hospital, under the IPPS. Under the final rule, in CY 2017, all items and services not provided at a grandfathered or otherwise excepted off-campus PBD will generally be paid by CMS under new Medicare physician fee schedule (“PFS”) rates that are approximately 50% of the applicable OPPS rate. CMS has indicated that it will likely use the same payment methodology for CY 2018 for items and services furnished in non-grandfathered or non-excepted off-campus PBDs in order to allow for the operational changes necessary to design and implement a long-term payment approach for non-excepted off-campus PBDs under the Medicare PFS System.

The Cures Act does provide some relief to hospitals that were in the process of constructing new off-campus PBDs when Section 603 of the BBA was enacted. Under the Cures Act, an off-campus PBD that was in “mid-build” when Section 603 of the BBA was enacted will be eligible for full OPPS reimbursement beginning in CY 2018 if (i) the hospital had a binding written agreement with an outside unrelated party for the construction of the new off-campus PBD before November 2, 2015 (the “mid-build requirement”), (ii) the hospital submitted a CMS-855A application to include the new off-campus PBDs on the hospital’s Medicare enrollment record, (iii) the hospital submits a provider-based attestation for the off-campus PBD prior to February 13, 2017 and (iv) the chief executive officer or the chief operating officer of the hospital certifies to CMS in writing that the off-campus PBD satisfies the mid-build requirement.

The following table lists our historical Medicare APC payments for the years presented (in millions):

	Medicare APC Payments
2016	$ 544.2
2015	$ 427.7
2014	$ 387.4

Medicare Dependent and Low Volume Hospital Programs

On December 26, 2013, the Pathway for SGR Reform Act of 2013 (the "Pathway Act") was enacted. Among other things, the Pathway Act extended through March 31, 2014, the Medicare dependent hospital program, which provides enhanced payment support for rural hospitals that have no more than 100 beds and at least 60% of their inpatient days or discharges covered by Medicare, and the Medicare low volume hospital program, which provides additional Medicare reimbursement for general acute care hospitals that are located a certain distance from another general acute care hospital and have less than a certain number of Medicare discharges each fiscal year. Both of these programs have been extended by PAMA and MACRA through October 1, 2017.

Medicare Bad Debt Reimbursement

Under Medicare, the costs attributable to the deductible and coinsurance amounts that follow reasonable collection efforts and remain unpaid by Medicare beneficiaries can be added to the Medicare share of allowable costs as cost reports are filed. Hospitals generally receive interim pass-through payments during the cost report year which were determined by the fiscal intermediary from the prior cost report filing.

The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases, an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period. In these cases, the recoveries must be used to reduce the cost of beneficiary services for the period in which the collection is made. In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs is reduced by 35%. Under this program, our hospitals received an aggregate of approximately $29.8 million, $25.9 million and $18.1 million for 2016, 2015 and 2014, respectively.

TABLE OF CONTENTS

Physician Services

Physician services are reimbursed under the PFS, under which CMS has assigned a national relative value unit ("RVU") to most medical procedures and services that reflects the various resources required by a physician to provide the services relative to all other services. Each RVU is calculated based on a combination of work required in terms of time and intensity of effort for the service, practice expense (overhead) attributable to the service and malpractice insurance expense attributable to the service. These three elements are each modified by a geographic adjustment factor to account for local practice costs then aggregated. The aggregated amount has historically been multiplied by a conversion factor that accounts for inflation and targeted growth in Medicare expenditures (as calculated by the sustainable growth rate ("SGR")) to arrive at the payment amount for each service. The SGR has generally resulted in significant reductions to payments made under the PFS, and, since 2003, Congress has passed multiple legislative acts delaying application of the SGR to the PFS.

On April 16, 2015, MACRA was enacted into law. Among other things, MACRA replaced the SGR formula with new systems for establishing the annual updates to payments made under the PFS. Under MACRA, the PFS payment rates that were in effect when MACRA was enacted were extended through June 30, 2015, and then increased by 0.5% for the remainder of CY 2015. PFS payment rates were increased by an additional 0.5% for CYs 2016 and 2017 and will be increased by 0.5% a year for CYs 2018 and 2019. PFS payment rates would then remain at their CY 2019 levels through CY 2025. Beginning in CY 2019, amounts paid to individual physicians would be subject to adjustment through either the Merit-Based Incentive Payment System ("MIPS") or the Alternative Payment Model ("APM") program. Physicians who participate in the MIPS program, which would essentially consolidate the existing Physician Quality Reporting System, the Value-Based Modifier, and the Meaningful Use of EHR incentive programs, would be subject to positive, zero, or negative performance adjustments depending on how the physician's performance compared to a performance threshold. In addition, from CY 2019 through CY 2024, MACRA provides an additional $500 million per year for an additional performance adjustment for physicians who participate in MIPS and achieve exceptional performance. Physicians who participate in an APM program and receive a substantial amount of their revenue from an alternative payment model would receive, from CY 2019 through 2024, a lump-sum payment equal to 5% of their Medicare payments in the prior year for services paid under the PFS. Beginning in CY 2026, PFS payment rates for physicians participating in an APM program would be increased by 0.75% a year. Payments for other providers would be increased by 0.25% per year.

Medicaid

Our revenues under the various state Medicaid programs, including state-funded managed care programs, were approximately $922.5 million, or 14.5% of total revenues for the year ended December 31, 2016. Included in these payments are DSH and other supplemental payments received under various state Medicaid programs. For 2016, 2015 and 2014, our revenues attributable to DSH and other supplemental payments were approximately $236.7 million, $205.4 million and $155.7 million, respectively. The increase in revenues from DSH and other supplemental payments is primarily attributable to additional funding provided by certain states, which was made available in part by additional annual state provider taxes on certain of our hospitals and changes in classification of state programs.

Medicaid programs are funded by both state governments and federal matching funds to provide healthcare benefits to certain low-income individuals and groups. These programs and the reimbursement methodologies are administered by the states and vary from state to state and from year to year. Amounts received under the Medicaid programs are often significantly less than the hospital's customary charges for the services provided. Most state Medicaid payments are made under a prospective payment system, fee schedule, cost reimbursement programs, or some combination of these three methods.

Many states in which we operate are facing budgetary challenges and have adopted, or may be considering, legislation that is intended to control or reduce Medicaid expenditures, enroll Medicaid recipients in managed care programs, and/or impose additional taxes on hospitals to help finance or expand their Medicaid programs. Additionally, as part of the movement to repeal, replace or modify the Affordable Care Act and as a means to reduce the federal budget deficit, there are renewed congressional efforts to move Medicaid from an open-ended program with coverage and benefits set by the federal government to one in which states receive a fixed amount of federal funds, either through block grants or per capita caps, and have more flexibility to determine benefits, eligibility or provider payments. Such efforts to reduce federal funding of the Medicaid program, as well as those that would reduce the amount of federal Medicaid matching funding available to states by curtailing the use of provider taxes, could have a negative impact on state Medicaid budgets resulting in less coverage for eligible individuals. If implemented, we cannot predict whether the amount of fixed federal funding to the states will be based on current payment amounts, or if it will be based on lower payment amounts, which would negatively impact those states that expanded their Medicaid programs in response to the Affordable Care Act.

Budget cuts, federal or state legislation, or other changes in the administration or interpretation of government health programs by government agencies or contracted managed care organizations could have a material adverse effect on our financial position and results of operations.

TABLE OF CONTENTS

Annual Cost Reports

Hospitals participating in the Medicare and some Medicaid programs, whether paid on a reasonable cost basis or under a prospective payment system, are required to meet certain financial reporting requirements. Federal and, where applicable, state regulations require submission of annual cost reports identifying medical costs and expenses associated with the services provided by each hospital to Medicare and Medicaid recipients.

Annual cost reports required under the Medicare and some Medicaid programs are subject to routine governmental audits. These audits may result in adjustments to the amounts ultimately determined to be payable to us under these reimbursement programs. Finalization of these audits often takes several years. Providers may appeal any final determination made in connection with an audit.

Recovery Audit Contractors

Recovery audit contractors, also referred to as RACs, are used by CMS and state agencies to detect Medicare and Medicaid overpayments not identified through existing claims review mechanisms. The RAC program relies on private companies to examine Medicare and Medicaid claims filed by healthcare providers. RACs perform post-discharge audits of medical records to identify overpayments resulting from incorrect payment amounts, non-covered services, medically unnecessary services, incorrectly coded services, and duplicate services and are paid on a contingency basis. Any claims identified as overpayments are subject to a RAC program appeals process.

The original recovery audit contracts expired in February 2014, and CMS did not award the next round of Medicare fee-for-service recovery audit contracts until October 2016. In connection with the procurement of the new recovery audit contracts, CMS made a number of enhancements to the RAC program, including the establishment of a RAC program Provider Relations Coordinator, requiring RACs to maintain an overturn rate of less than 10% at the first level of appeal, requiring RACs to maintain an accuracy rate of at least 95%, and establishing additional documentation request limits based on a provider’s compliance with Medicare rules, that are intended to address provider and other stakeholder concerns.

Although we believe our claims for reimbursement submitted to the Medicare and Medicaid programs are accurate, many of our hospitals have had Medicare claims audited by the RAC program. While our hospitals have successfully appealed many of the adverse determinations raised by Medicare RAC audits, we cannot predict if this trend will continue or the results of any future audits. We cannot predict the volume or outcome of any future audits conducted by the various state Medicaid RAC programs to which our hospitals will be subject. During the years ended December 31, 2016 and 2015, RAC audits resulted in additional revenue of approximately $0.6 million and a reduction to revenue of approximately $4.9 million, respectively. During the year ended December 31, 2014, as a result of both our participation in a CMS administrative agreement settlement process and our success in appealing adverse RAC determinations, we recognized additional revenue of approximately $9.1 million.

HMOs, PPOs and Other Private Insurers

In addition to government programs, our facilities are reimbursed by differing types of private payors including HMOs, PPOs, other private insurance companies and employers. Also included in this category are the patient responsibility portions for co-payment and deductible obligations under these programs. Our revenues from HMOs, PPOs and other private insurers were approximately $3,015.0 million, or 47.3% of total revenues for the year ended December 31, 2016. Revenues from HMOs, PPOs and other private insurers are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services. These discounted

arrangements often limit our ability to increase charges in response to increasing costs. We actively negotiate with these payors in an effort to maintain or increase the pricing of our healthcare services; however, we have no control over patients switching their healthcare coverage to a payor with which we have negotiated less favorable reimbursement rates. In recent years, an increasing number of our patients have moved to lower cost healthcare coverage plans, and such plans generally provide lower reimbursement rates and require patients to pay an increased portion of the costs of care through deductibles, co-payments or exclusions. We expect this trend to continue in the coming years.

Self-pay and Charity Care

Self-pay revenues are derived from patients who do not have any form of healthcare coverage. Our revenues from self-pay patients were approximately $832.8 million, or 13.1% of total revenues for the year ended December 31, 2016. The revenues associated with self-pay patients are generally reported at our gross charges. We evaluate these patients, after the patient's medical condition is determined to be stable, for qualifications of Medicaid or other governmental assistance programs, as well as our local hospital's policy for charity care. We do not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is our policy not to pursue collection of amounts related to these patients.

A significant portion of self-pay patients are admitted through the emergency department and often require high-acuity treatment that is more costly to provide and, therefore, results in higher billings. Beginning in 2014, our self-pay revenues began to decrease due largely to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our hospitals have experienced in recent years, including increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments.

The following table lists our self-pay revenues and charity care write-offs for the years presented (in millions):

	Self-Pay Revenues	Charity Care Write-Offs	Combined Total
2016	$ 832.8	$ 129.1	$ 961.9
2015	$ 749.0	$ 89.3	$ 838.3
2014	$ 744.9	$ 80.9	$ 825.8

Provision for Doubtful Accounts

To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. The primary uncertainty lies with uninsured patient receivables and deductibles, co-payments or other amounts due from individual patients. Our provision for doubtful accounts had the effect of reducing total revenues by approximately $909.6 million, or 14.3% of total revenues for the year ended December 31, 2016. Prior to 2014, our provision for doubtful accounts as a percentage of revenue increased steadily year over year as a result of increases in our self-pay revenues. Beginning in 2014, our self-pay revenues began to decrease as discussed above. As a result, for the year ended December 31, 2016, our provision for doubtful accounts as a percentage of revenue also decreased.

We have an established process to determine the adequacy of the allowance for doubtful accounts that relies on a number of analytical tools and benchmarks to arrive at a reasonable allowance. No single statistic or measurement determines the adequacy of the allowance for doubtful accounts. Some of the analytical tools that we utilize include, but are not limited to, historical cash collection experience, revenue trends by payor classification and revenue days in accounts receivable.

Health Care Reform

The Affordable Care Act, which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare by, among other things, requiring most Americans to obtain health insurance, providing additional funding for Medicaid in states that choose to expand their programs, reducing Medicaid DSH payments to providers, expanding the Medicare program's

use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, bundling payments to hospitals and other providers, and instituting certain private health insurance reforms. The Affordable Care Act also includes certain reductions in Medicare spending, such as negative adjustments to the hospital inpatient and outpatient prospective payment system market basket updates, the revision of annual inflation updates and other cost-containment measures, including planned payment reductions. Since 2010, we have expended substantial cost and effort to plan and prepare for and comply with the Affordable Care Act, which has been implemented on a rolling basis with further implementation scheduled over the next several years.

On January 20, 2017, newly-inaugurated President Trump issued an executive order that, among other things, stated that it was the intent of his administration to repeal the Affordable Care Act and, pending that repeal, instructed the executive branch of the federal government to defer or delay the implementation of any provision or requirement of the Affordable Care Act that would impose a fiscal burden on any state or a cost, fee, tax or penalty on any individual, family, health care provider, or health insurer. In addition, bills have been introduced in Congress that would repeal the Affordable Care Act and would replace it with varying health coverage plans, including plans that would allow insurers to sell health insurance across state lines, allow the use of health savings accounts ("HSAs") without a high-deductible plan, or give states the option to either keep the coverage framework created by the Affordable Care Act (e.g., expanded Medicaid, individual subsidies, and insurance exchanges) or utilize the increased federal funding that was intended to be provided by the federal government under the Affordable Care Act to create HSAs for low-income individuals and allow such individuals to use their HSAs to purchase health insurance. We cannot predict whether the Affordable Care Act will be repealed, replaced, or modified or the impact that the President's executive order will have on the implementation and enforcement of the provisions of the Affordable Care Act or the regulations adopted or to be adopted to implement the law. In addition, if the Affordable Care Act is replaced or modified, we cannot predict what the replacement plan or modifications would be, when the replacement plan or modifications would become effective, or whether any of the existing provisions of the Affordable Care Act would remain in place.

TABLE OF CONTENTS

Even if the current administration is not successful in efforts to repeal and replace the Affordable Care Act, there have been and likely will continue to be a number of legal challenges to various provisions of the Affordable Care Act. For example, in 2012, the U.S. Supreme Court upheld the constitutionality of the Affordable Care Act, including the "individual mandate" provisions of the Affordable Care Act that generally require all individuals to obtain healthcare insurance or pay a penalty. However, the U.S. Supreme Court also held that the provision of the Affordable Care Act that authorized the Secretary of the U.S. Department of Health and Human Services ("HHS") to penalize states that choose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. Furthermore, the U.S. House of Representatives filed a lawsuit challenging the use of federal funds to pay insurance companies for cost sharing reductions that are provided to certain individuals who purchase insurance through the Affordable Care Act health insurance marketplace exchange (the "Exchanges"). In May 2016, the United States District Court for the District of Columbia held that the use of federal funds for the payment of cost sharing reductions was unconstitutional because no funds had been appropriated by Congress for that purpose. The District Court's ruling is being appealed, but if the lawsuit is successful, it could result in insurance premium increases for individuals purchasing their insurance coverage through, or lead to a decrease in the number of insurers offering insurance coverage on, the Exchanges. We cannot predict how the results of the 2016 federal elections will impact the appeal of the lawsuit that has been filed by the U.S. House of Representatives or how the federal government responds to other litigation involving the Affordable Care Act.

The net effect of the Affordable Care Act, as currently adopted, on our business is subject to numerous variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, and the gradual implementation of the numerous programs designed to improve access and quality. Additional variables related to the Affordable Care Act impacting our business will be how states, providers, insurance companies, employers, and other market participants respond during this period of uncertainty surrounding the future of the Affordable Care Act. As a result, we are unable to predict the effect on our business, financial condition or results of operations, the availability of adequate insurance coverage for patients seeking health care at our facilities, the reductions in government healthcare reimbursement spending, and numerous other provisions potentially impacted by the possible repeal, replacement or modification of the Affordable Care Act.

Unless specifically stated otherwise, our summary of provisions of the Affordable Care Act throughout the remainder of this section and elsewhere in this report are based on the law as currently in effect.

Expanded Coverage

Based on original Congressional Budget Office ("CBO") and CMS estimates, by 2019, the Affordable Care Act was expected to expand coverage to 32 to 34 million additional individuals (resulting in coverage of an estimated 94% of the legal U.S. population). This increased coverage was expected to occur through a combination of public program expansion and private sector health insurance and other reforms. However, in July 2012, the CBO revised its estimate

to reflect the impact of the U.S. Supreme Court's determination that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that choose not to participate in the expansion of the Medicaid program was unconstitutional and indicated that three million fewer individuals would have coverage as a result of the decision. For 2016, the CBO has estimated that 12 million people had coverage through the health insurance marketplaces, 1 million people had coverage from state basic health programs and 13 million people had coverage through Medicaid and the Children's Health Insurance Program ("CHIP") due to the Affordable Care Act. Beginning in 2014 and continuing through 2016, primarily as a result of the expansion of health insurance coverage, we experienced an increase in revenues from providing care to certain previously uninsured individuals. Although we expect this trend to continue, the future impact and timing of such expansion remains difficult to predict for the reasons discussed above, will be gradual and may not offset scheduled decreases in reimbursement. Additionally, we cannot predict the impact of any modifications to the Affordable Care Act that may be adopted.

Medicaid Expansion

The primary public program coverage expansion has occurred through changes in Medicaid, and to a lesser extent, expansion of CHIP. The most significant changes will expand the categories of individuals eligible for Medicaid coverage and permit individuals with relatively higher incomes to qualify. The federal government reimburses the majority of a state's Medicaid expenses, and it conditions its payment on the state meeting certain requirements. The federal government currently requires that states provide coverage for only limited categories of low-income adults under 65 years old (e.g., women who are pregnant, and the blind or disabled). In addition, the income level required for individuals and families to qualify for Medicaid varies widely from state to state.

TABLE OF CONTENTS

The Affordable Care Act materially changed the requirements for Medicaid eligibility. As originally enacted, commencing January 1, 2014, the Affordable Care Act essentially required all state Medicaid programs to provide Medicaid coverage to virtually all adults under 65 years old with incomes at or under 133% of the federal poverty level ("FPL"). In addition, the Affordable Care Act also required states to apply a "5% income disregard" to the Medicaid eligibility standard, so that Medicaid eligibility would effectively be extended to those with incomes up to 138% of the FPL. To offset the cost of the Medicaid program's expansion, the Affordable Care Act authorized the federal government to provide states with "matching funds" (referred to as "Enhanced FMAP") to cover the costs of covering the newly eligible individuals. Beginning in 2014, states began receiving an Enhanced FMAP for the individuals enrolled in Medicaid pursuant to the Affordable Care Act. The Enhanced FMAP percentage is as follows: 100% for CYs 2014 through 2016; 95% in 2017; 94% in 2018; 93% in 2019; and 90% in 2020 and thereafter. The CBO has estimated that the new eligibility requirements expanded Medicaid and CHIP coverage by an estimated 12 million individuals in 2016, with a disproportionately large percentage of the new Medicaid coverage likely to be in states that currently have relatively low income eligibility requirements.

In 2012, the U.S. Supreme Court held that the provision of the Affordable Care Act that authorized the Secretary of HHS to penalize states that choose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. As a result, the expansion of the Medicaid program to all individuals under 65 years old with incomes at or under 133% of FPL is optional. CMS has stated that there is no deadline for states to determine whether they will expand their Medicaid programs and has indicated that if a state does decide to expand its Medicaid program, it may also decide to drop the expanded coverage at a later date. While the U.S. Supreme Court's decision has resulted in fewer individuals being covered by the Medicaid and CHIP programs, it is unclear how many states will ultimately elect to implement the Medicaid expansion particularly in light of the possible repeal and replacement of the Affordable Care Act. At December 31, 2016, only ten of the states in which we operate have decided to implement expansions to their Medicaid programs. Accordingly, some low-income persons in states that have not expanded Medicaid may not have insurance coverage as intended by the Affordable Care Act. Therefore, we are unable to predict the future impact of the Medicaid expansion on our business model, financial condition or result of operations.

The Affordable Care Act also provides that the federal government will subsidize states that create non-Medicaid plans for residents whose incomes are greater than 133% of the FPL but do not exceed 200% of the FPL. Approved state plans will be eligible to receive federal funding. The amount of that funding per individual will be equal to 95% of subsidies that would have been provided for that individual had he or she enrolled in a health plan offered through one of the Exchanges, as discussed below.

In addition, since 2014, the Affordable Care Act has allowed Medicaid participating hospitals to make presumptive determinations of Medicaid eligibility for certain categories of individuals, such as pregnant women, infants, children, and parents and other caretaker relatives and their spouses. If an individual is found to be presumptively eligible for Medicaid benefits, the hospital will get paid for the services it provides during the temporary presumptive eligibility period, just as though the patient were already enrolled in the Medicaid program. However, states have significant

flexibility in developing their state-specific presumptive eligibility rules and can establish standards that hospitals must meet in order to make presumptive eligibility determinations. For example, a state may impose standards related to the accuracy of a hospital's presumptive eligibility determinations, require hospitals to tell individuals how to apply for and obtain a full Medicaid application, establish policies that require hospitals to assist individuals in completing a Medicaid application, and develop proficiency standards, trainings, and audits with which hospitals must comply. If a presumptive eligibility determination is made in accordance with the applicable federal and state presumptive eligibility requirements, a state will not be permitted to recoup money from the hospital for the services that were rendered during the presumptive eligibility period. A state may, however, disqualify a hospital from making future presumptive eligibility determinations if the hospital does not meet the state's established performance standards.

Private Sector Expansion

The expansion of health coverage through the private sector as a result of the Affordable Care Act will occur through new requirements on health insurers, employers and individuals. Commencing January 1, 2014, health insurance companies were prohibited from imposing annual coverage limits, dropping coverage, excluding persons based upon pre-existing conditions or denying coverage for any individual who is willing to pay the premiums for such coverage. Since January 1, 2011, each health plan has been required to keep its annual non-medical costs lower than 15% of premium revenue for the group market and lower than 20% in the small group and individual markets or rebate its enrollees the amount spent in excess of the percentage. In addition, since September 23, 2010, health insurers have not been permitted to deny coverage to children based upon a pre-existing condition and must allow dependent care coverage for children up to 26 years old.

Larger employers will continue to be subject to new requirements and incentives to provide health insurance benefits to their full time employees. Effective January 1, 2016, all employers subject to the requirement are required to offer health insurance coverage to 95% of their full-time employees and their dependents in order to avoid penalties. The employer penalties range from $2,000 to $3,000 per employee, subject to certain thresholds and conditions.

TABLE OF CONTENTS

As enacted, the Affordable Care Act uses various means to induce individuals who do not have health insurance to obtain coverage. For individuals and families below 400% of the FPL, the cost of obtaining health insurance will be subsidized by the federal government. Those with lower incomes will be eligible to receive greater subsidies. To facilitate the purchase of health insurance by individuals and small employers, each state was required to establish an Exchange by January 1, 2014. Based on CBO estimates, approximately 12 million individuals obtained their health insurance coverage through an Exchange for 2016. Health insurers participating in the Exchange must offer a set of minimum benefits to be defined by HHS and may offer more benefits, and must offer at least two, and up to five, levels of plans that vary by the percentage of medical expenses that must be paid by the enrollee. Each level of plan must require the enrollee to share certain specified percentages of medical expenses up to the deductible/co-payment limit. Health insurers may establish varying deductible/co-payment levels, up to a statutory maximum. The health insurers must cover 100% of the amount of medical expenses in excess of the deductible/co-payment limit. For example, an individual making 100% to 200% of the FPL will have co-payments and deductibles reduced to about one-third of the amount payable by those with the same plan with incomes at or above 400% of the FPL.

Any benefits to us from the expansion of private sector coverage depend in large part on our success in contracting with payors whose policies are listed on the Exchanges. We currently have contracts with Exchange payors in every state in which we operate, and the reimbursement rates paid under those contracts generally are comparable to that paid to us by other private payors.

Public Program Spending

The Affordable Care Act provides for Medicare, Medicaid and other federal healthcare program spending reductions between 2010 and 2019. The CBO previously estimated that these program spending reductions would include $156 billion in Medicare fee-for-service market basket and productivity reimbursement reductions for all providers, the majority of which would come from hospitals. CMS previously set this estimate at $233 billion. The CBO's estimate also included an additional $36 billion in reductions of Medicare and Medicaid DSH funding ($22 billion for Medicare and $14 billion for Medicaid). The CMS estimate included an additional $64 billion in reductions of Medicare and Medicaid DSH funding, with $50 billion of the reductions coming from Medicare.

Payments for Hospitals

Under the Medicare program, hospitals receive reimbursement for general, acute care hospital inpatient services under the IPPS. CMS establishes fixed IPPS payment amounts per inpatient discharge based on the patient's assigned MS-DRG. These MS-DRG rates are updated each FFY using the hospital market basket index, which takes into account inflation experienced by hospitals and other entities outside the healthcare industry in purchasing goods and services.

The Affordable Care Act provides for a number of types of annual reductions in the market basket. One is a general reduction of a specified percentage each FFY extending through 2019 as follows: FFY 2014 (0.3%); 2015 (0.2%); 2016 (0.2%); 2017 (0.75%); 2018 (0.75%); and 2019 (0.75%).

Another type of reduction to the market basket is a "productivity adjustment" that was implemented by HHS beginning in FFY 2012. The amount of that reduction is the projected nationwide productivity gains over the preceding 10 years. The market basket updates for FFYs 2017, 2016 and 2015 were reduced by 0.3%, 0.5% and 0.5%, respectively, as a result of this productivity adjustment.

Additional types of reductions include reductions in connection with Medicare's value-based purchasing program, Hospital-Acquired Condition ("HAC") Reduction Program and Hospital Readmission Reduction Program, all of which are discussed in more detail below.

In addition to those reductions, there may be other upward or downward adjustments that CMS makes to the annual market basket update in any year, making it impracticable to predict in advance the overall impact on MS-DRG rates.

TABLE OF CONTENTS

Quality-Based Payment Adjustments and Reductions for Inpatient Services

The Affordable Care Act established or expanded provisions to promote value-based purchasing and to link payments to quality and efficiency. Among other things, it requires HHS to implement a value-based purchasing program for inpatient hospital services. This program rewards hospitals based either on how well the hospitals perform on certain quality measures or how much the hospitals' performance improves on certain quality measures from their performance during a baseline period. As part of the program, the Affordable Care Act requires HHS to reduce inpatient hospital payments for all discharges by a percentage beginning at 1.0% in FFY 2013 and increasing by 0.25% for each fiscal year up to 2.0% in FFY 2017 and subsequent years. HHS will pool the amount collected from these reductions to fund payments to reward hospitals that meet and exceed certain quality performance standards established by HHS. Under the program, each hospital's performance is evaluated during a specified performance period, and hospitals receive points on each of a number of pre-determined measures based on the higher of (i) their level of achievement relative to an established standard or (ii) their improvement in performance from their performance during a prior baseline period. Each hospital's combined scores on all the measures are translated into value-based incentive payments. Hospitals that receive higher total performance scores receive higher incentive payments than those that receive lower total performance scores. Because the Affordable Care Act provides that the funds pooled and otherwise set aside for the value-based purchasing program will be fully distributed, hospitals with high scores may receive greater reimbursement under the value-based purchasing program than they would have otherwise, and hospitals with low scores may receive reduced Medicare inpatient hospital payments.

In addition, the Affordable Care Act prohibits the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat HACs. With respect to Medicare, hospitals that fall into the top 25.0% of national risk-adjusted HAC rates for all hospitals in the previous year receive a 1.0% reduction in their total Medicare payments. Hospitals with excessive readmissions for conditions designated by HHS will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard.

Inpatient payments are reduced pursuant to the Affordable Care Act if a hospital experiences "excessive readmissions" within a 30-day period of discharge for heart attack, heart failure, pneumonia or other conditions designated by HHS. Hospitals with what HHS defines as "excessive readmissions" for these conditions will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard. Each hospital's performance will be publicly reported by HHS. HHS has the discretion to determine what "excessive readmissions" means, the amount of the payment reduction and other terms and conditions of this program. The basic maximum payment reduction amount is 3.0%. The Cures Act does, however, allow for an adjustment factor that would reduce the penalties imposed on hospitals, based on the portion of beneficiaries the hospitals serve that are eligible for both Medicare and Medicaid, beginning in FFY 2019.

Outpatient Market Basket and Productivity Adjustment

Hospital outpatient services paid under OPPS are classified into APCs. The APC payment rates are updated each calendar year based on the market basket. The first two market basket changes outlined above — the general reduction and the productivity adjustment — apply to outpatient services as well as inpatient services, although these are applied on a calendar year basis. The percentage changes specified in the Affordable Care Act summarized above as the general reduction for the IPPS — e.g., 0.75% in CY 2017 — are the same for the OPPS.

Medicare and Medicaid Disproportionate Share Hospital Payments

The Medicare DSH program provides for additional payments to hospitals that treat a disproportionate share of low-income patients. Under the Affordable Care Act, beginning in FFY 2014, Medicare DSH payments were reduced to 25% of the amount they otherwise would have been absent the new law. The remaining 75% of the amount that would otherwise be paid under Medicare DSH will be effectively pooled, and this pool will be reduced further each year by a formula that reflects reductions in the national level of uninsured who are under 65 years of age. In other words, the greater the level of coverage for the uninsured nationally, the more the Medicare DSH payment pool will be reduced. Each hospital will then be paid, out of the reduced DSH payment pool, an amount allocated based upon its level of uncompensated care. CMS estimates that Medicare DSH payments and additional payments for uncompensated care made to hospitals in FFY 2017 will be reduced overall by approximately 0.4% as compared to the Medicare DSH payments and uncompensated care payments distributed to hospitals in FFY 2016.

TABLE OF CONTENTS

In addition to Medicare DSH funding, hospitals that provide care to a disproportionately high number of low-income patients may receive Medicaid DSH payments. The federal government distributes federal Medicaid DSH funds to each state based on a statutory formula. The states then distribute the DSH funding among qualifying hospitals. Although federal Medicaid law defines some level of hospitals that must receive Medicaid DSH funding, states have broad discretion to define additional hospitals that also may qualify for Medicaid DSH payments and the amount of such payments. As originally enacted, the Affordable Care Act reduced funding for the Medicaid DSH hospital program in FFYs 2014 through 2020. In addition, the Middle Class Tax Relief and Job Creation Act of 2012 (the "Tax Relief Act") and the ATRA provide for additional Medicaid DSH reductions in FFYs 2021 and 2022. However, the Pathway Act repealed the Medicaid DSH reductions that were set to become effective in FFY 2014 and delayed the Medicaid DSH reductions that were set to become effective in FFY 2015 until FFY 2016. It also increased the Medicaid DSH reductions that were to become effective in FFY 2016 and extended Medicaid DSH reductions through FFY 2023. PAMA and MACRA further delayed the Medicaid DSH reductions required by the Affordable Care Act that were scheduled to become effective in FFY 2016 to FFY 2018 and extended those reductions through FFY 2025. The cumulative effect of those acts is to reduce funds for the Medicaid DSH hospital program in FFYs 2018 through 2025 by the following amounts: 2018 ($2 billion); 2019 ($3 billion); 2020 ($4 billion); 2021 ($5 billion); 2022 ($6 billion); 2023 ($7 billion); 2024 ($8 billion); and 2025 ($8 billion).

Accountable Care Organizations

The Affordable Care Act requires HHS to establish a Medicare Shared Savings Program that promotes accountability and coordination of care through the creation of accountable care organizations ("ACOs"). The Medicare Shared Savings Program allows providers (including hospitals), physicians and other designated professionals and suppliers to voluntarily work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS will be eligible to share in a portion of the amounts saved by the Medicare program. As of January 2017, approximately 562 ACOs had been established to participate in the Medicare Shared Savings Program, the Next Generation ACO Model and the comprehensive End-Stage Renal Disease Care Model and additional ACOs are being established by private payors.

Bundled Payment Pilot Programs

The Affordable Care Act created the Center for Medicare & Medicaid Innovation (the "Innovation Center") with responsibility for establishing demonstration projects and other initiatives in order to identify, develop, test and encourage the adoption of new methods of delivering and paying for healthcare that create savings under the Medicare and Medicaid programs while improving quality of care. One initiative announced by the Innovation Center is a

voluntary bundled payment initiative involving over 400 participants that links payments to participating providers for services provided during an episode of care. As required by the Affordable Care Act, HHS established a separate five-year, voluntary, national pilot program on payment bundling for Medicare services. Under the program, organizations enter into payment arrangements that include financial and performance accountability for episodes of care, and these models are intended to lead to higher quality, more coordinated care at a lower cost to the Medicare program. Participating providers agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care. The Affordable Care Act also provides for a bundled payment demonstration project for Medicaid services.

In November 2015, CMS published a final rule that created a new payment model, called the Comprehensive Care for Joint Replacement Model ("CJR Model"), that will test, for a five year period, whether bundled payments to acute care hospitals for episodes of care for lower-extremity joint (hip or knee) replacement reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. Under the CJR Model, the hospital in which the lower extremity replacement or other procedure takes place will be accountable for the costs and quality of related care from the time of the surgery through 90 days after hospital discharge, which will be considered to be the "episode" of care. Depending on the hospital's quality and cost performance during the episode, the hospital will either receive an additional payment from Medicare or will be required to repay Medicare for a portion of the episode spending. The CJR Model will be implemented in 67 metropolitan statistical areas ("MSAs"), including some MSAs in which our facilities are located, and most hospitals in those MSAs will be required to participate.

On December 20, 2016, CMS released a final rule that, among other things, would expand the existing CJR Model to certain hip surgeries and would create a new bundled payment model for cardiac care. The bundle payment model for cardiac care would apply to patients who are admitted for a heart attack or bypass surgery and would be similar to the CJR Model. CMS will implement the heart attack and bypass surgery bundled payment models in 98 MSAs that were randomly selected, which includes some MSAs where the Company has facilities. In addition, the rule also establishes a cardiac rehabilitation incentive payment program that will be implemented in 90 MSAs and will test the impact of providing incentive payments to hospitals based on Medicare beneficiary utilization of cardiac rehabilitation and intensive cardiac rehabilitation services in the 90 day period following the beneficiary's discharge from the hospital for a heart attack or bypass surgery. On February 15, 2017, CMS announced that the effective date of the final rule would be postponed until March 21, 2017. We cannot predict whether there will be any further delays in the implementation of the rule or whether the rule will be implemented in its current form.

TABLE OF CONTENTS

Specialty Hospital Limitations

Over the last decade, we have faced competition from hospitals that have physician ownership. The Affordable Care Act prohibits newly created physician-owned hospitals from billing for Medicare patients referred by their physician owners. While the Affordable Care Act grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand. As of December 31, 2016, we operate one hospital through a joint venture with physicians in which we own a controlling interest.

Impact of the Affordable Care Act on the Company

The expansion of health insurance coverage under the Affordable Care Act has resulted in an increase in the number of patients using our facilities who have either private or public program coverage. Although the Affordable Care Act has had a positive impact on our revenue as it has been implemented over time, it is difficult to predict with great precision the timing or size of any potential revenue gains to us as a result of these elements of the Affordable Care Act, because of uncertainty surrounding a number of material factors, including the following:

- the possibility that the Affordable Care Act will be significantly modified, repealed and/or replaced;
- even if the Affordable Care Act is not repealed, replaced or materially modified, the level of disruption that may be caused by continuing legal challenges and other efforts to delay, block or eliminate specific provisions of the Affordable Care Act, including the outcome of litigation relating to the use of federal funds for cost sharing reductions provided to certain individuals who purchase insurance through the Exchanges;
- how many previously uninsured individuals will ultimately obtain coverage as a result of the Affordable Care Act;
- what percentage of the future newly insured patients will be covered under the Medicaid program and what percentage will be covered by private health insurers;
- the number of states that ultimately elect to expand their Medicaid programs, when that expansion occurs, and whether any states that have expanded their Medicaid programs will scale back such expansion as the Enhanced FMAP is reduced;
- the extent to which states will enroll any new Medicaid participants in managed care programs;
- the rates charged by private payors for insurance purchased on the Exchanges;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- the future rates paid to hospitals by private payers for newly covered individuals under different plans, including those covered through the newly created Exchanges and those who might be covered under the Medicaid program under contracts with the state;

- increasing self-pay as a result of individuals in the Exchanges who select high deductible plans, and risks presented by their ability to pay such deductibles;
- whether or not private insurers will participate in the Exchanges, and whether such participation is through the use of narrow networks that restrict the number of participating providers or tiered networks that impose significantly higher cost sharing obligations on patients that obtain services from providers in a disfavored tier; and
- whether the net effect of the Affordable Care Act, including the prohibition on excluding individuals based on pre-existing conditions, the requirement to keep medical costs lower than a specified percentage of premium revenue, other health insurance reforms and the annual fee applied to all health insurers, will be to put pressure on the bottom line of health insurers, which in turn might cause them to seek to reduce payments to hospitals with respect to both newly insured individuals and their existing business.

TABLE OF CONTENTS

Additionally, since 51.8% of our revenues in 2016 were from Medicare and Medicaid, collectively, the reductions in Medicare and Medicaid reimbursement and in the growth of spending by the Medicare and Medicaid programs that are contemplated by the Affordable Care Act will significantly impact us and could offset any positive effects of the Affordable Care Act. It is difficult to predict with great precision the size of the revenue reductions to Medicare and Medicaid spending, because of uncertainty regarding a number of material factors, including the following:

- the amount of overall revenues we will generate from Medicare and Medicaid business when the reductions are fully implemented;
- whether reductions required by the Affordable Care Act will be changed by statute;
- whether efforts to reform Medicaid funding into block grants or per capita caps will be successful, and, if implemented, the impact such changes may have on the Medicaid programs of states in which we operate;
- the size of the Affordable Care Act’s annual productivity adjustment to the market basket in future years;
- the amount of the Medicare DSH reductions that are made;
- the allocation to our hospitals of the Medicaid DSH reductions, commencing in FFY 2018;
- what the losses in revenues will be, if any, from the Affordable Care Act’s quality initiatives;
- the scope and nature of potential changes to Medicare reimbursement methods, such as an emphasis on bundling payments or coordination of care programs; and
- reductions to Medicare payments CMS may impose for “excessive readmissions.”

Because of the many variables involved, we are unable to predict the future effect on the Company of the expected increases in insured individuals using our facilities, the reductions in Medicare spending and reductions in Medicare and Medicaid DSH funding, and numerous other provisions in the Affordable Care Act that may affect us. Additionally, it is unclear how many states will ultimately implement the Medicaid expansion, whether the Medicaid program will be reformed, or whether the Affordable Care Act will be repealed, replaced or modified. Due to these factors, we are unable to predict with any reasonable certainty or otherwise quantify the future impact of the Affordable Care Act on our business model, financial condition or result of operations.

Competition for Patients

Our hospitals and other healthcare businesses operate in extremely competitive environments. Competition among healthcare providers occurs primarily at the local level. Accordingly, each facility develops its own strategies to address competition locally. A hospital’s position within the geographic area in which it operates is affected by a number of competitive factors, including, but not limited to:

- the scope, breadth and quality of services a hospital offers to its patients and physicians;
- whether new, competitive services are subject to certificate of need or other restrictions;
- the number, quality and specialties of the physicians who admit and refer patients to the hospital;
- nurses and other healthcare professionals employed by the hospital or on the hospital’s staff;
- the hospital’s reputation;
- its managed care contracting relationships;
- its location and the location and number of competitive facilities and other healthcare alternatives;
- the physical condition of its buildings and improvements;
- the quality, age and state-of-the-art of its medical equipment;
- its parking or proximity to public transportation;
- the length of time it has been a part of the community;
- the relative convenience of the manner in which care is provided (for example, whether services are available on an outpatient basis and whether services can be obtained quickly);

- the choices made by the physicians on the medical staff of the hospital; and
- the charges for its services.

In addition, tax-exempt competitors may have certain financial advantages not available to our facilities, such as endowments, charitable contributions, tax-exempt financing, and exemptions from sales, property and income taxes. In certain states, some not-for-profit hospitals are permitted by law to directly employ physicians while for-profit hospitals are prohibited from doing so.

We also face increasing competition from specialized care providers, including outpatient surgery, oncology, physical therapy and diagnostic centers, as well as competing services rendered in physician offices. To the extent that other providers are successful in developing specialized outpatient facilities, our market share for those specialized services will likely decrease. Physician competition also has increased as physicians, in some cases, have become equity owners in surgery centers and outpatient diagnostic centers to which they refer patients. Some of our hospitals have developed specialized outpatient facilities where necessary to compete with these other providers.

TABLE OF CONTENTS

Competition for Professionals

Our facilities must also compete for professional talent. A significant factor in our future success will be the ability of our facilities to attract and retain physicians, as it is physicians who decide whether a patient is admitted to the hospital and the procedures to be performed. We seek to attract physicians by striving to employ excellent nurses, equipping our facilities with technologically advanced equipment and an attractive, up-to-date physical plant, properly maintaining the equipment and physical plant, and otherwise creating an environment within which physicians choose to practice. While physicians may terminate their association with our facilities at any time, we believe that by striving to maintain and improve the quality of care at our facilities and by maintaining ethical and professional standards, our facilities will be better positioned to attract and retain qualified physicians with a variety of specialties.

We also recruit physicians to the communities in which our facilities are located. The types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the federal physician self-referral law (Stark law), the Anti-kickback Statute, state anti-kickback statutes, and related regulations. The Stark law requires, among other things, that recruitment assistance can only be provided to physicians who meet certain geographic and practice requirements, that the amount of assistance cannot be changed during the term of the recruitment agreement, and that the recruitment payments cannot generally benefit physicians currently in practice in the community beyond recruitment costs actually incurred. In addition to these legal requirements, there is competition from other communities and facilities for these physicians, and this competition continues after the physician begins practicing in one of our communities.

Many physicians today prefer to be employed, rather than operating their own practices or joining existing medical groups. Our hospitals and affiliated entities had more employed physicians at the end of 2016 than at the end of 2015. When employing office-based physicians, we also often employ office employees and other personnel necessary to support these physicians and incur additional expenses as a result. We expect this trend to continue.

We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our facilities, including nurses and other non-physician healthcare professionals. In some markets, the scarce availability of nurses and other medical support personnel presents a significant operating issue. This shortage may require us to enhance wages and benefits to recruit and retain nurses and other medical support personnel, recruit personnel from foreign countries, and hire more expensive temporary personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate.

Employees

At December 31, 2016, we had approximately 47,000 employees. The majority are hospital-based employees, including nursing staff, physical and occupational therapists, laboratory and radiology technicians, pharmacy staff, facility maintenance workers and the administrative staffs of our facilities. We are subject to federal minimum wage and hour laws and various state labor laws, and we maintain a number of different employee benefit plans. Approximately 1,100 of our employees are subject to collective bargaining agreements. We consider our employee relations to be generally good. Some of our facilities experience union organizing activity from time to time; however, we do not currently expect any of these efforts to materially affect our future operations.

Government Regulation

Overview

All participants in the healthcare industry are required to comply with extensive government regulations at the federal, state and local levels. Under these laws and regulations, facilities must meet requirements for licensure and to qualify to participate in government healthcare programs, including the Medicare and Medicaid programs. These requirements relate to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, rate-setting, compliance with building codes and environmental protection laws. If we fail to comply with applicable laws and regulations, we may be subject to criminal penalties and civil sanctions, and our facilities may lose their licenses and ability to participate in Medicare and Medicaid. In addition, government regulations frequently change. When regulations change, we may be required to make changes in our facilities, equipment, personnel and services so that our facilities remain licensed and qualified to participate in these programs. We believe that our facilities are in substantial compliance with current federal, state and local regulations and standards.

Acute care hospitals are subject to periodic inspection by federal, state and local authorities to determine their compliance with applicable regulations and requirements necessary for licensing, certification and accreditation. All of our hospitals are currently licensed under appropriate state laws and are qualified to participate in the Medicare and Medicaid programs. In addition, as of December 31, 2016, with the exception of Bluegrass, Meyersdale and Miners, all of our hospitals were accredited by the Joint Commission.

Utilization Review

Federal law contains numerous provisions designed to ensure that services rendered to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by quality improvement organizations, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, the validity of MS-DRG classifications and the appropriateness of cases of extraordinary length of stay or cost on a post-discharge basis. Quality improvement organizations may deny payment for services or assess fines and also have the authority to recommend to HHS that a provider which is in substantial noncompliance with the standards of the quality improvement organization be excluded from participation in the Medicare program. Utilization review is also a requirement of most non-governmental managed care organizations.

Value-Based Purchasing

There is a trend in the healthcare industry toward value-based purchasing of healthcare services. These value-based purchasing programs include both public reporting of quality data and preventable adverse events tied to the quality and efficiency of care provided by facilities. Governmental programs including Medicare and Medicaid currently require hospitals to report certain quality data to receive full reimbursement updates. In addition, Medicare does not reimburse for care related to certain preventable adverse events, reduces payments to hospitals that have high HAC rates and rewards hospitals that meet or exceed certain quality performance standards established by CMS. Many large commercial payers currently require hospitals to report quality data, and several commercial payers also do not reimburse hospitals for certain preventable adverse events.

Fraud and Abuse Laws

Participation in Medicare and/or Medicaid programs is heavily regulated by federal statutes and regulations. If a hospital fails to comply substantially with the numerous federal laws governing the facility's activities, the hospital's participation in the Medicare and/or Medicaid programs may be terminated, and/or civil or criminal penalties may be imposed. For example, a hospital may lose its ability to participate in Medicare and/or Medicaid programs if it, among other things:

- submits claims to Medicare and/or Medicaid for services not provided or misrepresents actual services provided in order to obtain higher payments;
- pays money to induce the referral of patients or purchase of items or services where such items or services are reimbursable under a federal or state healthcare program; or
- fails to provide appropriate emergency medical screening services to any individual who comes to a hospital's campus or otherwise fails to properly treat and transfer emergency patients.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") broadened the scope of the fraud and abuse laws by adding several criminal statutes that apply to all health plans regardless of whether any payments by such plans are made by or through a federal healthcare program. In addition, HIPAA created civil penalties for certain proscribed conduct, including upcoding and billing for medically unnecessary goods or services and established new enforcement mechanisms to combat fraud and abuse. These new mechanisms include a bounty system, where a portion of the payments recovered is returned to the applicable government agency, as well as a whistleblower program. HIPAA also expanded the categories of persons that may be excluded from participation in federal and state

healthcare programs.

The Anti-kickback Statute prohibits the payment, receipt, offer or solicitation of anything of value, whether in cash or in kind, with the intent of generating referrals or orders for services or items covered by a federal or state healthcare program. Violations of the Anti-kickback Statute are punishable by criminal and civil fines, exclusion from federal and state healthcare programs, imprisonment and damages up to three times the total dollar amount involved.

TABLE OF CONTENTS

The Office of Inspector General ("OIG") of HHS is responsible for identifying fraud and abuse activities in government programs. In order to fulfill its duties, the OIG performs audits, investigations and inspections. In addition, it provides guidance to healthcare providers by identifying types of activities that could violate the Anti-kickback Statute. The OIG has identified the following hospital/physician incentive arrangements as potential violations:

· payment of any incentive by a hospital based on physician referrals of patients to the hospital;
· use of free or significantly discounted office space or equipment;
· provision of free or significantly discounted billing, nursing or other staff services;
· free training (other than compliance training) for a physician's office staff, including management and laboratory technique training;
· guarantees which provide that if a physician's income fails to reach a predetermined level, the hospital will pay any portion of the remainder;
· low-interest or interest-free loans, or loans which may be forgiven if a physician refers patients to the hospital;
· payment of the costs for a physician's travel and expenses for conferences;
· payment of services which require few, if any, substantive duties by the physician or which are in excess of the fair market value of the services rendered; or
· purchasing goods or services from physicians at prices in excess of their fair market value.

We have a variety of financial relationships with physicians who refer patients to our facilities, including employment contracts, independent contractor agreements, professional service agreements, leases and joint ventures. Physicians may also own shares of our common stock. We provide financial incentives to recruit physicians to relocate to communities served by our facilities. These incentives for relocation include minimum revenue guarantees and, in some cases, loans. The OIG is authorized to publish regulations outlining activities and business relationships that would be deemed not to violate the Anti-kickback Statute. These regulations are known as "safe harbor" regulations. Failure to comply with the safe harbor regulations does not make conduct illegal, but instead the safe harbors delineate standards that, if complied with, protect conduct that might otherwise be deemed in violation of the Anti-kickback Statute. We intend for all our business arrangements to be in full compliance with the Anti-kickback Statute and seek to structure each of our arrangements with physicians to fit as closely as possible within an applicable safe harbor. However, not all of our business arrangements fit wholly within safe harbors, so we cannot guarantee that these arrangements will not be scrutinized by government authorities or, if scrutinized, that they will be determined to be in compliance with the Anti-kickback Statute or other applicable laws. If we violate the Anti-kickback Statute, we would be subject to criminal and civil penalties and/or possible exclusion from participating in Medicare, Medicaid or other governmental healthcare programs.

The Stark law prohibits physicians from referring Medicare and Medicaid patients to selected types of healthcare entities in which they or any of their immediate family members have ownership or a compensation relationship unless an exception applies. These types of referrals are commonly known as "self referrals". A violation of the Stark law may result in (i) a denial of payment and require refunds to patients and the Medicare program for all claims that were unlawfully submitted during the entire period that the violation existed, (ii) civil monetary penalties of up to $23,863 for each violation, $159,089 for circumvention schemes, and up to $10,000 for each day that an entity fails to report required information to HHS, and (iii) exclusion from participation in the Medicare and Medicaid programs and other federal programs. In addition, violations of the Stark law could also result in penalties under the federal False Claims Act. In accordance with the requirements of the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (the "2015 Act"), the civil monetary penalties assessed after August 1, 2016 for violations of the Stark law occurring after November 2, 2015, are subject to an initial "catch-up" adjustment in 2016 and annual adjustments for inflation thereafter. There are ownership and compensation arrangement exceptions to the self-referral prohibition. There are also exceptions for many of the customary financial arrangements between physicians and facilities, including employment contracts, leases and recruitment agreements, and there is a "whole hospital exception,"

which allows a physician to make a referral to a hospital if the physician owns an interest in the entire hospital, as opposed to an ownership interest in a department of the hospital. The Affordable Care Act significantly modified the requirements of the whole hospital exception and placed a number of restrictions on the ownership structure, operations, and expansion of physician owned hospitals. One of our facilities is subject to those requirements. We intend for our financial arrangements with physicians to comply with the exceptions included in the Stark law and regulations. In recent years, CMS has issued a number of proposed and final rules modifying the Stark law exceptions. While some changes have been implemented, others remain in proposed form or have been delayed. Further, the Stark law and related regulations have been subject to little judicial interpretation to date. We anticipate that there will be further changes in the future and those changes may require us to modify our activities.

In addition to issuing new regulations, or applying new interpretations to existing rules or regulations, the federal government has modified its approach for ensuring compliance with and enforcing penalties for violations of the Stark law. In 2010, CMS also issued a "self-referral disclosure protocol" for hospitals and other providers that wish to self-disclose potential violations of the Stark law and attempt to resolve those potential violations and any related overpayment liabilities at levels below the maximum penalties and amounts set forth in the statute.

TABLE OF CONTENTS

Federal False Claims Act

The federal False Claims Act prohibits providers from, among other things, knowingly submitting false or fraudulent claims for payment to the federal government and failing to refund identified overpayments received from the government. The federal False Claims Act defines the term "knowingly" broadly, and while simple negligence generally will not give rise to liability, submitting a claim with reckless disregard to its truth or falsity can constitute the "knowing" submission of a false or fraudulent claim for the purposes of the False Claims Act. The "qui tam" or "whistleblower" provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are entitled to share in any amounts recovered by the government, and, as a result, the number of "whistleblower" lawsuits that have been filed against providers has increased significantly in recent years. When a private party brings a qui tam action under the federal False Claims Act, the defendant will generally not be aware of the lawsuit until the government makes a determination whether it will intervene and take a lead in the litigation. If a provider is found to be liable under the federal False Claims Act, the provider may be required to pay up to three times the actual damages sustained by the government plus mandatory civil monetary penalties of between $10,781 to $21,563 for each separate false claim. In accordance with the requirements of the 2015 Act, the civil monetary penalties assessed after January 15 each year, for violations of the False Claims Act are subject to annual adjustments for inflation. The government and whistleblowers have used the federal False Claims Act to prosecute Medicare and other government healthcare program fraud such as coding errors, billing for services not provided, submitting false cost reports, and providing care that is not medically necessary or that is substandard in quality.

Changes in the Regulatory Environment

The Fraud Enforcement and Recovery Act of 2009 ("FERA") expanded the scope of the federal False Claims Act by, among other things, creating liability for knowingly and improperly avoiding or decreasing an obligation to pay money to the federal government and broadening protections for whistleblowers. In addition, the Affordable Care Act made several significant changes to healthcare fraud and abuse laws, including providing additional enforcement tools to the government, increasing cooperation between agencies by establishing mechanisms for the sharing of information and enhancing criminal and administrative penalties for non-compliance. For example, the Affordable Care Act (1) provides $350 million in increased federal funding over 10 years to fight healthcare fraud, waste and abuse; (2) expands the scope of the RAC program to include Medicaid; (3) authorizes HHS, in consultation with the OIG, to suspend Medicare and Medicaid payments to a provider of services or a supplier "pending an investigation of a credible allegation of fraud;" (4) provides Medicare contractors with additional flexibility to conduct random prepayment reviews; and (5) requires providers to adopt compliance programs that meet certain specified requirements as a condition of their Medicare enrollment. The Affordable Care Act also expanded the scope of the False Claims Act to cover payments in connection with health insurance exchanges if those payments include any federal funds and provides that claims submitted in connection with patient referrals that result from violations of the Stark law or the Anti-kickback Statute constitute false claims for the purposes of the federal False Claims Act.

In addition to the changes mentioned above, the Affordable Care Act created federal False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later. On February 11, 2016, CMS published a final rule that provides clarification around the meaning of overpayment identification and generally establishes a six year lookback period for Medicare Part A and Part B providers and suppliers. To avoid liability, providers must, among other things, carefully and accurately code claims for reimbursement, promptly return overpayments, and accurately

prepare cost reports. In light of the provisions of FERA and the Affordable Care Act relating to reporting and refunding overpayments and the robust funding for enforcement activities and audits, an increasing number of healthcare providers have self-reported potential violations of law, including technical violations of certain fraud and abuse laws, and refunded overpayments to avoid incurring fines and penalties. It is likely such refunds and voluntary disclosures will continue in the future, and we will make such refunds and disclosures in accordance with the law. Finally, the 2015 Act requires each agency, including HHS and the Department of Justice ("DOJ"), to make "catch-up" inflation adjustments to civil monetary penalty amounts, including those that may be assessed under the Stark law and False Claims Act, by August 1, 2016, subject to a maximum increase of 150%, and thereafter to make annual inflation adjustments based on updates to the Consumer Price Index or a lesser amount if the agency involved determines that increasing the civil monetary penalty amount by the Consumer Price Index would have a negative economic impact or the costs of the increase outweigh the benefits.

TABLE OF CONTENTS

State Laws

Many of the states in which we operate have adopted laws similar to the Anti-kickback Statute and the Stark law. These state laws are generally very broad in scope and typically apply to patients whose treatment is covered by the Medicaid program and, in some cases, to all patients regardless of payment source. In addition, many of the states in which we operate have false claims statutes that impose civil and/or criminal liability for the types of acts prohibited by the federal False Claims Act or that otherwise prohibit the submission of false or fraudulent claims to the state government or Medicaid program. Violations of these laws are punishable by civil and/or criminal penalties and, in many cases, the loss of the facility's license. Although we believe that our operations and arrangements with physicians and other referral sources comply with the applicable state fraud and abuse laws, most of these laws have not been interpreted by any court or governmental agency, and there can be no assurance that the regulatory authorities responsible for enforcing these laws will determine that our arrangements comply with the applicable requirements.

Emergency Medical Treatment and Active Labor Act

All of our facilities are subject to the Emergency Medical Treatment and Active Labor Act ("EMTALA"). This federal law requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency department for treatment and, if the patient is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the patient to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions or transfer exists regardless of a patient's ability to pay for treatment. Off-campus facilities such as specialty clinics, surgery centers and other facilities that lack emergency departments or otherwise do not treat emergency medical conditions are not generally subject to the EMTALA. They must, however, have policies in place that explain how the location should proceed in an emergency situation, such as transferring the patient to the closest hospital with an emergency department. There are severe penalties under the EMTALA if a hospital fails to screen or appropriately stabilize or transfer a patient or if the hospital delays appropriate treatment in order to first inquire about the patient's ability to pay, including civil monetary penalties and exclusion from participation in the Medicare program. In addition, an injured patient, the patient's family or a medical facility that suffers a financial loss as a direct result of another hospital's violation of the law can bring a civil suit against that other hospital. CMS has actively enforced the EMTALA and has indicated that it will continue to do so in the future. Although we believe that our hospitals comply with the EMTALA, we cannot predict whether CMS will implement new requirements in the future and, if so, whether our hospitals will comply with any new requirements.

Administrative Simplification Provisions and Privacy and Security Requirements

We are subject to the administrative simplification provisions of HIPAA which require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. Additionally, we are subject to the privacy, security and breach notification regulations promulgated under HIPAA and the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), which are designed to protect the confidentiality, availability and integrity of protected health information and establish an array of patient rights with respect to such information. The HIPAA privacy, security and breach notification regulations apply to covered entities, which include health plans, health care clearinghouses, and health care providers that conduct certain standard transactions (such as billing insurance) electronically. In addition, certain provisions of the privacy, security and

breach notification regulations apply to business associates, which are entities that perform certain functions or activities on behalf of covered entities that require access to or the use or disclosure of protected health information. In certain circumstances, a covered entity may be held liable for the actions of its business associate if HHS determines an agency relationship exists between the covered entity and the business associate under federal agency law.

TABLE OF CONTENTS

The HIPAA privacy regulations, which apply to individually identifiable health information held or disclosed by a covered entity in any form, whether communicated electronically, on paper or orally, impose extensive administrative requirements on us; require that we adopt policies and procedures to comply with HIPAA; require that we routinely train our workforce members on our HIPAA policies; require that we provide patients with a copy of our notice of privacy practices; require our compliance with rules governing the use and disclosure of protected health information; and require us to impose these rules, by contract, on any business associate to whom we disclose such information in order to perform functions on our behalf. They also create rights for patients in their health information, such as the right to access and amend their health information and to request an accounting for certain disclosures of their health information. The HIPAA security regulations require us to establish and maintain reasonable and appropriate administrative, technical and physical safeguards to ensure the integrity, confidentiality and the availability of electronic health information and to perform ongoing assessments of the potential risks and vulnerabilities to the confidentiality, integrity and availability of such information. In addition, the HIPAA breach notification regulations require that we report breaches of unsecured (unencrypted) protected health information to affected individuals without unreasonable delay, but in no case later than 60 calendar days of discovery of the breach. Notification must also be made to HHS and, in certain cases involving large breaches, to the local media. HHS is required to report on its website a list of all covered entities that report a breach involving more than 500 individuals. All non-permitted uses or disclosures are presumed to be breaches unless the covered entity or business associate can demonstrate that there is a low probability that the information has been compromised. We implement a comprehensive set of HIPAA policies and procedures, which we believe materially complies with the privacy, security and breach notification requirements of HIPAA.

Violations of the HIPAA regulations may result in criminal penalties and a range of civil penalties of up to $50,000 per violation with a maximum civil penalty of $1.5 million for violations of the same requirement in a calendar year. The civil monetary penalties are subject to the initial "catch-up" and annual inflation adjustments required by the 2015 Act. In addition, state attorneys general are authorized to bring civil actions seeking either injunction or damages up to $25,000 for violations of the same requirement in a calendar year in response to HIPAA violations that affect their state residents. HHS has the discretion in many cases to resolve HIPAA violations through informal means without the imposition of penalties. However, the HIPAA privacy, security and breach notification regulations have and will continue to impose significant costs on our facilities in order to comply with these standards. We expect increased enforcement of the HIPAA regulations. In fact, HHS began phase II of its HIPAA audit program in early 2016, which consists of a combination of remote desk audits and comprehensive onsite evaluations of covered entities and business associates and is intended to focus on compliance with the HIPAA privacy, security and breach notification rules. Onsite audits are expected to begin in early 2017. HHS officials have indicated that these audits could lead to compliance reviews or enforcement actions against organizations that fail to respond appropriately to audit requests or for which an audit reveals significant compliance issues. We cannot predict whether our facilities will be selected for any future audit or the results of any such audit.

Our facilities continue to remain subject to other applicable federal or state laws that are more restrictive than the HIPAA privacy and security regulations, which could impose additional penalties on us. For example, the Federal Trade Commission uses its consumer protection authority to initiate enforcement actions against companies whose inadequate data security programs may expose consumers to fraud, identity theft and privacy intrusions, including the security programs of entities subject to HIPAA regulation.

Corporate Practice of Medicine and Fee-Splitting

Some states have laws that prohibit unlicensed persons or business entities, including corporations or business organizations that own hospitals, from employing physicians. Some states also have adopted laws that prohibit direct or indirect payments or fee-splitting arrangements between physicians and unlicensed persons or business entities. Possible sanctions for violations of these restrictions include loss of a physician's license, civil and criminal penalties and rescission of business arrangements. These laws vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies. We attempt to structure our arrangements with healthcare providers to comply with the relevant state laws and the few available regulatory interpretations.

Certificates of Need

The construction of new facilities, the acquisition or expansion of existing facilities and the addition of new services and expensive equipment at our facilities may be subject to state laws that require prior approval by state regulatory agencies. These certificate of need laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of the new equipment or services and allow competing healthcare providers to challenge the need for the facility, service or equipment. We operate facilities in certain states that have adopted certificate of need laws. If we fail to obtain necessary state approval, we will not be able to expand our facilities, complete acquisitions or add new services at our facilities in these states. Violation of these state laws may result in the imposition of civil sanctions or the revocation of hospital licenses. Some states in which we operate do not have certificate of need requirements. Additionally, from time to time, states with existing requirements may repeal or limit the scope of their certificate of need programs. Our facilities in states that do not have (or limit the scope of) certificate of need programs could be subject to increased competition from other providers who may choose to enter the market.

TABLE OF CONTENTS

Not-for-Profit Hospital Conversion Legislation

Many states have adopted legislation regarding the sale or other disposition of hospitals operated by not-for-profit entities. In states that do not have such legislation, the attorneys general have demonstrated an interest in reviewing these transactions under their general obligations to protect charitable assets. These legislative and administrative efforts primarily focus on the appropriate valuation of the assets divested and the use of the proceeds of the sale by the not-for-profit seller. Reviews and, in some instances, approval processes adopted by state authorities can add additional time to the closing of a not-for-profit hospital acquisition. Future actions by state legislators or attorneys general may seriously delay or even prevent our ability to acquire certain hospitals.

State Hospital Rate-Setting Activity

We currently operate two hospitals in West Virginia. The West Virginia Health Care Authority requires that requests for increases in hospital charges be submitted annually. Requests for rate increases are reviewed by the West Virginia Health Care Authority and are either approved at the amount requested, approved for lower amounts than requested, or are rejected. As a result, in West Virginia, our ability to increase our rates to compensate for increased costs per admission is limited, and the operating margins for our hospitals located in West Virginia may be adversely affected if we are not able to increase our rates as our expenses increase. We can provide no assurance that other states in which we operate hospitals will not enact similar rate-setting laws in the future.

Environmental Regulation

Our healthcare operations generate medical waste that must be disposed of in compliance with federal, state and local environmental laws, rules and regulations. Our operations, as well as our purchases and sales of healthcare facilities, are also subject to compliance with various other environmental laws, rules and regulations. Such compliance costs are not significant, and we do not anticipate that such compliance costs will be significant in the future.

Regulatory Compliance Program

It is our policy to conduct our business with integrity and in compliance with the law. We have in place and continue to enhance a company-wide compliance program that focuses on all areas of regulatory compliance including billing, reimbursement, cost reporting practices and contractual arrangements with referral sources.

This regulatory compliance program is intended to help ensure that high standards of conduct are maintained in the operation of our business and that policies and procedures are implemented so that employees act in full compliance with all applicable laws, regulations and company policies. Under the regulatory compliance program, every employee and certain contractors involved in patient care, coding and billing, receive initial and periodic legal compliance and ethics training. In addition, we regularly monitor our ongoing compliance efforts and develop and implement policies and procedures designed to foster compliance with the law. The program also includes a mechanism for employees to report, without fear of retaliation, any suspected legal or ethical violations to their supervisors, designated compliance officers in our facilities, our compliance hotline or directly to our corporate compliance office. We believe our compliance program is consistent with standard industry practices.

The Audit and Compliance Committee of the Board of Directors oversees the Company’s compliance efforts, and receives periodic reports from the Company’s compliance and audit services groups, as well as guidelines, policies and processes for monitoring and mitigating risk relating to the financial statements and financial reporting processes, key credit risks, liquidity risks and market risks. The Company’s Quality Committee also plays a significant role in

evaluating clinical performance and industry practices.

TABLE OF CONTENTS

Risk Management and Insurance

Given the nature of our operating environment, we are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention ("SIR") and deductible levels. Our SIR for professional liability claims is $5.0 million per claim at December 31, 2016 with a $5.0 million inner aggregate. Additionally, our deductible for workers' compensation claims is $1.0 million per claim in all states in which we operate except for Wyoming. We participate in a state specific program in Wyoming for our workers' compensation claims arising in this state. Our SIR and deductible levels are evaluated annually as a part of our insurance program's renewal process.

We also maintain directors' and officers', property, some professional liability and other types of insurance coverage with unrelated commercial carriers. Our directors' and officers' liability insurance coverage for current officers and directors is a program that protects us as well as the individual director or officer. We maintain property insurance through an unrelated commercial insurance company. We maintain large property insurance deductibles with respect to our facilities in coastal regions because of the high wind exposure and the related cost of such coverage. We have one location that is considered to have a high exposure to named-storm risk. It carries a deductible of 5% of its property value.

We operate a captive insurance company under the name Point of Life Indemnity, Ltd. This captive insurance company, which is licensed by the Cayman Islands Monetary Authority and is a wholly-owned subsidiary of LifePoint, issues malpractice insurance policies primarily to our employed physicians in addition to providing workers' compensation deductible coverage.

TABLE OF CONTENTS

Item 1A. Risk Factors.

There are several factors, some beyond our control, that could cause results to differ significantly from our expectations. Some of these factors are described below. Other factors, such as market, operational, liquidity, interest rate and other risks, are described elsewhere in this report (see, for example, Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations). Any factor described in this report could by itself, or together with one or more factors, materially and adversely affect our business, results of operations and/or financial condition. There may be factors not described in this report that could also cause results to differ from our expectations.

We cannot predict the effect that further healthcare reform, the possible repeal and replacement of the Affordable Care Act, and other changes in government programs may have on our business, financial condition or results of operations.

The Affordable Care Act dramatically altered the U.S. healthcare system. Since its adoption into law in 2010, the Affordable Care Act has been challenged before the U.S. Supreme Court, and several bills have been and continue to be introduced in Congress to delay, defund or repeal implementation of or amend significant provisions of the Affordable Care Act. In addition, there continues to be ongoing litigation over the interpretation and implementation of certain provisions of the law. Furthermore, on January 20, 2017, newly-inaugurated President Trump issued an executive order that, among other things, stated that it was the intent of his administration to repeal the Affordable Care Act and, pending that repeal, instructed the executive branch of the federal government to defer or delay the implementation of any provision or requirement of the Affordable Care Act that would impose a fiscal burden on any state or a cost, fee, tax or penalty on any individual, family, health care provider, or health insurer.

We have expended substantial cost and effort to plan and prepare for and comply with the Affordable Care Act, which has been implemented on a rolling basis since 2010 with further implementation scheduled over the next several years. We cannot predict whether the Affordable Care Act will be repealed, replaced, or modified or the impact that the President's executive order will have on the implementation and enforcement of the provisions of the Affordable Care Act or the regulations adopted or to be adopted to implement the law. In addition, if the Affordable Care Act is replaced or modified, we cannot predict what the replacement plan or modifications would be, when the replacement plan or modifications would become effective, or whether any of the existing provisions of the Affordable Care Act would remain in place.

The net effect of the Affordable Care Act on our business is subject to numerous variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, and the gradual implementation of the numerous programs designed to improve access and quality. Additional variables of the Affordable Care Act impacting our business will be how states, providers, insurance companies, employers, and other market participants respond during this period of uncertainty surrounding the future of the Affordable Care Act. As a result, we are unable to predict the effect on our business, financial condition or results of operations, the availability of adequate insurance coverage for patients seeking health care at our facilities, the reductions in government healthcare reimbursement spending, and numerous other provisions potentially impacted by the possible repeal, replacement or modification of the Affordable Care Act.

Our revenues will decline if federal or state programs reduce our Medicare or Medicaid payments.

In 2016, we derived 51.8% of our revenues from the Medicare and Medicaid programs, collectively. Numerous factors could materially decrease, or delay timing of, Medicare and Medicaid payments to our facilities. These factors include statutory and regulatory payment reduction or other changes, administrative rulings and determinations concerning patient and provider eligibility, the method of calculating reimbursements and requirements for utilization review. Furthermore, the Affordable Care Act, as amended by the Pathway Act and PAMA, the Tax Relief Act and the ATRA provide for material scheduled reductions in the growth of Medicare and Medicaid program spending, including reductions in market basket updates and DSH funding.

Medicaid programs, which are funded and administered by state governments with federal matching funds, provide healthcare benefits to qualifying individuals who are unable to afford care. A number of states have adopted or are considering legislation designed to reduce their Medicaid expenditures, including enrolling Medicaid recipients in managed care programs and imposing additional taxes on hospitals to help finance such states' Medicaid systems.

Additionally, as part of the movement to repeal, replace or modify the Affordable Care Act and as a means to reduce the federal budget deficit, there are renewed congressional efforts to move Medicaid from an open-ended program with coverage and benefits set by the federal government to one in which states receive a fixed amount of federal funds, either through block grants or per capita caps, and have more flexibility to determine benefits, eligibility or provider payments. Such efforts to reduce federal funding of the Medicaid program, as well as those that would reduce the amount of federal Medicaid matching funding available to states by curtailing the use of provider taxes, could have a negative impact on state Medicaid budgets resulting in less coverage for eligible individuals. If implemented, we cannot predict whether the amount of fixed federal funding to the states will be based on current payment amounts, or if it will be based on lower payment amounts, which would negatively impact those states that expanded their Medicaid programs in response to the Affordable Care Act.

TABLE OF CONTENTS

We expect that efforts to impose greater discounts and more stringent cost controls by government payors will continue, thereby reducing the payments we receive for our services. As reimbursement from payors is reduced, or if the scope of services covered by payors is limited, there could be a material adverse effect on our revenues and results of operations.

Consolidation among commercial insurance companies and shifts to insurance plans with narrow networks, high deductibles or high co-payments could adversely affect our revenues and results of operations.

The healthcare industry has experienced a trend of consolidation among commercial insurance companies, resulting in fewer but larger insurance companies that have significant bargaining power, given their market share. Payments from from HMOs, PPOs, insurance companies, employers and other private payors are the result of negotiated rates. These rates may decline based on renegotiations and larger payors have significant bargaining power to negotiate higher discounted fee arrangements with healthcare providers. As a result, payors increasingly are demanding discounted fee structures or the assumption by healthcare providers of all or a portion of the financial risk related to paying for care provided. This includes moving away from a percent of charge payment structure to a fixed payment, which typically reduces our reimbursement rate and limits our ability to raise prices going forward.

Additionally, commercial insurance plans and plans provided through the Exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices and impose increased financial liability on beneficiaries who use certain tiers of providers. These payors may also restrict or exclude our facilities and employed physicians from participation in their networks. The increased utilization of narrow and tiered networks has increased the bargaining power of commercial insurance companies and the potential adverse impact of ceasing to be a contracted provider with any such insurer.

There are also an increasing number of patients enrolling in insurance plans with high deductibles or high co-payments, including those purchased on the Exchanges, which increase the amount due from the patient and may result in reimbursement for a lower portion of the total payment amount relative to traditional employer-sponsored health insurance plans for the healthcare services provided by our facilities and employed physicians. Patients enrolled in higher deductible and co-payment plans tend to defer elective and non-emergency procedures or default on their portion of the payment. We may be adversely affected by the growth in patient responsibility accounts because of plan structures, including HSAs, which shift greater responsibility for care to individuals through greater exclusions and higher co-deductible and co-payment amounts. If we experience shifts in our patient volumes to these types of plan structures, our revenue and results of operations may be adversely affected.

We may encounter difficulty operating, integrating and improving financial performance at acquired facilities. If we acquire facilities with unknown or contingent liabilities, we could become liable for material obligations.

We may be unable to timely and effectively integrate facilities that we acquire with our ongoing operations and to achieve the anticipated financial results and synergies from such acquisitions, individually or in the aggregate. Many of the facilities we have acquired had, or future acquisitions may have, significantly lower operating margins than we do and/or operating losses prior to the time we acquired or will acquire them. Additionally, we typically retain and rely on existing local management teams at newly acquired facilities to implement changes to operating procedures and systems. Integrating local management teams can involve cultural and systems challenges that may demand a disproportionate share of our resources and senior management's attention. In the past, we have occasionally experienced delays in improving the operating margins or effectively integrating the operations of our acquired facilities and we may experience such delays in implementing operating procedures and systems in newly or future acquired facilities. Integrating an acquired facility could be expensive and time consuming and could disrupt our ongoing business, negatively affect cash flow and distract management and other key personnel. As a result of such business disruption, we may experience turnover of physicians and other key personnel. Furthermore, we may experience delays in reimbursement from governmental and third-party payors as a result of the change of ownership of our acquired facilities.

We must integrate complex information, compliance, accounting and operational systems and internal controls over financial reporting of acquired facilities into our existing systems and internal controls. While we devote a significant amount of employee and management resources on these integrations, we also rely heavily on third parties for systems integration. Our efforts to integrate new facilities, including causing those third parties to convert our newly acquired facilities' systems, may fail or be significantly delayed. Failure to timely and effectively integrate or convert any of these systems could cause business interruption, affect physician and staff morale and our ability to accurately manage accounting, clinical, compliance and operational functions. As our acquisitions have become and may continue to become larger, any such failure could cause a material adverse effect on our results of operations.

Businesses we have acquired, or businesses we acquire in the future, may have known and unknown or contingent liabilities for past activities, including liabilities for failure to comply with laws and regulations, retroactive payment adjustments or recoupments from payor audits, medical and general professional malpractice liabilities, unfunded pension liabilities, worker's compensation or other employee-related liabilities, previous tax liabilities and unacceptable business or accounting practices. Although we endeavor to obtain contractual indemnification from sellers covering these matters, any indemnification obtained from sellers may be insufficient to cover material claims or liabilities for past activities of acquired businesses. In addition, the actions we take to resolve compliance or regulatory issues within acquired facilities may affect our revenue or results of operations.

TABLE OF CONTENTS

Changes to Medicaid supplemental payment programs may materially and adversely affect our revenues and results of operations.

Medicaid supplemental payments ("MSPs") are payments made to providers separate from and in addition to those made at a state's standard Medicaid payment rate. The two most prevalent forms of MSPs are DSH and Upper Payment Limit ("UPL") payments. Medicaid DSH payments are federally required to be made by the states to hospitals that serve significant numbers of Medicaid and uninsured patients in recognition of the added costs incurred by hospitals in treating these patients. The total amount of Medicaid DSH payments a state may make and the total amount any one hospital may receive are both capped by federal law. Unlike Medicaid DSH payments, UPL payments are not required to be made by states under federal law. Rather, federal regulations establish an upper payment limit above which states may not receive federal matching dollars. UPL programs have expanded in recent years and related MSPs to our hospitals have similarly increased as states use UPL programs as a way to avoid or mitigate reimbursement cuts to providers.

Pursuant to the Affordable Care Act, as amended by the Pathway Act, PAMA and MACRA, funding for Medicaid DSH programs is to be significantly reduced beginning in FFY 2018. Because many of the states in which we operate have not expanded Medicaid programs as intended under the Affordable Care Act, the reduction in Medicaid DSH payments may take place without a coupled increase in the Medicaid eligible population, thus increasing the net amount of uncompensated care we provide.

Additionally, some states that provide MSPs are reviewing these programs or have filed waiver requests with CMS to replace these programs, and CMS has performed and continues to perform compliance reviews of some states' programs, which could result in MSPs being reduced or eliminated. We cannot predict whether MSP programs will continue (and, if continued, whether we will qualify for such programs) or guarantee that revenues recognized from these programs will not decrease. Furthermore, we cannot predict how these programs will be impacted by the 2016 federal and state elections or potential fundamental changes to the Medicaid program.

We conduct a significant portion of our operations through joint ventures, which may expose us to risks and uncertainties.

For financial or strategic reasons, we conduct much of our business through joint ventures. As a general matter, our joint venture partners could have investment and operational goals that are not consistent with our company-wide objectives, including the timing, terms and strategies for future growth and development opportunities, and we could reach an impasse on certain decisions, which may hinder our ability to pursue preferred strategies for growth and development, could require significant resource to resolve and could have an adverse effect on our operations and revenue growth. In addition, our joint venture relationships with not-for-profit partners and the agreements that govern these relationships are structured based on current provisions of the Internal Revenue Code (and the Treasury Regulations thereunder), published rulings by the Internal Revenue Service, as well as case law relevant to joint ventures between for-profit and not-for-profit entities. Material changes in these legal authorities could adversely affect our relationships with not-for-profit partners and related joint venture arrangements.

By far the largest of our joint ventures is Duke LifePoint Healthcare, which is owned by the Company and a wholly-controlled affiliate of Duke, and which currently operates 14 hospital campuses in four states. In recent years, many of our large acquisitions have been conducted through Duke LifePoint Healthcare. While we own a substantial majority of the equity in Duke LifePoint Healthcare, the long term success of Duke LifePoint Healthcare is dependent on ongoing collaboration and the alignment of our interests with those of Duke. In the event of a material disagreement with Duke or the breach of our joint venture agreement, Duke LifePoint Healthcare may be subject to dissolution, unwinding or purchase of either party’s interest, which could have a material adverse effect on our revenues and results of operations. Even if Duke LifePoint Healthcare is not dissolved or unwound, our inability to involve Duke LifePoint Healthcare in our acquisitions and future operations could make it more difficult to source new targets or win competitive bidding processes, and our revenue or earnings growth may be hindered.

We are subject to increasingly stringent governmental regulations, and we may face allegations that we have failed to comply with such regulations, which could result in sanctions and even greater scrutiny that reduce our revenues and profitability.

All participants in the healthcare industry are required to comply with numerous overlapping laws and regulations at the federal, state and local government levels. These laws and regulations require that hospitals meet various requirements, including those relating to relationships with physicians and other referral sources, the adequacy and quality of medical care, inpatient admission criteria, privacy and security of health information, standards for equipment, personnel, operating policies and procedures, billing and cost reports, payment for services and supplies, maintenance of adequate records, compliance with building codes and environmental protection, among other matters.

Many of the laws and regulations applicable to the healthcare industry are complex and may be violated inadvertently, and there are numerous enforcement authorities, including CMS, OIG, the DOJ, state attorneys general, and contracted auditors, as well as private plaintiffs. Moreover, the Affordable Care Act created potential False Claims Act liabilities for failing to report and repay identified overpayments within 60 days of identifying the overpayment or the date by which a corresponding cost report is due, whichever is later.

TABLE OF CONTENTS

There are also heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry, including the hospital segment. Recent enforcement actions have focused on financial arrangements between hospitals and physicians, billing for services without adequately documenting the medical necessity for such services and billing for services outside the coverage guidelines for such services. Hospitals continue to be one of the primary focal areas of the OIG and other governmental fraud and abuse programs, as described in the annual OIG Work Plan. Certain of our facilities have received inquiries and subpoenas from various governmental agencies regarding these matters, and we are also subject to various claims and lawsuits relating to these and other matters. For a further discussion of these inquiries, proceedings and claims, see "Legal Proceedings" in Item 3 of this Report.

The laws and regulations with which we must comply are constantly changing. In the future, different interpretations or enforcement of these laws and regulations could subject our business practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. If we fail to comply with applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate our hospitals or loss of our ability to participate in the Medicare, Medicaid and other governmental programs.

Finally, we are subject to various federal, state and local statutes and ordinances regulating the discharge of materials into the environment. For example, our healthcare operations generate medical waste, such as pharmaceuticals, biological materials and disposable medical instruments that must be disposed of in compliance with federal, state and local environmental laws, rules and regulations. Environmental regulations also may apply when we build new facilities or renovate existing hospitals, particularly older facilities. If we fail to comply with environmental regulations we may be liable for substantial investigation and clean-up costs or we may be subject to lawsuits by governmental authorities or private plaintiffs.

We may be subjected to actions brought by the government under anti-fraud and abuse provisions or by individuals on the government's behalf under the False Claims Act's "qui tam" or "whistleblower" provisions.

The federal False Claims Act prohibits providers from, among other things, knowingly submitting false claims for payment to the federal government. The "qui tam" or "whistleblower" provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are entitled to share in any amounts recovered by the government, and, as a result, the number of "whistleblower" lawsuits that have been filed against providers has increased significantly in recent years. We are required to provide information to our employees and certain contractors about state and federal false claims laws and whistleblower provisions and protections. Defendants found to be liable under the federal False Claims Act may be required to pay up to three times the actual damages sustained by the government, plus mandatory civil penalties ranging between $10,781 and $21,563 for each separate false claim, subject to the initial "catch-up" adjustment and annual inflation increases as set forth in the 2015 Act.

There are many potential bases for liability under the False Claims Act, including reckless or intentional acts or omissions. In addition, the Affordable Care Act created False Claims Act liability for the knowing failure to report and return an overpayment within 60 days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later, and a number of states have adopted their own false claims and whistleblower provisions whereby a private party may file a civil lawsuit in state court.
Although we intend and will endeavor to conduct our business in compliance with all applicable federal and state laws, many o

fraud and abuse laws.

We may be subject to liabilities because of malpractice and related legal claims brought against our facilities or healthcare providers associated with, or employed by, our facilities or affiliated entities. If we become subject to these claims, we could be required to pay significant damages, which may not be covered by insurance.

We may be subject to medical malpractice lawsuits and other legal actions arising out of the operations of our owned and leased facilities and the activities of our employed or affiliated physicians. As a matter of policy, we typically notify patients of any potential harms they may have suffered at our facilities, regardless of whether such notifications are required by law and notwithstanding our uncertainty as to the severity of such harms or whether they even took place. This may lead to class actions or other multi-plaintiff lawsuits or whistleblower reports. These actions may involve large claims and significant defense costs and, if we or our facilities are found liable, any judgments against us may be material. In an effort to resolve one or more of these matters, we may choose to negotiate a settlement whether or not we believe we are liable. Amounts we pay to settle any of these matters also may be material.

Although we maintain professional and general liability insurance with unrelated commercial insurance carriers, each individual plaintiff's claim is generally subject to the SIR, which for some periods has been as high as $10.0 million. Any successful claim against us that is within our SIR amounts could have an adverse effect on our results of results of operations or liquidity. Some of these claims could exceed the scope of the excess coverage in effect, or coverage of particular claims could be denied, and any amounts not covered by insurance could be material.

TABLE OF CONTENTS

Insurance coverage in the future may not continue to be available at a cost allowing us to maintain adequate levels of insurance with acceptable SIR level amounts. One or more of our insurance carriers may become insolvent and unable to fulfill its obligation to defend, pay or reimburse us when that obligation becomes due. In addition, physicians using our facilities may be unable to obtain insurance on acceptable terms, which could result in these physicians not being able to meet the minimum insurance requirements in the applicable medical staff bylaws or necessitate a reduction in the level of insurance required to be carried under such bylaws.

Factors related to our employment of physicians could affect our financial performance.

We have significantly increased, and anticipate a continued increase in, the number of physicians we employ. We believe that physician employment by acute care hospitals is consistent with industry trends and has become more common as a result of actual and potential reductions in payment amounts for physician services and increasing costs to physicians, such as EHR implementation and professional liability insurance expenses. Employed physicians generally present more direct risks to us than those presented by independent members of our hospitals' medical staffs, such as risks of unsuccessful physician integration, difficulties associated with physician practice management or increased government scrutiny of physician employment arrangements. Employed physicians also require us to incur additional expenses, such as increased salary and benefit costs, medical malpractice expense and rent expense. The potential liabilities and increased expenses of employing physicians could have an adverse effect on our results of operations.

As a result of reviews of claims to Medicare and Medicaid for our services, we may experience delayed payments or incur additional costs and may be required to repay amounts already paid to us.

We are subject to regular post-payment inquiries, investigations and audits of the claims we submit to Medicare for payment for our services. These post-payment reviews may increase as a result of government cost-containment initiatives, including enhanced medical necessity reviews for Medicare patients admitted as inpatients to general acute care hospitals for certain procedures (e.g., cardiovascular procedures) and audits of Medicare claims under the RAC programs. RACs utilize a post-payment targeted review process employing data analysis techniques in order to identify those Medicare claims most likely to contain overpayments, such as incorrectly coded services, incorrect payment amounts, non-covered services and duplicate payments. The claims review strategies used by the RACs generally include a review of high dollar claims, including inpatient hospital claims. As a result, a large majority of the total amounts recovered by RACs has come from hospitals.

The Affordable Care Act expanded the RAC program's scope to include managed Medicare and to include Medicaid claims, and all states are now required to establish programs to contract with RACs. In addition, CMS employs Medicaid Integrity Contractors ("MICs") to perform post-payment audits of Medicaid claims and identify overpayments. In addition to RACs and MICs, the state Medicaid agencies and other contractors have also increased their review activities. Third party audits or investigations of Medicare or Medicaid claims could result in increases or decreases in operating revenues to be recognized in periods subsequent to when the related services were performed, which could have a material adverse effect on our results of operations.

Controls designed to reduce inpatient services may reduce our revenues.

Over the last several years, payors have instituted policies and procedures to substantially reduce or limit the use of inpatient services. Controls imposed by Medicare, Medicaid, and commercial third-party payors designed to reduce admissions and lengths of stay, commonly referred to as "utilization review," have affected and are expected to continue to affect our facilities. Federal law contains numerous provisions designed to ensure that services rendered by facilities to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payor-required preadmission authorization and utilization review and by payor pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Significant limits on the scope of services reimbursed and on reimbursement rates and fees could have a material adverse effect on our revenues and results of operations.

We are subject to risks associated with outsourcing functions to third parties.

To improve operating margins, productivity and efficiency, we outsource selected nonclinical business functions to third parties. We take steps to monitor and regulate the performance of independent third parties to whom the Company delegates selected functions, including revenue cycle management, patient access, billing, cash collections, payment compliance and support services, project implementation, supply chain management and payroll services.

TABLE OF CONTENTS

Arrangements with third party service providers may make our operations vulnerable if vendors fail to satisfy their obligations to us as a result of their performance, changes in their own operations, financial condition, or other matters outside of our control. We may also face legal, financial or reputational harm for the actions or omissions of such providers, and we may not have effective recourse against the providers for those harms. Effective management, development and implementation of our outsourcing strategies are important to our business and strategy. If there are delays or difficulties in enhancing business processes or our third party providers do not perform as anticipated, we may not fully realize on a timely basis the anticipated economic and other benefits of the outsourcing projects or other relationships we enter into with key vendors, which could result in substantial costs, divert management's attention from other strategic activities, negatively affect employee morale or create other operational or financial problems for us. Terminating or transitioning arrangements with key vendors could result in additional costs and a risk of operational delays, potential errors and possible control issues as a result of the termination or during the transition phase.

Deterioration in the collectability of "patient due" accounts could adversely affect our revenues and results of operations.

The primary collection risks of our accounts receivable relate to the uninsured patient accounts and patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (exclusions, deductibles and co-payments) remain outstanding. The provision for doubtful accounts relates primarily to amounts due directly from patients. The amount of our provision for doubtful accounts is based on management's assessment of historical collection trends, business and economic conditions, trends in federal and state governmental and private employer health coverage, the rate of growth in uninsured patient admissions and other collection indicators.

If we experience growth in self-pay volume and revenue, including increased acuity levels for uninsured patients and increases in co-payments and deductibles for insured patients, our revenues and results of operations could be adversely affected. Although we have experienced a reduction in uninsured patients since 2014 as a result of the Affordable Care Act and the expansion of state Medicaid programs, the risk of collection from insured patients (and the amounts due) have increased, and will likely continue to increase, as more individuals are enrolled in insurance plans with high deductibles or high co-payments, including those purchased on the Exchanges. Additionally, only ten of the states in which we operate have decided to implement expansions to their Medicaid programs. Accordingly, some low-income persons in states that are not expanding Medicaid will not have insurance coverage as intended by the Affordable Care Act. Furthermore, our ability to improve collections from self-pay patients may be limited by regulatory and investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients.

If the recent decrease in the uninsured population as a result of the Affordable Care Act does not continue, or if the Affordable Care Act is repealed, replaced, or modified, the proportion of accounts receivable being comprised of uninsured accounts and deterioration in the collectability of these accounts could adversely affect our collections of accounts receivable, results of operations and revenues. In addition, even if the Affordable Care Act is fully implemented in its current form, we may continue to experience bad debts and be required to provide uninsured

discounts and charity care for patients that choose not to purchase coverage, undocumented immigrants who are not permitted to enroll in the Exchanges or government healthcare programs and in states that do not expand their Medicaid programs. Furthermore, states that have expanded their Medicaid programs may be unable to sustain such expansion as the Enhanced FMAP is reduced or if the federal government changes, or is unable to fund the expansion of, the Medicaid program.

The industry emphasis on value-based purchasing and bundled payment arrangements may negatively affect our revenues.

There is a trend in the healthcare industry toward value-based purchasing of healthcare services and bundled payment arrangements. These value-based purchasing programs include, among other things, programs that require public reporting of quality data and tie reimbursement to the quality and efficiency of care that is provided by a facility. For example, Medicare and Medicaid currently require hospitals to report certain quality data to receive full reimbursement updates. In addition, Medicare does not reimburse for care related to certain hospital acquired conditions and reduces reimbursement to hospitals that have excessive readmissions. Many large commercial payors currently require hospitals to report quality data, and several commercial payors also do not reimburse hospitals for certain hospital acquired conditions. Bundled payment arrangements generally set a single target spending level for all healthcare services provided to a patient during an episode of care and are intended to create incentives for physicians, hospitals and other providers to work together to provide higher quality and more coordinated care at a lower cost. While participation in most bundled payment arrangements is voluntary, CMS made participation in certain surgical and cardiac bundled payment arrangements mandatory for some providers.

TABLE OF CONTENTS

We expect value-based purchasing programs to become more common and to involve a higher percentage of procedures and payments. CMS has previously announced its goal that 90% of Medicare fee-for-service payments be within value-based purchasing categories by the end of 2018, with 50% of Medicare payments being tied to quality or value through the use of alternative payment models, and many large private payors and state Medicaid programs have declared similar goals. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively affect our revenues.

If we do not effectively attract, recruit and retain qualified physicians, our ability to deliver healthcare services efficiently will be adversely affected.

The success of our facilities depends in part on the number and quality of the physicians on the medical staffs of our hospitals. The success of our efforts to recruit and retain quality physicians depends on several factors, including the actual and perceived quality of services provided by our facilities, our ability to meet demands for new technology, our ability to identify and communicate with physicians who want to practice in our communities. Our ability to attract and retain physicians is increasingly dependent on the ability of our facilities to offer and sustain employment arrangements. In particular, we face intense competition in the recruitment and retention of specialists and primary care physicians. We may not be able to recruit all of the physicians we target.

Additionally, our ability to recruit and employ physicians is closely regulated. For example, the types, amount and duration of compensation and assistance we can provide to recruited physicians are limited by the Stark law, the Anti-kickback Statute, state anti-kickback statutes, and related regulations. All arrangements with physicians must also be fair market value and commercially reasonable.

In addition to these legal requirements, there is competition from other communities and facilities for these physicians, and this competition continues after the physician is practicing in one of our communities. For example, integrated accountable care organizations and other kinds of “narrow” provider networks or organizations may exclude our physicians from their plans’ networks of healthcare providers. If our affiliated providers are excluded from such networks, we may have difficulty recruiting new providers or retaining existing providers.

Generally, a small number of attending physicians within each of our facilities represent a large share of our inpatient revenues and admissions. The loss of one or more of these physicians — even if temporary — could cause a material reduction in our revenues, which could take significant time and operational resources to replace given the difficulty and cost associated with recruiting and retaining physicians.

Finally, a significant portion of the physicians serving our facilities are native to countries other than the U.S. Our ability to recruit such physicians and their ability and willingness to remain and work in the U.S. are impacted by immigration laws and regulations. Changes in immigration or naturalization laws, regulations, or procedures may adversely affect our ability to hire or retain physicians and may adversely affect our costs of doing business and/or our ability to deliver services in our communities.

We are subject to potential legal and reputational risk as a result of our access to personal information of our patients and employees. A cybersecurity attack or security breach could adversely affect our relationships with business partners and subject us to legal claims and liabilities, reputational harm and business disruption.

There are numerous federal and state laws and regulations addressing employee, patient and consumer privacy concerns, including unauthorized access to or theft of personal information. In the ordinary course of our business, we, and vendors acting on our behalf, collect and store sensitive data, including individual health data and other personally

identifiable information of our patients and employees, and such information is often targeted by criminal organizations. The secure processing, maintenance and transmission of this information is critical to our operations and business strategy. We have developed a comprehensive set of policies and procedures in our efforts to comply with HIPAA and other privacy and information security laws.

We may be subject to security breaches, employee error, theft, malfeasance, phishing schemes, ransomware, faulty password or data security management, or other irregularities. The loss or exposure of personal information may trigger notification requirements under HIPAA and state laws, and could result in civil or criminal penalties. The HHS Office for Civil Rights has imposed civil monetary penalties and corrective action plans on covered entities for violating HIPAA's privacy and security rules. In addition, state attorneys general and private plaintiffs have brought civil actions seeking injunctions and damages in response to violations of HIPAA's privacy and security rules. As cybersecurity threats continue to evolve, we may not be able to anticipate certain attack methods in order to implement effective protective measures, and we may be required to expend significant additional resources to continue to modify and strengthen our security measures, investigate and remediate any vulnerabilities in our information systems and infrastructure, or invest in new technology designed to mitigate security risks.

TABLE OF CONTENTS

Cyber-attacks could also target theft of information in addition to personal health information, including financial assets, intellectual property, or other sensitive information belonging to us, our patients or our business partners. Cyber-attacks also may be directed at disrupting our operations or the operations of our business partners. If, in spite of our security and compliance efforts, we our any of our business associates we fall victim to cyber-attacks, we may incur substantial costs and suffer other negative consequences. These costs and consequences include, but are not limited to, remediation costs such as liability for stolen assets or information and repairing system damage that may have been caused, including incentives offered to patients or business partners in an effort to maintain business relationships after an attack; increased cybersecurity protection costs such as organizational changes, deploying additional personnel and protection technologies, training employees, and engaging third party experts and consultants; lost revenues resulting from unauthorized use of proprietary information or the failure to retain or attract patients following an attack; litigation; and reputational damage adversely affecting patient or investor confidence. Any or all of these consequences could have a material adverse effect on our business and results of operations.

If we are unable to successfully implement enterprise-wide information technology systems, our operating results could be negatively impacted.

We have initiated a multi-year business initiative to migrate our multiple information technology platforms to a smaller number of enterprise-wide systems solutions. If we do not allocate and effectively manage the resources necessary to build and sustain the proper information technology infrastructure, or if we fail to achieve the expected benefits from this initiative, it may impact our ability to operate profitably and efficiently, and to timely comply with changing regulatory requirements and with the requests of patients, payors and business partners. The failure to transition to these systems on time, or anticipate necessary readiness and training needs, could lead to business disruption and loss of revenue. In addition, the operating results of newly acquired facilities could be impacted if such facilities are not integrated on a timely basis into our new systems.

In addition, as new information systems are developed in the future, we will need to integrate them into our existing systems. Evolving industry and regulatory standards, such as HIPAA and EHR meaningful use regulations, may require changes to our information systems in the future. System conversions are costly, time consuming and disruptive for physicians, staff and, in some cases, patients. Some of our hospitals have recently converted or are currently converting from their existing system to another third party information system. If such conversions occurred on a large scale or if conversions at our larger facilities experience difficulties, the costs and disruptions could have a material adverse effect on our revenues or results of operations.

If access to our information systems is interrupted or restricted, or if we are unable to make changes to our information systems, our operations could suffer.

Our business depends heavily on effective information systems to process clinical, operational and financial information. Information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and to develop new systems in order to keep pace with continuing changes in information processing technology. We rely on multiple third party providers of financial, clinical, patient accounting and network information services and, as a result, we face operational challenges in maintaining multiple provider platforms and facilitating the interface of such systems with one another. The third party providers may not have appropriate controls to protect confidential information. We do not control the information systems of third party providers, and in some cases we may have difficulty accessing information archived on third party systems, which could subject us to liability for failure to respond to legal or payor information requests. Our networks and technology systems are also subject to disruption due to events such as a major earthquake, fire, telecommunications failure, terrorist attack or

other catastrophic event. If the information systems on which we rely fail or are interrupted, if our access to these systems is limited in the future or if providers develop systems more appropriate for the urban healthcare market and not suited for our facilities, our operations could suffer.

We may not be able to generate sufficient cash flow through operations or successfully access other capital resources to fund all of our capital expenditure programs and commitments.

We require substantial capital resources to fund our growth strategy and ongoing capital expenditure programs, including capital expenditure programs for renovation, expansion and construction at our facilities and the addition of equipment and technology at our facilities. As part of our growth strategy, as well as our regular capital allocation efforts, we often commit to significant capital expenditures well in advance of the time these expenditures will be made. Furthermore, as part of our on-going acquisition strategy, we often commit to making significant capital improvements at acquired facilities over a number of years. At December 31, 2016, we estimated our total remaining unfulfilled capital expenditure commitments to be approximately $1,547.7 million. Please see "Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations - Contractual Obligations, Commitments and Off-Balance Sheet Arrangements" for more information about the general timing and impact of these contractual obligations.

TABLE OF CONTENTS

Our cash flows and available capital resources may be insufficient to fund our capital expenditure programs and commitments, and we may be forced to reduce or delay planned and required capital expenditures. Additionally, we may experience delays or impediments in satisfying the schedule for capital expenditure commitments because of a variety of factors beyond our control, such as zoning, environmental, licensing and certificate of need regulations and restrictions.

The failure to satisfy our capital expenditure commitment obligations could damage our reputation within our communities, expose us to potential claims from former owners of acquired facilities or other governing or regulatory agencies, and adversely impact our ability to negotiate and complete future acquisitions.

We may have difficulty acquiring hospitals on favorable terms.

A significant element of our business strategy is expansion through the acquisition of acute care hospitals, especially those around which a system of hospitals and other healthcare services can be created. We face significant competition to acquire attractive hospitals, and we may not find suitable acquisitions on favorable terms. Our primary competitors for acquisitions have included for-profit and tax-exempt hospitals and hospital systems and privately capitalized start-up companies. Buyers with a strategic desire for any particular hospital — for example, a hospital located near existing hospitals or those who will realize economic synergies — have demonstrated an ability and willingness to pay premium prices for hospitals. Strategic buyers, as a result, can present a competitive barrier to our acquisition efforts.

The cost of an acquisition could result in a dilutive effect on our results of operations, depending on various factors, including the amount paid for the acquisition, the acquired hospital's results of operations, allocation of purchase price, effects of subsequent legislation and limitations on rate increases.

Even if we are able to identify an attractive target, we may need to obtain financing for acquisitions, joint ventures or required capital improvements. Such financing may not be available, or we may incur or assume additional indebtedness as a result. Any financing arrangements we enter into may not be on terms favorable to us, and this could have a material adverse effect on our results of operations or stock price.

In recent years, the legislatures and attorneys general of several states have become more interested in approving the sales of hospitals by tax-exempt entities. Furthermore, as a condition to approving an acquisition, the state attorney general of the state in which the acquisition takes place may require us to maintain specific service lines or provide charity care at certain minimum levels for set periods of time after closing of the acquisition, regardless of profitability. This heightened scrutiny may increase the cost and difficulty, or prevent the completion, of transactions with tax-exempt organizations in the future. Our failure to acquire hospitals consistent with our growth plans could prevent us from increasing our revenues.

Our facilities face competition for management and other non-physician staffing, which may increase labor costs and reduce profitability.

In addition to our physicians, the operations of our facilities are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians. We compete with other healthcare providers in recruiting and retaining qualified management and staff personnel responsible for the day-to-day operations of each of our facilities, including nurses and other non-physician healthcare professionals. In some markets, the scarce availability of nurses and other medical support personnel presents a significant operating issue and the competition for experienced and talented hospital management personnel is intense. This may result in

employee turnover, require us to enhance wages and benefits to recruit and retain management, nurses and other medical support personnel, hire more expensive temporary or contract personnel and recruit personnel from foreign countries (which may be limited by changes in immigration law, regulation and policy). In addition, the states in which we operate could adopt mandatory nurse-staffing ratios or could reduce mandatory nurse staffing ratios already in place. State-mandated nurse-staffing ratios could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required ratios. If our labor costs increase, we may not be able to raise rates to offset these increased costs. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is constrained. Our failure to recruit and retain qualified management, nurses and other medical support personnel, or to control our labor costs could have a material adverse effect on our revenues or results of operations.

TABLE OF CONTENTS

Other hospitals and outpatient facilities provide services similar to those which we offer. In addition, physicians provide services in their offices that could be provided in our facilities. These factors increase the level of competition we face and may therefore adversely affect our revenues and results of operations.

Competition among hospitals and other healthcare service providers, including outpatient facilities, has intensified in recent years. We compete with other hospitals, including larger tertiary care centers located in metropolitan areas. Although the hospitals with which we compete may be a significant distance away from our facilities, patients in our markets may migrate on their own to, may be referred by local physicians to, or may be required by their health plan to travel to these hospitals. Furthermore, some of the hospitals with which we compete may offer more or different services than those available at our facilities, may have more advanced equipment or technology or may have a medical staff that is perceived to be better qualified. Also, most of the hospitals that compete with our facilities are owned by tax-supported governmental agencies or not-for-profit entities supported by endowments and charitable contributions. These hospitals, in most instances, are also exempt from paying sales, property and income taxes.

Quality of care and value-based purchasing have also become significant trends and competitive factors in the healthcare industry. CMS makes public the performance data relating to multiple quality measures that hospitals submit in connection with their Medicare reimbursement. If the publicly-available performance data become a primary factor in where patients choose to receive care, and if competing hospitals have better results than our hospitals on those measures, our revenues and/or patient volumes could decline.

We also face significant and increasing competition from services offered by physicians (including physicians on our medical staffs) in their offices and from other specialized care providers, including outpatient surgery, oncology, physical therapy and diagnostic centers (including many in which physicians may have an ownership interest). We also compete with specialty hospitals that focus on one or a small number of lucrative service lines, some of which are not required to operate emergency departments. Some of our hospitals have and will seek to develop outpatient facilities where necessary to compete effectively. However, to the extent that other providers are successful in developing outpatient facilities or physicians are able to offer additional, advanced services in their offices, our market share for these services will likely decrease in the future.

Many of the non-urban communities in which we operate continue to face challenging economic conditions and the closure of a small number of large employers in our markets can have a disproportionate impact on our facilities.

While the U.S. economy as a whole is expanding, many of the non-urban communities in which we operate continue to face challenging economic conditions, including high levels of unemployment. The economies in the non-urban communities in which our facilities primarily operate are often dependent on a small number of large employers, especially manufacturing or similar facilities. These employers often provide income and health insurance for a disproportionately large number of community residents who may depend on our facilities for care. The failure of one or more large employers, or the closure or substantial reduction in the number of individuals employed at manufacturing or similar facilities located in or near many of the non-urban communities in which our facilities primarily operate, could cause affected employees to move elsewhere for employment or lose insurance coverage that was otherwise available to them. When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose to:

•defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for hospitals; or

•purchase a high-deductible insurance plan or no insurance at all, which increases a hospital's dependence on self-pay revenue. Moreover, a greater number of uninsured patients may seek care in our emergency rooms.

The occurrence of these events may impede our business strategies intended to generate organic growth and improve operating results at our facilities.

TABLE OF CONTENTS

Our revenues are especially concentrated in a small number of states which will make us particularly sensitive to regulatory and economic changes in those states.

Our revenues are particularly sensitive to regulatory and economic changes in states in which we generate the majority of our revenues including North Carolina, Kentucky, Virginia, Pennsylvania, Michigan, Georgia, Tennessee and New Mexico. The following table contains our revenues and revenues as a percentage of our total revenues by state for each of these states for the years presented (dollars in millions):

		Revenue Concentration by State					
	Hospital Campuses in State as of December 31, 2016	2016		2015		2014	
		Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
North Carolina	9	$ 947.9	14.9 %	$ 580.3	11.1 %	$ 372.6	8.3 %
Kentucky	10	679.9	10.7	638.5	12.2	587.9	13.1
Virginia	6	661.8	10.4	641.9	12.3	624.4	13.9
Pennsylvania	4	562.5	8.8	566.5	10.9	*	*
Michigan	3	468.0	7.4	476.2	9.1	460.8	10.3
Georgia	2	453.7	7.1	*	*	*	*
Tennessee	10	450.1	7.1	420.7	8.1	404.5	9.0
New Mexico	2	320.4	5.0	287.3	5.5	266.5	5.9

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* - Not considered significant for the period presented.

Accordingly, any changes in the current demographic, economic, competitive or regulatory conditions, or to Medicaid programs, in the above-mentioned states could have an adverse effect on our revenues or results of operations. Our concentration of revenues in these states also make it more likely that hurricanes, floods, persistent drought, power grid interruption or other factors beyond our control in these states could adversely affect our revenues or results of operations.

We have substantial indebtedness, and we may incur significant amounts of additional indebtedness in the future which could affect our ability to finance operations and capital expenditures, pursue desirable business opportunities or successfully operate our business in the future.

As of December 31, 2016, our total debt, excluding unamortized debt issuance costs and premium, was $2,936.2 million. We also have the ability to incur significant amounts of additional indebtedness, subject to the conditions imposed by the terms of the agreements and indentures governing our existing indebtedness or any additional indebtedness that we may incur in the future.

Although we believe that our future operating cash flow, together with available financing arrangements, will be sufficient to fund our operating requirements, our leverage and debt service obligations could have important consequences, including the following:

- Under our debt agreements, we are required to satisfy and maintain specified financial ratios and tests. Failure to comply with these obligations may cause an event of default which, if not cured or waived, could require us to repay substantial indebtedness immediately. Moreover, if debt repayment is accelerated, we will be subject to higher

interest rates on our debt obligations as a result of these covenants, and our credit ratings may be adversely impacted.

· We may be vulnerable in the event of downturns and adverse changes in the general economy or our industry.

· We may have difficulty obtaining additional financing at favorable interest rates to meet our requirements for working capital, capital expenditures, acquisitions, general corporate or other purposes.

· We will be required to dedicate a substantial portion of our cash flow to the payment of principal and interest on indebtedness, which will reduce the amount of funds available for operations, capital expenditures and future acquisitions.

· Any borrowings we incur at variable interest rates generally expose us to increases in interest rates.

· A breach of any of the restrictions or covenants in our debt agreements could cause a cross-default under other debt agreements. We may be required to pay our indebtedness immediately if we default on any of the numerous financial or other restrictive covenants contained in the debt agreements. It is not certain whether we will have, or will be able to obtain, sufficient funds to make these accelerated payments. If any senior debt is accelerated, our assets may not be sufficient to repay such indebtedness and our other indebtedness.

· In the event of a default, we may be forced to pursue one or more alternative strategies, such as restructuring or refinancing our indebtedness, selling assets, reducing or delaying capital expenditures or seeking additional equity capital. There can be no assurances that any of these strategies could be effected on satisfactory terms, if at all, or that sufficient funds could be obtained to make these accelerated payments.

TABLE OF CONTENTS

Covenant restrictions under certain of our debt agreements and indentures impose operating and financial restrictions on us and may limit our ability to operate our business and to make payments on the notes and other outstanding indebtedness.

Agreements governing our existing indebtedness contain covenants that restrict our ability to finance future operations or capital needs, to take advantage of other business opportunities that may be in our interest or to satisfy our other debt obligations. These covenants restrict our ability to, among other things:

· incur or guarantee additional debt or extend credit;
· pay dividends or make distributions on, or redeem or repurchase, our capital stock or certain other debt;
· make other restricted payments, including investments;
· dispose of assets;
· engage in transactions with affiliates;
· enter into agreements restricting our subsidiaries' ability to pay dividends;
· create liens on our assets or engage in sale/leaseback transactions;
· effect a consolidation or merger, or sell, transfer, lease all or substantially all of our assets; and
· repay our existing outstanding indebtedness.

If we fail to effectively and timely implement electronic health record and coding systems, our operations could be adversely affected.

As required by the American Recovery and Reinvestment Act of 2009 ("ARRA"), the HHS has developed and implemented an incentive payment program for eligible hospitals and healthcare professionals that adopt and meaningfully use EHR technology. The HHS uses the Provider Enrollment, Chain and Ownership System ("PECOS") to verify Medicare enrollment prior to making EHR incentive program payments. If our hospitals and employed professionals are unable to meet the requirements for participation in the incentive payment program, including having an enrollment record in PECOS, we will not be eligible to receive incentive payments that could offset some of the costs of implementing EHR systems. Furthermore, eligible hospitals and professionals that fail to demonstrate meaningful use of certified EHR technology are subject to reduced payments from Medicare. Even if we do meet such requirements, the incentive payments we have received in prior years for EHR implementation are scheduled to end in 2017. EHR incentive payments that we have previously recognized are subject to audit and potential recoupment if it is determined that we did not meet the applicable meaningful use standards required in connection with such incentive payments.

We are in the process of converting certain of our clinical and patient accounting information system applications to newer versions of existing applications or all together new applications at several of our facilities. In connection with our implementations and conversions, we have incurred significant capitalized costs and additional training and implementation expenses. System conversions to comply with EHR could be time consuming and disruptive for physicians and employees. Failure to implement EHR systems effectively and in a timely manner could have a material adverse effect on our results of operations.

Certificate of need laws and regulations regarding licenses, ownership and operation may impair our future expansion in some states. In states without certificate of need laws, competing providers of healthcare services are able to expand and construct facilities without the need for significant regulatory approval.

Some states require prior approval for the purchase, construction and expansion of healthcare facilities, based on the state's determination of need for additional or expanded healthcare facilities or services. In addition, certain states in which we operate facilities require a certificate of need for capital expenditures exceeding a prescribed amount,

changes in bed capacity or services, and for certain other planned activities. We may not be able to obtain certificates of need required for expansion activities in the future. In addition, all of the states in which we operate facilities require hospitals and most healthcare providers to maintain one or more licenses. If we fail to obtain any required certificate of need or license, our ability to operate or expand operations in those states could be impaired.

Some states in which we operate do not require certificates of need for the purchase, construction and expansion of healthcare facilities or services. Additionally, from time to time, states with existing requirements may repeal or limit the scope of their certificate of need programs. Our competing healthcare providers face lower barriers to entry and expansion in such states. If these competing providers of healthcare services are able to purchase, construct or expand healthcare facilities without the need for regulatory approval, we may face decreased market share and revenues in those markets.

Item 1B. Unresolved Staff Comments.

We have no unresolved SEC staff comments.

TABLE OF CONTENTS

Item 2. Properties.

The following table presents certain information with respect to our hospital campuses as of December 31, 2016:

Hospital	City	Acquisition/Opening/ Lease Date	Licensed Beds	Real Property Status
Alabama				
Andalusia Regional Hospital	Andalusia	May 11, 1999	88	Own
Vaughan Regional Medical Center (a)	Selma	April 15, 2005	175	Own (a)
Arizona				
Havasu Regional Medical Center (b)	Lake Havasu City	April 15, 2005	171	Own (b)
Valley View Medical Center	Fort Mohave	November 8, 2005	84	Own
Colorado				
Colorado Plains Medical Center	Fort Morgan	April 15, 2005	50	Lease
Georgia				
Rockdale Medical Center	Conyers	February 1, 2009	158	Own
St. Francis Hospital	Columbia	January 1, 2016	376	Own
Indiana				
Clark Memorial Hospital (c)	Jeffersonville	August 1, 2015	236	Own (c)
Scott Memorial Hospital (c)	Scottsburg	January 1, 2013	25	Own (c)
Kansas				
Western Plains Medical Complex	Dodge City	May 11, 1999	99	Own
Kentucky				
Bluegrass Community Hospital	Versailles	January 2, 2001	25	Own
Bourbon Community Hospital	Paris	May 11, 1999	58	Own
Clark Regional Medical Center	Winchester	May 1, 2010	79	Own
Fleming County Hospital	Flemingsburg	August 1, 2015	52	Own
Georgetown Community Hospital	Georgetown	May 11, 1999	75	Own
Jackson Purchase Medical Center	Mayfield	May 11, 1999	107	Own
Lake Cumberland Regional Hospital	Somerset	May 11, 1999	295	Own
Logan Memorial Hospital	Russellville	May 11, 1999	75	Own
Meadowview Regional Medical Center	Maysville	May 11, 1999	100	Own
Spring View Hospital	Lebanon	October 1, 2003	75	Own
Louisiana				
Mercy Regional Medical Center - Acadian	Eunice	April 15, 2005	42	Own
Mercy Regional Medical Center - Ville Platte	Ville Platte	December 1, 2001	67	Own
Minden Medical Center	Minden	April 15, 2005	161	Own
Teche Regional Medical Center	Morgan City	April 15, 2005	164	Lease
Michigan				
Bell Hospital	Ishpeming	December 1, 2013	25	Own
Marquette General Hospital (d)	Marquette	September 1, 2012	307	Own (d)
Portage Health (a)	Hancock	December 1, 2013	96	Own (a)

Mississippi				
Bolivar Medical Center	Cleveland	April 15, 2005	199	Lease
Nevada				
Northeastern Nevada Regional Hospital	Elko	April 15, 2005	75	Own
New Mexico				
Los Alamos Medical Center	Los Alamos	April 15, 2005	47	Own
Memorial Medical Center of Las Cruces	Las Cruces	April 15, 2005	199	Lease
North Carolina				
Central Carolina Hospital (d)	Sanford	January 1, 2016	137	Own (d)
Frye Regional Medical Center (d)	Hickory	January 1, 2016	355	Lease (d)
Harris Regional Hospital (d)	Sylva	August 1, 2014	86	Own (d)
Haywood Regional Medical Center (d)	Clyde	August 1, 2014	169	Own (d)
Maria Parham Medical Center (e)	Henderson	November 1, 2011	102	Own (e)
Person Memorial Hospital (d)	Roxboro	October 1, 2011	98	Own (d)
Rutherford Regional Medical Center (e)	Rutherfordton	June 1, 2014	143	Own (e)
Swain County Hospital (d)	Bryson City	August 1, 2014	48	Own (d)
Wilson Medical Center (e)	Wilson	March 1, 2014	384	Own (e)

TABLE OF CONTENTS

Hospital	City	Acquisition/Opening/ Lease Date	Licensed Beds	Real Property Status
Pennsylvania				
Conemaugh Memorial Medical Center (d)	Johnstown	September 1, 2014	539	Own (d)
Meyersdale Medical Center (d)	Meyersdale	September 1, 2014	20	Own (d)
Miners Medical Center (d)	Hastings	September 1, 2014	30	Own (d)
Nason Medical Center	Roaring Spring	February 1, 2015	45	Own
South Carolina				
Providence Hospital - Downtown	Columbia	February 1, 2016	258	Own
Providence Hospital - Northeast	Columbia	February 1, 2016	74	Own
Tennessee				
Crockett Hospital	Lawrenceburg	May 11, 1999	99	Own
Emerald-Hodgson Hospital	Sewanee	May 11, 1999	41	Own
Hillside Hospital	Pulaski	May 11, 1999	95	Own
Livingston Regional Hospital	Livingston	May 11, 1999	114	Own
Riverview Regional Medical Center	Carthage	September 1, 2010	35	Own
Southern Tennessee Medical Center	Winchester	May 11, 1999	157	Own
Starr Regional Medical Center - Athens	Athens	October 1, 2001	118	Own
Starr Regional Medical Center - Etowah	Etowah	July 1, 2012	160	Own
Sumner Regional Medical Center	Gallatin	September 1, 2010	155	Own
Trousdale Medical Center	Hartsville	September 1, 2010	25	Own
Texas				
Ennis Regional Medical Center	Ennis	April 15, 2005	60	Lease
Palestine Regional Medical Center	Palestine	April 15, 2005	156	Own
Parkview Regional Hospital	Mexia	April 15, 2005	58	Lease
Utah				
Ashley Regional Medical Center	Vernal	May 11, 1999	39	Own
Castleview Hospital	Price	May 11, 1999	49	Own
Virginia				
Clinch Valley Medical Center	Richlands	July 1, 2006	175	Own
Danville Regional Medical Center	Danville	July 1, 2005	250	Own
Fauquier Health (a)	Warrenton	November 1, 2013	210	Own (a)
Memorial Hospital of Martinsville and Henry County	Martinsville	April 15, 2005	220	Own
Twin County Regional Hospital (e)	Galax	April 1, 2012	141	Own (e)
Wythe County Community Hospital	Wytheville	June 1, 2005	100	Lease
West Virginia				
Logan Regional Medical Center	Logan	December 1, 2002	140	Own
Raleigh General Hospital	Beckley	July 1, 2006	300	Own
Wisconsin				
Watertown Regional Medical Center (a)	Watertown	September 1, 2015	95	Own (a)
Wyoming				
SageWest Healthcare - Lander	Lander	July 1, 2000	89	Own
SageWest Healthcare - Riverton	Riverton	May 11, 1999	70	Own
			9,424	

(a) The hospital is owned and operated by a joint venture between us and a local not-for-profit entity. A wholly-owned LifePoint affiliate owns a controlling interest in the joint venture.
(b) The hospital is owned and operated by a joint venture with physicians in which a wholly-owned LifePoint affiliate has a controlling interest. The real property on which the hospital is located is owned by the LifePoint member and leased to the joint venture.
(c) The hospital is owned and operated by RHN, a joint venture between us and Norton Healthcare, Inc. A wholly-owned LifePoint affiliate owns a controlling interest in RHN.
(d) The hospital is owned and operated by Duke LifePoint Healthcare. A wholly-owned LifePoint affiliate owns a controlling interest in Duke LifePoint Healthcare.
(e) The hospital is owned and operated by a joint venture between a local not-for-profit entity and Duke LifePoint Healthcare.

We own and operate medical office buildings in conjunction with many of our hospitals. These medical office buildings are primarily occupied by physicians who practice at our hospitals. Additionally, we lease office space in Brentwood, Tennessee for our health support center. All of our facilities are suitable for their respective uses and are generally adequate for our present needs.

TABLE OF CONTENTS

Item 3. Legal Proceedings.

Healthcare facilities are, from time to time, subject to claims and suits arising in the ordinary course of business, including claims for damages for personal injuries, medical malpractice, breach of contracts, wrongful restriction of or interference with physicians' staff privileges and employment related claims. In certain of these actions, plaintiffs request payment for damages, including punitive damages that may not be covered by insurance.

In addition, healthcare facilities are subject to the regulation and oversight of various state and federal governmental agencies. Further, under the federal False Claims Act, private parties have the right to bring qui tam, or "whistleblower," suits against healthcare facilities that submit false claims for payments to, or improperly retain identified overpayments from, governmental payors. Some states have adopted similar state whistleblower and false claims provisions. These qui tam or "whistleblower" actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act's requirements for filing such suits. As a result, they could be proceeding without our knowledge. In addition, the DOJ published an interim final rule that, effective as of August 1, 2016, increases the civil monetary penalties that may be imposed for violations of the False Claims Act from a minimum of $5,500 and a maximum of $11,000 to a minimum of $10,781 and a maximum of $21,563 for each false and fraudulent claim. The interim final rule also establishes a mechanism for increasing the amounts of those civil monetary penalties for inflation on an annual basis beginning in 2017 and continuing each year thereafter. These civil monetary penalties are in addition to violators' liability for three times the amount of damages which the government sustains as a result of the false or fraudulent claim.

Although the healthcare industry has seen numerous ongoing investigations related to compliance and billing practices, hospitals, in particular, continue to be a primary enforcement target for the OIG, the DOJ and other governmental fraud and abuse programs. Certain of our individual facilities have received, and from time to time, other facilities may receive, inquiries or subpoenas from MACs, and federal and state agencies. Any proceedings against us may involve potentially substantial amounts as well as the possibility of civil, criminal, or administrative fines, penalties, or other sanctions, which could be material. Settlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material adverse effect on our financial position, results of operations and liquidity.

The Affordable Care Act imposed an affirmative obligation on healthcare providers to report and refund any overpayments received. "Overpayments" in this context include any amount received from a government program by a provider to which it is not entitled, regardless of the cause. Such overpayments are deemed to be fraudulent and become violations of the False Claims Act if not reported and refunded within the later of 60 days of identification or the date any corresponding cost report is due (if applicable). Hospitals can meet the obligation to report and refund in three ways: (1) refunding overpayments directly to the program; (2) self-disclosing the overpayment to the OIG via its voluntary self-disclosure protocol (with respect to False Claims Act and other violations not related to the federal physician self-referral law (Stark law)); and (3) self-disclosing to CMS via the self-referral disclosure protocol (with

respect to overpayments caused by potential violations of the Stark law only) for which CMS has the authority to reduce the amounts otherwise owed.

We do not control and cannot predict with certainty the progress or final outcome of discussions with government agencies, investigations and legal proceedings against us. Therefore, the final amounts paid to resolve such matters, claims and obligations could be material and could materially differ from amounts currently recorded, if any. Any such changes in our estimates or any adverse judgments could materially adversely impact our future results of operations and cash flows.

In connection with our acquisitions of Marquette General Hospital (“Marquette General”) and Conemaugh Health System (“Conemaugh”), the two sellers self-disclosed various potentially non-compliant physician arrangements under the CMS voluntary self-disclosure protocol. These self-disclosures are pending with CMS. With respect to Marquette General, to the extent that the seller’s satisfaction of its retained liabilities, including those under its CMS voluntary self-disclosure, causes its net proceeds from the acquisition to be less than $15.0 million, we have agreed to pay additional purchase consideration to the seller. With respect to Conemaugh, to the extent that the potential settlement exceeds the seller’s indemnification threshold in accordance with the asset purchase agreement, we will likely be responsible for funding any deficit. We believe we have made reasonable estimates of our potential exposure for these two matters, and at December 31, 2016, we have recorded a reserve for Marquette General of $18.0 million.

TABLE OF CONTENTS

On September 16, 2013, we and two of our affiliated hospitals, Vaughan Regional Medical Center, located in Selma, Alabama, and Raleigh General Hospital, located in Raleigh, West Virginia, made a voluntary self-disclosure to the Civil Division of the DOJ. The voluntary self-disclosure related to concerns regarding the clinical appropriateness of certain interventional cardiology procedures conducted by one physician in each of these hospitals' cardiac catheterization laboratories. We cooperated with the government in its investigations of the voluntary self-disclosure and provided additional documentation, as requested. We believe that the government's investigations are now closed. Following reviews by independent interventional cardiologists, we notified patients of these two physicians who may have received an unnecessary procedure of such fact.

We and/or Vaughan Regional Medical Center and several of our subsidiaries, as well as Dr. Seydi V. Aksut and certain parties unaffiliated with us, are named defendants in 26 individual lawsuits filed since December 2014, and two putative class action lawsuits, all filed in the Circuit Court of Dallas County, Alabama. These lawsuits allege that patients at Vaughan Regional Medical Center underwent improper interventional cardiology procedures. One of the putative class action lawsuits, filed on November 21, 2014, seeks certification of a class consisting of all Alabama citizens who underwent an invasive cardiology procedure at any Company-owned Alabama hospital and who received notice regarding the medical necessity of that procedure. The other putative class action lawsuit, filed on February 6, 2015 also in the Circuit Court for Dallas County, Alabama, seeks certification of a class of individuals that underwent an interventional cardiology procedure that was not medically necessary and performed by Dr. Aksut. This action asserts, among other claims, claims under the Racketeer Influenced and Corrupt Organizations Act ("RICO"), which, if successful, would result in the awarding of treble damages for any injury resulting from the RICO violation and attorneys' fees. In March 2015, we removed this action to the U.S. District Court in Mobile, Alabama and filed a motion to dismiss and for summary judgment, as well as a stay of discovery pending resolution of these motions. On April 17, 2015 the court entered an order granting the requested stay of discovery. On November 17, 2015, the United States Magistrate Judge for the Southern District of Alabama filed a Report and Recommendation that the RICO claim be dismissed with prejudice, and that the court not exercise jurisdiction over the remaining state law claims, resulting in those claims being dismissed without prejudice. By Order dated March 28, 2016, the United States District Court Judge adopted in full the Report and Recommendation of the Magistrate, dismissing with prejudice the RICO claim and refusing to exercise jurisdiction over the remaining state law claims. In a filing made April 7, 2016 the plaintiffs appealed the District Court's Order to the United States Court of Appeals for the Eleventh Circuit.

In February 2017, we settled the claims against us, our subsidiaries and Vaughn Regional Medical Center with certain of the individual plaintiffs and claimants, and we are in discussions to settle the remaining individual lawsuits and claims. We are also in discussions to settle the putative class action lawsuits. As of the date of this filing, we believe that all such settlements will be accomplished within the amounts previously accrued for loss contingencies for cardiology-related lawsuits. However, there can be no assurance that we will complete any or all of these settlements, that definitive settlement documentation will be agreed upon by all parties, that the courts overseeing the putative class action lawsuits will approve those settlements, or that the final resolution will not materially exceed the amounts previously accrued.

Additionally, we, and two of our subsidiaries, including Raleigh General Hospital, as well as Dr. Kenneth Glaser, were named in 82 individual lawsuits filed in the circuit court of Raleigh County, West Virginia. Additionally, three

patients had notified Raleigh General of their claims and intent to file a lawsuit. These lawsuits and claims alleged that patients at Raleigh General Hospital underwent unnecessary interventional cardiology procedures. In January 2017, all parties to these lawsuits and claims entered into settlement agreements settling all claims against us, our subsidiaries, Raleigh General Hospital and Dr. Glaser. These settlements were accomplished within the amounts previously accrued for loss contingencies for cardiology-related lawsuits. Following these settlements, two additional lawsuits were filed against the same parties alleging the same claims. In addition, in February 2017, we received a notice of claim with respect to a putative class action lawsuit in the Circuit Court of Raleigh County, West Virginia against us, two of our subsidiaries, Raleigh General Hospital and Dr. Glaser, alleging that patients at Raleigh General Hospital underwent medically unnecessary interventional cardiology procedures and seeking to certify a class of such patients.

The lawsuits identified above variously seek compensatory and punitive damages, costs, attorneys' fees and other available damages. Additional claims, including claims involving patients to whom we did not send notice, have been threatened and may be asserted against us or the hospital. Any present or future claims that are ultimately successful could result in us and/or the hospitals being found liable. Such liability could be material.

We accrue an estimate for a contingent liability when losses are both probable and reasonably estimable. We review our accruals each quarter and adjust them to reflect the impact of developments, advice of legal counsel and other information pertaining to a particular matter. During the year ended December 31, 2016, we recorded an accrual for loss contingencies for cardiology-related lawsuits, which resulted in a net expense of $24.7 million, $15.5 million net of income taxes, or $0.36 loss per diluted share.

Item 4. Mine Safety Disclosures.

Not applicable.

TABLE OF CONTENTS

PART II

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

Market Information for Common Stock

Our common stock is listed on the NASDAQ Global Select Market under the symbol "LPNT." The high and low sales prices per share of our common stock were as follows for the periods presented:

	High	Low
2017		
First Quarter (through February 16, 2017)	$ 64.25	$ 56.60
2016		
First Quarter	$ 74.70	$ 58.20
Second Quarter	$ 75.70	$ 62.99
Third Quarter	$ 67.47	$ 54.82
Fourth Quarter	$ 62.50	$ 50.60
2015		
First Quarter	$ 77.84	$ 64.52
Second Quarter	$ 86.99	$ 69.21
Third Quarter	$ 88.18	$ 68.41
Fourth Quarter	$ 76.39	$ 58.61

On February 16, 2017, the last reported sales price for our common stock on the NASDAQ Global Select Market was $62.95 per share.

Stockholders

As of February 10, 2017, there were 9,152 holders of record of shares of our common stock.

Dividends

We have never declared or paid cash dividends on our common stock. We intend to retain future earnings to finance the growth and development of our business and, accordingly, do not currently intend to declare or pay any cash

dividends on our common stock. Our Board of Directors will evaluate our future earnings, results of operations, financial condition and capital requirements in determining whether to declare or pay cash dividends. Delaware law prohibits us from paying any dividends unless we have capital surplus or net profits available for this purpose. In addition, the senior secured credit agreement with, among others, Citibank, N.A., as administrative agent, and the lenders party thereto (the "Senior Credit Agreement") and certain other indebtedness of the Company impose restrictions on our ability to pay dividends.

TABLE OF CONTENTS

Stock Performance

The graph below compares the yearly percentage change of cumulative total stockholder return on our common stock with (a) the cumulative total return of a broad equity market index, the NASDAQ Composite Index (the “Broad Index”) and (b) the cumulative total return of a published industry index, the S&P Health Care Facilities (Hospital Management) Index (the “Industry Index”). The graph begins on December 31, 2011, and the comparison assumes the investment of $100 on such date in each of our common stock, the Broad Index and the Industry Index and assumes the reinvestment of all dividends, if any. The table following the graph presents the corresponding data for December 31, 2011, and each subsequent fiscal year end.

	12/11	12/12	12/13	12/14	12/15	12/16
LifePoint Health, Inc.	$ 100.00	$ 101.62	$ 142.23	$ 193.57	$ 197.58	$ 152.89
NASDAQ Composite	$ 100.00	$ 116.41	$ 165.47	$ 188.69	$ 200.32	$ 216.54
S&P Health Care Facilities	$ 100.00	$ 158.24	$ 205.26	$ 281.04	$ 249.76	$ 254.13

TABLE OF CONTENTS

Recent Purchases of Equity Securities by the Issuer and Affiliated Purchasers

Our Board of Directors has authorized the repurchase of outstanding shares of our common stock either in the open market or through privately negotiated transactions, subject to market conditions, regulatory constraints and other customary factors in accordance with a repurchase plan adopted in 2014, as subsequently amended and extended in October 2015 (the "2014 Repurchase Plan"), a repurchase plan adopted on June 3, 2015 (the "2015 Repurchase Plan") and a repurchase plan adopted on September 14, 2016 (the "2016 Repurchase Plan"). The 2014 Repurchase Plan and 2015 Repurchase Plan each provided for the repurchase of up to $150.0 million in shares of our common stock, and we have repurchased all shares authorized for repurchase under these plans. The 2016 Repurchase Plan provides for the repurchase of up to $200.0 million in shares of our common stock through March 14, 2018. As of December 31, 2016, we had remaining authority to repurchase approximately $100.0 million in shares in accordance with the 2016 Repurchase Plan. We are not obligated to repurchase any specific number of shares under the 2016 Repurchase Plan. We have designated the shares repurchased in accordance with our repurchase plans as treasury stock.

We repurchased approximately 1.2 million shares for an aggregate purchase price, including commissions, of $74.0 million at an average purchase price of $59.89 per share during the three months ended December 31, 2016 in connection with our repurchase plans. Additionally, we redeem shares from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to our various stockholder-approved stock-based compensation plans. We redeemed a nominal number of shares vested under these plans during the three months ended December 31, 2016. We have designated these shares as treasury stock.

Our repurchase activity in accordance with our repurchase plans and the shares that we redeem from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to our various stockholder-approved stock-based compensation plans are more fully discussed in Note 8 to our consolidated financial statements included elsewhere in this report.

The following table summarizes our share repurchase activity by month for the three months ended December 31, 2016:

	Total Number of Shares Purchased	Weighted Average Price Paid per Share	Total Number of Shares Purchased as Part of a Publicly Announced Plan	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plan (In millions)
October 1, 2016 to October 31, 2016	1,078,870	$ 60.02	1,078,870	$ 109.3
November 1, 2016 to November 30, 2016	157,455	$ 59.02	157,455	$ 100.0
December 1, 2016 to December 31, 2016 (a)	405	$ 56.73	-	$ 100.0
Total	1,236,730	$ 59.89	1,236,325	$ 100.0

(a) Represents shares redeemed for tax withholding purposes upon vesting of certain previously granted stock awards under our various stockholder-approved stock-based compensation plans.

TABLE OF CONTENTS

Item 6. Selected Financial Data.

The table below contains our selected financial data for, or as of the end of, the last five years ended December 31, 2016. The selected financial data is derived from our consolidated financial statements. The timing of acquisitions and divestitures completed during the years presented affects the comparability of the selected financial data. Additionally, we have recognized certain transaction costs in connection with acquisitions as well as certain other non-operating (gains) losses and impairment charges during certain of the periods presented that affected the comparability of the selected financial data. You should read this table in conjunction with the consolidated financial statements and related notes included elsewhere in this report and in Part II, Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations.

	Years Ended December 31,				
	2016	2015	2014	2013	2012
	(In millions, except per share amounts)				
Statements of Operations Data:					
Revenues	$ 6,364.0	$ 5,214.3	$ 4,483.1	$ 3,678.3	$ 3,391.8
Net income attributable to LifePoint Health, Inc.	121.9	181.9	126.1	128.2	151.9
Earnings per share attributable to LifePoint Health, Inc. stockholders:					
Basic	$ 2.90	$ 4.14	$ 2.81	$ 2.77	$ 3.22
Diluted	$ 2.82	$ 3.95	$ 2.69	$ 2.69	$ 3.14
Weighted average shares outstanding:					
Basic	42.0	43.9	44.9	46.3	47.2
Diluted	43.2	46.1	46.9	47.6	48.4
Balance Sheet Data (as of end of year):					
Cash and cash equivalents	$ 96.1	$ 284.0	$ 191.5	$ 637.9	$ 85.0
Working capital	527.1	647.3	640.1	390.8	337.9
Property and equipment, net	3,066.8	2,482.3	2,377.5	2,197.2	2,030.9
Total assets	6,319.0	5,996.8	5,355.3	5,411.8	4,557.8
Total debt, excluding unamortized debt issuance costs, discount and premium	2,936.2	2,691.0	2,208.6	2,386.3	1,739.3
Total LifePoint Health, Inc. stockholders' equity	2,180.4	2,263.9	2,154.6	2,210.1	2,050.5
Statements of Cash Flows Data:					
Purchases of property and equipment	$ (399.5)	$ (274.7)	$ (207.1)	$ (185.2)	$ (221.4)
Cash provided by operating activities	435.2	627.1	412.3	354.0	382.2
Cash used in investing activities	(520.7)	(876.3)	(473.2)	(372.3)	(422.1)
Cash (used in) provided by financing activities	(102.4)	341.7	(385.5)	571.2	(1.3)

TABLE OF CONTENTS

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

We recommend that you read this discussion together with our consolidated financial statements and related notes included elsewhere in this report.

Forward-Looking Statements

We make forward-looking statements in this report, other reports and in statements we file with the SEC and/or release to the public. In addition, our senior management makes forward-looking statements orally to analysts, investors, the media and others. Broadly speaking, forward-looking statements include: projections of our revenues, net income, earnings per share, capital expenditures, cash flows, debt repayments, interest rates, operating statistics and data or other financial items; efforts to reduce the cost of providing healthcare while increasing quality; descriptions of plans or objectives of our management for future operations, services or growth plans including acquisitions, divestitures, business strategies, core strategies and other initiatives, including our relationship with Duke University Health System, Inc. through Duke LifePoint Healthcare; interpretations of Medicare and Medicaid laws and regulations and their effect on our business; and descriptions of assumptions underlying or relating to any of the foregoing.

In this report, for example, we make forward-looking statements, including statements discussing our expectations about: future financial performance and condition; future liquidity and capital resources; future cash flows; existing debt; changes in depreciation and amortization expenses; our business strategy and operating philosophy; effects of competition in a hospital’s market; costs of providing care to our patients; our compliance with new and existing laws and regulations as well as costs and benefits associated with compliance; the impact of national healthcare reform; the impact of efforts to modify, repeal and/or replace the Affordable Care Act; income from electronic health record (“EHR”) incentive programs; anticipated capital expenditures, including routine projects, investments in information systems and capital projects related to previous acquisitions and the expectation that capital commitments could be a significant component of future acquisitions; timeframes for completion of capital projects; implementation of supply chain management and revenue cycle functions; accounting estimates and the impact of accounting methodologies; industry and general economic trends; consolidation of commercial insurance companies and patient shifts to lower cost healthcare plans which generally provide lower reimbursement; participation in the healthcare exchanges and the impact of increasing enrollment by patients in insurance plans with narrow networks, tiered networks, high deductibles or high co-payments; the effect on self-pay revenue of increasing enrollment in insurance plans with high deductibles or high co-payments; reimbursement changes, including policy considerations and changes resulting from state budgetary restrictions; patient volumes and related revenues; the impact of cybersecurity threats; claims and legal actions relating to professional liabilities; governmental investigations and voluntary self-disclosures; and physician recruiting, employment and retention.

Forward-looking statements discuss matters that are not historical facts. Because they discuss future events or conditions, forward-looking statements often include words such as “can,” “could,” “may,” “should,” “believe,” “will,” “would “expect,” “project,” “estimate,” “seek,” “anticipate,” “intend,” “target,” “continue,” “predict” or similar expressions. You shou unduly rely on forward-looking statements, which give our expectations about the future and are not guarantees. Forward-looking statements speak only as of the date they are made. We operate in a continually changing business environment, and new risk factors emerge from time to time. We cannot predict such new risk factors nor can we assess the impact, if any, of such new risk factors on our business or the extent to which any factor or combination of factors may cause actual results to differ materially from those expressed or implied by any forward-looking

statement. We do not undertake any obligation to update our forward-looking statements to reflect events or circumstances after the date of this document or to reflect the occurrence of unanticipated events.

There are several factors, some beyond our control, that could cause results to differ significantly from our expectations. Some of these factors are described in Part I, Item 1A. Risk Factors . Other factors, such as market, operational, liquidity, interest rate and other risks, are described elsewhere in this section and Part II, Item 7A. Quantitative and Qualitative Disclosures about Market Risk. Any factor described in this report could by itself, or together with one or more factors, materially and adversely affect our business, results of operations and/or financial condition. There may be factors not described in this report that could also cause results to differ from our expectations.

TABLE OF CONTENTS

Overview

We own and operate community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities. At December 31, 2016, on a consolidated basis, we operated 72 hospital campuses in 22 states throughout the U.S, having a total of 9,424 licensed beds. We generate revenues primarily through patient services offered at our facilities. We generated $6,364.0 million, $5,214.3 million and $4,483.1 million, respectively, in revenues during the years ended December 31, 2016, 2015 and 2014. In 2016, we derived 51.8% of our revenues from the Medicare and Medicaid programs, collectively. Payments made to our facilities pursuant to the Medicare and Medicaid programs for services rendered rarely exceed our costs for such services. As a result, we rely largely on payments made by private or commercial payors, together with certain limited services provided to Medicare recipients, to generate an operating profit. The healthcare industry continues to endure a period where the costs of providing care are rising faster than reimbursement rates from government or private commercial payors. This places a premium on efficient operation, the ability to reduce or control costs and the need to leverage the benefits of our organization across all of our facilities.

Competitive and Structural Environment

The environment in which our facilities operate is extremely competitive. Our hospitals face competition from other acute care hospitals, including larger tertiary hospitals located in larger markets and/or affiliated with universities; specialty hospitals that focus on one or a small number of very lucrative service lines but that are not required to operate emergency departments; stand-alone centers at which surgeries or diagnostic tests can be performed; and physicians on the medical staffs of our hospitals. In many cases, our competitors focus on the service lines that offer the highest margins. By doing so, our competitors can potentially draw the best-paying business out of our hospitals. This, in turn, can reduce the overall operating profit of our hospitals as we are often obligated to offer service lines that operate at a loss or that have much lower profit margins. We continue to see the shift of increasingly complex procedures from the inpatient to the outpatient setting and have also seen growth in the general shift of lower acuity procedures to physician offices and other non-hospital outpatient settings. These trends have, to some extent, offset our efforts to improve equivalent admission rates at many of our hospitals.

Our hospitals also face extreme competition in their efforts to recruit and retain physicians on their medical staffs. It is widely recognized that the U.S. has a shortage of physicians in certain practice areas, including primary care physicians and specialists such as cardiologists, oncologists, urologists and orthopedists, in various areas of the country. This fact, and our ability to overcome these shortages, is directly relevant to our growth strategies because cardiologists, oncologists, urologists and orthopedists are often the physicians in highest demand in communities where our hospitals are located. Larger tertiary medical centers are acquiring physician practices and employing physicians in some of our communities. While physicians in these practices may continue to be members of the medical staffs of our hospitals, they may be less likely to refer patients to our hospitals over time.

We believe other key factors in our competition for patients is the quality of our patient care and the perception of that quality in the communities where our facilities are located, which may be influenced by, among other things, the technology, service lines and capital improvements made at our facilities and by the skills and experience of our non-physician employees involved in patient care.

In addition to competitive concerns, many of our communities are experiencing slow growth, and in some cases, population losses. We believe this trend has occurred mainly as a result of recent challenging economic conditions because the economies in the non-urban communities in which our facilities primarily operate are often dependent on a small number of larger employers, especially manufacturing or other facilities. This causes the economies of our

communities to be more sensitive to economic downturns and slower to rebound when the overall U.S. economy improves. In addition, other economic factors, including, potentially, self-rationing of healthcare services, have made it more difficult to increase the number of patients who seek care at many of our facilities.

TABLE OF CONTENTS

Business Strategy

In order to achieve growth in patient volumes, revenues and profitability given the competitive and structural environment, we continue to focus our business strategy on the following:

- Measurement and improvement of quality of patient care and perceptions of such quality in communities where our facilities are located;
- Targeted recruiting of primary care physicians and physicians in key specialties;
- Retention of physicians and efforts to improve physician satisfaction, including employing a greater number of primary care physicians as well as physicians in certain specialties;
- Retention and, where needed, recruitment of non-physician employees involved in patient care and efforts to improve employee satisfaction;
- Targeted investments in new technologies, new service lines and capital improvements at our facilities;
- Improvements in management of expenses and revenue cycle;
- Negotiation of improved reimbursement rates with non-governmental payors;
- Strategic growth through acquisition and integration of hospitals and other healthcare facilities where valuations are attractive and we can identify opportunities for improved financial performance through our management or ownership; and
- Developing strategic partnerships with not-for-profit healthcare providers to achieve growth in new regions.

As part of our ongoing efforts to further manage costs and improve the results of our revenue cycle, we have partnered with a third party to provide certain nonclinical business functions, including payroll processing, supply chain management and revenue cycle functions. We believe this model of sharing centralized resources to support common business functions across multi-facility enterprises provides us efficiencies and is the most cost effective approach to managing these nonclinical business functions.

Regulatory Environment

Our business and our facilities are highly regulated, and the penalties for noncompliance can be severe. We are required to comply with extensive, complicated and overlapping government laws and regulations at the federal, state and local levels. These laws and regulations govern every aspect of how our hospitals conduct their operations, from what service lines must be offered in order to be licensed as an acute care hospital, to whether our hospitals may employ physicians, and to how (and whether) our hospitals may receive payments pursuant to the Medicare and Medicaid programs. The failure to comply with these laws and regulations can result in severe penalties including criminal penalties, civil sanctions, and the loss of our ability to receive reimbursements through the Medicare and Medicaid programs.

Not only are our facilities heavily regulated, but the rules, regulations and laws to which they are subject often change, with little or no notice, and are often interpreted and applied differently by various regulatory agencies with authority to enforce such requirements. Each change or conflicting interpretation may require our facilities to make changes in space usage, equipment, personnel or services, and may also require that standard operating policies and procedures be re-written and re-implemented. The cost of complying with such laws and regulations is a significant component of our overall expenses. Further, this expense has grown in recent periods because of new regulatory requirements and the severity of the penalties associated with non-compliance. Management anticipates that compliance expenses will continue to grow in the foreseeable future. The healthcare industry has seen a number of ongoing investigations related to patient referrals, physician recruiting and employment practices, cost reporting and billing practices, medical necessity of inpatient admissions, physician office leasing, laboratory and home healthcare services, physician ownership of hospitals and other healthcare providers, and joint ventures involving hospitals and physicians.

Hospitals continue to be one of the primary focal areas of the Office of Inspector General ("OIG"), the Department of Justice ("DOJ") and other governmental fraud and abuse programs.

TABLE OF CONTENTS

Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively the "Affordable Care Act"), which became federal law in 2010, dramatically altered the U.S. healthcare system and was intended to decrease the number of uninsured Americans and reduce the overall cost of healthcare by, among other things, requiring most Americans to obtain health insurance, providing additional funding for Medicaid in states that choose to expand their programs, reducing Medicaid disproportionate share hospital ("DSH") payments to providers, expanding the Medicare program's use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, bundling payments to hospitals and other providers, and instituting certain private health insurance reforms. The Affordable Care Act also includes certain reductions in Medicare spending, such as negative adjustments to the hospital inpatient and outpatient prospective payment system market basket updates, the revision of annual inflation updates and other cost-containment measures, including planned payment reductions.

On January 20, 2017, newly-inaugurated President Trump issued an executive order that, among other things, stated that it was the intent of his administration to repeal the Affordable Care Act and, pending that repeal, instructed the executive branch of the federal government to defer or delay the implementation of any provision or requirement of the Affordable Care Act that would impose a fiscal burden on any state or a cost, fee, tax or penalty on any individual, family, health care provider, or health insurer. In addition, bills have been introduced in Congress that would repeal the Affordable Care Act and would replace it with varying health coverage plans, including plans that would allow insurers to sell health insurance across state lines, allow the use of health savings accounts ("HSAs") without a high-deductible plan, or give states the option to either keep the coverage framework created by the Affordable Care Act (e.g., expanded Medicaid, individual subsidies, and insurance exchanges) or utilize the increased federal funding that was intended to be provided by the federal government under the Affordable Care Act to create HSAs for low-income individuals and allow such individuals to use their HSAs to purchase health insurance. We cannot predict whether the Affordable Care Act will be repealed, replaced, or modified or the impact that the President's executive order will have on the implementation and enforcement of the provisions of the Affordable Care Act or the regulations adopted or to be adopted to implement the law. In addition, if the Affordable Care Act is replaced or modified, we cannot predict what the replacement plan or modifications would be, when the replacement plan or modifications would become effective, or whether any of the existing provisions of the Affordable Care Act would remain in place.

Even if the current administration is not successful in efforts to repeal and replace the Affordable Care Act, there have been and likely will continue to be a number of legal challenges to various provisions of the Affordable Care Act. For example, in 2012, the U.S. Supreme Court upheld the constitutionality of the Affordable Care Act, including the "individual mandate" provisions of the Affordable Care Act that generally require all individuals to obtain healthcare insurance or pay a penalty. However, the U.S. Supreme Court also held that the provision of the Affordable Care Act that authorized the Secretary of the U.S. Department of Health and Human Services ("HHS") to penalize states that choose not to participate in the expansion of the Medicaid program by removing all of their existing Medicaid funding was unconstitutional. Furthermore, the U.S. House of Representatives filed a lawsuit challenging the use of federal funds to pay insurance companies for cost sharing reductions that are provided to certain individuals who purchase insurance through the Affordable Care Act health insurance marketplace exchange (the "Exchanges"). In May 2016, the

United States District Court for the District of Columbia held that the use of federal funds for the payment of cost sharing reductions was unconstitutional because no funds had been appropriated by Congress for that purpose. The District Court's ruling is being appealed, but if the lawsuit is successful, it could result in insurance premium increases for individuals purchasing their insurance coverage through, or lead to a decrease in the number of insurers offering insurance coverage on, the Exchanges. We cannot predict how the results of the 2016 federal elections will impact the appeal of the lawsuit that has been filed by the U.S. House of Representatives or how the federal government responds to other litigation involving the Affordable Care Act.

The net effect of the Affordable Care Act, as currently adopted, on our business is subject to numerous variables, including the law's complexity, lack of complete implementing regulations and interpretive guidance, and the gradual implementation of the numerous programs designed to improve access and quality. Additional variables related to the Affordable Care Act impacting our business will be how states, providers, insurance companies, employers, and other market participants respond during this period of uncertainty surrounding the future of the Affordable Care Act. As a result, we are unable to predict the effect on our business, financial condition or results of operations, the availability of adequate insurance coverage for patients seeking health care at our facilities, the reductions in government healthcare reimbursement spending, and numerous other provisions potentially impacted by the possible repeal, replacement or modification of the Affordable Care Act.

TABLE OF CONTENTS

Revenue Sources

Our facilities generate revenues by providing healthcare services to our patients. Depending upon the patient's medical insurance coverage, we are paid for these services by governmental Medicare and Medicaid programs, commercial insurance, including managed care organizations, and directly by the patient. The amounts we are paid for providing healthcare services to our patients vary depending upon the payor. Governmental payors generally pay significantly less than the hospital's customary charges for the services provided. Insured patients are generally not responsible for any difference between customary hospital charges and the amounts received from commercial insurance payors. However, insured patients are responsible for payments not covered by insurance, such as exclusions, deductibles and co-payments.

Medicare and Medicaid Reimbursement

Revenues from governmental payors, such as Medicare and Medicaid, are controlled by complex rules and regulations that stipulate the amount a hospital is paid for providing healthcare services. We must comply with these rules and regulations to continue to be eligible to participate in the Medicare and Medicaid programs. These rules and regulations are subject to frequent changes as a result of legislative and administrative action and annual payment adjustments on both the federal and the state levels.

In addition, Medicare payment methodologies have been, and are expected to continue to be, revised significantly based on cost containment and policy considerations. While CMS has already implemented a number of the Medicare reimbursement reductions required by the Affordable Care Act, additional reductions will become effective in the future and some of the reductions that have already been imposed by CMS will be increased in accordance with the terms of the Affordable Care Act. Additionally, the Middle Class Tax Relief and Job Creation Act of 2012 and the American Taxpayer Relief Act of 2012 require further reductions in Medicare payments, and the Budget Control Act of 2011 ("BCA") imposed a 2% reduction in Medicare spending effective as of April 1, 2013. The Bipartisan Budget Act of 2015 ("BBA"), which provides $80 billion in discretionary spending sequestration relief for federal fiscal years ("FFYs") 2016 and 2017, extends the 2% reduction in Medicare spending, which was imposed by the BCA, through FFY 2025 and, effective January 1, 2017, reduces Medicare payments to off-campus hospital outpatient departments that were not billing the Medicare program for covered outpatient services prior to November 2, 2015. This will limit our ability to expand the scope and profitability of outpatient services.

Medicaid programs are funded by both state governments and federal matching funds to provide healthcare benefits to certain low income individuals and groups. Many states in which we operate are facing budgetary challenges and have adopted, or may be considering, legislation that is intended to control or reduce Medicaid expenditures, enroll Medicaid recipients in managed care programs, and/or impose additional taxes on hospitals to help finance or expand their Medicaid programs. As of December 31, 2016, only ten of the states in which we operate are currently implementing expansions to their Medicaid programs. Additionally, as part of the movement to repeal, replace or modify the Affordable Care Act and as a means to reduce the federal budget deficit, there are renewed congressional efforts to move Medicaid from an open-ended program with coverage and benefits set by the federal government to one in which states receive a fixed amount of federal funds, either through block grants or per capita caps, and have more flexibility to determine benefits, eligibility or provider payments. Such efforts to reduce federal funding of the Medicaid program, as well as those that would reduce the amount of federal Medicaid matching funding available to states by curtailing the use of provider taxes, could have a negative impact on state Medicaid budgets resulting in less coverage for eligible individuals. If implemented, we cannot predict whether the amount of fixed federal funding to the states will be based on current payment amounts, or if it will be based on lower payment amounts, which would negatively impact those states that expanded their Medicaid programs in response to the Affordable Care Act.

Given the reduced federal financing of expanded Medicaid programs that took effect in 2017, and in light of the possible repeal, replacement or modification of the Affordable Care Act, we are unable to predict how many, if any, additional states in which we operate will expand their Medicaid programs or how many, if any, of the states in which we operate that have expanded their Medicaid programs will keep their expansions in place in the future.

Physician Services

We employ an increasing number of physicians in our hospital markets. Medicare pays us for services provided by our employed physicians under the Medicare physician fee schedule ("PFS") system. Under the PFS, CMS has assigned a national relative value unit ("RVU") to most medical services and procedures that reflects the various resources required by a physician to provide the services relative to all other services. Historically, the conversion factor that is used to determine physician payments for each RVU has been updated by the sustainable growth rate ("SGR") that is intended to account for inflation and targeted growth in Medicare expenditures. The SGR has generally resulted in significant reductions to payments made under the PFS, and, since 2003, Congress has passed multiple legislative acts delaying application of the SGR to the PFS.

TABLE OF CONTENTS

On April 16, 2015, the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”) was enacted into law, which replaced the SGR formula with new systems for establishing the annual updates to payments made under the PFS. Under MACRA, the PFS payment rates that were in effect when MACRA was enacted were extended through June 30, 2015, and then increased by 0.5% for the remainder of calendar year (“CY”) 2015, and increased by an additional 0.5% for CYs 2016 and 2017, and will be increased by 0.5% a year for CYs 2018 and 2019. PFS payment rates would then remain at their CY 2019 levels through CY 2025. Beginning in CY 2019, amounts paid to individual physicians would be subject to adjustment for achieving certain value and quality incentives set forth in MACRA.

HMOs, PPOs, and Other Private Insurers

In addition to government programs, our facilities are reimbursed by differing types of private payors, including health maintenance organizations (“HMOs”), preferred provider organizations (“PPOs”) and other private insurers. Revenues from HMOs, PPOs, and other private insurers are subject to contracts and other arrangements that require us to discount the amounts we customarily charge for healthcare services. These discounted arrangements often limit our ability to increase charges in response to increasing costs. We actively negotiate with these payors in an effort to maintain or increase the pricing of our healthcare services; however, we have no control over patients switching their healthcare coverage to a payor with which we have negotiated less favorable reimbursement rates. In recent years, an increasing number of our patients have moved to lower cost healthcare coverage plans, and such plans generally provide lower reimbursement rates and require patients to pay an increased portion of the costs of care through deductibles, co-payments or exclusions. Additionally, plans purchased through the healthcare exchanges are increasingly using narrow and tiered networks that limit beneficiary provider choices. If we provide services when not a participating provider in the network, it can result in higher patient responsibility amounts that a patient may not have the ability to pay or may choose not to pay. We expect these trends to continue in the coming years.

Self-pay Patients

Self-pay revenues are primarily generated through the treatment of uninsured patients. Beginning in 2014, our self-pay revenues began to decrease due largely to a shift from self-pay to Medicaid and HMOs, PPOs and other private insurers for a portion of our patient population, which primarily was a result of healthcare reform and the expansion of Medicaid coverage in certain of the states in which we operate. These reductions partially offset trends our facilities have experienced in recent years, including increases in self-pay revenues due to a combination of broad economic factors, including high levels of unemployment in many of our markets and increasing numbers of individuals and employers who purchase insurance plans with high deductibles and high co-payments.

To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. Our provision for doubtful accounts serves to reduce our reported revenues.

Adoption of Electronic Health Records

In accordance with the requirements of the American Recovery and Reinvestment Act of 2009 ("ARRA"), HHS has developed and implemented an incentive payment program for eligible hospitals and healthcare professionals that adopt and meaningfully use EHR technology. EHR meaningful use objectives and measures that hospitals and physicians must meet in order to qualify for incentive payments were divided into three stages with increasing requirements for participation. We strive to comply with the EHR meaningful use requirements of ARRA in time to qualify for the maximum available incentive payments. Our compliance has and will continue to result in significant costs including business process changes, professional services focused on successfully designing and implementing our EHR solutions, along with costs associated with the hardware and software components of the project. If our hospitals and employed professionals are unable to meet the requirements for participation in the incentive payment program, we will not be eligible to receive incentive payments that could offset some of the costs of implementing EHR systems. Furthermore, eligible hospitals and professionals that fail to demonstrate meaningful use of certified EHR technology are subject to reduced payments from Medicare. Even if we do meet such requirements, the incentive payments we have received in prior years for EHR implementation are schedule to end in 2017, and EHR incentive payments that we have previously received are subject to audit and recoupment if it is determined that we did not meet the applicable meaningful use standards. We currently estimate that at a minimum, total costs incurred to comply will be recovered through the total EHR incentive payments over the projected lifecycle of this initiative.

An important component of the effective implementation of our EHR initiatives involves our uninterrupted access to reliable information systems. In late 2011, we entered into an agreement with a third party technology provider to design and operate a hosted data center for our critical third party information systems. In addition to providing a hosted data center, the third party technology provider offers help desk end-user support for certain clinical information systems, provides help desk and support functions for certain clinical information system applications, performs backups and recoveries of certain critical data, and monitors critical systems to facilitate the identifications of and rapid responses to certain system issues. We believe this agreement provides us with a single technology platform for the delivery of critical third party information systems for the majority of our hospitals and will improve the effectiveness and efficiency of key information support functions in a cost-effective and high quality manner.

TABLE OF CONTENTS

Results of Operations

Certain Definitions

The following definitions apply throughout the remaining portion of Management's Discussion and Analysis of Financial Condition and Results of Operations.

Adjusted EBITDA. Earnings before depreciation and amortization; interest expense, net; debt transaction costs; impairment charges; other non-operating gain; provision for income taxes; and net income attributable to noncontrolling interests and redeemable noncontrolling interests (when applicable for the periods presented).

Admissions. Represents the total number of patients admitted to our hospitals and used by management and investors as a general measure of inpatient volume.

bps. Basis points.

Consolidated. Consolidated information includes the results of our health support center, our same-hospital operations and the results of our recent acquisitions. Additionally, consolidated information includes the results of our hospitals have been previously disposed.

Effective tax rate. Provision for income taxes as a percentage of income before income taxes, or income before income taxes, less net income attributable to noncontrolling interests and redeemable noncontrolling interests.

Emergency room visits. Represents the total number of hospital-based emergency room visits.

Equivalent admissions. Management and investors use equivalent admissions as a general measure of combined inpatient and outpatient volume. We compute equivalent admissions by multiplying admissions (inpatient volume) by the outpatient factor (the sum of gross inpatient revenue and gross outpatient revenue and then dividing the resulting amount by gross inpatient revenue). The equivalent admissions computation "equates" outpatient revenue to the volume measure (admissions) used to measure inpatient volume resulting in a general measure of combined inpatient and outpatient volume.

Medicare case mix index. Refers to the acuity or severity of illness of an average Medicare patient at our hospitals.

N/A. Not applicable.

Net revenue days outstanding. We compute net revenue days outstanding by dividing our accounts receivable net of allowance for doubtful accounts, by our revenue per day. Our revenue per day is calculated by dividing our quarterly healthcare services revenues by the number of calendar days in the quarter.

Outpatient surgeries. Outpatient surgeries are those surgeries that do not require admission to our hospitals.

Revenues. Revenues represent amounts recognized from all payors for the delivery of healthcare services, net of contractual discounts and the provision for doubtful accounts.

Same-hospital. Same-hospital information includes the results of our health support center and the same 67 hospitals operated during the three months ended December 31, 2016 and 2015, and the same 63 hospitals operated during the years ended December 31, 2016 and 2015. Same-hospital information excludes our hospitals that have previously been disposed.

TABLE OF CONTENTS

For the Three Months Ended December 31, 2016 and 2015

Operating Results Summary

The following table summarizes the results of operations for the three months ended December 31, 2016 and 2015 (dollars in millions):

	Three Months Ended December 31,					
	2016			2015		
	Amount	% of Revenues		Amount	% of Revenues	
Revenues before provision for doubtful accounts	$ 1,835.4	114.3	%	$ 1,570.7	114.6	%
Provision for doubtful accounts	230.2	14.3		200.0	14.6	
Revenues	1,605.2	100.0		1,370.7	100.0	
Salaries and benefits	766.4	47.7		652.7	47.6	
Supplies	273.3	17.0		218.4	15.9	
Other operating expenses	378.8	23.6		330.9	24.2	
Other income	(10.1)	(0.6)		(15.5)	(1.1)	
Depreciation and amortization	87.5	5.5		71.9	5.2	
Interest expense, net	36.4	2.3		29.7	2.2	
Other non-operating gain	-	-		(4.0)	(0.3)	
	1,532.3	95.5		1,284.1	93.7	
Income before income taxes	72.9	4.5		86.6	6.3	
Provision for income taxes	26.3	1.6		31.2	2.3	
Net income	46.6	2.9		55.4	4.0	
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(2.7)	(0.2)		(2.4)	(0.1)	
Net income attributable to LifePoint Health, Inc.	$ 43.9	2.7	%	$ 53.0	3.9	%

Revenues

The following table presents the components of revenues for the three months ended December 31, 2016 and 2015 (dollars in millions):

	Three Months Ended December 31,			
	2016	2015	Increase	% Increase
Consolidated:				
Revenues before provision for doubtful accounts	$ 1,835.4	$ 1,570.7	$ 264.7	16.8 %
Provision for doubtful accounts	230.2	200.0	30.2	15.1
Revenues	$ 1,605.2	$ 1,370.7	$ 234.5	17.1
Same-hospital:				
Revenues before provision for doubtful accounts	$ 1,587.4	$ 1,570.7	$ 16.7	1.1 %
Provision for doubtful accounts	206.5	200.0	6.5	3.2
Revenues	$ 1,380.9	$ 1,370.7	$ 10.2	0.7

The following table shows the sources of our revenues by payor, including adjustments to estimated reimbursement amounts and provision for doubtful accounts, for the three months ended December 31, 2016 and 2015 (in millions):

	Three Months Ended December 31,			
	2016		2015	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 606.2	37.8 %	$ 483.6	35.3 %
Medicaid	223.8	13.9	220.4	16.1
HMOs, PPOs and other private insurers	768.8	47.9	639.0	46.6
Self-pay	206.0	12.8	197.0	14.4
Other	30.6	1.9	30.7	2.2
Revenues before provision for doubtful accounts	1,835.4	114.3	1,570.7	114.6
Provision for doubtful accounts	(230.2)	(14.3)	(200.0)	(14.6)
Revenues	$ 1,605.2	100.0 %	$ 1,370.7	100.0 %

TABLE OF CONTENTS

Certain changes have been made to the classification of our historical sources of revenues. Primarily, we changed the classification of revenues related to our managed Medicare programs from HMOs, PPOs and other private insurers to Medicare for each of the periods presented above. This change had no impact on our historical results of operations.

Our revenues per equivalent admission on a consolidated and same-hospital basis were as follows for the three months ended December 31, 2016 and 2015:

	Three Months Ended December 31,			
	2016	2015	Increase	% Increase
Revenues per equivalent admission - consolidated	$ 9,014	$ 8,715	$ 299	3.4 %
Revenues per equivalent admission - same-hospital	$ 8,840	$ 8,715	$ 125	1.4 %

Revenues Before Provision for Doubtful Accounts

The following table shows the key drivers of our revenues before provision for doubtful accounts for the three months ended December 31, 2016 and 2015:

	Three Months Ended December 31,		Increase	% Increase
	2016	2015	(Decrease)	(Decrease)
Consolidated:				
Admissions	68,674	59,219	9,455	16.0 %
Equivalent admissions	178,072	157,280	20,792	13.2 %
Medicare case mix index	1.50	1.47	0.03	2.0 %
Average length of stay (days)	4.9	4.9	-	- %
Inpatient surgeries	18,810	16,635	2,175	13.1 %
Outpatient surgeries	70,739	63,013	7,726	12.3 %
Total surgeries	89,549	79,648	9,901	12.4 %
Emergency room visits	414,089	371,508	42,581	11.5 %
Outpatient factor	2.59	2.65	(0.06)	(2.3) %
Same-hospital:				
Admissions	58,683	59,219	(536)	(0.9) %
Equivalent admissions	156,214	157,280	(1,066)	(0.7) %
Medicare case mix index	1.46	1.47	(0.01)	(0.7) %
Average length of stay (days)	4.9	4.9	-	- %

Inpatient surgeries	15,635	16,635	(1,000)	(6.0)	%
Outpatient surgeries	62,621	63,013	(392)	(0.6)	%
Total surgeries	78,256	79,648	(1,392)	(1.7)	%
Emergency room visits	362,479	371,508	(9,029)	(2.4)	%
Outpatient factor	2.66	2.65	0.01	0.4	%

For the three months ended December 31, 2016, our consolidated revenues before provision for doubtful accounts increased $264.7 million, or 16.8%, to $1,835.4 million as compared to $1,570.7 million for the same period last year primarily as a result of our 2016 acquisitions and an increase in our same-hospital revenues before provision for doubtful accounts of $16.7 million, or 1.1%. The increase in our same-hospital revenues before provision for doubtful accounts was primarily driven by higher contracted rates from HMOs, PPOs and other private insurers. For the three months ended December 31, 2016, our same-hospital revenues per equivalent admission increased 1.4% as compared to the same period last year. This increase was partially offset by a 0.7% decrease in same-hospital equivalent admissions for the three months ended December 31, 2016 as compared to the same period last year, primarily as a result of a 2.4% decrease in emergency room visits and a 0.6% decrease in outpatient surgeries.

TABLE OF CONTENTS

Provision for Doubtful Accounts

The following table summarizes the key drivers and key indicators of our provision for doubtful accounts for the three months ended December 31, 2016 and 2015 (dollars in millions):

	Three Months Ended December 31,										
	2016	% of Revenues		2015	% of Revenues		Increase (Decrease)		% Increase (Decrease)	
Consolidated:										
Related key indicators:										
Charity care write-offs	$ 29.9	1.9	%	$ 22.1	1.6	%	$	7.8	35.5	%
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 206.0	12.8	%	$ 197.0	14.4	%	$	9.0	4.6	%
Net revenue days outstanding (at end of period)	53.5	N/A		51.3	N/A			2.2	4.3	%
Same-hospital:										
Related key indicators:										
Charity care write-offs	$ 22.5	1.6	%	$ 22.1	1.6	%	$	0.4	1.9	%
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 185.7	13.4	%	$ 197.0	14.4	%	$	(11.3)	(5.7)	%
Net revenue days outstanding (at end of period)	52.4	N/A		51.3	N/A			1.1	2.1	%

Our provision for doubtful accounts relates principally to amounts due from patients included in our self-pay population and other amounts such as co-payments and deductibles due from patients included in other payor categories. For the three months ended December 31, 2016, our provision for doubtful accounts increased by $30.2 million, or 15.1%, to $230.2 million on a consolidated basis and by $6.5 million, or 3.2%, to $206.5 million on a same-hospital basis as compared to the same period last year. The provision and allowance for doubtful accounts are critical accounting estimates and are further discussed in Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations, "Critical Accounting Estimates."

Our net revenue days outstanding at December 31, 2016 increased to 53.5 days compared to 51.3 days at December 31, 2015 on a consolidated basis. On a same-hospital basis, our net revenue days outstanding at December 31, 2016 increased to 52.4 days compared to 51.3 days at December 31, 2015. These increases are primarily a result of growth in our outstanding accounts receivable generated in connection with billing delays caused by the implementation of a new physician coding and billing system in one of our markets. Excluding the growth in our

outstanding accounts receivable related to this system implementation, our net revenue days outstanding would have been 52.6 days on a consolidated basis and 51.4 days on a same hospital basis at December 31, 2016.

Expenses and Other Income

Salaries and Benefits

The following table summarizes our salaries and benefits, man-hours per equivalent admission and salaries and benefits per equivalent admission for the three months ended December 31, 2016 and 2015:

	Three Months Ended December 31,					
	2016	% of Revenues	2015	% of Revenues	Increase	% Increase
Salaries and benefits (dollars in millions)	$ 766.4	47.7 %	$ 652.7	47.6 %	$ 113.7	17.4 %
Man-hours per equivalent admission	116	N/A	114	N/A	2	1.8 %
Salaries and benefits per equivalent admission	$ 4,304	N/A	$ 4,150	N/A	$ 154	3.7 %

For the three months ended December 31, 2016, our salaries and benefits expense increased to $766.4 million, or 17.4%, as compared to $652.7 million for the same period last year primarily as a result of our 2016 acquisitions and the impact of an increasing number of employed physicians and their related support staff.

TABLE OF CONTENTS

Supplies

The following table summarizes our supplies and supplies per equivalent admission for the three months ended December 31, 2016 and 2015:

	Three Months Ended December 31,					
	2016	% of Revenues	2015	% of Revenues	Increase	% Increase
Supplies (dollars in millions)	$ 273.3	17.0 %	$ 218.4	15.9 %	$ 54.9	25.1 %
Supplies per equivalent admission	$ 1,535	N/A	$ 1,389	N/A	$ 146	10.5 %

For the three months ended December 31, 2016, our supplies expense increased to $273.3 million, or 25.1%, as compared to $218.4 million for the same period last year primarily as a result of our 2016 acquisitions as well as an increase in our same-hospital supplies per equivalent admission as a result of a higher utilization of more expensive supplies in areas such as oncology, pharmacy and orthopedics. These increases were partially offset by improvements as a result of generic drug substitutions, monitoring of physician preference items and growth within our group purchasing organization.

Other Operating Expenses

The following table summarizes our other operating expenses for the three months ended December 31, 2016 and 2015 (dollars in millions):

	Three Months Ended December 31,					
	2016	% of Revenues	2015	% of Revenues	Increase (Decrease)	% Increase (Decrease)
Professional fees	$ 70.1	4.4 %	$ 55.0	4.0 %	$ 15.1	27.6 %
Utilities	27.4	1.7	23.3	1.7	4.1	17.4
Repairs and maintenance	49.4	3.1	37.7	2.8	11.7	31.1
Rents and leases	16.7	1.0	13.5	1.0	3.2	23.4
Insurance	11.4	0.7	13.8	1.0	(2.4)	(17.2)
Physician recruiting	4.8	0.3	4.0	0.3	0.8	18.2
Contract services	118.7	7.4	103.0	7.5	15.7	15.2

Non-income taxes		35.7	2.2			35.2	2.6			0.5	1.4	
Other		44.6	2.8			45.4	3.3			(0.8)	(1.8)	
	$	378.8	23.6	%	$	330.9	24.2	%	$	47.9	14.5	%

For the three months ended December 31, 2016, our other operating expenses increased to $378.8 million, or 14.5%, as compared to $330.9 million for the same period last year primarily as a result of our 2016 acquisitions.

Other Income

We recognize EHR incentive payments received or anticipated to be received under the HITECH Act as other income in accordance with Accounting Standards Codification (“ASC”) 450-30, “Gain Contingencies” (“ASC 450-30”) when our eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information for the full cost report year that determines the final calculation of the EHR incentive payment is available. For the three months ended December 31, 2016, we recognized $10.1 million in Medicare and Medicaid EHR incentive payments, collectively, as compared to $15.5 million recognized in the same period last year.

Depreciation and Amortization

For the three months ended December 31, 2016, our depreciation and amortization expense increased by $15.6 million, or 21.7%, to $87.5 million, or 5.5% of revenues, as compared to $71.9 million, or 5.2% of revenues for the same period last year. Our depreciation and amortization expense increased primarily as a result of our 2016 acquisitions as well as a result of significant increases in our spending related to information systems as the result of various initiatives and requirements, including compliance with the HITECH Act. Accordingly, we anticipate that our depreciation and amortization expense will continue to increase in future periods as a result of these factors in addition to the impact of capital expenditure commitments associated with our recent acquisitions.

TABLE OF CONTENTS

Interest Expense

For the three months ended December 31, 2016, our interest expense increased by $6.7 million, or 22.5%, to $36.4 million as compared to $29.7 million for the same period last year. The increase in our interest expense is primarily attributable to an increase in our weighted average total debt outstanding during the three months ended December 31, 2016 as compared to the same period last year. On December 4, 2015, we issued in a public offering $500.0 million aggregate principal amount of 5.875% unsecured senior notes due December 1, 2023 (the "5.875% Senior Notes"). Additionally, on May 26, 2016, we issued in a private placement $500.0 million aggregate principal amount of 5.375% unsecured senior notes due May 1, 2024 (the "5.375% Senior Notes") and used the proceeds, in part, to redeem all $400.0 million aggregate principal amount of our outstanding 6.625% unsecured senior notes due October 1, 2020 (the "6.625% Senior Notes") on June 13, 2016. For a further discussion of our debt and corresponding interest rates, see "Liquidity and Capital Resources — Debt."

Other Non-Operating Gain

During the three months ended December 31, 2015, we recorded a bargain purchase gain of approximately $4.0 million, $2.5 million net of income taxes, or $0.05 per diluted share, as a result of the final fair values assigned to the tangible and intangible assets acquired less obligations assumed, in connection with our acquisition of a hospital, exceeding the total cash consideration paid.

Provision for Income Taxes

Our provision for income taxes was $26.3 million, or 1.6% of revenues, for the three months ended December 31, 2016, as compared to $31.2 million, or 2.3% of revenues, for the same period last year. The decrease in the provision for income taxes for the three months ended December 31, 2016 was primarily attributable to a decrease in our income before income taxes for the three months ended December 31, 2016, as compared to the same period last year, partially offset by an increase in the effective tax rate to 37.5% for the three months ended December 31, 2016, as compared to 37.1% for the same period last year.

Supplemental Non-GAAP Information

We use Adjusted EBITDA to evaluate our operating performance and as a measure of performance for incentive compensation purposes. Additionally, our credit facilities use Adjusted EBITDA, subject to further permitted adjustments, for certain financial covenants. We believe Adjusted EBITDA is a measure of performance used by some investors, equity analysts, rating agencies and lenders to make informed decisions as to, among other things, our

ability to incur and service debt and make capital expenditures. In addition, multiples of current or projected Adjusted EBITDA are used by some investors and equity analysts to estimate current or prospective enterprise value. Adjusted EBITDA should not be considered a measure of financial performance under U.S. generally accepted accounting principles ("GAAP"), and the items excluded from Adjusted EBITDA are significant components in understanding and assessing financial performance. Adjusted EBITDA should not be considered in isolation or as an alternative to net income, cash flows generated by operating, investing or financing activities or other financial statement data presented in the condensed consolidated financial statements as an indicator of financial performance. Because Adjusted EBITDA is not a measurement determined in accordance with GAAP and is susceptible to varying calculations, Adjusted EBITDA as presented may not be comparable to other similarly titled measures of other companies. See "— Certain Definitions" above for a description of how we define Adjusted EBITDA.

The following table sets forth Adjusted EBITDA for the three months ended December 31, 2016 and 2015 and reconciles Adjusted EBITDA to net income, the most comparable GAAP measure (in millions):

	Three Months Ended December 31,			
	2016		2015	
	Amount	% of Revenues	Amount	% of Revenues
Net income	$ 46.6	2.9 %	$ 55.4	4.0 %
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(2.7)	(0.2)	(2.4)	(0.1)
Net income attributable to LifePoint Health, Inc.	43.9	2.7	53.0	3.9
Add: Depreciation and amortization	87.5	5.5	71.9	5.2
Interest expense, net	36.4	2.3	29.7	2.2
Other non-operating gain	-	-	(4.0)	(0.3)
Provision for income taxes	26.3	1.6	31.2	2.3
Net income attributable to noncontrolling interests and redeemable noncontrolling interests	2.7	0.2	2.4	0.1
Adjusted EBITDA	$ 196.8	12.3 %	$ 184.2	13.4 %

TABLE OF CONTENTS

For the Years Ended December 31, 2016 and 2015

Operating Results Summary

The following table summarizes the results of operations for the years ended December 31, 2016 and 2015 (dollars in millions):

	Years Ended December 31,			
	2016		2015	
	Amount	% of Revenues	Amount	% of Revenues
Revenues before provision for doubtful accounts	$ 7,273.6	114.3 %	$ 6,014.4	115.3 %
Provision for doubtful accounts	909.6	14.3	800.1	15.3
Revenues	6,364.0	100.0	5,214.3	100.0
Salaries and benefits	3,047.4	47.9	2,496.9	47.9
Supplies	1,066.6	16.8	815.0	15.6
Other operating expenses	1,558.1	24.5	1,246.4	24.0
Other income	(29.9)	(0.5)	(49.7)	(1.0)
Depreciation and amortization	344.6	5.5	279.0	5.3
Interest expense, net	149.2	2.3	114.4	2.2
Debt transaction costs	22.0	0.3	-	-
Impairment charges	1.2	-	13.8	0.3
Other non-operating gain	-	-	(4.0)	(0.1)
	6,159.2	96.8	4,911.8	94.2
Income before income taxes	204.8	3.2	302.5	5.8
Provision for income taxes	73.0	1.1	109.5	2.1
Net income	131.8	2.1	193.0	3.7
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(9.9)	(0.2)	(11.1)	(0.2)
Net income attributable to LifePoint Health, Inc.	$ 121.9	1.9 %	$ 181.9	3.5 %

Revenues

The following table presents the components of revenues for the years ended December 31, 2016 and 2015 (dollars in millions):

	Years Ended December 31,			
	2016	2015	Increase	% Increase
Consolidated:				
Revenues before provision for doubtful accounts	$ 7,273.6	$ 6,014.4	$ 1,259.2	20.9 %
Provision for doubtful accounts	909.6	800.1	109.5	13.7
Revenues	$ 6,364.0	$ 5,214.3	$ 1,149.7	22.0
Same-hospital:				
Revenues before provision for doubtful accounts	$ 5,965.9	$ 5,830.3	$ 135.6	2.3 %
Provision for doubtful accounts	811.1	775.3	35.8	4.6
Revenues	$ 5,154.8	$ 5,055.0	$ 99.8	2.0

The following table shows the sources of our revenues by payor, including adjustments to estimated reimbursement amounts and provision for doubtful accounts, for the years ended December 31, 2016 and 2015 (in millions):

	Years Ended December 31,			
	2016		2015	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 2,372.4	37.3 %	$ 1,894.9	36.3 %
Medicaid	922.5	14.5	855.2	16.4
HMOs, PPOs and other private insurers	3,015.0	47.3	2,393.5	45.9
Self-pay	832.8	13.1	749.0	14.4
Other	130.9	2.1	121.8	2.3
Revenues before provision for doubtful accounts	7,273.6	114.3	6,014.4	115.3
Provision for doubtful accounts	(909.6)	(14.3)	(800.1)	(15.3)
Revenues	$ 6,364.0	100.0 %	$ 5,214.3	100.0 %

TABLE OF CONTENTS

Certain changes have been made to the classification of our historical sources of revenues. Primarily, we changed the classification of revenues related to our managed Medicare programs from HMOs, PPOs and other private insurers to Medicare for each of the periods presented above. This change had no impact on our historical results of operations.

Our revenues per equivalent admission on a consolidated and same-hospital basis were as follows for the years ended December 31, 2016 and 2015:

	Years Ended December 31,			
	2016	2015	Increase	% Increase
Revenues per equivalent admission - consolidated	$ 8,876	$ 8,445	$ 431	5.1 %
Revenues per equivalent admission - same-hospital	$ 8,756	$ 8,509	$ 247	2.9 %

Revenues Before Provision for Doubtful Accounts

The following table shows the key drivers of our revenues before provision for doubtful accounts for the years ended December 31, 2016 and 2015:

	Years Ended December 31,		Increase	% Increase
	2016	2015	(Decrease)	(Decrease)
Consolidated:				
Admissions	274,611	236,474	38,137	16.1 %
Equivalent admissions	717,009	617,434	99,575	16.1 %
Medicare case mix index	1.49	1.43	0.06	4.2 %
Average length of stay (days)	4.9	4.9	-	- %
Inpatient surgeries	77,121	65,432	11,689	17.9 %
Outpatient surgeries	283,127	243,820	39,307	16.1 %
Total surgeries	360,248	309,252	50,996	16.5 %
Emergency room visits	1,689,119	1,477,113	212,006	14.4 %
Outpatient factor	2.61	2.61	-	- %
Same-hospital:				
Admissions	220,906	227,522	(6,616)	(2.9) %
Equivalent admissions	588,714	594,060	(5,346)	(0.9) %

Medicare case mix index	1.47	1.43	0.04	2.8	%
Average length of stay (days)	5.0	5.0	-	-	%
Inpatient surgeries	60,004	62,493	(2,489)	(4.0)	%
Outpatient surgeries	234,255	233,315	940	0.4	%
Total surgeries	294,259	295,808	(1,549)	(0.5)	%
Emergency room visits	1,407,924	1,427,307	(19,383)	(1.4)	%
Outpatient factor	2.67	2.61	0.06	2.3	%

For the year ended December 31, 2016, our consolidated revenues before provision for doubtful accounts increased $1,259.2 million, or 20.9%, to $7,273.6 million as compared to $6,014.4 million for the prior year primarily as a result of our 2016 and 2015 acquisitions and an increase in our same-hospital revenues before provision for doubtful accounts of $135.6 million, or 2.3%. The increase in our same-hospital revenues before provision for doubtful accounts was primarily driven by higher contracted rates from HMOs, PPOs and other private insurers, in addition to higher acuity services as evidenced by an increase in the Medicare case mix index. For the year ended December 31, 2016, our same-hospital revenues per equivalent admission increased 2.9% as compared to the prior year. This increase was partially offset by a 0.9% decrease in our same-hospital equivalent admissions as compared to the prior year, primarily as a result of a 1.4% decrease in emergency room visits and a 0.5% decrease in total surgeries.

TABLE OF CONTENTS

Provision for Doubtful Accounts

The following table summarizes the key drivers and key indicators of our provision for doubtful accounts for the years ended December 31, 2016 and 2015 (dollars in millions):

	Years Ended December 31,					
	2016	% of Revenues	2015	% of Revenues	Increase	% Increase
Consolidated:						
Related key indicators:						
Charity care write-offs	$ 129.1	2.0 %	$ 89.3	1.7 %	$ 39.8	44.5 %
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 832.8	13.1 %	$ 749.0	14.4 %	$ 83.8	11.2 %
Net revenue days outstanding (at end of period)	53.5	N/A	51.3	N/A	2.2	4.3 %
Same-hospital:						
Related key indicators:						
Charity care write-offs	$ 84.9	1.6 %	$ 84.2	1.7 %	$ 0.7	0.9 %
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 738.2	14.3 %	$ 727.2	14.4 %	$ 11.0	1.5 %
Net revenue days outstanding (at end of period)	52.4	N/A	51.3	N/A	1.1	2.1 %

Our provision for doubtful accounts relates principally to amounts due from patients included in our self-pay population and other amounts such as co-payments and deductibles due from patients included in other payor categories. For the year ended December 31, 2016, our provision for doubtful accounts increased by $109.5 million, or 13.7%, to $909.6 million on a consolidated basis and by $35.8 million, or 4.6%, to $811.1 million on a same-hospital basis as compared to the prior year. The provision and allowance for doubtful accounts are critical accounting estimates and are further discussed in Part II, Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations, “Critical Accounting Estimates.”

Our net revenue days outstanding at December 31, 2016 increased to 53.5 days compared to 51.3 days at December 31, 2015 on a consolidated basis. On a same-hospital basis, our net revenue days outstanding at December 31, 2016 increased to 52.4 days compared to 51.3 days at December 31, 2015. These increases are primarily a result of growth in our outstanding accounts receivable generated in connection with billing delays caused by the implementation of a new physician coding and billing system in one of our markets. Excluding the growth in our outstanding accounts receivable related to this system implementation, our net revenue days outstanding would have

been 52.6 days on a consolidated basis and 51.4 days on a same hospital basis at December 31, 2016.

Expenses and Other Income

Salaries and Benefits

The following table summarizes our salaries and benefits, man-hours per equivalent admission and salaries and benefits per equivalent admission for the years ended December 31, 2016 and 2015:

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	Years Ended December 31,					
	2016	% of Revenues	2015	% of Revenues	Increase	% Increase
Salaries and benefits (dollars in millions)	$ 3,047.4	47.9 %	$ 2,496.9	47.9 %	$ 550.5	22.0 %
Man-hours per equivalent admission	114	N/A	111	N/A	3	2.7 %
Salaries and benefits per equivalent admission	$ 4,250	N/A	$ 4,044	N/A	$ 206	5.1 %

For the year ended December 31, 2016, our salaries and benefits expense increased to $3,047.4 million, or 22.0%, as compared to $2,496.9 million for the prior year primarily as a result of our 2016 and 2015 acquisitions and the impact of an increasing number of employed physicians and their related support staff.

61

TABLE OF CONTENTS

Supplies

The following table summarizes our supplies and supplies per equivalent admission for the years ended December 31, 2016 and 2015:

	Years Ended December 31,					
		% of		% of		%
	2016	Revenues	2015	Revenues	Increase	Increase
Supplies (dollars in millions)	$ 1,066.6	16.8 %	$ 815.0	15.6 %	$ 251.6	30.9 %
Supplies per equivalent admission	$ 1,488	N/A	$ 1,320	N/A	$ 168	12.7 %

For the year ended December 31, 2016, our supplies expense increased to $1,066.6 million, or 30.9% as compared to $815.0 million for the prior year primarily as a result of our 2016 and 2015 acquisitions as well as an increase in our same-hospital supplies per equivalent admission as a result of a higher utilization of more expensive supplies in areas such as orthopedics, pharmacy and oncology. These increases were partially offset by improvements as a result of generic drug substitutions, monitoring of physician preference items and growth within our group purchasing organization.

Other Operating Expenses

The following table summarizes our other operating expenses for the years ended December 31, 2016 and 2015 (dollars in millions):

	Years Ended December 31,					
		% of		% of	Increase	% Increase
	2016	Revenues	2015	Revenues	(Decrease)	(Decrease)
Professional fees	$ 276.5	4.3 %	$ 199.1	3.8 %	$ 77.4	38.9 %
Utilities	112.1	1.8	94.4	1.8	17.7	18.7
Repairs and maintenance	186.5	2.9	141.2	2.7	45.3	32.1
Rents and leases	69.3	1.1	52.9	1.0	16.4	30.8
Insurance	76.9	1.2	56.4	1.1	20.5	36.4
Physician recruiting	17.8	0.3	20.4	0.4	(2.6)	(12.8)
Contract services	468.9	7.4	378.2	7.3	90.7	24.0
Non-income taxes	168.8	2.7	137.2	2.6	31.6	23.1
Other	181.3	2.8	166.6	3.3	14.7	8.8
	$ 1,558.1	24.5 %	$ 1,246.4	24.0 %	$ 311.7	25.0 %

For the year ended December 31, 2016, our other operating expenses increased to $1,558.1 million, or 25.0%, as compared to $1,246.4 million for the prior year primarily as a result of our 2016 and 2015 acquisitions as well as increases in our same-hospital professional fees, contract services and insurance expenses. As a result of a continued shortage of physicians in many of our communities, we have experienced increasing professional fees in areas such as anesthesiology and hospitalists. Our same-hospital contract services expenses have increased primarily as a result of higher business office collection efforts arising from an increase in our same-hospital revenues as well as additional contract services associated with an increasing number of employed physicians. We experienced an increase in our insurance expenses for the year ended December 31, 2016 as a result of recording an accrual for loss contingencies for cardiology-related legal proceedings as described further in Note 11 to our accompanying consolidated financial statements included elsewhere in this report.

Additionally, during the second quarter of 2016, one of our largest facilities experienced the loss of certain key physicians, including our decision to part ways with the physician leader of a key service line. This resulted in additional professional fees and recruiting expenses. Furthermore, during the second quarter of 2016, we incurred additional contract services expense due to the implementation of a new physician billing system in order to ensure accuracy and to help achieve long-term synergies at one of our recently acquired facilities.

Other Income

We recognize EHR incentive payments received or anticipated to be received under the HITECH Act as other income in accordance with ASC 450-30 when our eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information for the full cost report year that determines the final calculation of the EHR incentive payment is available. For the year ended December 31, 2016, we recognized $29.9 million in Medicare and Medicaid EHR incentive payments, collectively, as compared to $49.7 million recognized in the prior year.

Depreciation and Amortization

For the year ended December 31, 2016, our depreciation and amortization expense increased by $65.6 million, or 23.5% to $344.6 million, or 5.5% of revenues, as compared to $279.0 million, or 5.3% of revenues for the prior year. Our depreciation and amortization expense increased primarily as a result of our 2016 and 2015 acquisitions as well as a result of increases in our spending related to information systems due to various initiatives and requirements, including compliance with the HITECH Act. Additionally, we incurred approximately $6.2 million, $3.9 million net of income taxes, or $0.09 loss per diluted share, of additional depreciation expense during the year ended December 31, 2016 as a result of accelerating the depreciation on one of our hospital campuses as further discussed in Note 11 to our accompanying consolidated financial statements included elsewhere in this report. We anticipate that our depreciation and amortization expense will continue to increase in future periods as a result of these factors in addition to the impact of capital expenditure commitments associated with our recent acquisitions.

Interest Expense

Our interest expense increased by $34.8 million, or 30.4%, to $149.2 million, for the year ended December 31, 2016, as compared to $114.4 million for the prior year. The increase in our interest expense is primarily attributable to an increase in our weighted average total debt outstanding during 2016 as compared to 2015. On December 4, 2015, we issued $500.0 million aggregate principal amount of 5.875% Senior Notes. Additionally, on May 26, 2016, we issued $500.0 million aggregate principal amount of 5.375% Senior Notes and used the proceeds, in part, to redeem all $400.0 million aggregate principal amount of our outstanding 6.625% Senior Notes on June 13, 2016. For a further discussion of our debt and corresponding interest rates, see “Liquidity and Capital Resources — Debt.”

Debt Transaction Costs

On June 10, 2016, we repaid the outstanding balances of the prior senior secured term loan facility (the “Prior Term Facility”) and the senior secured incremental term loans (the “Incremental Term Loans”) under our prior senior secured credit agreement with, among others, Citibank, N.A. as administrative agent, and the lenders party thereto (the “Prior Credit Agreement”) with the proceeds from the $700.0 million senior secured term loan facility (the “Term Facility”) under our Senior Credit Agreement. Additionally, on May 26, 2016, we issued $500.0 million aggregate principal amount of 5.375% Senior Notes and used the proceeds, in part, to redeem all $400.0 million aggregate principal amount of our outstanding 6.625% Senior Notes on June 13, 2016. These transactions are more fully discussed in Note 5 to our accompanying consolidated financial statements included elsewhere in this report. In connection with these debt transactions, we recognized debt transaction costs of approximately $22.0 million, $13.7 million net of income taxes, or $0.32 loss per diluted share, during the year ended December 31, 2016. The debt transaction costs include the write-offs of previously capitalized issuance costs and new non-capital costs related to our various debt transactions entered into during the second quarter of 2016.

Impairment Charges

During the year ended December 31, 2016, we recognized an impairment charge of $1.2 million, $0.8 million net of income taxes, or $0.02 loss per diluted share, related to the write-off of certain capital assets which we have determined are no longer a necessary component of our ongoing information technology strategy.

Additionally, during the year ended December 31, 2015, we recognized impairment charges of $10.8 million, $7.0 million net of income taxes, or $0.15 loss per diluted share, in connection with the sale of Putnam Community Medical Center ("Putnam"), effective May 1, 2015. The impairment charges include the write-down of property, equipment, allocated goodwill and certain other assets to their estimated fair values as well as the finalization of the net working capital settlement. Additionally, during the year ended December 31, 2015, we recognized impairment charges of $3.0 million, $1.9 million net of income taxes, or $0.04 loss per diluted share, related to the finalization of the divestitures of Lakeland Community Hospital ("Lakeland"), Northwest Medical Center ("Northwest") and Russellville Hospital ("Russellville") which were sold effective January 1, 2015.

Other Non-Operating Gain

During the year ended December 31, 2015, we recorded a bargain purchase gain of approximately $4.0 million, $2.5 million net of income taxes, or $0.05 per diluted share, as a result of the final fair values assigned to the tangible and intangible assets acquired less obligations assumed, in connection with our acquisition of a hospital, exceeding the total cash consideration paid.

TABLE OF CONTENTS

Provision for Income Taxes

Our provision for income taxes was $73.0 million, or 1.1% of revenues, for the year ended December 31, 2016, as compared to $109.5 million, or 2.1% of revenues, for the prior year. The decrease in the provision for income taxes for the year ended December 31, 2016 was primarily attributable to a decrease in our income before income taxes for the year ended December 31, 2016, as compared to the prior year. Additionally, our effective tax rate decreased slightly to 37.5% for the year ended December 31, 2016, as compared to 37.6% for the prior year.

Supplemental Non-GAAP Information

See "— Results of Operations. For the Three Months Ended December 31, 2016 and 2015 — Supplemental Non-GAAP Information" for a description of how we use Adjusted EBITDA, why we believe Adjusted EBITDA is useful to investors and others, and other important information regarding Adjusted EBITDA.

The following table sets forth Adjusted EBITDA for the years ended December 31, 2016 and 2015 and reconciles Adjusted EBITDA to net income, the most comparable GAAP measure (in millions):

	Years Ended December 31,			
	2016		2015	
	Amount	% of Revenues	Amount	% of Revenues
Net income	$ 131.8	2.1 %	$ 193.0	3.7 %
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(9.9)	(0.2)	(11.1)	(0.2)
Net income attributable to LifePoint Health, Inc.	121.9	1.9	181.9	3.5
Add: Depreciation and amortization	344.6	5.5	279.0	5.3
Interest expense, net	149.2	2.3	114.4	2.2
Debt transaction costs	22.0	0.3	-	-
Impairment charges	1.2	-	13.8	0.3
Other non-operating gain	-	-	(4.0)	(0.1)
Provision for income taxes	73.0	1.1	109.5	2.1
Net income attributable to noncontrolling interests and redeemable noncontrolling interests	9.9	0.2	11.1	0.2
Adjusted EBITDA	$ 721.8	11.3 %	$ 705.7	13.5 %

TABLE OF CONTENTS

For the Years Ended December 31, 2015 and 2014

Operating Results Summary

The following table summarizes the results of operations for the years ended December 31, 2015 and 2014 (dollars in millions):

	Years Ended December 31,					
	2015			2014		
	Amount	% of Revenues		Amount	% of Revenues	
Revenues before provision for doubtful accounts	$ 6,014.4	115.3	%	$ 5,300.9	118.2	%
Provision for doubtful accounts	800.1	15.3		817.8	18.2	
Revenues	5,214.3	100.0		4,483.1	100.0	
Salaries and benefits	2,496.9	47.9		2,134.5	47.6	
Supplies	815.0	15.6		699.0	15.6	
Other operating expenses	1,246.4	24.0		1,087.3	24.3	
Other income	(49.7)	(1.0)		(71.9)	(1.6)	
Depreciation and amortization	279.0	5.3		250.5	5.6	
Interest expense, net	114.4	2.2		123.0	2.7	
Impairment charges	13.8	0.3		57.7	1.3	
Other non-operating gain	(4.0)	(0.1)		-	-	
	4,911.8	94.2		4,280.1	95.5	
Income before income taxes	302.5	5.8		203.0	4.5	
Provision for income taxes	109.5	2.1		68.1	1.5	
Net income	193.0	3.7		134.9	3.0	
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(11.1)	(0.2)		(8.8)	(0.2)	
Net income attributable to LifePoint Health, Inc.	$ 181.9	3.5	%	$ 126.1	2.8	%

Revenues

The following table presents the components of revenues for the years ended December 31, 2015 and 2014 (dollars in millions):

	Increase	% Increase

	Years Ended December 31,			
	2015	2014	(Decrease)	(Decrease)
Revenues before provision for doubtful accounts	$ 6,014.4	$ 5,300.9	$ 713.5	13.5 %
Provision for doubtful accounts	800.1	817.8	(17.7)	(2.2)
Revenues	$ 5,214.3	$ 4,483.1	$ 731.2	16.3

The following table shows the sources of our revenues by payor, including adjustments to estimated reimbursement amounts and provision for doubtful accounts, for the years ended December 31, 2015 and 2014 (dollars in millions):

	Years Ended December 31,			
	2015		2014	
	Amount	% of Revenues	Amount	% of Revenues
Medicare	$ 1,894.9	36.3 %	$ 1,627.6	36.3 %
Medicaid	855.2	16.4	619.8	13.8
HMOs, PPOs and other private insurers	2,393.5	45.9	2,210.5	49.3
Self-pay	749.0	14.4	744.9	16.6
Other	121.8	2.3	98.1	2.2
Revenues before provision for doubtful accounts	6,014.4	115.3	5,300.9	118.2
Provision for doubtful accounts	(800.1)	(15.3)	(817.8)	(18.2)
Revenues	$ 5,214.3	100.0 %	$ 4,483.1	100.0 %

Certain changes have been made to the classification of our historical sources of revenues. Primarily, we changed the classification of revenues related to our managed Medicare programs from HMOs, PPOs and other private insurers to Medicare for each of the periods presented above. This change had no impact on our historical results of operations.

TABLE OF CONTENTS

Our revenues per equivalent admission were as follows for the years ended December 31, 2015 and 2014:

	Years Ended December 31,			
	2015	2014	Increase	% Increase
Revenues per equivalent admission	$ 8,445	$ 8,145	$ 300	3.7 %

Revenues Before Provision for Doubtful Accounts

The following table shows the key drivers of our revenues before provision for doubtful accounts for the years ended December 31, 2015 and 2014:

	Years Ended December 31,			
	2015	2014	Increase	% Increase
Admissions	236,474	221,587	14,887	6.7 %
Equivalent admissions	617,434	550,422	67,012	12.2 %
Medicare case mix index	1.43	1.38	0.05	3.6 %
Average length of stay (days)	4.9	4.9	-	- %
Inpatient surgeries	65,432	59,231	6,201	10.5 %
Outpatient surgeries	243,820	214,130	29,690	13.9 %
Total surgeries	309,252	273,361	35,891	13.1 %
Emergency room visits	1,477,113	1,363,459	113,654	8.3 %
Outpatient factor	2.61	2.48	0.13	5.2 %

For the year ended December 31, 2015, our revenues before provision for doubtful accounts increased $713.5 million, or 13.5%, to $6,014.4 million as compared to $5,300.9 million for the prior year. This increase was primarily a result of our 2015 and 2014 acquisitions in addition to increases in our same-hospital equivalent admissions as well as higher contracted rates from HMOs, PPOs and other private insurers.

Provision for Doubtful Accounts

The following table summarizes the key drivers and key indicators of our provision for doubtful accounts for the years ended December 31, 2015 and 2014 (dollars in millions):

	Years Ended December 31,							
	2015	% of Revenues		2014	% of Revenues		Increase (Decrease)	% Increase (Decrease)	
Related key indicators:								
Charity care write-offs	$ 89.3	1.7	%	$ 80.9	1.8	%	$ 8.4	10.4	%
Self-pay revenues, net of charity care write-offs and uninsured discounts	$ 749.0	14.4	%	$ 744.9	16.6	%	$ 4.1	0.6	%
Net revenue days outstanding (at end of period)	51.3	N/A		56.4	N/A		(5.1)	(9.0)	%

Our provision for doubtful accounts relates principally to amounts due from patients included in our self-pay population and other amounts such as co-payments and deductibles due from patients included in other payor categories. For the year ended December 31, 2015, our provision for doubtful accounts decreased by $17.7 million, or 2.2%, to $800.1 million on a consolidated basis as compared to the prior year. This decrease in our provision for doubtful accounts is generally reflective of an improvement in the amount and timing of cash collections, including recoveries of amounts that were previously fully reserved. Additionally for the year ended December 31, 2015, our results were further benefited from the successful obtainment of provider numbers for the Medicare and Medicaid programs at certain of our recently acquired facilities compared to the prior year. Improvements in our accounts receivable are reflected in the reduction to our net revenue days outstanding. Specifically, our net revenue days outstanding at December 31, 2015 improved to 51.3 days compared to 56.4 days at December 31, 2014 on a consolidated basis.

The provision and allowance for doubtful accounts are critical accounting estimates and are further discussed in Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations, "Critical Accounting Estimates."

TABLE OF CONTENTS

Expenses and Other Income

Salaries and Benefits

The following table summarizes our salaries and benefits, man-hours per equivalent admission and salaries and benefits per equivalent admission for the years ended December 31, 2015 and 2014:

	Years Ended December 31,					
	2015	% of Revenues	2014	% of Revenues	Increase	% Increase
Salaries and benefits (dollars in millions)	$ 2,496.9	47.9 %	$ 2,134.5	47.6 %	$ 362.4	17.0 %
Man-hours per equivalent admission	111	N/A	108	N/A	3	2.8 %
Salaries and benefits per equivalent admission	$ 4,044	N/A	$ 3,870	N/A	$ 174	4.5 %

For the year ended December 31, 2015, our salaries and benefits expense increased to $2,496.9 million, or 17.0%, as compared to $2,134.5 million for the prior year primarily as a result of our 2015 and 2014 acquisitions and the impact of an increasing number of employed physicians and their related support staff.

Supplies

The following table summarizes our supplies and supplies per equivalent admission for the years ended December 31, 2015 and 2014:

	Years Ended December 31,					
	2015	% of Revenues	2014	% of Revenues	Increase	% Increase
Supplies (dollars in millions)	$ 815.0	15.6 %	$ 699.0	15.6 %	$ 116.0	16.6 %
Supplies per equivalent admission	$ 1,320	N/A	$ 1,270	N/A	$ 50	3.9 %

For the year ended December 31, 2015, our supplies expense increased to $815.0 million, or 16.6%, as compared to $699.0 million for the prior year primarily as a result of our 2015 and 2014 acquisitions.

Other Operating Expenses

The following table summarizes our other operating expenses for the years ended December 31, 2015 and 2014 (dollars in millions):

	Years Ended December 31,					
	2015	% of Revenues	2014	% of Revenues	Increase (Decrease)	% Increase (Decrease)
Professional fees	$ 199.1	3.8 %	$ 161.1	3.6 %	$ 38.0	23.6 %
Utilities	94.4	1.8	87.7	2.0	6.7	7.7
Repairs and maintenance	141.2	2.7	122.4	2.7	18.8	15.4
Rents and leases	52.9	1.0	45.4	1.0	7.5	16.6
Insurance	56.4	1.1	50.6	1.1	5.8	11.6
Physician recruiting	20.4	0.4	22.9	0.5	(2.5)	(10.9)
Contract services	378.2	7.3	319.7	7.1	58.5	18.3
Non-income taxes	137.2	2.6	124.2	2.8	13.0	10.5
Other	166.6	3.3	153.3	3.5	13.3	8.6
	$ 1,246.4	24.0 %	$ 1,087.3	24.3 %	$ 159.1	14.6 %

For the year ended December 31, 2015, our other operating expenses increased to $1,246.4 million, or 14.6%, as compared to $1,087.3 million for the prior year primarily as a result of our 2015 and 2014 acquisitions.

Other Income

We recognize EHR incentive payments received or anticipated to be received under the HITECH Act as other income in accordance with ASC 450-30 when our eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information for the full cost report year that determines the final calculation of the EHR incentive payment is available. For the year ended December 31, 2015, we recognized $49.7 million in Medicare and Medicaid EHR incentive payments, collectively, as compared to $71.9 million recognized in the prior year.

TABLE OF CONTENTS

Depreciation and Amortization

For the year ended December 31, 2015, our depreciation and amortization expense increased by $28.5 million, or 11.4% to $279.0 million, or 5.3% of revenues, as compared to $250.5 million, or 5.6% of revenues for the prior year. Our depreciation and amortization expense increased primarily as a result of our 2015 and 2014 acquisitions as well as a result of increases in our spending related to information systems as the result of various initiatives and requirements, including compliance with the HITECH Act.

Interest Expense

Our interest expense decreased by $8.6 million, or 6.9%, to $114.4 million, for the year ended December 31, 2015, as compared to $123.0 million for the prior year. The decrease in our interest expense is attributable to decreases in our weighted average total debt outstanding and our weighted average effective interest rate during the year ended December 31, 2015 as compared to the prior year. For a further discussion of our debt and corresponding interest rates, see "Liquidity and Capital Resources — Debt."

Impairment Charges

During the year ended December 31, 2015, we recognized impairment charges of $10.8 million, $7.0 million net of income taxes, or $0.15 loss per diluted share, in connection with the sale of Putnam, effective May 1, 2015. The impairment charges include the write-down of property, equipment, allocated goodwill and certain other assets to their estimated fair values as well as the finalization of the net working capital settlement. Additionally, during the year ended December 31, 2015, we recognized impairment charges of $3.0 million, $1.9 million net of income taxes, or $0.04 loss per diluted share, related to the finalization of the divestitures of Lakeland, Northwest and Russellville which were sold effective January 1, 2015.

During the year ended December 31, 2014, we recognized impairment charges in the aggregate of $57.7 million, $35.9 million net of income taxes, or $0.76 loss per diluted share, in connection with the sale of certain assets of River Parishes Hospital ("River Parishes"), effective November 1, 2014, and the sale of substantially all of the assets of Lakeland, Northwest and Russellville, effective January 1, 2015. The impairment charges include the write-down of property, equipment, allocated goodwill and certain other assets to their estimated fair values.

Other Non-Operating Gain

During the year ended December 31, 2015, we recorded a bargain purchase gain of approximately $4.0 million, $2.5 million net of income taxes, or $0.05 per diluted share, as a result of the final fair values assigned to the tangible and intangible assets acquired less obligations assumed, in connection with our acquisition of a hospital, exceeding the total cash consideration paid.

Provision for Income Taxes

Our provision for income taxes was $109.5 million, or 2.1% of revenues, for the year ended December 31, 2015, as compared to $68.1 million, or 1.5% of revenues, for the prior year. The effective tax rate increased to 37.6% for the year ended December 31, 2015, as compared to 35.1% for the prior year. Our effective tax rate was lower for the year ended December 31, 2014 as a result of the reversal of a $6.0 million valuation allowance that was established during 2013 against our deferred tax assets for federal net operating losses generated by our Michigan physician practice operations which were previously thought to be unrecoverable.

Supplemental Non-GAAP Information

See "— Results of Operations. For the Three Months Ended December 31, 2016 and 2015 — Supplemental Non-GAAP Information" for a description of how we use Adjusted EBITDA, why we believe Adjusted EBITDA is useful to investors and others, and other important information regarding Adjusted EBITDA.

TABLE OF CONTENTS

The following table sets forth Adjusted EBITDA for the years ended December 31, 2015 and 2014 and reconciles Adjusted EBITDA to net income, the most comparable GAAP measure (in millions):

	Years Ended December 31,					
	2015			2014		
	Amount	% of Revenues		Amount	% of Revenues	
Net income	$ 193.0	3.7	%	$ 134.9	3.0	%
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(11.1)	(0.2)		(8.8)	(0.2)	
Net income attributable to LifePoint Health, Inc.	181.9	3.5		126.1	2.8	
Add: Depreciation and amortization	279.0	5.3		250.5	5.6	
Interest expense, net	114.4	2.2		123.0	2.7	
Impairment charges	13.8	0.3		57.7	1.3	
Other non-operating gain	(4.0)	(0.1)		-	-	
Provision for income taxes	109.5	2.1		68.1	1.5	
Net income attributable to noncontrolling interests and redeemable noncontrolling interests	11.1	0.2		8.8	0.2	
Adjusted EBITDA	$ 705.7	13.5	%	$ 634.2	14.1	%

Liquidity and Capital Resources

Liquidity

Our primary sources of liquidity are cash flows provided by our operations and our debt borrowings. On June 10, 2016, we entered into our Senior Credit Agreement, comprised of the $700.0 million Term Facility and a $600.0 million senior secured revolving credit facility (the "Revolving Facility"), and used the proceeds from the Term Facility to repay outstanding amounts under our Prior Credit Agreement. Additionally, on May 26, 2016, we issued $500.0 million aggregate principal amount of 5.375% Senior Notes and used the proceeds, in part, to redeem all $400.0 million aggregate principal amount of our outstanding 6.625% Senior Notes on June 13, 2016.

The following table presents summarized cash flow information for the years ended December 31, 2016, 2015 and 2014 (in millions):

	2016	2015	2014
Net cash provided by operating activities	$ 435.2	$ 627.1	$ 412.3
Less: Purchases of property and equipment	(399.5)	(274.7)	(207.1)

Free operating cash flow	35.7	352.4	205.2
Acquisitions, net of cash acquired	(121.1)	(619.4)	(265.6)
Proceeds from sale of hospital	-	18.8	-
Proceeds from borrowings	1,350.0	500.0	412.0
Payments of borrowings	(1,186.3)	(16.9)	(585.4)
Repurchases of common stock	(233.1)	(134.5)	(222.3)
Payments of debt financing costs	(30.0)	(7.2)	(7.2)
Proceeds from exercise of stock options	12.1	11.5	23.9
Other	(15.2)	(12.2)	(7.0)
Net change in cash and cash equivalents	$ (187.9)	$ 92.5	$ (446.4)

The non-GAAP metric of free operating cash flow is an important liquidity measure for us. Our computation of free operating cash flow consists of net cash provided by operating activities less cash flows used for the purchase of property and equipment. We believe that free operating cash flow is useful to investors and management as a measure of the ability of our business to generate cash and to repay and incur additional debt. Free operating cash flow does not fully reflect our ability to freely deploy generated cash, as it does not reflect required debt payments or other fixed obligations. Computations of free operating cash flow may differ from company to company. Therefore, free operating cash flow should be used as a complement to, and in conjunction with, our consolidated statements of cash flows presented in our consolidated financial statements included elsewhere in this report.

Our cash flows provided by operating activities for the year ended December 31, 2016 as compared to 2015 were negatively impacted by the timing of cash collections of outstanding accounts receivable primarily as a result of the normal revenue cycle build-up of accounts receivable at certain of our recently acquired hospitals where we did not acquire outstanding accounts receivable. Additionally, our cash flows provided by operating activities for the year ended December 31, 2016 as compared to 2015 were negatively impacted by increases in the amount and timing of payments for income taxes and interest and a decrease in the amount and timing of receipts related to certain Medicaid DSH programs These decreases were partially offset by decreases in the amount and timing of payments for accounts payable and accrued salaries.

Our cash flows provided by operating activities for the year ended December 31, 2015 as compared to 2014 were positively impacted by higher net income, improvements in the amount and timing of cash collections of outstanding accounts receivable, including the successful obtainment of provider numbers for the Medicare and Medicaid programs at certain of our recently acquired facilities, and the timing of payments for income taxes. These improvements were partially offset by an increase in the amount and timing of payments for accrued salaries.

Capital Expenditures

We continue to make significant, targeted investments at our facilities to add new technologies, modernize facilities and expand the services available. These investments are designed to assist in our efforts to attract and retain physicians, to offset outmigration of patients and to make our hospitals more desirable to our employees and potential patients.

The following table reflects our capital expenditures for the years ended December 31, 2016, 2015 and 2014 (dollars in millions):

	2016		2015		2014	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Routine capital	$ 158.5	2.5 %	$ 126.4	2.4 %	$ 116.0	2.6 %
Growth capital	143.9	2.3	79.8	1.5	45.4	1.0
Information systems	97.1	1.5	68.5	1.3	45.7	1.0
	$ 399.5	6.3 %	$ 274.7	5.2 %	$ 207.1	4.6 %
Depreciation expense	$ 342.4		$ 276.7		$ 247.6	
Ratio of capital expenditures to						

depreciation expense	116.7%	99.3%	83.6%

We have a formal and intensive review procedure for the authorization of capital expenditures that exceed an established threshold. One of the most important financial measures of acceptability for a discretionary capital project is whether its projected discounted cash flow return on investment exceeds our projected cost of capital for that project. We expect to continue to invest in information systems, modern technologies, emergency room and operating room expansions, the construction of medical office buildings for physician expansion and the reconfiguration of the flow of patient care. Additionally, we may from time to time replace existing hospital buildings with new buildings as we evaluate ongoing repair and maintenance costs and other factors that impact the future operations of the existing buildings.

Our total capital expenditures in 2016 were higher than in 2015 as a result of our various capital commitments in connection with several of our facilities.

TABLE OF CONTENTS

Debt

An analysis and roll-forward of our long-term debt, including current maturities, during 2016 is as follows (in millions):

	December 31, 2015	Proceeds from Borrowings	Payments of Borrowings	Debt Issuance Costs, Discount and Premium (a)	Capital Leases Assumed in Connection with Acquisitions and Other	December 31, 2016
Senior Credit Agreement:						
Term Facility	$ -	$ 700.0	(8.7)	-	-	$ 691.3
Prior Credit Agreement:						
Prior Term Facility	405.0	-	(405.0)	-	-	-
Incremental Term Loans	222.6	-	(222.6)	-	-	-
Prior Revolving Facility	-	150.0	(150.0)	-	-	-
6.625% Senior Notes	400.0	-	(400.0)	-	-	-
5.5% Senior Notes	1,100.0	-	-	-	-	1,100.0
5.875% Senior Notes	500.0		-	-	-	500.0
5.375% Senior Notes	-	500.0	-	-	-	500.0
Unamortized debt issuance costs, discount and premium	(22.2)	-	-	0.3	-	(21.9)
Capital leases and financing obligations	63.4	-	(5.7)	-	87.2	144.9
	$ 2,668.8	$ 1,350.0	$ (1,192.0)	$ 0.3	$ 87.2	$ 2,914.3

(a) Represents new capitalized debt issuance costs of approximately $12.0 million, write-offs of previously capitalized debt issuance costs and debt discount of approximately $8.1 million and amortization of debt issuance costs, discount and premium of $4.2 million.

We use leverage, or our total debt to total capitalization ratio, to make financing decisions. The following table illustrates our financial statement leverage and the classification of our debt, all of which was senior, as either fixed rate or variable rate at December 31, 2016 and 2015 (dollars in millions):

	December 31, 2016	December 31, 2015	Increase (Decrease)
Current portion of long-term debt	$ 22.3	$ 25.0	$ (2.7)
Long-term debt, net	2,892.0	2,643.8	248.2
Unamortized debt issuance costs, discount and premium	21.9	22.2	(0.3)
Total debt, excluding unamortized debt issuance costs, discount and premium	2,936.2	2,691.0	245.2
Total LifePoint Health, Inc. stockholders' equity	2,180.4	2,263.9	(83.5)
Total capitalization	$ 5,116.6	$ 4,954.9	$ 161.7
Total debt to total capitalization	57.4 %	54.3 %	310 bps
Percentage of total debt:			
Fixed rate debt	76.5 %	76.7 %	
Variable rate debt	23.5	23.3	
	100.0 %	100.0 %	

Liquidity and Capital Resources Outlook

We expect the total level of spending for capital expenditures to be greater in 2017 as compared to 2016 as a result of our various capital commitments in connection with several of our facilities.

At December 31, 2016, we had uncompleted projects with an estimated additional cost to complete and equip of approximately $521.8 million. We anticipate funding these expenditures through cash provided by operating activities, available cash and borrowings available under the Senior Credit Agreement.

TABLE OF CONTENTS

Our business strategy contemplates the selective acquisition of additional hospitals and other healthcare service providers, and we regularly review potential acquisitions. It could be necessary for us to seek additional financing to fund larger hospital acquisitions. We regularly evaluate opportunities to sell additional equity or debt securities, obtain credit agreements from lenders or restructure our long-term debt or equity for strategic reasons or to further strengthen our financial position. The sale of additional equity or convertible debt securities could result in additional dilution to our stockholders.

We believe that cash generated from our operations and borrowings available under the Senior Credit Agreement will be adequate to meet our working capital needs, service existing debt, finance internal growth and fund capital expenditures and the purchase prices for certain small to mid-size hospital acquisitions over the next twelve months and into the foreseeable future prior to the maturity dates of our outstanding debt. Certain larger hospital acquisitions may, however, require additional financing.

Contractual Obligations, Commitments and Off-Balance Sheet Arrangements

Contractual Obligations

We have various contractual obligations, which are recorded as liabilities in our consolidated financial statements. Other items, such as certain purchase commitments and other executory contracts, are not recognized as liabilities in our consolidated financial statements but are required to be disclosed. For example, we are required to make certain minimum lease payments for the use of property under certain of our operating lease agreements.

The following table summarizes our significant contractual obligations as of December 31, 2016 and the future periods in which such obligations are expected to be settled in cash (in millions):

	Payment Due by Period				
Contractual Obligations	Total	2017	2018 - 2019	2020 - 2021	After 2021
Long-term debt obligations (a)	$ 3,585.8	$ 154.3	$ 315.9	$ 1,989.6	$ 1,126.0
Capital expenditure obligations (b)	1,547.7	224.2	291.1	294.3	738.1
Capital and financing lease obligations (c)	200.8	16.5	32.4	33.6	118.3
Operating lease obligations (d)	161.1	37.8	49.6	27.0	46.7
Other liabilities (e)	263.7	92.1	69.5	35.6	66.5
Purchase obligations (f)	804.8	272.2	302.6	173.6	56.4
Total	$ 6,563.9	$ 797.1	$ 1,061.1	$ 2,553.7	$ 2,152.0

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(a) Included in long-term debt obligations are principal and interest owed on our outstanding debt obligations. These amounts exclude our unamortized debt issuance costs, discount and premium and related

non-cash amortization. These obligations are explained further in Note 5 to our consolidated financial statements included elsewhere in this report. We used the 2.52% effective interest rate at December 31, 2016 for our $691.3 million outstanding Term Facility to estimate interest payments on this variable rate debt instrument.

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(b) We are subject to annual capital expenditure commitments in connection with several of our facilities including our recent acquisitions. Additionally, we had projects under construction with an estimated additional cost to complete and equip of approximately $521.8 million as of December 31, 2016. However, because we can terminate substantially all of the related construction contracts at any time without paying a termination fee, these costs are excluded from the above table except for amounts contractually committed by us.

(c) Included in capital leases and financing obligations are the future cash payments, including interest, due under our capital lease and financing obligation agreements. These obligations are explained further in Note 11 to our consolidated financial statements included elsewhere in this report.

(d) This reflects our future minimum operating lease payments. We enter into operating leases in the normal course of business. Substantially all of our operating lease agreements have fixed payment terms based on the passage of time. Some lease agreements provide us with the option to renew the lease. Our future operating lease obligations would change if we exercised these renewal options and if we entered into additional operating lease agreements. These obligations are explained further in Note 11 to our consolidated financial statements included elsewhere in this report.

(e) Included in other liabilities are the current and long-term portions of our reserves for self-insurance claims of $81.1 million and $161.5 million, respectively, but excluding the portion of the reserve related to our estimate of recoveries for certain claims in excess of our self-insured retention levels that do not require us to make cash payments. Please refer to "Critical Accounting Estimates — Reserves for Self-Insurance Claims" in this report for more information on our reserves for self-insurance claims. Additionally, included in other long-term liabilities are the estimated cash contributions we expect to make to our defined benefit pension plans sufficient to meet our minimum funding requirements as prescribed by the Employee Retirement Income Security Act of 1974, as amended, and our other long-term obligations which require the delivery of cash and for which we can reasonably estimate the timing of such payments.

TABLE OF CONTENTS

(f) The following table summarizes our significant purchase obligations as of December 31, 2016 and the future periods in which such obligations are expected to be settled in cash (in millions):

	Payment Due by Period				
Purchase Obligations	Total	2017	2018 - 2019	2020 - 2021	After 2021
Shared centralized resource model agreements (1)	$ 351.0	$ 60.5	$ 119.0	$ 115.5	$ 56.0
IT Services (2)	96.5	65.1	30.1	1.3	-
GEMS obligations (3)	190.8	47.7	95.4	47.7	-
Other purchase obligations (4)	166.5	98.9	58.1	9.1	0.4
Total	$ 804.8	$ 272.2	$ 302.6	$ 173.6	$ 56.4

(1) We have various arrangements with a third party to provide certain nonclinical business functions to us, including payroll, supply chain management and revenue cycle functions under a shared centralized resource model for periods ranging from two to seven years.
(2) We have various arrangements with third parties to provide information technology services, including, but not limited to, financial, clinical, patient accounting and other information services to us under contracts ranging from one to four years.
(3) General Electric Medical Services ("GEMS") provides diagnostic imaging equipment maintenance and bio-medical services to us pursuant to a contract that expires on December 31, 2020.
(4) Reflects our minimum commitments to purchase goods or services under non-cancelable contracts as of December 31, 2016.

Off-Balance Sheet Arrangements

We had standby letters of credit outstanding of approximately $20.7 million as of December 31, 2016, all of which relates to the self-insured retention levels of our professional and general liability insurance and workers' compensation programs as security for the payment of claims.

Recently Issued Accounting Pronouncements

Please refer to Note 1 to our consolidated financial statements included elsewhere in this report for a discussion of the impact of the adoption of recently issued accounting standards and accounting standards not yet adopted.

Critical Accounting Estimates

The preparation of financial statements in accordance with GAAP requires us to make estimates and assumptions that affect reported amounts and related disclosures. We consider an accounting estimate to be critical if:

- it requires assumptions to be made that were uncertain at the time the estimate was made; and
- changes in the estimate or different estimates that could have been made could have a material impact on our consolidated results of operations or financial condition.

Our management has discussed the development and selection of these critical accounting estimates with the audit committee of our Board of Directors and with our independent registered public accounting firm, and they both have reviewed our disclosure relating to our critical accounting estimates. Our critical accounting estimates include the following areas:

- Revenue recognition and accounts receivable;
- Goodwill impairment analysis;
- Reserves for self-insurance claims;
- Accounting for stock-based compensation; and
- Accounting for income taxes.

The following discussion of critical accounting estimates is not intended to be a comprehensive list of all of our accounting policies that require estimates, but the estimates discussed below involve a higher degree of judgment and complexity. We believe the current assumptions and other considerations used to estimate amounts reflected in our consolidated financial statements are appropriate. However, if actual experience differs from the assumptions and other considerations used in estimating amounts reflected in our consolidated financial statements, the resulting changes could have a material adverse effect on our consolidated results of operations and our financial condition. The discussion that follows presents information about our critical accounting estimates, as well as the effects of hypothetical changes in the material assumptions used to develop each estimate.

Revenue Recognition and Accounts Receivable

We recognize revenues in the period in which services are provided. Accounts receivable primarily consist of amounts due from third-party payors and patients. Our ability to collect outstanding receivables is critical to our results of operations and cash flows. Amounts we receive for treatment of patients covered by governmental programs, such as Medicare and Medicaid, and other third-party payors such as HMOs, PPOs and other private insurers, are generally less than our established billing rates. Additionally, to provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. Accordingly, our revenues and accounts receivable are reduced to net realizable value through an allowance for contractual discounts and a provision for doubtful accounts.

Approximately 99.1%, 98.6% and 99.4% of our revenues during the years ended December 31, 2016, 2015 and 2014, respectively, relate to discounted charges, which were comprised of the following sources (as a percentage of revenues):

	2016	2015	2014
Medicare	37.3 %	36.3 %	36.3 %
Medicaid	14.5	16.4	13.8
HMO's, PPO's and other private insurers	47.3	45.9	49.3

Certain changes have been made to the classification of our historical sources of revenues. Primarily, we changed the classification of revenues related to our managed Medicare programs from HMOs, PPOs and other private insurers to Medicare for each of the periods presented above. This change had no impact on our historical results of operations.

Revenues are recorded at estimated net amounts due from patients, third-party payors and others for healthcare services provided. For certain payors, such as Medicare, Medicaid, as well as some managed care payors with which we have contractual arrangements, the contractual allowances are calculated by computerized logging systems based on defined payment terms. For other payors, the contractual allowances are determined based on historical data by insurance plan. All contractual adjustments, regardless of type of payor or method of calculation, are reviewed and compared to actual experience.

We monitor our processes for calculating contractual allowances through:

- review of payment discrepancy reports for logged payors;
- analysis of historical contractual allowance trends based on actual claims paid by HMOs, PPOs and other private insurers;
- review of contractual allowance information reflecting current contract terms;
- consideration and analysis of changes in charge rates and payor mix reimbursement levels; and
- other issues that may impact contractual allowances.

Medicare and Medicaid

The majority of services performed on Medicare and Medicaid patients are reimbursed at predetermined reimbursement rates. The differences between the established billing rates (i.e., gross charges) and the predetermined reimbursement rates are recorded as contractual discounts and deducted from gross charges. Under the Medicaid

program's prospective reimbursement systems, there is no adjustment or settlement of the difference between the actual cost to provide the service and the predetermined reimbursement rates.

Discounts for retrospectively cost-based revenues are estimated based on historical and current factors and are adjusted in future periods when settlements of filed cost reports are received. Final settlements under these programs are subject to adjustment based on administrative review and audit by third party intermediaries, which can take several years to resolve completely. The net adjustments to estimated cost report settlements had the following impact to our consolidated statements of operations for the years ended December 31, 2016, 2015 and 2014 (in millions, except per share amounts):

	Revenues	Net Income (Loss)	Diluted Earnings (Loss) Per Share
Year ended December 31, 2016	$ 6.3	$ 3.9	$ 0.09
Year ended December 31, 2015	$ (0.5)	$ (0.3)	$ (0.01)
Year ended December 31, 2014	$ 2.5	$ 1.6	$ 0.03

Because the laws and regulations governing the Medicare and Medicaid programs are complex and subject to change, the estimates of contractual discounts we record could change by material amounts. A significant increase in our estimate of contractual discounts for Medicare and Medicaid would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

TABLE OF CONTENTS

HMOs, PPOs and Other Private Insurers

Amounts we receive for the treatment of patients covered by HMOs, PPOs and other private insurers (collectively "managed care plans") are generally less than our established billing rates. We include contractual allowances as a reduction to revenues in our consolidated financial statements based on payor specific identification and payor specific factors for rate increases and denials. For most managed care plans, estimated contractual allowances are adjusted to actual contractual allowances as cash is received and claims are reconciled.

If our overall estimated contractual discount percentage on our managed care program revenues for the year ended December 31, 2016 were changed by 1%, our net income would change by approximately $49.8 million, or diluted earnings per share of $1.15. This is only one example of reasonably possible sensitivity scenarios. The process of determining the allowance requires us to estimate the amount expected to be received based on payor contract provisions, historical collection data as well as other factors and requires a high degree of judgment. It is impacted by changes in managed care contracts and other related factors. A significant increase in our estimate of contractual discounts for managed care plans would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

Provision and Allowance for Doubtful Accounts

To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts. Our allowance for doubtful accounts, included in our consolidated balance sheets as of December 31, 2016 and 2015 was $891.2 million and $796.8 million, respectively. Our provision for doubtful accounts, included in our consolidated results of operations for the years ended December 31, 2016, 2015 and 2014, was $909.6 million, $800.1 million and $817.8 million, respectively.

The largest component of our allowance for doubtful accounts relates to accounts for which patients are responsible, which we refer to as patient responsibility accounts or self-pay accounts. These accounts include both amounts payable by uninsured patients and co-payments and deductibles payable by insured patients. In general, we attempt to collect deductibles, co-payments and self-pay accounts prior to the time of service for non-emergency care. If we do not collect these patient responsibility accounts prior to the delivery of care, the accounts are handled through our billing and collections processes.

The approximate amounts and percentages of billed insured and uninsured (including self-pay, co-payments, deductibles and Medicaid pending) gross accounts receivable (prior to allowance for contractual discounts and allowance for doubtful accounts) in summarized aging categories as of December 31, 2016 and 2015 are presented below (in millions). Prior year uninsured gross accounts receivable amounts have been adjusted to conform to current year presentation.

	December 31, 2016					
	Insured Receivables		Uninsured Receivables		Combined	
	Amount	Percent of Receivables	Amount	Percent of Receivables	Amount	Percent of Receivables
0 to 90 days	$ 1,393.5	77.6 %	$ 283.2	27.7 %	$ 1,676.7	59.4 %
91 to 150 days	139.4	7.8	183.7	17.9	323.1	11.5

151 to 360 days	189.7	10.5		449.9	43.9		639.6	22.7	
Over 361	73.0	4.1		107.6	10.5		180.6	6.4	
	$ 1,795.6	100.0	%	$ 1,024.4	100.0	%	$ 2,820.0	100.0	%

	December 31, 2015								
	Insured Receivables			Uninsured Receivables			Combined		
	Amount	Percent of Receivables		Amount	Percent of Receivables		Amount	Percent of Receivables	
0 to 90 days	$ 1,064.3	83.5	%	$ 246.7	26.1	%	$ 1,311.0	59.1	%
91 to 150 days	89.0	7.0		160.7	17.0		249.7	11.3	
151 to 360 days	90.0	7.1		425.3	45.1		515.3	23.2	
Over 361	30.8	2.4		111.0	11.8		141.8	6.4	
	$ 1,274.1	100.0	%	$ 943.7	100.0	%	$ 2,217.8	100.0	%

TABLE OF CONTENTS

We verify each patient's insurance coverage as early as possible before a scheduled admission or procedure, including with respect to eligibility, benefits and authorization/pre-certification requirements, in order to notify patients of the amounts for which they will be responsible. We attempt to verify insurance coverage within a reasonable amount of time for all emergency room visits and urgent admissions in compliance with EMTALA.

In general, we perform the following steps in collecting accounts receivable:

- if possible, cash collection of deductibles, co-payments and self-pay accounts prior to or at the time service is provided;
- billing and follow-up with third party payors;
- collection calls;
- utilization of collection agencies; and
- if collection efforts are unsuccessful, write-off of the accounts.

Our policy is to write-off accounts after all collection efforts have failed, which is generally one year after the date of discharge of the patient. Patient responsibility accounts represent the majority of our write-offs. All of our hospitals retain third-party collection agencies for billing and collection of delinquent accounts. At most of our hospitals, more than one collection agency is used to promote competition and improve performance results. The selection of collection agencies and the timing of referral of an account to a collection agency vary among our hospitals.

We determine the adequacy of the allowance for doubtful accounts utilizing a number of analytical tools and benchmarks. No single statistic or measurement alone determines the adequacy of the allowance. Specifically, we monitor the revenue trends by payor classification on a month-by-month basis along with the composition of our accounts receivable agings. This review is focused primarily on trends in self-pay revenues, accounts receivable, co-payment receivables, historic payment patterns and other factors such as revenue days in accounts receivable.

The process of determining our allowance for doubtful accounts requires us to estimate uncollectible self-pay accounts. Our estimate of uncollectible self-pay accounts is primarily based on our collection history, adjusted for anticipated changes in collection trends, if significant. Our estimate may be impacted by changes in regional economic conditions, business office operations, payor mix and trends in federal or state governmental healthcare coverage or other third party payors. If the actual self-pay collection percentage would change by 1.5% from our estimated self-pay collection percentage for the year ended December 31, 2016, our net income would change by approximately $7.8 million, or diluted earnings per share of $0.18. The resulting change in this analytical tool is considered to be a reasonably likely change that would affect our overall assessment of this critical accounting estimate.

Goodwill Impairment Analysis

Goodwill represents the excess of the purchase price over the fair value of the net assets of acquired businesses. Our goodwill included in our consolidated balance sheets as of December 31, 2016 and 2015 was $1,777.9 million and $1,667.5 million, respectively. Please refer to Note 4 to our consolidated financial statements included elsewhere in this report for a detailed rollforward of our goodwill.

In accordance with ASC 350-10, "Intangibles — Goodwill and Other" ("ASC 350-10") goodwill and intangible assets with indefinite lives are reviewed by us at least annually for impairment. Our business comprises a single operating

reporting unit for impairment test purposes. For the purposes of these analyses, our estimate of fair value are based on a combination of the income approach, which estimates the fair value of us based on our future discounted cash flows, and the market approach, which estimates the fair value of us based on comparable market prices. Our estimate of future discounted cash flows is based on assumptions and projections we believe to be currently reasonable and supportable. Our assumptions take into account revenue and expense growth rates, patient volumes, changes in payor mix, and changes in legislation and other payor payment patterns.

If we determine the carrying value of goodwill is impaired, or if the carrying value of a business that is to be sold or otherwise disposed of exceeds its fair value, then we reduce the carrying value, including any allocated goodwill, to fair value. During the years ended December 31, 2016, 2015 and 2014, we performed our annual impairment tests as of October 1, and did not incur an impairment charge.

TABLE OF CONTENTS

Reserves for Self-Insurance Claims

We are subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, we maintain insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention and deductible levels. Our deductible level for professional liability claims is $5.0 million per claim at December 31, 2016 with a $5.0 million inner aggregate per claim. Additionally, as of December 31, 2016, our deductible level for workers' compensation claims is $1.0 million per claim in all states in which we operate except for Wyoming. We participate in a state specific program in Wyoming for our workers' compensation claims arising in this state. Our self-insured retention level is evaluated annually as a part of our insurance program's renewal process.

Each year, we obtain quotes from various insurers with respect to the cost of obtaining insurance coverage. We compare these quotes to our most recent actuarially determined estimates of losses at various self-insured retention and deductible levels. Accordingly, changes in insurance costs affect the self-insured retention and deductible levels we choose each year.

Our reserves for self-insurance and deductible claims reflects the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations as of the balance sheet date. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances. Our expense for self-insurance and deductible claims coverage each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; the insurance premiums for losses in excess of our self-insured retention and deductible levels; the administrative costs of the insurance program; and interest expense related to the discounted portion of the liability.

Our reserves for professional liability claims are based upon quarterly actuarial calculations. Our reserves for employee workers' compensation claims are based upon semi-annual actuarial calculations. Our reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. We have discounted our reserves for self-insured claims to their present value using a discount rate of 1.31%, 1.35% and 1.50% at December 31, 2016, 2015 and 2014, respectively. We select a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

The following table provides information regarding our reserves for self-insured claims at December 31, 2016 and 2015 (in millions):

	December 31, 2016	December 31, 2015
Undiscounted	$ 251.7	$ 205.0
Discounted (as reported)	$ 242.6	$ 196.2

The following table presents the changes in our reserves for self-insured claims for the years ended December 31, 2016 and 2015 (in millions):

	2016	2015
Reserve at the beginning of the period	$ 196.2	$ 177.5
Increase for the provision of current year claims	96.3	72.8
Decrease for the provision of prior year claims	(31.0)	(21.7)
Payments related to current year claims	(5.4)	(6.1)
Payments related to prior year claims	(34.5)	(28.0)
Provision for the change in discount rate	0.2	0.9
Noncash change in reserve for claims in excess of self-insured retention levels	12.9	0.8
Liability assumed in acquisition	7.9	-
Reserve at the end of the period	$ 242.6	$ 196.2

As of December 31, 2016 and 2015, less than 1% of our reserves for self-insured claims represents reserves for settled and unpaid claims. Our average lag time between the settlement and payment of a self-insured claim ranges from 1 to 2 weeks.

Our estimated reserves for self-insured claims will be significantly affected if current and future claims differ from historical trends. While we monitor reported claims closely and consider potential outcomes when determining our reserves for self-insured claims, the complexity of the claims, the extended period of time to settle the claims and the wide range of potential outcomes complicates the estimation process. In addition, certain states have passed varying forms of tort reform which attempt to limit the amount of awards. If such laws are passed in the states where our hospitals are located, our loss estimates could decrease.

TABLE OF CONTENTS

Our estimate of reserves for self-insured and deductible claims are based upon actuarial calculations and are significantly influenced by key assumptions and other factors. These factors include, but are not limited to: historical paid claims; trending of loss development factors; trends in the frequency and severity of claims, which can differ significantly by jurisdiction as a result of the legislative and judicial climate in such jurisdictions; coverage limits of third-party insurance and actuarial determined statistical confidence levels. Given the number of assumptions and characteristics of each assumption considered in establishing the reserves for self-insured claims, it is difficult to compute the individual financial impact of each assumption or groups of assumptions. Some of the assumptions are dependent upon the quantitative measurement of other assumptions, and therefore are not accurately evaluated in isolation. For example, a change in the frequency of claims assumption is also affected by the estimated severity of these claims resulting in an inability to properly isolate and quantify the impact of a change in this assumption.

Professional and general liability claims are typically resolved over an extended period of time, often as long as five years or more, while workers' compensation claims are typically resolved in one to two years. Our reserves for self-insured claims are comprised of estimated indemnity and expense payments related to reported events and incurred but not reported events as of the end of the period. We have the ability to reliably determine the amount and timing of payments based on sufficient history of our claims development, the use of external actuarial expertise and our rigorous review process. Actuarial payment patterns are based on our individual hospital historical data both prior to and after our inception in 1999. The processes, performed by both external actuaries and our management, enable us to reliably determine the amount of our ultimate losses as well as the timing of the loss settlements such that discounting of the reserves for self-insured claims is appropriate. Given the number of factors considered in establishing the reserves for self-insured claims, it is neither practical nor meaningful to isolate a particular assumption or parameter of the process and calculate the impact of changing that single item.

Ultimately, from an actuarial standpoint, the sensitivity in the estimates of reserves for self-insured claims is reflected in the various actuarial confidence levels. Our best estimate of our reserves for self-insured claims utilizes a statistical confidence level that is 50%. Higher statistical confidence levels, while not representative of our best estimate, reflect reasonably likely outcomes upon the ultimate resolution of related claims. Using a higher statistical confidence level would increase the estimated reserves for self-insured claims. Changes in our estimates of reserves for self-insured claims are non-cash charges and accordingly, do not impact our liquidity or capital resources.

The assumptions included in the table below are presented for the sensitivity analysis (in millions):

December 31, 2016 reserve:		
As reported	$	242.6
With 70% Confidence Level	$	249.9
With 80% Confidence Level	$	262.4
With 90% Confidence Level	$	297.0
December 31, 2015 reserve:		
As reported	$	196.2
With 70% Confidence Level	$	210.6
With 80% Confidence Level	$	222.5
With 90% Confidence Level	$	255.6

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of our quarterly and semi-annual actuarial calculations resulted in changes to our reserves for self-insured claims for prior years. As a result, for the years ended December 31, 2016, 2015 and 2014, our related self-insured claims expense decreased by $31.0 million, $21.7 million and $9.8 million, which increased net income by approximately $19.4 million, $13.5 million and $6.4 million, or $0.45, $0.29 and $0.14 per diluted share, respectively.

Accounting for Stock-Based Compensation

We issue stock-based awards, including stock options and other stock-based awards (nonvested stock, restricted stock, restricted stock units and performance shares) to certain officers, employees and non-employee directors in accordance with our stockholder-approved 2013 Long-Term Incentive Plan (the “2013 LTIP”). We account for our stock-based awards in accordance with the provisions of ASC 718-10, “Compensation — Stock Compensation” (“ASC 718-10”) and accordingly recognize compensation expense over each of the stock-based award’s requisite service period based on the estimated grant date fair value. Our stock-based compensation expense was $22.0 million, $35.0 million and $29.7 million for the years ended December 31, 2016, 2015 and 2014, respectively.

TABLE OF CONTENTS

We estimate the fair value of stock options granted using a binomial lattice option valuation model and a single option award approach. We use a binomial lattice option valuation model because it considers characteristics of fair value option pricing, such as an option's contractual term and the probability of exercise before the end of the contractual term. In addition, the complications surrounding the expected term of an option are material, as indicated in ASC 718-10. Given our relatively large pool of unexercised options, we believe a binomial lattice option valuation model that specifically addresses this fact and models a full term of exercises is the most appropriate and reliable means of valuing our stock options. We are amortizing the fair value on a straight-line basis over the requisite service periods of the awards, which are the vesting periods of three years. The stock options vest 33.3% on each grant anniversary date over three years of continued employment.

The following table shows the weighted average assumptions we used to develop the fair value estimates under our binomial lattice option valuation model and the resulting estimates of weighted-average fair value per share of stock options granted during the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
Expected volatility	32.2 %	29.0 %	29.0 %
Risk-free interest rate	1.76	2.20	2.71
Expected dividends	-	-	-
Average expected term (years)	5.9	5.3	5.4
Fair value per share of stock options granted	$ 19.58	$ 18.66	$ 13.95

Population Stratification

In accordance with ASC 718-10, a company should aggregate individual awards into relatively homogeneous groups with respect to exercise and post-vesting employment behaviors for the purpose of refining the expected term assumption, regardless of the valuation technique used to estimate the fair value. In addition, ASC 718-10 indicates that a company may generally make a reasonable fair value estimate with as few as one or two groupings. We have determined that a single employee population group is appropriate based on an analysis of our historical exercise patterns.

Expected Volatility

Volatility is a measure of the tendency of investment returns to vary around a long-term average rate. Historical volatility is an appropriate starting point for setting this assumption in accordance with ASC 718-10. According to ASC 718-10, companies should also consider how future experience may differ from the past. This may require using other factors to adjust historical volatility, such as implied volatility, peer-group volatility and the range and mean-reversion of volatility estimates over various historical periods. ASC 718-10 acknowledges that there is likely to be a range of reasonable estimates for volatility. In addition, ASC 718-10 requires that if a best estimate cannot be made, management should use the mid-point in the range of reasonable estimates for volatility. We estimate the volatility of our common stock at the date of grant based on both historical volatility and implied volatility from traded options of our common stock, consistent with ASC 718-10.

Risk-Free Interest Rate

Lattice models require risk-free interest rates for all potential times of exercise obtained by using a grant-date yield curve. A lattice model would, therefore, require the yield curve for the entire time period during which employees might exercise their options. We base the risk-free rate on the implied yield in effect at the time of option grant on U.S. Treasury zero-coupon issues with equivalent remaining terms.

Expected Dividends

We have never paid any cash dividends on our common stock and do not anticipate paying any cash dividends in the foreseeable future. Accordingly, we use an expected dividend yield of zero.

Pre-Vesting Forfeitures

Pre-vesting forfeitures do not affect the fair value calculation, but they affect the expense calculation. ASC 718-10 requires us to estimate pre-vesting forfeitures at the time of grant and revise those estimates in subsequent periods if actual forfeitures differ from those estimates. We use historical data to estimate pre-vesting forfeitures and record share-based compensation expense only for those awards that are expected to vest.

We apply a dynamic forfeiture rate methodology over the vesting period of the award. The dynamic forfeiture rate methodology incorporates the lapse of time into the resulting expense calculation and results in a forfeiture rate that diminishes as the granted awards approach its vest date. Accordingly, the dynamic forfeiture rate methodology results in a more consistent stock compensation expense calculation over the vesting period of the award.

TABLE OF CONTENTS

Post-Vesting Cancellations

Post-vesting cancellations include vested options that are cancelled, exercised or expire unexercised. Lattice models treat post-vesting cancellations and voluntary early exercise behavior as two separate assumptions. We use historical data to estimate post-vesting cancellations.

Expected Term

ASC 718-10 calls for an extinguishment calculation, dependent upon how long a granted option remains outstanding before it is fully extinguished. While extinguishment may result from exercise, it can also result from post-vesting cancellation or expiration at the contractual term. Expected term is an output in lattice models so we do not have to determine this amount.

The fair value calculations of our stock option grants are affected by assumptions that are believed to be reasonable based upon the facts and circumstances at the time of grant. Changes in our volatility estimates can materially affect the fair values of our stock option grants. If our estimated weighted-average volatility for the year ended December 31, 2016 were 10% higher, our net income would decrease by approximately $1.2 million, or $0.03 loss per diluted share.

Generally, the fair value of our restricted stock unit awards is determined based on the closing price of our common stock on the trading date immediately prior to the grant date. However, of the restricted stock units granted during the years ended December 31, 2016, 2015 and 2014, 159,248, 145,000 and 236,000 were performance-based restricted stock units respectively, subject to the achievement of a combination of performance and/or market conditions. In addition to the achievement of the performance and/or market conditions, these performance-based restricted stock units are generally subject to the continuing service of the employee over the cliff-vesting period from the grant date of three years.

The performance condition for the targeted performance-based restricted stock units granted during the year ended December 31, 2016 is based on the Company’s actual earnings before interest, taxes, depreciation and amortization (“EBITDA”) financial performance for hospital acquisitions completed in 2014 and 2015 as compared to the pro forma EBITDA target for this same group of hospitals. The market condition for the targeted performance-based restricted stock units granted during each of the years ended December 31, 2016, 2015 and 2014 is based on the Company’s three-year annualized total shareholder return relative to a peer group, Standard and Poor’s Global Industry Classification Standard’s Sub-Industry: Health Care Facilities with over $500.0 million in revenues or its equivalent. For the performance-based restricted stock units granted during the years ended December 31, 2016 and 2015, the number of shares payable at the end of the three-year performance period ranges from 0% to 200% of the targeted units based on the Company’s actual performance and/or market conditions results as compared to the targets. For the performance-based restricted stock units granted during the year ended December 31, 2014, the number of shares payable at the end of the three-year performance period ranges from 0% to 100% of the targeted units, with any portion of the award that exceeds 100% up to 200% of the targeted units settled in cash equal to the fair market value on the date certification of the level of performance is achieved.

The fair value of these restricted stock units was determined based on a combination, where applicable, of the closing price of the Company’s common stock on the trading date immediately prior to the grant date for units subject to performance conditions, or at its Monte-Carlo simulation value for units subject to market conditions. The Company recognizes compensation expense for the portion of the targeted performance-based restricted stock units subject to market conditions even if the condition is never satisfied. However, if the performance conditions are not met for the

portion of the targeted performance-based restricted stock units subject to such performance conditions, no compensation expense will be recognized, and any previously recognized compensation expense will be reversed.

Accounting for Income Taxes

Deferred tax assets generally represent items that will result in a tax deduction in future years for which we have already recorded the tax benefit in our income statement. We assess the likelihood that deferred tax assets will be recovered from future taxable income. To the extent we believe that recovery is not probable, a valuation allowance is established. To the extent we establish a valuation allowance or increase this allowance, we must include an expense as part of the income tax provision in our results of operations. Our deferred tax asset balances in our consolidated balance sheets were $364.7 million and $303.7 million as of December 31, 2016 and 2015, respectively. Our valuation allowances for deferred tax assets in our consolidated balance sheets were $77.6 million and $64.5 million as of December 31, 2016 and 2015, respectively.

TABLE OF CONTENTS

In addition, significant judgment is required in determining and assessing the impact of certain tax-related contingencies. We establish accruals when, despite our belief that our tax return positions are fully supportable, it is probable that we have incurred a loss related to tax contingencies and the loss or range of loss can be reasonably estimated. We adjust the accruals related to tax contingencies as part of our provision for income taxes in our results of operations based upon changing facts and circumstances, such as progress of a tax audit, development of industry related examination issues, as well as legislative, regulatory or judicial developments. A number of years may elapse before a particular matter, for which we have established an accrual, is audited and resolved.

The first step in determining the deferred tax asset valuation allowance is identifying reporting jurisdictions where we have a history of tax and operating losses or are projected to have losses in future periods as a result of changes in operational performance. We then determine if a valuation allowance should be established against the deferred tax assets for that reporting jurisdiction.

The second step is to determine the amount of the valuation allowance. We will generally establish a valuation allowance equal to the net deferred tax asset (deferred tax assets less deferred tax liabilities) related to the jurisdiction identified in step one of the analysis. In certain cases, we may not reduce the valuation allowance by the amount of the deferred tax liabilities depending on the nature and timing of future taxable income attributable to deferred tax liabilities.

In assessing tax contingencies, we apply the provisions of ASC 740-10, “Income Taxes”. We apply the recognition threshold and measurement of a tax position taken or expected to be taken in a tax return and follow the guidance on various matters such as derecognition, interest, penalties and disclosure. We classify interest and penalties as a component of income tax expense.

During each reporting period, we assess the facts and circumstances related to recorded tax contingencies. If tax contingencies are no longer deemed probable based upon new facts and circumstances, the contingency is reflected as a reduction of the provision for income taxes in the current period.

Our deferred tax assets exceeded our deferred tax labilities by $27.6 million as of December 31, 2016, excluding the impact of valuation allowances. Historically, we have produced federal taxable income, and as such, we believe that the likelihood of not realizing the federal tax benefit of our deferred tax assets is remote. However, we do have subsidiaries with a history of tax losses in certain state jurisdictions and, based upon those historical tax losses, we assumed that the subsidiaries would not be profitable in the future for those states’ tax purposes. If our assertion regarding the future profitability of those subsidiaries was incorrect, then our deferred tax assets would be understated by the amount of the state valuation allowance of $77.6 million at December 31, 2016.

The IRS may propose adjustments for items we have failed to identify as tax contingencies. If the IRS were to propose and sustain assessments equal to 10% of our taxable income for 2016, we would incur approximately $11.6 million of additional tax payments for 2016 plus interest and penalties, if applicable.

Segment Reporting

We provide healthcare services. Accordingly, we have one operating segment, healthcare services, for segment reporting purposes in accordance with ASC 280-10, “Segment Reporting”. Additionally, we have one reporting unit for goodwill impairment testing in accordance with ASC 350-10.

Inflation

The healthcare industry is labor-intensive. Wages and other expenses increase during periods of inflation and when labor shortages in marketplaces occur. In addition, suppliers pass along rising costs to us in the form of higher prices. Private insurers pass along their rising costs in the form of lower reimbursement to us. Our ability to pass on these increased costs in increased rates is limited because of increasing regulatory and competitive pressures and the fact that the majority of our revenues are fee-based. Accordingly, inflationary pressures could have a material adverse effect on our results of operations.

TABLE OF CONTENTS

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

Interest Rates

The following discussion relates to our exposure to market risk based on changes in interest rates:

Outstanding Debt

As of December 31, 2016, we had outstanding debt, excluding unamortized debt issuance costs and premium, of $2,936.2 million, 23.5%, or $691.3 million, of which was subject to variable rates of interest. If the interest rate on our variable rate long-term debt outstanding as of December 31, 2016 was 100 basis points higher during the year ended December 31, 2016, our net income would have decreased by approximately $4.3 million, or $0.10 loss per diluted share.

Cash Balances

Certain of our outstanding cash balances are invested overnight with high credit quality financial institutions. We do not hold direct investments in auction rate securities, collateralized debt obligations, structured investment vehicles or mortgage-backed securities. We do not have significant exposure to changing interest rates on invested cash at December 31, 2016. As a result, the interest rate market risk implicit in these investments at December 31, 2016, if any, is low.

Item 8. Financial Statements and Supplementary Data.

Information with respect to this Item is contained in our consolidated financial statements beginning on Page F-1 of this report.

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

We did not experience a change in or disagreement with our accountants during the year ended December 31, 2016.

Item 9A. Controls and Procedures.

Conclusion Regarding the Effectiveness of Disclosure Controls and Procedures

We carried out an evaluation, under the supervision and with the participation of management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures as of the end of the period covered by this report pursuant to Rule 13a-15 of the Exchange Act. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective in ensuring that information required to be disclosed by us (including our consolidated subsidiaries) in reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported on a timely basis and is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate, to allow timely decisions regarding required disclosure.

Management’s Annual Report on Internal Control Over Financial Reporting

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

Changes in Internal Control Over Financial Reporting

There has been no change in our internal control over financial reporting during the fourth quarter ended December 31, 2016 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information.

None.

TABLE OF CONTENTS

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

Executive Officers

This information is incorporated by reference to the information contained under the caption “Executive Compensation — Executive Officers of the Company” included in our proxy statement relating to our 2017 annual meeting of stockholders.

Code of Ethics

Our Board of Directors expects its members, as well as our officers and employees, to act ethically at all times and to acknowledge in writing their adherence to the policies comprising our Code of Conduct, which is known as “Common Ground,” and, as applicable, our Code of Ethics for Senior Financial Officers and Chief Executive Officer (the “Code of Ethics”). The Code of Ethics and Common Ground are posted on our website located at www.lifepointhealth.net under the heading “Corporate Governance.” We intend to disclose any amendments to our Code of Ethics and any waiver from a provision of our code, as required by the SEC, on our website within four business days following such amendment or waiver.

Directors

This information is incorporated by reference to the information contained under the caption “Proposal 1: Election of Directors” included in our proxy statement relating to our 2017 annual meeting of stockholders.

Section 16(a) Beneficial Ownership Reporting Compliance

This information is incorporated by reference to the information contained under the caption “Ownership of Equity Securities of the Company — Section 16(a) Beneficial Ownership Reporting Compliance” included in our proxy statement relating to our 2017 annual meeting of stockholders.

Stockholder Nominees

This information is incorporated by reference to the information contained under the caption “Proposal 1: Election of Directors — Director Nomination Process” included in our proxy statement relating to our 2017 annual meeting of stockholders.

Audit and Compliance Committee

This information is incorporated by reference to the information contained under the caption “Audit and Compliance Committee Report” included in our proxy statement relating to our 2017 annual meeting of stockholders.

Item 11. Executive Compensation.

This information is incorporated by reference to the information contained under the captions “Compensation Committee Report,” “Compensation Discussion and Analysis,” “Executive Compensation,” “Corporate Governance — Compensation Committee Interlocks and Insider Participation,” and “Director Compensation,” included in our proxy statement relating to our 2017 annual meeting of stockholders.

TABLE OF CONTENTS

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

This information is incorporated by reference to the information contained under the captions "Ownership of Equity Securities of the Company" and "Executive Compensation — Potential Payments upon Termination or Change in Control" included in our proxy statement relating to our 2017 annual meeting of stockholders.

Equity Compensation Plan Information

Effective June 4, 2013, upon the approval of our stockholders, we replaced the Amended and Restated 1998 Long-Term Incentive Plan (the "1998 LTIP") and Amended and Restated Outside Directors Stock and Incentive Compensation Plan (the "ODSICP") with the 2013 LTIP, a new combined plan covering all of our employees and non-employee directors. No shares remain available for grant under the 1998 LTIP or the ODSICP.

The following table provides aggregate information as of December 31, 2016, with respect to shares of common stock that may be issued in accordance with our equity compensation plans:

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)		Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights (b)		Number of Securities Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)	
Equity Compensation Plans Approved by Security Holders	4,092,992	(1)	$ 49.51	(2)	2,279,399	(3)
Equity Compensation Plans not Approved by Security Holders	None		None		None	
Total	4,092,992		$ 49.51		2,279,399	

(1) Includes the following:

- 4,088,028 shares of common stock to be issued upon exercise of outstanding stock options granted in accordance with the 1998 LTIP and the 2013 LTIP; and
- 4,964 shares of common stock to be issued upon the vesting of deferred stock units outstanding in accordance with the ODSICP.

(2) Upon vesting, deferred stock units are settled for shares of common stock on a one-for-one basis. Accordingly, the deferred stock units have been excluded for purposes of computing the weighted-average exercise price.

(3) Includes the following:

· 2,252,186 shares of common stock available for issuance in accordance with the 2013 LTIP; and
· 27,213 shares of common stock available for issuance in accordance with the Amended and Restated Management Stock Purchase Plan (the “MSPP”).

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

This information is incorporated by reference to the information contained under the captions “Corporate Governance —Independence and Related Person Transactions” and “Corporate Governance — Board Meetings and Committees” included in our proxy statement relating to our 2017 annual meeting of stockholders.

Item 14. Principal Accountant Fees and Services.

This information is incorporated by reference to the information contained under the caption “Proposal 4: Ratification of Selection of Independent Registered Public Accounting Firm” and “— Fees and Services of the Independent Registered Public Accounting Firm” included in our proxy statement relating to our 2017 annual meeting of stockholders.

TABLE OF CONTENTS

PART IV

Item 15. Exhibits, Financial Statement Schedules.

(a) Index to Consolidated Financial Statements, Financial Statement Schedules and Exhibits:

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

(2) Consolidated Financial Statement Schedules:
All schedules are omitted because they are not applicable or not required, or because the required information is included in the consolidated financial statements or notes in this report.

(3) Exhibits:

Exhibit Number	Description of Exhibits
3.1	—Amended and Restated Certificate of Incorporation of LifePoint Health, Inc., as amended (incorporated by reference from exhibits to the LifePoint Health, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2015, File No. 000-51251).
3.2	—Seventh Amended and Restated By-Laws of LifePoint Health, Inc. (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed November 3, 2016, File No. 000-51251).
4.1	—Form of Specimen Stock Certificate (incorporated by reference from exhibits to the Registration Statement on Form S-4, as amended, filed by Historic LifePoint Hospitals, Inc. on October 25, 2004, File No. 333-119929).
4.2	—Indenture, dated as of December 6, 2013, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Bank of New York Mellon Trust Company, N.A. as trustee (including the Form of 5.5% Senior Note due 2021) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed December 9, 2013, File No. 000-51251).

4.3 — Senior Debt Securities Indenture, dated as of December 4, 2015, by and between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed December 4, 2015, File No. 000-51251).

4.4 — Supplemental Indenture, dated as of December 4, 2015, by and among the Company, the Guarantors party thereto, and The Bank of New York Mellon Trust Company, N.A., as trustee (including the form of 5.875% Senior Notes due 2023) (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed December 4, 2015, File No. 000-51251).

4.5 — Indenture, dated as of May 26, 2016, by and among Lifepoint Health, Inc., the Guarantors (as defined therein) and Bank of New York Mellon Trust Company, N.A., as trustee (including the Form of 5.375% Senior Note due 2024) (incorporated by reference from exhibits to the Lifepoint Health, Inc. Current Report on Form 8-K filed May 26, 2016, File No. 000-51251).

4.6 — Registration Rights Agreement, dated as of May 26, 2016, by and among LifePoint Health, Inc., the Guarantors (as defined therein) and Goldman, Sachs & Co. as representative of the several initial purchasers (incorporated by reference from exhibits to the Lifepoint Health, Inc. Current Report on Form 8-K filed May 26, 2016, File No. 000-51251).

10.1 — Computer and Data Processing Services Agreement dated May 19, 2008, by and between HCA Information Technology Services, Inc. and LifePoint Hospitals, Inc. (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed May 21, 2008, File No. 000-51251).

10.2 — Amendment to the Computer and Data Processing Services Agreement, dated June 13, 2012, by and between HCA – Information Technology & Services, Inc. and LifePoint Corporate Services, General Partnership (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2012, File No. 000-51251).

10.3 — LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan, dated June 30, 2005, as amended by the Amendment dated May 13, 2008, the Amendment dated December 10, 2008, the Amendment dated April 27, 2010, and the Amendment dated June 8, 2010, the Amendment dated April 23, 2012 and the Amendment dated June 5, 2012 (incorporated by reference from Appendices A and B to the LifePoint Hospitals, Inc. Proxy Statement filed April 23, 2012, File No. 000-51251).*

10.4 — Form of LifePoint Hospitals, Inc. Restricted Stock Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*

10.5 — LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from Appendix C to the Historic LifePoint Hospitals, Inc. Proxy Statement dated April 28, 2004, File No. 000-29818).*

10.6 — First Amendment, dated December 10, 2008, to the LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2008, File No. 000-51251).*

10.7 — Amendment No. 2 to the LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed June 6, 2014, File No. 000-51251).*

10.8 — Form of LifePoint Hospitals, Inc. Performance Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*

10.9 — LifePoint Hospitals, Inc. Change in Control Severance Plan, as amended and restated (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed December 16, 2008, File No. 000-51251).*

10.10 — LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan, dated January 1, 2003, as amended by the Amendment dated May 22, 2003, the Amendment dated May 13, 2008, the Amendment dated December 10, 2008, the Amendment dated March 24, 2009, the Amendment dated April 27, 2010, and the Amendment dated June 8, 2010 (incorporated by reference from Appendix C and D to the LifePoint Hospitals, Inc. Proxy Statement filed April 29, 2010, File No. 000-51251).*

10.11 — Amendment, dated April 18, 2012 to the LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan (incorporated by reference from exhibits to LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2012, File No. 000-51251).*

10.12 — Form of Outside Directors Restricted Stock Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2006, File No. 000-51251).*

10.13 — LifePoint Hospitals, Inc. Amended and Restated Outside Directors Stock and Incentive Compensation Plan, dated May 12, 2009, as amended by the Amendment dated April 27, 2010, the Amendment dated June 8, 2010 and the Amendment dated June 5, 2012 (incorporated by reference from Appendix C and D to the LifePoint Hospitals, Inc. Proxy Statement filed April 23, 2012, File No. 000-51251).*

10.14 — Form of LifePoint Hospitals, Inc. Deferred Restricted Stock Award (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*

10.15 — LifePoint Health Deferred Compensation Plan Amended and Restated Effective January 1, 2016 (filed herewith).*

10.16 — Credit Agreement, dated as of June 10, 2016, among LifePoint Health, Inc., as borrower, the lenders referred to therein, and Citibank, N.A. as administrative agent (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed June 13, 2016, File No. 000-51251).

10.17 — Executive Severance and Restrictive Covenant Agreement, dated December 11, 2008, by and between LifePoint CSGP, LLC and William F. Carpenter III (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2008, File No. 000-51251).*

TABLE OF CONTENTS

10.18	—	First Amendment to the Amended and Restated Executive Severance and Restrictive Covenant Agreement, dated December 11, 2012, by and between HSCGP, LLC and William F. Carpenter III (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed December 17, 2012, File No. 000-51251).*
10.19	—	Recoupment Policy Relating to Unearned Incentive Compensation of Executive Officers (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed May 20, 2008, File No. 000-51251).*
10.20	—	LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan (incorporated by reference from Appendix A to the LifePoint Hospitals, Inc. Proxy Statement filed April 24, 2013, File No. 000-51251).*
10.21	—	Amendment to the LifePoint Health, Inc. 2013 Long-Term Incentive Plan, dated June 2, 2015 (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed June 4, 2015, File No. 000-51251).*
10.22	—	Amendment to the LifePoint Health, Inc. 2013 Long-Term Incentive Plan, dated January 23, 2017 (filed herewith).*
10.23	—	Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement (Performance-Based Vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*
10.24	—	Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*
10.25	—	Form of LifePoint Hospitals, Inc. Nonqualified Stock Option Agreement for the LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*
10.26	—	Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement for non-employee directors (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2013, File No. 000-51251).*
10.27	—	

		Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Outside Director Restricted Stock Unit Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*
10.28	—	Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Restricted Stock Unit Award Agreement (time-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*
10.29	—	Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Restricted Stock Unit Award Agreement (performance-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*
10.30	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Restricted Stock Unit Agreement (performance-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2014, File No. 000-51251).*
10.31	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Restricted Stock Unit Agreement (performance-based vesting; deferral provision) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2014, File No. 000-51251).*
10.32	—	Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Restricted Stock Unit Agreement (performance-based vesting; deferral provision) (incorporated by reference from exhibits to the LifePoint Health, Inc. Annual Report on Form 10-K for the year ended December 31, 2015, File No. 000-51251).*

TABLE OF CONTENTS

10.33 — Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Non-Qualified Stock Option Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2014, File No. 000-51251).*

10.34 — Form of Indemnification Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, File No. 000-51251).*

12.1 — Ratio of Earnings to Fixed Charges

21.1 — List of Subsidiaries

23.1 — Consent of Independent Registered Public Accounting Firm

31.1 — Certification of the Chief Executive Officer of LifePoint Health, Inc. pursuant to Section 302 of the Sarbanes-Oxley Act of 2002

31.2 — Certification of the Chief Financial Officer of LifePoint Health, Inc. pursuant to Section 302 of the Sarbanes Oxley Act of 2002

32.1 — Certification of the Chief Executive Officer of LifePoint Health, Inc. pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

32.2 — Certification of the Chief Financial Officer of LifePoint Health, Inc. pursuant to Section 906 of the Sarbanes Oxley Act of 2002

101.INS — XBRL Instance Document**

101.SCH — XBRL Taxonomy Extension Schema Document**

101.CAL — XBRL Taxonomy Calculation Linkbase Document**

101.DEF — XBRL Taxonomy Definition Linkbase Document**

101.LAB —XBRL Taxonomy Label Linkbase Document**

101.PRE —XBRL Taxonomy Presentation Linkbase Document**

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*- Management Compensation Plan or Arrangement

** - Furnished electronically herewith

Item 16. Form 10-K Summary.

None.

TABLE OF CONTENTS

INDEX TO FINANCIAL STATEMENTS

	Page
Management's Report on Internal Control Over Financial Reporting	F-2
Report of Independent Registered Public Accounting Firm	F-3
Report of Independent Registered Public Accounting Firm	F-4
Consolidated Statements of Operations - for the years ended December 31, 2016 , 2015 and 2014	F-5
Consolidated Statements of Comprehensive Income - for the years ended December 31, 2016 , 2015 and 2014	F-6
Consolidated Balance Sheets - December 31, 2016 and 2015	F-7
Consolidated Statements of Cash Flows - for the years ended December 31, 2016 , 2015 and 2014	F-8
Consolidated Statements of Stockholders' Equity - for the years ended December 31, 2016 , 2015 and 2014	F-9
Notes to Consolidated Financial Statements - December 31, 2016	F-10

Management’s Report on Internal Control Over Financial Reporting

Management of LifePoint Health, Inc. is responsible for the preparation, integrity and fair presentation of its published consolidated financial statements. The financial statements have been prepared in accordance with U.S. generally accepted accounting principles and, as such, include amounts based on judgments and estimates made by management. The Company also prepared the other information included in the annual report and is responsible for its accuracy and consistency with the consolidated financial statements.

Management is also responsible for establishing and maintaining effective internal control over financial reporting. The Company’s internal control over financial reporting includes those policies and procedures that pertain to the Company’s ability to record, process, summarize and report reliable financial data. The Company maintains a system of internal control over financial reporting, which is designed to provide reasonable assurance to the Company’s management and Board of Directors regarding the preparation of reliable published financial statements and safeguarding of the Company’s assets. The system includes a documented organizational structure and division of responsibility, established policies and procedures, including a code of conduct to foster a strong ethical climate, which are communicated throughout the Company, and the careful selection, training and development of our people.

The Board of Directors, acting through its Audit and Compliance Committee, is responsible for the oversight of the Company’s accounting policies, financial reporting and internal control. The Audit and Compliance Committee of the Board of Directors is comprised entirely of outside directors who are independent of management. The Audit and Compliance Committee is responsible for the appointment and compensation of the independent registered public accounting firm. It meets periodically with management, the independent registered public accounting firm and the internal auditors to ensure that they are carrying out their responsibilities. The Audit and Compliance Committee is also responsible for performing an oversight role by reviewing and monitoring the financial, accounting and auditing procedures of the Company in addition to reviewing the Company’s financial reports. Internal auditors monitor the operation of the internal control system and report findings and recommendations to management and the Audit and Compliance Committee. Corrective actions are taken to address control deficiencies and other opportunities for improving the internal control system as they are identified. The independent registered public accounting firm and the internal auditors have full and unlimited access to the Audit and Compliance Committee, with or without management, to discuss the adequacy of internal control over financial reporting, and any other matters which they believe should be brought to the attention of the Audit and Compliance Committee.

Management recognizes that there are inherent limitations in the effectiveness of any system of internal control over financial reporting, including the possibility of human error and the circumvention or overriding of internal control. Accordingly, even effective internal control over financial reporting can provide only reasonable assurance with respect to financial statement preparation and may not prevent or detect misstatements. Further, because of changes in conditions, the effectiveness of internal control over financial reporting may vary over time.

The Company assessed its internal control system as of December 31, 2016 in relation to criteria for effective internal control over financial reporting described in “Internal Control — Integrated Framework” issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework). Based on its assessment, the Company has determined that, as of December 31, 2016, its system of internal control over financial reporting was effective.

The Company acquired Providence Hospitals effective February 1, 2016. The Company excluded these hospitals from its assessment of and conclusion on the effectiveness of its internal control over financial reporting. As of December 31, 2016, these hospitals constituted $166.0 million of total assets, and $231.7 million of revenues for the year then ended.

The consolidated financial statements have been audited by the independent registered public accounting firm of Ernst & Young LLP, which was given unrestricted access to all financial records and related data, including minutes of all meetings of stockholders, the Board of Directors and committees of the Board. Reports of the independent registered public accounting firm, which includes the independent registered public accounting firm's attestation report on the Company's internal control over financial reporting, are also presented within this document.

/s/ William F. Carpenter III	/s/ Michael S. Coggin
Chief Executive Officer and	Executive Vice President and
Chairman of the Board of Directors	Chief Financial Officer

Brentwood, Tennessee
February 17, 2017

TABLE OF CONTENTS

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders of LifePoint Health, Inc.

We have audited LifePoint Health, Inc.'s (the "Company") internal control over financial reporting as of December 31, 2016, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework) (the COSO criteria). The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

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

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

As indicated in the accompanying Management's Report on Internal Control over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Providence Hospitals, which are included in the 2016 consolidated financial statements of LifePoint Health, Inc. and constituted $166.0 million total assets as of December 31, 2016 and $231.7 million of revenues for the year then ended. Our audit of internal control over financial reporting of the Company also did not include an evaluation of the internal control over financial reporting of Providence Hospitals.

In our opinion, LifePoint Health, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of LifePoint Health, Inc. as of December 31, 2016 and 2015 and the related consolidated statements of operations, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2016 of LifePoint Health, Inc. and our report dated February 17, 2017 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 17, 2017

TABLE OF CONTENTS

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders of LifePoint Health, Inc.

We have audited the accompanying consolidated balance sheets of LifePoint Health, Inc. (the "Company") as of December 31, 2016 and 2015, and the related consolidated statements of operations, comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2016. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

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

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of LifePoint Health, Inc. at December 31, 2016 and 2015, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2016, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), LifePoint Health, Inc.'s internal control over financial reporting as of December 31, 2016, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework) and our report dated February 17, 2017 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Nashville, Tennessee

February 17, 2017

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

CONSOLIDATED STATEMENTS OF OPERATIONS

For the Years Ended December 31, 2016, 2015 and 2014

(In millions, except per share amounts)

	2016	2015	2014
Revenues before provision for doubtful accounts	$ 7,273.6	$ 6,014.4	$ 5,300.9
Provision for doubtful accounts	909.6	800.1	817.8
Revenues	6,364.0	5,214.3	4,483.1
Salaries and benefits	3,047.4	2,496.9	2,134.5
Supplies	1,066.6	815.0	699.0
Other operating expenses	1,558.1	1,246.4	1,087.3
Other income	(29.9)	(49.7)	(71.9)
Depreciation and amortization	344.6	279.0	250.5
Interest expense, net	149.2	114.4	123.0
Debt transaction costs	22.0	-	-
Impairment charges	1.2	13.8	57.7
Other non-operating gain	-	(4.0)	-
	6,159.2	4,911.8	4,280.1
Income before income taxes	204.8	302.5	203.0
Provision for income taxes	73.0	109.5	68.1
Net income	131.8	193.0	134.9
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(9.9)	(11.1)	(8.8)
Net income attributable to LifePoint Health, Inc.	$ 121.9	$ 181.9	$ 126.1
Weighted average shares outstanding - basic	42.0	43.9	44.9
Effect of dilutive securities:			
Stock options and other stock-based awards	1.2	2.2	1.8
Convertible debt instruments	-	-	0.2
Weighted average shares outstanding - diluted	43.2	46.1	46.9

Earnings per share attributable to LifePoint Health, Inc. stockholders:

Basic	$ 2.90	$ 4.14	$ 2.81
Diluted	$ 2.82	$ 3.95	$ 2.69

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

For the Years Ended December 31, 2016, 2015 and 2014

(In millions)

	2016	2015	2014
Net income	$ 131.8	$ 193.0	$ 134.9
Other comprehensive (loss) income, net of income taxes:			
Unrealized (loss) gain on changes in funded status of pension benefit obligations, net of benefit (provision) for income taxes of $0.1, ($0.9) and $4.2 for the years ended December 31, 2016, 2015 and 2014, respectively	(0.1)	1.7	(7.8)
Other comprehensive (loss) income	(0.1)	1.7	(7.8)
Comprehensive income	131.7	194.7	127.1
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	(9.9)	(11.1)	(8.8)
Comprehensive income attributable to LifePoint Health, Inc.	$ 121.8	$ 183.6	$ 118.3

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

CONSOLIDATED BALANCE SHEETS

For the Years Ended December 31, 2016 and 2015

(In millions)

	2016	2015
ASSETS		
Current assets:		
Cash and cash equivalents	$ 96.1	$ 284.0
Accounts receivable, less allowances for doubtful accounts of $891.2 and $796.8 at December 31, 2016 and 2015, respectively	912.7	743.7
Inventories	154.3	127.7
Prepaid expenses	71.9	50.8
Other current assets	80.3	59.8
	1,315.3	1,266.0
Property and equipment:		
Land	191.6	162.8
Buildings and improvements	2,601.6	2,272.3
Equipment	2,237.7	1,767.8
Construction in progress (estimated costs to complete and equip after December 31, 2016 is $521.8)	178.3	119.4
	5,209.2	4,322.3
Accumulated depreciation	(2,142.4)	(1,840.0)
	3,066.8	2,482.3
Intangible assets, net	80.3	70.6
Other long-term assets	78.7	510.4
Goodwill	1,777.9	1,667.5
Total assets	$ 6,319.0	$ 5,996.8
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 261.2	$ 164.3
Accrued salaries	212.9	206.0
Income taxes payable	47.8	28.9
Other current liabilities	244.0	194.5
Current maturities of long-term debt	22.3	25.0
	788.2	618.7

Long-term debt, net	2,892.0	2,643.8
Deferred income taxes	50.0	94.4
Long-term portion of reserves for self-insurance claims	161.5	154.7
Other long-term liabilities	85.2	72.8
Total liabilities	3,976.9	3,584.4
Redeemable noncontrolling interests	113.7	103.6
Equity:		
LifePoint Health, Inc. stockholders' equity:		
Preferred stock, $0.01 par value; 10,000,000 shares authorized; no shares issued	-	-
Common stock, $0.01 par value; 90,000,000 shares authorized; 67,301,082 and 66,613,238 shares issued at December 31, 2016 and 2015, respectively	0.7	0.7
Capital in excess of par value	1,584.2	1,556.4
Accumulated other comprehensive loss	(2.8)	(2.7)
Retained earnings	1,776.9	1,655.0
Common stock in treasury, at cost, 27,358,126 and 23,480,203 shares at December 31, 2016 and 2015, respectively	(1,178.6)	(945.5)
Total LifePoint Health, Inc. stockholders' equity	2,180.4	2,263.9
Noncontrolling interests	48.0	44.9
Total equity	2,228.4	2,308.8
Total liabilities and equity	$ 6,319.0	$ 5,996.8

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

For the Years Ended December 31, 2016, 2015 and 2014

(In millions)

	2016	2015	2014
Cash flows from operating activities:			
Net income	$ 131.8	$ 193.0	$ 134.9
Adjustments to reconcile net income to net cash provided by operating activities:			
Stock-based compensation	29.4	30.0	27.3
Depreciation and amortization	344.6	279.0	250.5
Amortization of physician minimum revenue guarantees	9.9	12.0	14.7
Amortization of debt issuance costs, discounts and premium	5.4	5.1	14.0
Debt transaction costs	22.0	-	-
Impairment charges	1.2	13.8	57.7
Other non-operating gain	-	(4.0)	-
Deferred income taxes	(44.7)	(14.4)	22.8
Reserve for self-insurance claims, net of payments	25.4	17.9	11.7
Increase (decrease) in cash from operating assets and liabilities, net of effects from acquisitions and divestitures:			
Accounts receivable	(123.7)	38.7	(54.3)
Inventories, prepaid expenses and other current assets	(24.8)	19.9	(18.6)
Accounts payable, accrued salaries and other current liabilities	45.7	(24.7)	(14.4)
Income taxes payable/receivable	18.9	61.9	(35.5)
Other	(5.9)	(1.1)	1.5
Net cash provided by operating activities	435.2	627.1	412.3
Cash flows from investing activities:			
Purchases of property and equipment	(399.5)	(274.7)	(207.1)

Acquisitions, net of cash acquired	(121.1)	(619.4)	(265.6)
Proceeds from sale of hospital	-	18.8	-
Other	(0.1)	(1.0)	(0.5)
Net cash used in investing activities	(520.7)	(876.3)	(473.2)
Cash flows from financing activities:			
Proceeds from borrowings	1,350.0	500.0	412.0
Payments of borrowings	(1,186.3)	(16.9)	(585.4)
Repurchases of common stock	(233.1)	(134.5)	(222.3)
Payments of debt financing costs	(30.0)	(7.2)	(7.2)
Proceeds from exercise of stock options	12.1	11.5	23.9
Other	(15.1)	(11.2)	(6.5)
Net cash (used in) provided by financing activities	(102.4)	341.7	(385.5)
Change in cash and cash equivalents	(187.9)	92.5	(446.4)
Cash and cash equivalents at beginning of period	284.0	191.5	637.9
Cash and cash equivalents at end of period	$ 96.1	$ 284.0	$ 191.5
Supplemental disclosure of cash flow information:			
Interest payments	$ 138.8	$ 103.2	$ 112.8
Capitalized interest	$ 5.1	$ 2.2	$ 1.0
Income tax payments, net	$ 98.6	$ 62.0	$ 80.9

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

For the Years Ended December 31, 2016, 2015 and 2014

(In millions)

	LifePoint Health, Inc. Stockholders							
	Common Stock		Capital in Excess of	Accumulated Other Comprehensive Income	Retained	Treasury	Noncontrolling	
	Shares	Amount	Par Value	(Loss)	Earnings	Stock	Interests	Total
Balance at January 1, 2014	47.1	$ 0.7	$ 1,470.7	$ 3.4	$ 1,347.0	$ (611.7)	$ 22.5	$ 2,232.6
Net income	-	-	-	-	126.1	-	2.3	128.4
Other comprehensive loss	-	-	-	(7.8)	-	-	-	(7.8)
Exercise of stock options, tax benefits of stock-based awards and other	0.8	-	28.0	-	-	-	-	28.0
Stock-based compensation	-	-	27.3	-	-	-	-	27.3
Repurchases of common stock, at cost	(3.9)	-	-	-	-	(222.3)	-	(222.3)
Conversion of 3 ½ % Notes	0.6	-	(22.1)	-	-	23.0	-	0.9
Noncash change in noncontrolling interests as a result of acquisition and other	-	-	(7.7)	-	-	-	4.4	(3.3)
Cash distributions to noncontrolling interests	-	-	-	-	-	-	(1.9)	(1.9)
Balance at December 31, 2014	44.6	0.7	1,496.2	(4.4)	1,473.1	(811.0)	27.3	2,181.9
Net income	-	-	-	-	181.9	-	1.7	183.6

Other comprehensive income	-	-	-	1.7	-	-	-	1.7
Exercise of stock options and tax benefits of stock-based awards	0.3	-	19.4	-	-	-	-	19.4
Stock-based compensation	-	-	30.0	-	-	-	-	30.0
Repurchases of common stock, at cost	(1.8)	-	-	-	-	(134.5)	-	(134.5)
Issuance of warrant and reclassification of warrant liability	-	-	13.7	-	-	-	-	13.7
Noncash change in noncontrolling interests as a result of acquisition and other	-	-	(2.9)	-	-	-	18.3	15.4
Cash distributions to noncontrolling interests	-	-	-	-	-	-	(2.4)	(2.4)
Balance at December 31, 2015	43.1	0.7	1,556.4	(2.7)	1,655.0	(945.5)	44.9	2,308.8
Net income (loss)	-	-	-	-	121.9	-	(1.6)	120.3
Other comprehensive loss	-	-	-	(0.1)	-	-	-	(0.1)
Exercise of stock options and tax benefits of stock-based awards	0.7	-	12.1	-	-	-	-	12.1
Stock-based compensation	-	-	29.4	-	-	-	-	29.4
Repurchases of common stock, at cost	(3.9)	-	-	-	-	(233.1)	-	(233.1)
Noncash change in noncontrolling interests as a result of acquisition and other	-	-	(13.7)	-	-	-	6.6	(7.1)
Cash distributions to noncontrolling interests	-	-	-	-	-	-	(1.9)	(1.9)
Balance at December 31, 2016	39.9	$ 0.7	$ 1,584.2	$ (2.8)	$ 1,776.9	$ (1,178.6)	$ 48.0	$ 2,228.4

F-9

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Note 1. Organization and Summary of Significant Accounting Policies

Organization

LifePoint Health, Inc., a Delaware corporation, acting through its subsidiaries, owns and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities in 22 states throughout the United States ("U.S."). Unless the context otherwise indicates, LifePoint Health, Inc. and its subsidiaries are referred to herein as "LifePoint" or the "Company."

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and all subsidiaries and entities controlled by the Company through the Company's direct or indirect ownership of a majority interest and exclusive rights granted to the Company as the sole general partner or controlling member of such entities, including Duke LifePoint Healthcare, a joint venture between LifePoint and a wholly-controlled affiliate of Duke University Health System, Inc., and the Regional Health Network of Kentucky and Southern Indiana, a joint venture between LifePoint and Norton Healthcare, Inc. Additionally, the Company consolidates any entities for which it receives the majority of the entity's expected returns or is at risk for the majority of the entity's expected losses based upon its investment or financial interest in the entity. All significant intercompany accounts and transactions within the Company have been eliminated in consolidation.

In connection with certain acquisitions, the Company has entered into agreements to provide management and administrative support for the operations of seven hospitals. The Company has concluded that these hospitals qualify as variable interest entities in accordance with Accounting Standards Codification ("ASC") 810-10 "Consolidations" and, due to its economic interest in these hospitals combined with its agreements to provide management and administrative support, it is the primary beneficiary. Accordingly, the Company has consolidated the operations of these seven hospitals.

The Company accounts for its investments in entities in which the Company exhibits significant influence, but not control, in accordance with the equity method of accounting. The Company does not consolidate its equity method investments, but rather measures them at their initial costs and then subsequently adjusts their carrying values through income for their respective shares of the earnings or losses during the period.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles ("GAAP") requires management to make estimates and assumptions that affect the amounts reported in the Company's accompanying consolidated financial statements and notes to consolidated financial statements. Actual results could differ from those estimates.

General and Administrative Costs

The majority of the Company's expenses are "cost of revenue" items. Costs that could be classified as "general and administrative" by the Company would include its health support center overhead costs, which were $223.5 million, $235.5 million and $223.4 million for the years ended December 31, 2016, 2015 and 2014, respectively.

Fair Value of Financial Instruments

In accordance with ASC 825-10, "Financial Instruments", the fair value of the Company's financial instruments are further described as follows.

Cash and Cash Equivalents, Accounts Receivable and Accounts Payable

The carrying amounts reported in the accompanying consolidated balance sheets for cash and cash equivalents, accounts receivable and accounts payable approximate fair value because of the short-term maturity of these instruments.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Long-Term Debt

The carrying amounts and fair values of the Company's senior secured term loan facility (the "Term Facility") under its senior secured credit agreement with, among others, Citibank, N.A. as administrative agent, and the lenders party thereto (the "Senior Credit Agreement"), the prior senior secured term loan facility (the "Prior Term Facility") and prior senior secured incremental term loans (the "Incremental Term Loans") under its prior senior secured credit agreement with, among others, Citibank, N.A. as administrative agent, and the lenders party thereto (the "Prior Credit Agreement"), 6.625% unsecured senior notes due October 1, 2020 (the "6.625% Senior Notes"), 5.5% unsecured senior notes due December 1, 2021 (the "5.5% Senior Notes"), 5.875% unsecured senior notes due December 1, 2023 (the "5.875% Senior Notes") and 5.375% unsecured senior notes due May 1, 2024 (the "5.375% Senior Notes"), excluding unamortized debt issuance costs, discount and premium, as of December 31, 2016 and December 31, 2015 were as follows (in millions):

	Carrying Amount		Fair Value	
	December 31, 2016	December 31, 2015	December 31, 2016	December 31, 2015
Senior Credit Agreement:				
Term Facility	$ 691.3	$ -	$ 684.4	$ -
Prior Credit Agreement:				
Prior Term Facility	$ -	$ 405.0	$ -	$ 404.5
Incremental Term Loans	$ -	$ 222.6	$ -	$ 222.3
6.625% Senior Notes	$ -	$ 400.0	$ -	$ 414.0
5.5% Senior Notes	$ 1,100.0	$ 1,100.0	$ 1,127.5	$ 1,105.5
5.875% Senior Notes	$ 500.0	$ 500.0	$ 503.8	$ 506.3
5.375% Senior Notes	$ 500.0	$ -	$ 483.1	$ -

The fair values of the Company's long-term debt instruments were estimated based on the average bid and ask price as determined using published rates and categorized as Level 2 within the fair value hierarchy in accordance with ASC 820-10, "Fair Value Measurements and Disclosures" ("ASC 820-10"). On June 10, 2016, the Company repaid the outstanding balances of the Prior Term Facility and the Incremental Term Loans with the proceeds from the $700.0 million Term Facility. Additionally, on May 26, 2016, the Company issued $500.0 million aggregate principal amount of 5.375% Senior Notes and used the proceeds, in part, to redeem all $400.0 million aggregate principal amount of the outstanding 6.625% Senior Notes on June 13, 2016. These transactions are more fully discussed in Note 5.

Revenue Recognition and Accounts Receivable

Overview

The Company recognizes revenues in the period in which services are performed. Accounts receivable primarily consist of amounts due from third-party payors and patients. The Company's ability to collect outstanding receivables is critical to its results of operations and cash flows. Amounts the Company receives for treatment of patients covered by governmental programs such as Medicare and Medicaid and other third-party payors such as health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and other private insurers are generally less than the Company's established billing rates. Additionally, to provide for accounts receivable that could become uncollectible in the future, the Company establishes an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. Accordingly, the revenues and accounts receivable reported in the Company's consolidated financial statements are recorded at the net amount expected to be received.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

The Company's revenues by payor and approximate percentages of revenues were as follows for the years ended December 31, 2016, 2015 and 2014 (in millions):

	2016		2015		2014	
	Amount	Ratio	Amount	Ratio	Amount	Ratio
Medicare	$ 2,372.4	37.3 %	$ 1,894.9	36.3 %	$ 1,627.6	36.3 %
Medicaid	922.5	14.5	855.2	16.4	619.8	13.8
HMOs, PPOs and other private insurers	3,015.0	47.3	2,393.5	45.9	2,210.5	49.3
Self-pay	832.8	13.1	749.0	14.4	744.9	16.6
Other	130.9	2.1	121.8	2.3	98.1	2.2
Revenues before provision for doubtful accounts	7,273.6	114.3	6,014.4	115.3	5,300.9	118.2
Provision for doubtful accounts	(909.6)	(14.3)	(800.1)	(15.3)	(817.8)	(18.2)
Revenues	$ 6,364.0	100.0 %	$ 5,214.3	100.0 %	$ 4,483.1	100.0 %

Certain changes have been made to the Company's classification of historical sources of revenues. Primarily, the Company changed the classification of revenues related to its managed Medicare programs from HMOs, PPOs and other private insurers to Medicare for each of the periods presented above. This change had no impact on the Company's historical results of operations.

Contractual Discounts and Cost Report Settlements

The Company derives a significant portion of its revenues from Medicare, Medicaid and other payors that receive discounts from its established billing rates. The Company must estimate the total amount of these discounts to prepare its consolidated financial statements. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex and are subject to interpretation and adjustment. The Company estimates the allowance for contractual discounts on a payor-specific basis given its interpretation of the applicable regulations or contract terms. These interpretations sometimes result in payments that differ from the Company's estimates. Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management. Changes in estimates related to the allowance for contractual discounts affect revenues reported in the Company's accompanying consolidated statements of operations.

Cost report settlements under reimbursement agreements with Medicare, Medicaid and certain other payors are estimated and recorded in the period the related services are rendered and are adjusted in future periods as final

settlements are determined. There is a reasonable possibility that recorded estimates will change by a material amount in the near term. The net adjustments to estimated cost report settlements had the following impact to the Company's consolidated statements of operations for the years ended December 31, 2016, 2015 and 2014 (in millions, except per share amounts):

	Revenues	Net Income (Loss)	Diluted Earnings (Loss) Per Share
Year ended December 31, 2016	$ 6.3	$ 3.9	$ 0.09
Year ended December 31, 2015	$ (0.5)	$ (0.3)	$ (0.01)
Year ended December 31, 2014	$ 2.5	$ 1.6	$ 0.03

The net cost report settlements due to the Company at December 31, 2016 were $3.5 million and included under the caption "Accounts receivable" in the accompanying consolidated balance sheet. The net cost report settlements due from the Company at December 31, 2015 were $12.9 million and included under the caption "Other current liabilities" in the accompanying consolidated balance sheets. The Company's management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under these programs.

Charity Care

Self-pay revenues are derived primarily from patients who do not have any form of healthcare coverage. The revenues associated with self-pay patients are generally reported at the Company's gross charges. The Company evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs, as well as the local hospital's policy for charity care. The Company provides care without charge to certain patients that qualify under the local charity care policy of each of its hospitals. For the years ended December 31, 2016, 2015 and 2014, the Company estimates that its costs of care provided under its charity care programs approximated $32.5 million, $23.3 million and $21.2 million, respectively. The increase in the Company's estimated costs of charity care provided during the year ended December 31, 2016 as compared to the years ended December 31, 2015 and 2014 was primarily a result of the Company's 2016 acquisitions. The Company does not report a charity care patient's charges in revenues or in the provision for doubtful accounts as it is the Company's policy not to pursue collection of amounts related to these patients.

The Company's management estimates its costs of care provided under its charity care programs utilizing a calculated ratio of costs to gross charges multiplied by the Company's gross charity care charges provided. The Company's gross charity care charges include only services provided to patients who are unable to pay and qualify under the Company's local charity care policies. To the extent the Company receives reimbursement through the various governmental assistance programs in which it participates to subsidize its care of indigent patients, the Company does not include these patients' charges in its cost of care provided under its charity care program.

Provision and Allowance for Doubtful Accounts

To provide for accounts receivable that could become uncollectible in the future, the Company establishes an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. The primary uncertainty lies with uninsured patient receivables and deductibles, co-payments or other amounts due from individual patients.

The Company has an established process to determine the adequacy of the allowance for doubtful accounts that relies on a number of analytical tools and benchmarks to arrive at a reasonable allowance. No single statistic or measurement determines the adequacy of the allowance for doubtful accounts. Some of the analytical tools that the Company utilizes include, but are not limited to, historical cash collection experience, revenue trends by payor classification and revenue days in accounts receivable. Accounts receivable are written off after collection efforts have been followed in accordance with the Company's policies.

A summary of activity in the Company's allowance for doubtful accounts is as follows (in millions):

	Balances at Beginning of Year	Additions Recognized as a Reduction to Revenues	Accounts Written Off, Net of Recoveries	Balances at End of Year
Year ended December 31, 2016	$ 796.8	$ 909.6	$ (815.2)	$ 891.2
Year ended December 31, 2015	$ 709.5	$ 800.1	$ (712.8)	$ 796.8
Year ended December 31, 2014	$ 741.2	$ 817.8	$ (849.5)	$ 709.5

The allowances for doubtful accounts as a percentage of gross accounts receivable, net of contractual discounts were 49.4% and 51.7% as of December 31, 2016 and 2015, respectively. The decrease in the resulting ratio of the allowance for doubtful accounts as a percentage of gross accounts receivable, net of contractual discounts, at December 31, 2016 as compared to December 31, 2015 is primarily a result of our 2016 acquisitions. Additionally, as of December 31, 2016 and 2015, the allowances for doubtful accounts plus certain contractual allowances and discounts related to self-pay patients as a percentage of self-pay receivables were 92.6% and 88.9%, respectively.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Concentration of Revenues

During the years ended December 31, 2016, 2015 and 2014, approximately 51.8%, 52.7% and 50.1%, respectively, of the Company's revenues related to patients participating in the Medicare and Medicaid programs, collectively. The Company's management recognizes that revenues and receivables from government agencies are significant to the Company's operations, but it does not believe that there are significant credit risks associated with these government agencies. The Company's management does not believe that there are any other significant concentrations of revenues from any particular payor that would subject the Company to any significant credit risks in the collection of its accounts receivable.

The Company's revenues are particularly sensitive to regulatory and economic changes in certain states where the Company generates significant revenues. The following is an analysis by state of revenues as a percentage of the Company's total revenues for those states in which the Company generates significant revenues for the years ended December 31, 2016, 2015 and 2014:

		Revenue Concentration by State					
	Hospital Campuses in State as of December 31, 2016	2016		2015		2014	
		Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
North Carolina	9	$ 947.9	14.9 %	$ 580.3	11.1 %	$ 372.6	8.3 %
Kentucky	10	679.9	10.7	638.5	12.2	587.9	13.1
Virginia	6	661.8	10.4	641.9	12.3	624.4	13.9
Pennsylvania	4	562.5	8.8	566.5	10.9	*	*
Michigan	3	468.0	7.4	476.2	9.1	460.8	10.3
Georgia	2	453.7	7.1	*	*	*	*
Tennessee	10	450.1	7.1	420.7	8.1	404.5	9.0
New Mexico	2	320.4	5.0	287.3	5.5	266.5	5.9

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* - Not considered significant for the period presented.

Any changes in the current demographic, economic, competitive or regulatory conditions, or to Medicaid programs, in the above-mentioned states could have an adverse effect on the Company's revenues or results of operations.

Other Income

The American Recovery and Reinvestment Act of 2009 (“ARRA”) provides for incentive payments under the Medicare and Medicaid programs for certain hospitals and physician practices that demonstrate meaningful use of certified EHR technology. These provisions of ARRA, collectively referred to as the Health Information Technology for Economic and Clinical Health Act (the “HITECH Act”), are intended to promote the adoption and meaningful use of interoperable health information technology and qualified EHR technology.

The Company accounts for EHR incentive payments in accordance with ASC 450-30, “Gain Contingencies” (“ASC 450-30”). In accordance with ASC 450-30, the Company recognizes a gain for EHR incentive payments when its eligible hospitals and physician practices have demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information for the full cost report year that determines the final calculation of the EHR incentive payment is available. The demonstration of meaningful use is based on meeting a series of objectives and varies among hospitals and physician practices, between the Medicare and Medicaid programs and within the Medicaid program from state to state. Additionally, meeting the series of objectives in order to demonstrate meaningful use becomes progressively more stringent as its implementation is phased in through stages as outlined by the Centers for Medicare and Medicaid Services (“CMS”). EHR incentive payments are subject to audit and potential recoupment if it is determined that the Company’s hospitals did not meet the applicable meaningful use standards required in connection with such incentive payments. Furthermore, EHR incentive payments are subject to retrospective adjustment because the cost report data upon which the payments are based are further subject to audit.

For the years ended December 31, 2016, 2015 and 2014, the Company recognized $29.9 million, $49.7 million and $71.9 million in EHR incentive payments, respectively, under the Medicare and Medicaid HITECH Act programs, collectively. These payments are reflected separately in the accompanying consolidated statement of operations under the caption “Other income”. Amounts recognized as other income that the Company anticipates collecting in future periods, but that were uncollected as of the balance sheet date totaled approximately $10.9 million and $22.9 million as of December 31, 2016 and 2015, respectively, and are included in the accompanying consolidated balance sheets under the caption “Other current assets”.

The Company incurs both capital expenditures and operating expenses in connection with the implementation of its various EHR initiatives. The amount and timing of these expenditures does not directly correlate with the timing of the Company's receipt or recognition as other income of the EHR incentive payments. As the Company completes its full implementation of certified EHR technology in accordance with all three phases of the program, its EHR incentive payments will decline and ultimately end.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash on hand and marketable securities with original maturities of three months or less. The Company places its cash in financial institutions that are federally insured in limited amounts.

Inventories

Inventories are stated at the lower of cost (first-in, first-out) or market and are comprised of purchased items. These inventory items are primarily operating supplies used in the direct or indirect treatment of patients.

Long-Lived Assets

Property and Equipment

Purchases of property and equipment are recorded at cost. Property and equipment acquired in connection with business combinations are recorded at estimated fair value in accordance with the acquisition method of accounting as prescribed in ASC 805-10, "Business Combinations" ("ASC 805-10"). Routine maintenance and repairs are charged to expense as incurred. Expenditures that increase capacities or extend useful lives are capitalized. Fully depreciated assets are retained in property and equipment accounts until they are disposed of. Allocated interest on funds used to pay for the construction or purchase of major capital additions is included in the cost of each capital addition.

Depreciation is calculated by applying the straight-line method over the estimated useful lives of buildings and improvements and equipment. Assets under capital and financing leases are generally amortized using the straight-line method over the shorter of the estimated useful life of the assets or life of the lease term, excluding any lease renewals, unless the lease renewals are reasonably assured. Capitalized internal-use software costs are amortized over their expected useful life, which is generally four years. Useful lives are as follows:

	Years
Buildings and improvements (including those under capital leases and financing obligations)	10 - 40
Equipment	3 - 10

Equipment under capital leases	3 - 5

Depreciation expense was $342.4 million, $276.7 million and $247.6 million for the years ended December 31, 2016, 2015 and 2014, respectively. Amortization expense related to assets under capital leases and financing obligations and capitalized internal-use software costs are included in depreciation expense.

As of December 31, 2016, the majority of the Company's assets under capital leases and financing obligations are primarily comprised of prepaid capital leases. The Company's assets under capital leases and financing obligations are set forth in the following table at December 31, 2016 and 2015 (in millions):

	2016	2015
Buildings and improvements	$ 390.0	$ 305.6
Equipment	23.0	19.4
	413.0	325.0
Accumulated amortization	(127.7)	(108.6)
	$ 285.3	$ 216.4

The Company evaluates its long-lived assets for possible impairment whenever circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from estimated future cash flows, in accordance with ASC 360-10. Fair value estimates are derived from established market values of comparable assets or internal calculations of estimated future net cash flows. The Company's estimates of future cash flows are based on assumptions and projections it believes to be reasonable and supportable. The Company's assumptions take into account revenue and expense growth rates, patient volumes, changes in payor mix and changes in legislation and other payor payment patterns. These assumptions vary by type of facility.

During the year ended December 31, 2016, the Company recognized a pre-tax impairment charge of $1.2 million related to the write-off of certain capital assets which the Company determined were no longer a necessary component of its ongoing information technology strategy. As more fully discussed in Note 3, during the years ended December 31, 2015 and 2014, the Company recognized pre-tax impairment charges of $13.8 million and $57.7 million, respectively, in connection with the divestiture of certain of its hospitals. A portion of these charges related to the write-down of property and equipment to their estimated fair values.

Goodwill and Intangible Assets

The Company accounts for its acquisitions in accordance with ASC 805-10 using the acquisition method of accounting. Goodwill represents the excess of the cost of an acquired entity over the net amounts assigned to assets acquired and liabilities assumed. In accordance with ASC 350-10, "Intangibles — Goodwill and Other" ("ASC 350-10"), goodwill and intangible assets with indefinite lives are reviewed by the Company at least annually for impairment. The Company's business comprises a single reporting unit for impairment test purposes. For the purposes of these analyses, the Company's estimates of fair value are based on a combination of the income approach, which estimates the fair value of the Company based on its future discounted cash flows, and the market approach, which estimates the fair value of the Company based on comparable market prices. During the years ended December 31, 2016, 2015 and 2014, the Company performed its annual impairment tests as of October 1 and did not incur an impairment charge.

The Company's intangible assets relate to contract-based physician minimum revenue guarantees; non-competition agreements; certificates of need and certificates of need exemptions; and licenses, provider numbers, accreditations and other. Contract-based physician minimum revenue guarantees and non-competition agreements are amortized over the terms of the agreements. The certificates of need, certificates of need exemptions, licenses, provider numbers, accreditations and other have been determined to have indefinite lives and, accordingly, are not amortized. The Company's goodwill and intangible assets are further described in Note 4.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and

liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date. The Company assesses the likelihood that deferred tax assets will be recovered from future taxable income. To the extent the Company believes that recovery is not likely, a valuation allowance is established. To the extent the Company establishes a valuation allowance or increases this allowance, the Company must include an expense within the provision for income taxes in the consolidated statements of operations. The Company classifies interest and penalties related to its tax positions as a component of income tax expense. Income taxes are further described in Note 6.

Point of Life Indemnity, Ltd.

The Company operates, with approval from the Cayman Islands Monetary Authority, a captive insurance company under the name Point of Life Indemnity, Ltd. Through this wholly-owned subsidiary of the Company, the captive insurance company issues malpractice insurance policies to certain of the Company's employed physicians in addition to providing compensation deductible coverage. Fees charged to these employed physicians are eliminated in consolidation. Reserves for the Company's estimate of the related outstanding claims, including incurred but not reported losses, are actuarially determined and are included as a component of the Company's reserves for professional liability self-insurance claims, as further discussed in this note.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Reserves for Self-Insurance Claims

Given the nature of the Company's operating environment, it is subject to potential professional liability claims, employee workers' compensation claims and other claims. To mitigate a portion of this risk, the Company maintains insurance for individual professional liability claims and employee workers' compensation claims exceeding self-insured retention and deductible levels. The Company's self-insured retention level for professional liability claims is $5.0 million per claim at December 31, 2016 with a $5.0 million inner aggregate per claim. Additionally, the Company's deductible for workers' compensation claims is $1.0 million per claim in all states in which it operates except for Wyoming. The Company participates in a state specific program in Wyoming for its workers' compensation claims arising in this state. The Company's self-insured retention and deductible levels are evaluated annually as a part of its insurance program's renewal process.

The Company's reserves for self-insurance and deductible claims reflect the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations as of the balance sheet date. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances. The Company's expense for self-insurance and deductible claims coverage each year includes: the actuarially determined estimate of losses for the current year, including claims incurred but not reported; the change in the estimate of losses for prior years based upon actual claims development experience as compared to prior actuarial projections; the insurance premiums for losses in excess of the Company's self-insured retention and deductible levels; the administrative costs of the insurance program; and interest expense related to the discounted portion of the liability. The Company's expense for self-insurance and deductible claims was approximately $76.9 million, $56.4 million and $50.6 million for the years ended December 31, 2016, 2015 and 2014, respectively. The Company experienced an increase in its insurance expenses for the year ended December 31, 2016 primarily as a result of recording an accrual for loss contingencies for cardiology-related legal proceedings as described further in Note 11.

The Company's reserves for professional liability claims are based upon quarterly actuarial calculations. The Company's reserves for employee workers' compensation claims are based upon semi-annual actuarial calculations. These reserve calculations consider historical claims data, demographic considerations, severity factors and other actuarial assumptions, which are discounted to present value. The Company's reserves for self-insured claims have been discounted to their present value using a discount rate of 1.31%, 1.35% and 1.50% at December 31, 2016, 2015 and 2014, respectively. The Company's management selects a discount rate by considering a risk-free interest rate that corresponds to the period when the self-insured claims are incurred and projected to be paid.

Professional and general liability claims are typically resolved over an extended period of time, often as long as five years or more, while workers' compensation claims are typically resolved in one to two years. Accordingly, the Company's reserves for self-insured claims, comprised of estimated indemnity and expense payments related to reported events and incurred but not reported events as of the end of the period, include both a current and long-term component. The current portion of the Company's reserves for self-insured claims is included under the caption "Other current liabilities" and the long-term portion is included under the caption "Long-term portion of reserves for

self-insurance claims" in the accompanying consolidated balance sheets.

The following table provides information regarding the classification of the Company's reserves for self-insured claims at December 31, 2016 and 2015 (in millions):

	2016	2015
Current portion	$ 81.1	$ 41.5
Long-term portion	161.5	154.7
	$ 242.6	$ 196.2

The combination of changing conditions and the extended time required for claim resolution results in a loss estimation process that requires actuarial skill and the application of judgment, and such estimates require periodic revision. As a result of the variety of factors that must be considered, there is a risk that actual incurred losses may develop differently from estimates. The results of the Company's quarterly and semi-annual actuarial calculations resulted in changes to its reserves for self-insured claims for prior years. As a result, for the years ended December 31, 2016, 2015 and 2014, the Company's related self-insured claims expense decreased by $31.0 million, $21.7 million and $9.8 million, which increased net income by approximately $19.4 million, $13.5 million and $6.4 million, or $0.45, $0.29 and $0.14 per diluted share, respectively.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Self-Insured Medical Benefits

The Company is self-insured for substantially all of the medical expenses and benefits of its employees. The reserve for medical benefits primarily reflects the current estimate of incurred but not reported losses based upon an annual actuarial calculation as of the balance sheet date. The undiscounted reserve for self-insured medical benefits was $39.4 million and $28.5 million at December 31, 2016 and 2015, respectively, and is included in the Company's accompanying consolidated balance sheets under the caption "Other current liabilities".

Noncontrolling Interests and Redeemable Noncontrolling Interests

Noncontrolling interests represent the portion of equity in a subsidiary not attributable, directly or indirectly, to a parent. The Company's accompanying consolidated financial statements include all assets, liabilities, revenues and expenses at their consolidated amounts, which include the amounts attributable to the Company and the noncontrolling interest. The Company recognizes as a separate component of equity and earnings on the portion of income or loss attributable to noncontrolling interests based on the portion of the entity not owned by the Company.

The following table presents the changes in the Company's noncontrolling interests during the years ended December 31, 2016 and 2015 (in millions):

Balance at January 1, 2015	$ 27.3
Net income attributable to noncontrolling interests	1.7
Noncash change as a result of acquisition and other	18.3
Distributions	(2.4)
Balance at December 31, 2015	44.9
Net loss attributable to noncontrolling interests	(1.6)
Noncash change as a result of acquisition and other	6.6
Distributions	(1.9)
Balance at December 31, 2016	$ 48.0

Certain of the Company's noncontrolling interests include redemption features that cause these interests not to meet the requirements for classification as equity in accordance with ASC 480-10-S99-3, "Distinguishing Liabilities from Equity". Redemption features related to these interests, if exercised, would currently require the Company to deliver cash. Accordingly, these redeemable noncontrolling interests are classified in the mezzanine section of the Company's accompanying consolidated balance sheets under the caption "Redeemable noncontrolling interests". Changes in the fair value of the Company's redeemable noncontrolling interests are recognized as adjustments to consolidated stockholders' equity.

The following table presents the changes in the Company's redeemable noncontrolling interests during the years ended December 31, 2016 and 2015 (in millions):

Balance at January 1, 2015	$ 87.1
Net income attributable to redeemable noncontrolling interests	9.4
Noncash change as a result of acquisition and other	8.0
Fair value adjustments	3.6
Distributions	(4.5)
Balance at December 31, 2015	103.6
Net income attributable to redeemable noncontrolling interests	11.5
Noncash change as a result of acquisition and other	(0.8)
Fair value adjustments	8.0
Distributions	(8.6)
Balance at December 31, 2016	$ 113.7

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Segment Reporting

The Company provides healthcare services. Accordingly, the Company has one operating segment, healthcare services, for segment reporting purposes in accordance with ASC 280-10, "Segment Reporting". Additionally, the Company has one reporting unit for goodwill impairment testing in accordance with ASC 350-10.

Stock-Based Compensation

The Company issues stock-based awards to key employees and directors under various stockholder-approved stock-based compensation plans, as further described in Note 9. The Company accounts for its stock-based awards in accordance with the provisions of ASC 718-10 "Compensation — Stock Compensation", ("ASC 718-10"). In accordance with ASC 718-10, the Company recognizes compensation expense over each of the stock-based award's requisite service period based on the estimated grant date fair value of each stock-based award.

Deferred Cash Awards

The Company grants deferred cash awards to certain employees that are subject to continuing service requirements and a ratable vesting term of three years. The Company recognizes compensation expense for these awards over their requisite service period. For the years ended December 31, 2016, 2015 and 2014, expense related to the Company's deferred cash awards was approximately $10.4 million, $8.6 million and $7.6 million, respectively. As of December 31, 2016, there was $15.3 million of total estimated unrecognized compensation costs related to deferred cash awards arrangements. The Company expects to recognize this cost over a weighted average period of 1.3 years.

Defined Contribution Plans

The Company maintains multiple defined contribution retirement plans that cover a majority of the Company's employees with a discretionary matching policy based on the Company's financial performance and definite contribution formulas for employees at certain facilities. The Company's expense related to its defined contribution plans was $27.3 million, $23.6 million and $24.5 million for the years ended December 31, 2016, 2015 and 2014, respectively.

Defined Benefit Pension Plans

The Company maintains certain defined benefit pension plans for a small population of the Company's employees. The Company accounts for its defined benefit pension plans in accordance with ASC 715-30 "Compensation – Defined Benefit Plans", ("ASC 715-30"). In accordance with ASC 715-30, the Company recognizes the unfunded liability of its defined benefit pension plans in the Company's consolidated balance sheets and unrecognized gains (losses) and prior

service credits (costs) as changes in other comprehensive income (loss). The measurement date of the defined benefit pension plans' assets and liabilities coincides with the Company's year-end. The Company's pension benefit obligation is measured using actuarial calculations that incorporate discount rates, rate of compensation increases, when applicable, expected long-term returns on plan assets and consider expected age of retirement and mortality. The Company's defined benefit pension plans are described further in Note 10.

Earnings Per Share ("EPS")

EPS is based on the weighted average number of common shares outstanding and the effect of stock options, other stock-based awards, common stock warrants and convertible debt instruments, when dilutive. The Company's previously outstanding convertible debt instrument was included in the calculation of diluted earnings per share for the year ended December 31, 2014 whether or not the contingent requirements were met for conversion when its conversion price was less than the average market price of the Company's common stock for the period the convertible debt instrument was outstanding.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Adoption of Recently Issued Accounting Standards

ASU 2015-16, “Business Combinations: Simplifying the Accounting for Measurement-Period Adjustments”

In September 2015, the Financial Accounting Standards Board (“FASB”) issued Accounting Standards Update (“ASU”) 2015-16, “Business Combinations: Simplifying the Accounting for Measurement-Period Adjustments” (“ASU 2015-16”). ASU 2015-16 eliminates the requirement for an acquirer to retrospectively adjust its financial statements for changes to provisional amounts that are identified during the measurement-period following the consummation of a business combination. Instead, ASU 2015-16 requires these types of adjustments to be made during the reporting period in which they are identified and would require additional disclosure or separate presentation of the portion of the adjustment that would have been recorded in the previously reported periods as if the adjustment to the provisional amounts had been recognized as of the acquisition date. The Company adopted ASU 2015-16 during the first quarter of 2016, which had no impact on the Company’s financial position, results of operation, cash flows or financial disclosures.

ASU 2015-5, “Intangibles – Goodwill and Other – Internal-Use Software”

In April 2015, the FASB issued ASU 2015-5, “Intangibles - Goodwill and Other - Internal-Use Software” (“ASU 2015-5”). ASU 2015-5 provides guidance to customers about whether a cloud computing arrangement includes a software license. If a cloud computing arrangement includes a software license, ASU 2015-5 specifies that the customer should account for the software license element of the arrangement consistent with the acquisition of other software licenses. ASU 2015-5 further specifies that the customer should account for a cloud computing arrangement as a service contract if the arrangement does not include a software license. The Company prospectively adopted the provisions of ASU 2015-5 during the first quarter of 2016, which had no material impact on the Company’s financial position, results of operation, cash flows or financial disclosures.

ASU 2015-2, “Consolidation”

In February 2015, the FASB issued ASU 2015-2 “Consolidation” (“ASU 2015-2”). ASU 2015-2 includes amendments that are intended to improve targeted areas of consolidation for legal entities including reducing the number of consolidation models from four to two and simplifying the FASB Accounting Standards Codification. The Company

adopted ASU 2015-2 during the first quarter of 2016, which had no impact on the Company's financial position, results of operation, cash flows or financial disclosures.

Accounting Standards Not Yet Adopted

ASU 2016-9, "Compensation – Stock Compensation: Improvements to Employee Share-Based Payment Accounting"

In March 2016, the FASB issued ASU 2016-9 "Compensation – Stock Compensation: Improvements to Employee Share-Based Payment Accounting" ("ASU 2016-9"). ASU 2016-9 changes certain aspects of accounting for share-based payment awards to employees, including the accounting for income taxes, application of estimated rates of forfeiture and statutory tax withholding requirements. ASU 2016-9 is effective for annual reporting periods beginning after December 15, 2016, including interim periods within those years. The Company anticipates that the adoption of ASU 2016-9 will primarily impact its results of operations for the recognition of excess tax benefits or deficits related to the settlement of share-based payment awards in its provision for income taxes rather than through stockholders' equity. However, the Company does not anticipate that its adoption of ASU 2016-9 will result in a significant impact to its financial position or cash flows.

ASU 2016-2, "Leases"

In February 2016, the FASB issued ASU 2016-2 "Leases" ("ASU 2016-2"). ASU 2016-2 requires the rights and obligations arising from lease contracts, including existing and new arrangements, to be recognized as assets and liabilities on the balance sheet. ASU 2016-2 is effective for annual reporting periods beginning after December 15, 2018, including interim periods within those years. Early adoption is permitted. The Company anticipates that the adoption of ASU 2016-2 will result in an increase in both total assets and total liabilities. The Company is still evaluating the impact that the adoption of this standard will have on its policies, procedures and control framework.

ASU 2014-9, "Revenue from Contracts with Customers"

In May 2014, the FASB issued ASU 2014-9, "Revenue from Contracts with Customers", together along with subsequent amendments, updates and an extension of the effective date, (collectively the "New Revenue Standard"), which supersedes most existing revenue recognition guidance, including industry-specific healthcare guidance. The New Revenue Standard provides for a single comprehensive principles-based standard for the recognition of revenue across all industries through the application of the following five-step process:

Step 1: Identify the contract(s) with a customer.

Step 2: Identify the performance obligations in the contract.

Step 3: Determine the transaction price.

Step 4: Allocate the transaction price to the performance obligations in the contract.

Step 5: Recognize revenue when (or as) the entity satisfies a performance obligation.

This five-step process will require significant management judgment in addition to changing the way many companies recognize revenue in their financial statements. Additionally, and among other provisions, the New Revenue Standard requires expanded quantitative and qualitative disclosures, including disclosure about the nature, amount, timing and uncertainty of revenue.

The provisions of the New Revenue Standard are effective for annual periods beginning after December 15, 2017, including interim periods within those years by applying either the full retrospective method or the cumulative catch-up transition method. The full retrospective method requires application of the provisions of the New Revenue Standard for all periods presented while the cumulative catch-up transition method requires the application of the provisions of the New Revenue Standard as of the date of adoption with the cumulative effect of the retrospective application of the provisions as an adjustment through retained earnings. Currently, the Company anticipates adopting the provisions of the New Revenue Standard using the full retrospective method for all periods presented. Early adoption is permitted starting with annual periods beginning after December 31, 2016. The Company does not plan to

early adopt.

As the Company progresses with its implementation efforts to adopt the New Revenue Standard, management continues to evaluate and refine its estimates of the anticipated impacts it will have on its revenue recognition policies, procedures, financial position, results of operations, cash flows, financial disclosures and control framework. Specifically, the Company is continuing to evaluate its population of revenue sources to determine an appropriate level of stratification, as well as assess all of the potential effects the New Revenue Standard will have on variable consideration arising from settlements with third party payors, disproportionate share hospital payments and bundled payments. However, the Company does anticipate that, as a result of certain changes required by the New Revenue Standard, the majority of its provision for doubtful accounts will be recognized as a direct reduction to revenues, instead of separately as a deduction to arrive at revenue.

Note 2. Acquisitions

2016 Acquisitions

Central North Carolina Market

Effective January 1, 2016, through Duke LifePoint Healthcare, the Company acquired Frye Regional Medical Center (“Frye”), a 355 bed acute care hospital located in Hickory, North Carolina and Central Carolina Hospital (“Central Carolina”), a 137 bed acute care hospital located in Sanford, North Carolina for approximately $191.9 million in cash, including net working capital, excluding accounts receivable, plus the assumption of certain capital lease obligations of approximately $86.4 million. The purchase price of Frye and Central Carolina, which was paid on December 31, 2015, was reflected as a deposit and was included under the caption “Other long-term assets” in the accompanying consolidated balance sheet as of December 31, 2015. The results of operations of Frye and Central Carolina are included in the Company’s results of operations beginning on January 1, 2016.

St. Francis Hospital (“St. Francis”)

Effective January 1, 2016, the Company acquired St. Francis Hospital, a 376 bed acute care hospital located in Columbus, Georgia for approximately $241.3 million, net of cash acquired. The purchase price of St. Francis, which was paid on December 31, 2015, was reflected as a deposit and was included under the caption “Other long-term assets” in the accompanying consolidated balance sheet as of December 31, 2015. The results of operations of St. Francis are included in the Company’s results of operations beginning on January 1, 2016.

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Providence Hospitals ("Providence")

Effective February 1, 2016, the Company acquired Providence Hospitals for approximately $131.1 million, including net working capital, net of cash acquired. Providence is comprised of Providence Hospital (Downtown), a 258 bed acute care hospital, and Providence Hospital Northeast, a 74 bed acute care hospital, each located in Columbia, South Carolina. The results of operations of Providence are included in the Company's results of operations beginning on February 1, 2016.

The final fair values assigned to the assets acquired and liabilities assumed at the date of acquisition in connection with the Company's 2016 hospital acquisitions in the aggregate were as follows (in millions):

Current assets	$	93.2
Property and equipment		518.2
Intangible assets		14.4
Other long-term assets		2.9
Goodwill		109.9
Total assets acquired, excluding cash		738.6
Current liabilities		(78.2)
Long-term debt		(83.5)
Other long-term liabilities		(12.6)
Total liabiliites assumed		(174.3)
Net assets acquired	$	564.3

2015 Acquisitions

Watertown Regional Medical Center ("Watertown")

Effective September 1, 2015, the Company acquired an 80% interest in an entity that owns and operates Watertown, a 95 bed acute care hospital located in Watertown, Wisconsin for total consideration, including 80% of

the net working capital, of approximately $32.9 million, comprised of $30.9 million in cash and the issuance of a warrant with an estimated fair value of $2.0 million. The Company's common stock warrants are described further in Note 8. The results of operations of Watertown are included in the Company's results of operations beginning on September 1, 2015.

Clark Memorial Hospital ("Clark Memorial")

Effective August 1, 2015, through its joint venture with Norton Healthcare, Inc., the Regional Health Network of Kentucky and Southern Indiana ("RHN"), the Company acquired Clark Memorial, a 236 bed acute care hospital located in Jeffersonville, Indiana for approximately $56.5 million, including net working capital. The results of operations of Clark Memorial are included in the Company's results of operations beginning on August 1, 2015.

Fleming County Hospital ("Fleming")

Effective August 1, 2015, the Company acquired Fleming, a 52 bed acute care hospital located in Flemingsburg, Kentucky for approximately $21.8 million, including net working capital. The results of operations of Fleming are included in the Company's results of operations beginning on August 1, 2015.

Nason Hospital ("Nason")

Effective February 1, 2015, the Company acquired Nason, a 45 bed acute care hospital located in Roaring Spring, Pennsylvania for approximately $3.5 million, including net working capital. The results of operations of Nason are included in the Company's results of operations beginning on February 1, 2015.

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

2014 Acquisitions

Conemaugh Health System (“Conemaugh”)

Effective September 1, 2014, through Duke LifePoint Healthcare, the Company acquired Conemaugh for total consideration, including net working capital, of approximately $125.0 million, comprised of $115.0 million in cash and the issuance of a warrant with an estimated fair value of $10.0 million. The Company’s common stock warrants are described further in Note 8. Conemaugh is comprised of Conemaugh Memorial Medical Center, a 470 bed acute care hospital, 39 bed rehabilitation facility and 30 bed long-term care facility located in Johnstown, Pennsylvania, Meyersdale Medical Center, a 20 bed critical access hospital located in Meyersdale, Pennsylvania, and Miners Medical Center, a 30 bed acute care hospital located in Hastings, Pennsylvania. The results of operations of Conemaugh are included in the Company’s results of operations beginning on September 1, 2014.

Haywood Regional Medical Center (“Haywood”)

Effective August 1, 2014, through Duke LifePoint Healthcare, the Company acquired Haywood, a 169 bed acute care hospital located in Clyde, North Carolina for approximately $28.5 million, including net working capital. The results of operations of Haywood are included in the Company’s results of operations beginning on August 1, 2014.

WestCare Health System (“WestCare”)

Effective August 1, 2014, through Duke LifePoint Healthcare, the Company acquired WestCare for approximately $19.0 million, including net working capital and the assumption of certain capital leases. WestCare is comprised of Harris Regional Hospital, an 86 bed acute care hospital located in Sylva, North Carolina, and Swain County Hospital, a 48 bed critical access hospital located in Bryson City, North Carolina. The results of operations of WestCare are included in the Company’s results of operations beginning on August 1, 2014.

Rutherford Regional Medical Center (“Rutherford”)

Effective June 1, 2014, through Duke LifePoint Healthcare, the Company acquired an 80% interest in an entity that owns Rutherford, a 143 bed acute care hospital located in Rutherfordton, North Carolina for approximately $27.2 million, including net working capital. The results of operations of Rutherford are included in the Company’s results of operations beginning on June 1, 2014.

Wilson Medical Center ("Wilson")

Effective March 1, 2014, through Duke LifePoint Healthcare, the Company acquired an 80% interest in an entity that owns Wilson, a 294 bed hospital and 90 bed long-term care facility located in Wilson, North Carolina for approximately $59.8 million, including net working capital. The results of operations of Wilson are included in the Company's results of operations beginning on March 1, 2014.

Other

The Company completed certain ancillary service-line acquisitions and finalized net working capital settlements totaling $3.7 million, $58.7 million and $16.1 million during the years ended December 31, 2016, 2015 and 2014, respectively.

Additionally, during the year ended December 31, 2015, the Company recorded a bargain purchase gain of approximately $4.0 million, $2.5 million net of income taxes, or $0.05 per diluted share, as a result of the final fair values assigned to the tangible and intangible assets acquired less obligations assumed, in connection with the acquisition of a hospital, exceeding the total cash consideration paid. This amount is reflected in the accompanying consolidated statement of operations under the caption "Other non-operating gain" for the year ended December 31, 2015.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Note 3. Divestitures

Putnam Community Medical Center

Effective May 1, 2015, the Company sold Putnam Community Medical Center ("Putnam") located in Palatka, Florida for $18.8 million, including net working capital. Included in the Company's consolidated statements of operations is a net loss before income taxes attributable to Putnam of $2.6 million for the year ended December 31, 2015, and net income before income taxes attributable to Putnam of $3.2 million for the year ended December 31, 2014.

In connection with the Company's sale of Putnam, the Company recognized impairment charges of $10.8 million, $7.0 million net of income taxes, or $0.15 loss per diluted share, during the year ended December 31, 2015. The impairment charges include the write-down of property, equipment, allocated goodwill and certain other assets to their estimated fair values as well as the finalization of the net working capital settlement.

Northwest Alabama Market

Effective January 1, 2015, the Company sold substantially all of the assets of Lakeland Community Hospital ("Lakeland"), Northwest Medical Center ("Northwest") and Russellville Hospital ("Russellville") located throughout northwest Alabama. Included in the Company's consolidated statements of operations is net income before income taxes attributable to these three facilities in the aggregate of $1.7 million for the year ended December 31, 2015, and net losses before income taxes attributable to these three facilities in the aggregate of $0.3 million for the year ended December 31, 2014.

In connection with the Company's sale of Lakeland, Northwest and Russellville, the Company recognized impairment charges in the aggregate of $3.0 million and $45.5 million, $1.9 million and $28.1 million net of income taxes, or $0.04 and $0.60 loss per diluted share, during the years ended December 31, 2015 and 2014, respectively. The impairment charges include the write-down of property, equipment, allocated goodwill and certain other assets to their

estimated fair values.

River Parishes

Effective November 1, 2014, the Company sold certain assets of River Parishes Hospital ("River Parishes") located in LaPlace, Louisiana and discontinued its operation. Included in the Company's consolidated statements of operations is a net loss before income taxes attributable to River Parishes of $4.0 million for the year ended December 31, 2014.

In connection with the Company's sale of River Parishes, the Company recognized an impairment charge of $12.2 million, $7.8 million net of income taxes, or $0.16 loss per diluted share, during the year ended December 31, 2014. The impairment charge includes the write-down of property, equipment and allocated goodwill to their estimated fair values.

Note 4. Goodwill and Intangible Assets

The following table presents the changes in the carrying amount of goodwill during the years ended December 31, 2016 and 2015 (in millions):

Balance at January 1, 2015	$	1,636.1
Acquisitions		31.5
Divestitures		(5.3)
Adjustments related to prior year acquisitions		5.2
Balance at December 31, 2015		1,667.5
Acquisitions		110.4
Balance at December 31, 2016	$	1,777.9

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

The following table provides information regarding the Company's intangible assets, which are included in the accompanying consolidated balance sheets at December 31, 2016 and 2015 (in millions):

	2016	2015
Amortized intangible assets:		
Contract-based physician minimum revenue guarantees		
Gross carrying amount	$ 40.9	$ 48.9
Accumulated amortization	(24.6)	(28.9)
Net total	16.3	20.0
Non-competition agreements and other		
Gross carrying amount	20.2	20.2
Accumulated amortization	(13.4)	(11.2)
Net total	6.8	9.0
Total amortized intangible assets		
Gross carrying amount	61.1	69.1
Accumulated amortization	(38.0)	(40.1)
Net total	23.1	29.0
Indefinite-lived intangible assets:		
Certificates of need and certificates of need exemptions	35.4	30.6
Licenses, provider numbers, accreditations and other	21.8	11.0
Net total	57.2	41.6
Total intangible assets:		
Gross carrying amount	118.3	110.7
Accumulated amortization	(38.0)	(40.1)
Net total	$ 80.3	$ 70.6

Contract-Based Physician Minimum Revenue Guarantees

The Company has committed to provide certain financial assistance pursuant to recruiting agreements, or "physician minimum revenue guarantees," with various physicians practicing in the communities it serves. In consideration for a physician relocating to one of its communities and agreeing to engage in private practice for the benefit of the

respective community, the Company may advance certain amounts of money to a physician to assist in establishing his or her practice.

The Company accounts for its physician minimum revenue guarantees in accordance with the provisions of ASC 460-10, "Guarantees" ("ASC 460-10"). In accordance with ASC 460-10, the Company records a contract-based intangible asset and a related guarantee liability for new physician minimum revenue guarantees. The contract-based intangible asset is amortized as a component of other operating expenses, in the accompanying consolidated statements of operations, over the period of the physician contract, which typically ranges from four to five years. As of December 31, 2016 and 2015, the Company's liability for contract-based physician minimum revenue guarantees was $8.3 million and $8.1 million, respectively. These amounts are included as a current liability under the caption "Other current liabilities" in the Company's accompanying consolidated balance sheets.

Non-Competition Agreements

The Company has entered into non-competition agreements with certain physicians and other individuals which are amortized on a straight-line basis over the term of the agreements.

Certificates of Need and Certificates of Need Exemptions

The construction of new facilities, the acquisition or expansion of existing facilities and the addition of new services and certain equipment at the Company's facilities may be subject to state laws that require prior approval by state regulatory agencies. These certificate of need laws generally require that a state agency determine the public need and give approval prior to the construction or acquisition of facilities or the addition of new services. The Company has acquired facilities in certain states that have adopted certificate of need laws. The Company has determined that these intangible assets have an indefinite useful life.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Licenses, Provider Numbers, Accreditations, Trade Names and Other

To operate hospitals, the Company must obtain certain licenses, provider numbers and accreditations from federal, state and other accrediting agencies. The Company has acquired facilities in certain jurisdictions that require licenses, provider numbers and accreditations. Additionally, the Company has acquired trade names in connection with certain acquisitions. The Company has determined that these intangible assets have an indefinite useful life.

Amortization Expense

Amortization expense for the Company's intangible assets, including physician minimum revenue guarantee expense in accordance with ASC 460-10, during the years ended December 31, 2016, 2015 and 2014 was $12.1 million, $14.5 million and $17.6 million, respectively.

Total estimated amortization expense for the Company's intangible assets during the next five years and thereafter are as follows (in millions):

2017	$ 9.8
2018	6.7
2019	4.1
2020	1.8
2021	0.6
Thereafter	0.1
	$ 23.1

Note 5. Long-Term Debt

The Company's long-term debt, all of which was senior, consists of the following at December 31, 2016 and 2015 (in millions):

	2016	2015

Senior Credit Agreement:		
Term Facility	$ 691.3	$ -
Prior Credit Agreement:		
Prior Term Facility	-	405.0
Incremental Term Loans	-	222.6
6.625% Senior Notes	-	400.0
5.5% Senior Notes	1,100.0	1,100.0
5.875% Senior Notes	500.0	500.0
5.375% Senior Notes	500.0	-
Unamortized debt issuance costs, discount and premium	(21.9)	(22.2)
	2,769.4	2,605.4
Capital leases and financing obligations	144.9	63.4
Total debt	$ 2,914.3	$ 2,668.8

Maturities of the Company's long-term debt at December 31, 2016, excluding unamortized debt issuance costs, premium and other obligations that do not require eventual settlement in cash, are as follows for the years indicated (in millions):

2017	$ 22.3
2018	22.2
2019	31.5
2020	40.9
2021	1,701.8
Thereafter	1,090.6
	$ 2,909.3

Senior Credit Agreement

Terms

On June 10, 2016, the Company replaced the Prior Credit Agreement with the Senior Credit Agreement maturing on June 10, 2021. The Senior Credit Agreement provides for the $700.0 million Term Facility and a $600.0 million senior secured revolving credit facility (the "Revolving Facility'). The proceeds from the Term Facility were used to repay the outstanding Prior Term Facility and Incremental Term Loans under the Prior Credit Agreement and to pay related fees and expenses, and thereafter, for general corporate purposes. The Term Facility requires scheduled quarterly repayments in an amount equal to 2.5% per annum for each of the first, second and third years and 5.0% per annum for the fourth year and first three quarters of the fifth year, with the balance due at maturity. Additionally, the Term Facility and Incremental Term Loans are subject to mandatory prepayments based on excess cash flow, as well as upon the occurrence of certain other events, as specifically described in the Senior Credit Agreement. The Senior Credit Agreement is guaranteed, on a senior basis, by the Company's subsidiaries that guaranteed the Prior Credit Agreement, subject to certain exceptions. The Senior Credit Agreement is secured by collateral consisting of a perfected first priority lien on, and pledge of, all of the capital stock and intercompany notes issued by the Company's subsidiaries and owned by the Company and each guarantor, subject to certain exceptions.

Letters of Credit and Availability

The Revolving Facility may be utilized for letters of credit and swingline loans up to a maximum of $100.0 million and $50.0 million, respectively. Issued letters of credit and outstanding swingline loans reduce the amounts available for borrowing under the Revolving Facility. As of December 31, 2016, the Company had $20.7 million in letters of credit outstanding that were related to the self-insured retention level of its general and professional liability insurance and workers' compensation programs as security for payment of claims. During 2016, the Company borrowed and repaid $150.0 million under the Revolving Facility associated with the Prior Credit Agreement for general corporate purposes. Under the terms of the Senior Credit Agreement, amounts available for borrowing under the Revolving Facility were $579.3 million as of December 31, 2016.

The Senior Credit Agreement may, subject to certain conditions and to receipt of commitments from new or existing lenders, be increased up to a total of (i) $800.0 million and (ii) an amount such that, after giving pro forma effect to such increase and to the use of proceeds therefrom, the Company's secured leverage ratio does not exceed 3.50:1.00; provided that no lender is obligated to participate in any such increase.

Interest Rates

Interest on the outstanding borrowings under the Senior Credit Agreement is payable at the Company's option at either an adjusted London Interbank Offer Rate ("LIBOR") or an adjusted base rate plus an applicable margin. The applicable margin under the Senior Credit Agreement ranges from 1.50% to 2.00% for LIBOR loans and from 0.50% to 1.00% for adjusted base rate loans based on the Company's total leverage ratio, calculated in accordance with the Senior Credit Agreement. As of December 31, 2016, the applicable annual interest rate under the Term Facility was 2.52%, which was based on the 30-day adjusted LIBOR of 0.77% plus the applicable margin.

Covenants

The Senior Credit Agreement requires the Company to satisfy a maximum total leverage ratio not to exceed 5.00:1.00 through June 30, 2018 with a step-down to 4.50:1.00 through the remaining term and as calculated on a trailing four quarter basis. The Company was in compliance with this covenant as of December 31, 2016.

In addition, the Senior Credit Agreement contains certain customary affirmative and negative covenants, which place limitations on the ability of the Company and its subsidiaries to, among other things, incur debt, create other liens on its assets, make investments, sell assets, pay dividends or distributions to stockholders, undertake transactions with affiliates and enter into merger transactions or consolidate with other companies. The Senior Credit Agreement also contains various customary representations and warranties, financial and collateral reporting requirements and other affirmative covenants.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Issuance of 5.375% Senior Notes and Redemption of 6.625% Senior Notes

On May 26, 2016, the Company issued in a private placement $500.0 million aggregate principal amount of 5.375% Senior Notes due May 1, 2024. The proceeds from this issuance were used to redeem all $400.0 million aggregate principal amount of the outstanding 6.625% Senior Notes at a redemption price of 103.313% of principal amount plus accrued and unpaid interest to the redemption date of June 13, 2016. The remaining proceeds were used for general corporate purposes. The 5.375% Senior Notes bear interest at the rate of 5.375% per year, payable semi-annually on May 1 and November 1. The 5.375% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by certain of the Company's existing and future domestic subsidiaries.

The Company may redeem up to 35% of the aggregate principal amount of the 5.375% Senior Notes, at any time before May 1, 2019, with the net cash proceeds of certain equity offerings at a redemption price equal to 105.375% of the principal amount to be redeemed, plus accrued and unpaid interest, provided that at least 65% of the aggregate principal amount of the 5.375% Senior Notes remain outstanding immediately after the occurrence of such redemption and such redemption occurs within 180 days of the date of the closing of any such qualified equity offering.

The Company may redeem the 5.375% Senior Notes, in whole or in part, at any time prior to May 1, 2019 at a price equal to 100% of the principal amount of the notes redeemed plus an applicable make-whole premium, plus accrued and unpaid interest, if any, to the date of redemption. The Company may redeem the 5.375% Senior Notes, in whole or in part, at any time on or after May 1, 2019 at the redemption prices (expressed as percentages of principal amount) listed below, plus accrued and unpaid interest, if any, to the date of redemption:

May 1, 2019 to April 30, 2020	104.031	%
May 1, 2020 to April 30, 2021	102.688	%
May 1, 2021 to April 30, 2022	101.344	%
May 1, 2022 and thereafter	100.000	%

If the Company experiences a change in control under certain circumstances, it must offer to purchase the notes at a purchase price equal to 101% of the principal amount, plus accrued and unpaid interest to the date of purchase.

The 5.375% Senior Notes contain customary restrictive covenants, which among other things, limit the ability of the Company and its subsidiaries to incur or guarantee additional indebtedness; pay dividends on, or redeem or repurchase, its capital stock; make investments; incur obligations that restrict the Company's subsidiaries from making dividend or other payment to the Company; sell or encumber its assets; engage in transactions with affiliates; enter into sale/leaseback transactions; and merge, consolidate, or transfer all or substantially all of its assets.

In connection with the issuance of the 5.375% Senior Notes, the Company agreed to use commercially reasonable efforts to register with the Securities and Exchange Commission exchange notes having substantially identical terms as the 5.375% Senior Notes and complete an exchange offer no later than 395 calendar days after the issuance date of the 5.375% Senior Notes. Under certain circumstances, the Company may be required to file a shelf registration statement with respect to the 5.375% Senior Notes. If the Company fails to meet these obligations, it has agreed to pay additional interest to the holders of the affected 5.375% Senior Notes under certain circumstances.

5.5% Senior Notes

Effective December 6, 2013 and again on May 12, 2014, the Company issued in two separate private placements $700.0 million and $400.0 million, respectively, of the 5.5% Senior Notes with The Bank of New York Mellon Trust Company, N.A., as trustee. Collectively, the 5.5% Senior Notes mature on December 1, 2021 and bear interest at the rate of 5.5% per year, payable semi-annually on June 1 and December 1. The 5.5% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by certain of the Company's existing and future domestic subsidiaries.

The Company may redeem up to 35% of the aggregate principal amount of the 5.5% Senior Notes, at any time before December 1, 2016, with the net cash proceeds of certain equity offerings at a redemption price equal to 105.500% of the principal amount to be redeemed, plus accrued and unpaid interest, provided that at least 65% of the aggregate principal amount of the 5.5% Senior Notes remain outstanding immediately after the occurrence of such redemption and such redemption occurs within 180 days of the date of the closing of any such qualified equity offering.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

The Company may redeem the 5.5% Senior Notes, in whole or in part, at any time prior to December 1, 2016 at a price equal to 100% of the principal amount of the notes redeemed plus an applicable make-whole premium, plus accrued and unpaid interest, if any, to the date of redemption. The Company may redeem the 5.5% Senior Notes, in whole or in part, at any time on or after December 1, 2016, plus accrued and unpaid interest, if any, to the date of redemption plus a redemption price equal to a percentage of the principal amount of the notes redeemed based on the following redemption schedule:

December 1, 2016 to November 30, 2017	104.125 %
December 1, 2017 to November 30, 2018	102.750 %
December 1, 2018 to November 30, 2019	101.375 %
December 1, 2019 and thereafter	100.000 %

If the Company experiences a change in control under certain circumstances, it must offer to purchase the notes at a purchase price equal to 101.000% of the principal amount, plus accrued and unpaid interest to the date of purchase.

The 5.5% Senior Notes contain customary affirmative and negative covenants, which among other things, limit the Company’s ability to incur additional debt, create liens, pay dividends, effect transactions with its affiliates, sell assets, pay subordinated debt, merge, consolidate, enter into acquisitions and effect sale leaseback transactions.

5.875% Senior Notes

Effective December 4, 2015, the Company issued in a public offering $500.0 million of 5.875% unsecured senior notes due December 1, 2023 with The Bank of New York Mellon Trust Company, N.A., as trustee. The 5.875% Senior Notes bear interest at the rate of 5.875% per year, payable semi-annually on June 1 and December 1. The 5.875% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by certain of the Company’s existing and future domestic subsidiaries.

The Company may redeem up to 35% of the aggregate principal amount of the 5.875% Senior Notes, at any time before December 1, 2018, with the net cash proceeds of certain equity offerings at a redemption price equal to 105.875% of the principal amount to be redeemed, plus accrued and unpaid interest, provided that at least 65% of the aggregate principal amount of the 5.875% Senior Notes remain outstanding immediately after the occurrence of such redemption and such redemption occurs within 180 days of the date of the closing of any such qualified equity offering.

The Company may redeem the 5.875% Senior Notes, in whole or in part, at any time prior to December 1, 2018 at a price equal to 100% of the principal amount of the notes redeemed plus an applicable make-whole premium, plus accrued and unpaid interest, if any, to the date of redemption. The Company may redeem the 5.875% Senior Notes, in

whole or in part, at any time on or after December 1, 2018, plus accrued and unpaid interest, if any, to the date of redemption plus a redemption price equal to a percentage of the principal amount of the notes redeemed based on the following redemption schedule:

December 1, 2018 to November 30, 2019	104.406 %
December 1, 2019 to November 30, 2020	102.938 %
December 1, 2020 to November 30, 2021	101.469 %
December 1, 2021 and thereafter	100.000 %

If the Company experiences a change in control under certain circumstances, it must offer to purchase the notes at a purchase price equal to 101.000% of the principal amount, plus accrued and unpaid interest to the date of purchase.

The 5.875% Senior Notes contain customary affirmative and negative covenants, which among other things, limit the Company's ability to incur additional debt, create liens, pay dividends, effect transactions with its affiliates, sell assets, pay subordinated debt, merge, consolidate, enter into acquisitions and effect sale leaseback transactions.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Debt Transaction Costs

In connection with the various debt transactions discussed above, the Company capitalized $16.0 million of new debt issuance costs and recognized debt transaction costs of approximately $22.0 million, $13.7 million net of income taxes, or $0.32 loss per diluted share, during the year ended December 31, 2016. The debt transaction costs include the write-offs of previously capitalized debt issuance costs and new non-capital costs related to the Company's various debt transactions entered into during the second quarter of 2016. Additionally, the Company capitalized costs incurred in connection with various issuances of debt of $7.2 million during each of the years ended December 31, 2015 and 2014.

Note 6. Income Taxes

The provision for income taxes for the years ended December 31, 2016, 2015 and 2014 consists of the following (in millions):

	2016	2015	2014
Current:			
Federal	$ 113.2	$ 122.8	$ 47.2
State	7.9	7.9	1.4
	121.1	130.7	48.6
Deferred:			
Federal	(47.5)	(17.1)	26.7
State	(9.4)	(2.9)	(4.8)
	(56.9)	(20.0)	21.9
Change in valuation allowance	8.8	(1.2)	(2.4)
Total	$ 73.0	$ 109.5	$ 68.1

The increase in the valuation allowance during the year ended December 31, 2016 was primarily the result of state net operating loss carry forwards that management believes, after evaluation of the four sources of taxable income pursuant to ASC 740, may not be fully utilized because of the uncertainty regarding the Company's ability to generate taxable income in certain separate return filing states. Various subsidiaries have state net operating loss carryforwards in the aggregate of approximately $1.1 billion, primarily in Alabama, Florida, Georgia, Indiana, Louisiana, Mississippi, North Carolina, Pennsylvania, South Carolina, Tennessee, Virginia, and West Virginia, with expiration dates through the year 2036.

The following is a reconciliation of the statutory federal income tax rate to the Company's effective income tax rate for income before income taxes and excluding net income from non-controlling interests for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
Federal statutory rate	35.0 %	35.0 %	35.0 %
State income taxes, net of federal income tax benefits	(2.1)	2.2	1.0
Valuation allowances	4.5	(1.1)	(1.3)
Other items, net	0.1	1.5	0.4
Effective income tax rate	37.5 %	37.6 %	35.1 %

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Deferred income taxes result from temporary differences in the recognition of assets, liabilities, revenues and expenses for financial accounting and tax purposes. Sources of these differences and the related tax effects are as follows as of December 31, 2016 and 2015 (in millions):

	2016	2015
Deferred income tax liabilities:		
Depreciation and amortization	$ (332.7)	$ (329.2)
Prepaid expenses	(4.3)	(2.8)
Other	(0.1)	(1.6)
Total deferred income tax liabilities	(337.1)	(333.6)
Deferred income tax assets:		
Provision for doubtful accounts	56.3	50.8
Employee compensation	99.5	103.7
Professional liability claims	65.4	53.4
Net operating losses and other	143.5	95.8
Total deferred income tax assets	364.7	303.7
Valuation allowance	(77.6)	(64.5)
Net deferred income tax assets	287.1	239.2
Deferred income taxes	$ (50.0)	$ (94.4)

The Company’s liability for unrecognized tax benefits was nominal at December 31, 2016 and 2015.

The Company’s U.S. Federal income tax returns for tax years 2013 and beyond remain subject to examination by the Internal Revenue Service. The expiration of the statutes of limitation related to the various state income tax returns that the Company and its subsidiaries file, varies by state. Generally, the Company’s various state income tax returns for tax years 2010 and beyond remain subject to examination by various state taxing authorities.

Note 7. Other Current Liabilities

The following table provides information regarding the Company’s other current liabilities, which are included in the accompanying consolidated balance sheets at December 31, 2016 and 2015 (in millions):

	2016	2015
Current portion of reserves for self-insurance claims	$ 81.1	$ 41.5
Self-insured medical benefits liability	39.4	28.5
Accrued interest	12.1	14.4
Accrued provider taxes related to Medicaid supplemental payment programs	10.9	10.4
Accrued property taxes	8.1	8.2
Physician minimum revenue guarantee liability	8.3	8.1
Other	84.1	83.4
	$ 244.0	$ 194.5

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Note 8. Stockholders' Equity

Preferred Stock

The Company's Amended and Restated Certificate of Incorporation provides that up to 10,000,000 shares of preferred stock may be issued, of which 90,000 shares have been designated as Series A Junior Participating Preferred Stock, par value $0.01 per share ("Series A Preferred Stock"). The Board of Directors has the authority to issue preferred stock in one or more series and to fix for each series the voting powers (full, limited or none), and the designations, preferences and relative participating, optional or other special rights and qualifications, limitations or restrictions on the stock and the number of shares constituting any series and the designations of this series, without any further vote or action by the stockholders. Because the terms of the preferred stock may be fixed by the Board of Directors without stockholder action, the preferred stock could be issued quickly with terms calculated to defeat a proposed takeover or to make the removal of the Company's management more difficult.

Preferred Stock Purchase Rights

On September 21, 2015, the Company entered into Amendment No. 1 (the "Amendment") to the Amended and Restated Rights Agreement (the "Rights Agreement"), dated as of February 25, 2009, between the Company and American Stock Transfer & Trust Company, LLC, as rights agent. The Amendment accelerated the expiration date of the preferred stock purchase rights (the "Rights") from February 25, 2019 to September 21, 2015. As a result, on September 21, 2015, the Rights Agreement was terminated and all of the Rights distributed to holders of the Company's common stock pursuant to the Rights Agreement expired.

Common Stock

Holders of the Company's common stock are entitled to one vote for each share held of record on all matters on which stockholders may vote. There are no preemptive, conversion, redemption or sinking fund provisions applicable to shares of the Company's common stock. In the event of liquidation, dissolution or winding up, holders of the Company's common stock are entitled to share ratably in the assets available for distribution, subject to any prior rights of any holders of preferred stock then outstanding. Delaware law prohibits the Company from paying any dividends unless it has capital surplus or net profits available for this purpose. In addition, certain restrictions imposed by the Company's various debt instruments may limit the Company's ability to pay dividends.

Common Stock in Treasury and Repurchases of Common Stock

The Company's Board of Directors has authorized the repurchase of outstanding shares of its common stock either in the open market or through privately negotiated transactions, subject to market conditions, regulatory constraints and other customary factors in accordance with a repurchase plan adopted in 2014, as subsequently amended and extended in October 2015 (the "2014 Repurchase Plan"), a repurchase plan adopted on June 3, 2015 (the "2015 Repurchase Plan"),

and a repurchase plan adopted on September 14, 2016 (the "2016 Repurchase Plan"). The 2014 Repurchase Plan and 2015 Repurchase Plan each provided for the repurchase of up to $150.0 million in shares of the Company's common stock, respectively, and the Company has repurchased all shares authorized for repurchase under these plans. The 2016 Repurchase Plan provides for the repurchase of up to $200.0 million in shares of the Company's common stock through March 14, 2018. As of December 31, 2016, the Company had remaining authority to repurchase approximately $100.0 million in shares in accordance with the 2016 Repurchase Plan. The Company is not obligated to repurchase any specific number of shares under the 2016 Repurchase Plan. The Company has designated the shares repurchased in accordance with its repurchase plans as treasury stock.

The following tables summarize the Company's share repurchases in accordance with its stock repurchase plans for the years ended December 31, 2016, 2015 and 2014 (in millions, except per share amounts):

	Amount	Total Number of Shares Repurchased	Weighted Average Price Paid per Share
Year ended December 31, 2016	$ 225.0	3.8	$ 60.05
Year ended December 31, 2015	$ 125.0	1.7	$ 74.64
Year ended December 31, 2014	$ 214.7	3.8	$ 57.00

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Additionally, the Company redeems shares from employees for minimum statutory tax withholding purposes upon vesting of certain stock awards granted pursuant to the Company's various stockholder-approved stock-based compensation plans. The Company redeemed approximately 0.1 million shares vested under these plans during each the years ended December 31, 2016, 2015 and 2014 for an aggregate price of approximately $8.1 million, $9.5 million and $7.6 million, respectively. The Company has designated these shares as treasury stock.

Common Stock Warrants

As partial consideration in connection with the Company's acquisitions of Watertown and Conemaugh, the Company issued a warrant to each seller with rights to purchase shares of the Company's common stock. The Watertown warrant provides rights to purchase 55,024 shares of the Company's common stock at an exercise price of $80.37 per share and is exercisable ratably over three years beginning on September 1, 2016 and expires August 31, 2025. The Conemaugh warrant provides rights to purchase 290,514 shares of the Company's common stock at an exercise price of $74.15 per share and is exercisable ratably over three years beginning on September 1, 2015 and expires August 31, 2024. These warrants carry a combined estimated fair value of $13.7 million and are classified as stockholders' equity in the accompanying consolidated balance sheets under the caption "Capital in excess of par value" as of December 31, 2016 and 2015.

Comprehensive Income

Comprehensive income consists of two components: net income and other comprehensive income (loss). Other comprehensive income (loss) refers to revenues, expenses, gains and losses that in accordance with ASC 220-10 "Comprehensive Income," are recorded as an element of stockholders' equity but are excluded from net income.

Changes in the funded status of the Company's pension benefit obligations resulted in a pretax comprehensive loss of $0.2 million, or $0.1 million net of taxes, for the year ended December 31, 2016, a pretax comprehensive gain of $2.6 million, or $1.7 million net of taxes, for the year ended December 31, 2015, and a pretax comprehensive loss of $12.0 million, or $7.8 million net of taxes, for the year ended December 31, 2014. The Company's defined benefit pension plans are further discussed in Note 10.

Note 9. Stock-Based Compensation

Overview

The Company issues stock-based awards, including stock options and other stock-based awards (nonvested stock, restricted stock, restricted stock units and performance shares) to certain officers, employees and non-employee directors in accordance with the Company's various stockholder-approved stock-based compensation plans. The Company accounts for its stock-based awards in accordance with the provisions of ASC 718-10 and accordingly recognizes compensation expense over each of the stock-based award's requisite service period based on the estimated grant date fair value.

Stockholder-Approved Stock-Based Compensation Plans

Effective June 4, 2013, upon the approval of the Company's stockholders, the Company replaced the Amended and Restated 1998 Long-Term Incentive Plan (the "1998 LTIP") and Amended and Restated Outside Directors Stock and Incentive Compensation Plan (the "ODSICP") with the 2013 Long-Term Incentive Plan (the "2013 LTIP"), a combined plan covering all of the Company's employees and non-employee directors. No shares remain available for grant under the 1998 LTIP or the ODSICP.

Notwithstanding the specific grant vesting requirements, award agreements under the 2013 LTIP and the 1998 LTIP may provide for accelerated vesting in certain circumstances. Generally, award agreements provide for full vesting upon the death or disability of the participant. Some award agreements also provide for partial or full vesting upon involuntary termination of employment, provided that if the award is performance-based then the accelerated vesting would occur only if the performance goals are attained.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Stock Options

The Company granted options to purchase 939,417, 828,910 and 716,150 shares of the Company's common stock to certain officers and employees in accordance with the 2013 LTIP during the years ended December 31, 2016, 2015 and 2014, respectively. Options to purchase shares granted to the Company's officers and employees were granted with an exercise price equal to the fair market value of the Company's common stock on the day of grant, based on the closing price of the Company's common stock on the trading date immediately prior to the grant date. Options to purchase shares granted to the Company's officers and employees become ratably exercisable beginning one year from the date of grant to three years after the date of grant and expire ten years from the date of grant.

Valuation

The Company estimated the fair value of stock options granted using a binomial lattice option valuation model and a single option award approach. The Company uses a binomial lattice option valuation model because it considers characteristics of fair value option pricing, such as an option's contractual term and the probability of exercise before the end of the contractual term. In addition, the complications surrounding the expected term of an option are material, as indicated in ASC 718-10. Given the Company's relatively large pool of unexercised options, the Company believes a binomial lattice option valuation model that specifically addresses this fact and models a full term of exercises is the most appropriate and reliable means of valuing its stock options. The Company is amortizing the fair value on a straight-line basis over the requisite service period of the awards, which is the vesting period of three years. The stock options vest 33.3% on each grant anniversary date over three years of continued employment.

The following table shows the weighted average assumptions the Company used to develop the fair value estimates under its lattice option valuation model and the resulting estimates of weighted-average fair value per share of stock options granted during the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
Expected volatility	32.2 %	29.0 %	29.0 %
Risk-free interest rate	1.76	2.20	2.71
Expected dividends	-	-	-
Average expected term (years)	5.9	5.3	5.4
Fair value per share of stock options granted	$ 19.58	$ 18.66	$ 13.95

Population Stratification

In accordance with ASC 718-10, a company should aggregate individual awards into relatively homogeneous groups with respect to exercise and post-vesting employment behaviors for the purpose of refining the expected term assumption, regardless of the valuation technique used to estimate the fair value. In addition, ASC 718-10 indicates that a company may generally make a reasonable fair value estimate with as few as one or two groupings. The Company has determined that a single employee population group is appropriate based on an analysis of the Company's historical exercise patterns.

Expected Volatility

Volatility is a measure of the tendency of investment returns to vary around a long-term average rate. Historical volatility is an appropriate starting point for setting this assumption in accordance with ASC 718-10. According to ASC 718-10, companies should also consider how future experience may differ from the past. This may require using other factors to adjust historical volatility, such as implied volatility, peer-group volatility and the range and mean-reversion of volatility estimates over various historical periods. ASC 718-10 acknowledges that there is likely to be a range of reasonable estimates for volatility. In addition, ASC 718-10 requires that if a best estimate cannot be made, management should use the mid-point in the range of reasonable estimates for volatility. The Company estimates the volatility of its common stock at the date of grant based on both historical volatility and implied volatility from traded options of its common stock, consistent with ASC 718-10.

Risk-Free Interest Rate

Lattice models require risk-free interest rates for all potential times of exercise obtained by using a grant-date yield curve. A lattice model would, therefore, require the yield curve for the entire time period during which employees might exercise their options. The Company bases the risk-free rate on the implied yield in effect at the time of option grant on U.S. Treasury zero-coupon issues with equivalent remaining terms.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Expected Dividends

The Company has never paid any cash dividends on its common stock and does not anticipate paying any cash dividends in the foreseeable future. Accordingly, the Company uses an expected dividend yield of zero.

Pre-Vesting Forfeitures

Pre-vesting forfeitures do not affect the fair value calculation, but they affect the expense calculation. ASC 718-10 requires the Company to estimate pre-vesting forfeitures at the time of grant and revise those estimates in subsequent periods if actual forfeitures differ from those estimates. The Company uses historical data to estimate pre-vesting forfeitures and record share-based compensation expense only for those awards that are expected to vest.

The Company applies a dynamic forfeiture rate methodology over the vesting period of the award. The dynamic forfeiture rate methodology incorporates the lapse of time into the resulting expense calculation and results in a forfeiture rate that diminishes as the granted awards approach its vest date. Accordingly, the dynamic forfeiture rate methodology results in a more consistent stock-based compensation expense calculation over the vesting period of the award.

Post-Vesting Cancellations

Post-vesting cancellations include vested options that are cancelled, exercised or expire unexercised. Lattice models treat post-vesting cancellations and voluntary early exercise behavior as two separate assumptions. The Company uses historical data to estimate post-vesting cancellations.

Expected Term

ASC 718-10 calls for an extinguishment calculation, dependent upon how long a granted option remains outstanding before it is fully extinguished. While extinguishment may result from exercise, it can also result from post-vesting cancellation or expiration at the contractual term. Expected term is an output in lattice models so the Company does not have to determine this amount.

Stock Option Activity

A summary of stock option activity during the year ended December 31, 2016 is as follows:

Weighted

Stock Options	Number Shares	Weighted Average Exercise Price	Weighted Average Fair Value	Total Fair Value	Aggregate Intrinsic Value (a)	Average Remaining Contractual Term
				(In millions)	(In millions)	(In years)
Outstanding at December 31, 2015	3,674,772	$ 46.46	$ 13.20	$ 48.5	$ 99.0	6.59
Exercisable at December 31, 2015	2,180,867	$ 36.26	$ 11.16	$ 24.3	$ 81.0	5.24
Unvested at December 31, 2015	1,493,905	$ 61.34	$ 16.18	$ 24.2	$ 18.0	8.55
Granted	939,417	$ 64.18	$ 19.58	$ 18.4	N/A	N/A
Exercised	(273,272)	$ 43.59	$ 12.22	$ (3.3)	$ 4.4	N/A
Forfeited (pre-vest cancellation)	(221,223)	$ 65.42	$ 18.52	$ (4.1)	N/A	N/A
Vested	727,630	$ 56.83	$ 15.04	$ 11.0	N/A	N/A
Expired (post-vest cancellation)	(31,666)	$ 71.00	$ 18.65	$ (0.6)	N/A	N/A
Outstanding at December 31, 2016	4,088,028	$ 49.51	$ 14.40	$ 58.9	$ 45.7	6.21
Exercisable at December 31, 2016	2,603,559	$ 40.82	$ 12.04	$ 31.4	$ 44.9	4.87
Unvested at December 31, 2016	1,484,469	$ 64.74	$ 18.54	$ 27.5	$ 0.8	8.58

(a) The aggregate intrinsic value represents the difference between the underlying stock's market price and the stock's exercise price.

The total intrinsic value of stock options exercised during the years ended December 31, 2016, 2015 and 2014 was $4.4 million, $8.7 million and $14.8 million, respectively. The Company received $12.1 million, $11.5 million and $23.9 million in cash from stock option exercises during the years ended December 31, 2016, 2015 and 2014, respectively. The actual tax benefit realized for the tax deductions from stock option exercises totaled $0.4 million, $2.1 million and $1.2 million for the years ended December 31, 2016, 2015 and 2014, respectively.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

As of December 31, 2016, there was $16.8 million of total estimated unrecognized compensation cost related to stock options. Total estimated unrecognized compensation cost will be adjusted for future changes in estimated forfeitures. The Company expects to recognize this cost over a weighted average period of 1.3 years.

Other Stock-Based Awards

The Company granted 159,868, 146,155 and 133,871 restricted stock units to certain officers, employees and non-employee directors in accordance with the 2013 LTIP during the years ended December 31, 2016, 2015 and 2014, respectively. Vesting and payment of these restricted stock units are generally subject to continuing service of the employee or non-employee director over the ratable vesting periods beginning one year from the date of grant to three years after the date of grant or cliff-vesting periods from the grant date of six months and one day. The fair values of these restricted stock units were determined based on the closing price of the Company's common stock on the trading date immediately prior to the grant date.

Additionally, during the years ended December 31, 2016, 2015 and 2014 , the Company granted 159,248, 145,000 and 236,000 targeted performance-based restricted stock units, respectively, subject to the achievement of a combination of performance and/or market conditions. In addition to the achievement of the performance and/or market conditions, these performance-based restricted stock units are generally subject to the continuing service of the employee over the cliff-vesting period from the grant date of three years.

The performance condition for the targeted performance-based restricted stock units granted during the year ended December 31, 2016 is based on the Company's actual earnings before interest, taxes, depreciation and amortization ("EBITDA") financial performance for hospital acquisitions completed in 2014 and 2015 as compared to the pro forma EBITDA target for this same group of hospitals. The market condition for the targeted performance-based restricted stock units granted during each of the years ended December 31, 2016, 2015 and 2014 is based on the Company's three-year annualized total shareholder return relative to a peer group, Standard and Poor's Global Industry Classification Standard's Sub-Industry: Health Care Facilities with over $500.0 million in revenues or its equivalent. For the performance-based restricted stock units granted during the years ended December 31, 2016 and 2015, the number of shares payable at the end of the three-year performance period ranges from 0% to 200% of the targeted units based on the Company's actual performance and/or market conditions results as compared to the targets. For the performance-based restricted stock units granted during the year ended December 31, 2014, the number of shares payable at the end of the three-year performance period ranges from 0% to 100% of the targeted units, with any portion of the award that exceeds 100% up to 200% of the targeted units settled in cash equal to the fair market value on the date certification of the level of performance is achieved.

The fair values of these restricted stock units were determined based on a combination, where applicable, of the closing price of the Company's common stock on the trading date immediately prior to the grant date for units subject to performance conditions, or at its Monte-Carlo simulation value for units subject to market conditions. The Company recognizes compensation expense for the portion of the targeted performance-based restricted stock units

subject to market conditions even if the condition is never satisfied. However, if the performance conditions are not met for the portion of the targeted performance-based restricted stock units subject to such performance conditions, no compensation expense will be recognized, and any previously recognized compensation expense will be reversed.

A summary of other stock-based awards activity during the year ended December 31, 2016 is as follows:

Other Stock-Based Awards	Number Shares	Weighted Average Fair Value	Total Fair Value (In millions)	Aggregate Intrinsic Value (In millions)
Outstanding at December 31, 2015	937,291	$ 64.17	$ 60.2	$ 68.8
Granted	319,116	$ 68.55	$ 21.9	N/A
Vested	(423,200)	$ 48.37	$ (20.5)	$ 26.2
Forfeited (pre-vest cancellation)	(95,283)	$ 75.18	$ (7.2)	N/A
Outstanding at December 31, 2016	737,924	$ 73.70	$ 54.4	$ 41.9
Unvested at December 31, 2016	682,339	$ 74.77	$ 51.0	$ 38.8

As of December 31, 2016, there was $20.4 million of total estimated unrecognized compensation cost related to other stock-based awards. Total estimated unrecognized compensation cost will be adjusted for future changes in estimated forfeitures. The Company expects to recognize this cost over a weighted average period of 1.5 years.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Summary of Stock-Based Compensation

The following table summarizes the activity in accordance with all of the Company's stock-based compensation plans for the years ended December 31, 2016, 2015 and 2014:

	Shares	Stock Options Outstanding		Other Stock-Based Awards Outstanding		Deferred Stock Units Outstanding
	Available For Grant	Number of Shares	Weighted Average Exercise Price	Number of Shares	Weighted Average Grant Date Price	Number of Shares
January 1, 2014	3,436,190	3,099,272	$ 36.30	1,189,764	$ 37.79	11,079
Stock-based awards granted (a),(b)	(1,489,180)	716,150	52.87	369,871	66.91	-
Stock-based awards cancelled under the 1998 LTIP (c)	-	(959)	15.23	(1,335)	38.95	-
Stock-based awards cancelled under the MSPP (d)	6,257	-	-	(6,257)	10.87	-
Stock-based awards exercised or vested	-	(641,653)	37.04	(444,023)	33.44	(798)
December 31, 2014	1,953,267	3,172,810	39.90	1,108,020	49.55	10,281
Stock-based awards granted (a),(b)	(1,740,474)	828,910	71.03	291,155	82.07	-
Stock-based awards cancelled under the 2013 LTIP	92,742	(43,667)	63.26	(23,481)	65.23	-
Stock-based awards cancelled under the 1998 LTIP (c)	-	(10,134)	43.42	(4,002)	44.34	-
Stock-based awards cancelled under the MSPP (d)	387	-	-	(387)	12.15	-
Increase in shares available for grant upon stockholder approval	3,368,611	-	-	-	-	-
Stock-based awards exercised or vested	-	(273,147)	42.26	(434,014)	39.03	(5,317)
December 31, 2015	3,674,533	3,674,772	46.46	937,291	64.17	4,964
Stock-based awards granted (a),(b)	(1,939,198)	939,417	64.18	319,116	68.55	-

Stock-based awards cancelled under the 2013 LTIP	544,064		(252,889)		66.12	(95,283)		75.18	-
Stock-based awards exercised or vested	-		(273,272)		43.59	(423,200)		48.37	-
December 31, 2016	2,279,399	(e)	4,088,028	$	49.51	737,924	$	73.70	4,964

(a) Under the 2013 LTIP, stock-based awards are granted at a rate of 1.00 share for each stock option or appreciation rights award and 2.09 shares for each full-value award per 1.00 shared granted.

(b) Of the other stock-based awards granted during the years ended December 31, 2016, 2015 and 2014, 159,248, 145,000 and 236,000, respectively, were performance-based awards. The number of shares payable at the end of the three-year performance period ranges from 0% to 200% of the targeted units for awards granted in 2016 and 2015 and from 0% to 100% of the targeted units for awards granted in 2014. The Company has assumed that the maximum number of shares will be issued for purposes of reflecting shares available for grant. Shares available for grant will be adjusted in the future to reflect the actual number of shares issued upon vesting and settlement of these awards.

(c) Shares subject to awards granted under the 1998 LTIP that are cancelled subsequent to the effective date of the 2013 LTIP are not added to the shares available for grant under the 2013 LTIP.

(d) The Company is authorized to issue shares of the Company's common stock in the form of restricted stock at a discount of 25% in accordance with the Amended and Restated Management Stock Purchase Plan ("MSPP"). Effective July 1, 2012, the Company's Board of Directors suspended the right to acquire shares under the MSPP until further notice. Shares that were originally granted under the MSPP that were cancelled have been added back to shares available for future grant under the MSPP at a rate of 1.00 share per 1.00 share originally granted.

(e) Of the 2,279,399 shares available for grant as of December 31, 2016, 2,252,186 shares are available for grant under the 2013 LTIP and 27,213 shares are available for grant under the MSPP.

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

The following table summarizes the Company's total stock-based compensation expense as well as the total recognized tax benefits related thereto for the years ended December 31, 2016, 2015 and 2014 (in millions):

	2016	2015	2014
Equity awards:			
Other stock-based awards	$ 17.1	$ 19.3	$ 18.0
Stock options	12.3	10.7	9.3
	29.4	30.0	27.3
Liability awards:			
Other stock-based awards	(7.4)	5.0	2.4
Total stock-based compensation expense	$ 22.0	$ 35.0	$ 29.7
Tax benefit on stock-based compensation expense	$ 8.7	$ 14.0	$ 11.8

The Company did not capitalize any stock-based compensation cost during the years ended December 31, 2016, 2015 or 2014. As of December 31, 2016, there was $37.2 million of total estimated unrecognized compensation cost related to all of the Company's stock compensation arrangements. Total estimated unrecognized compensation cost may be adjusted for future changes in estimated forfeitures. The Company expects to recognize this cost over a weighted-average period of 1.4 years.

Note 10. Defined Benefit and Multiemployer Pension Plans

Defined Benefit Pension Plans

In connection with its acquisition of Marquette General Health System ("Marquette General") in 2012, the Company acquired certain assets and assumed certain liabilities associated with the benefits in the seller's defined benefit pension plan of certain employees covered by a collective bargaining agreement. The Company has established a separate defined benefit pension plan (the "Marquette Pension Plan") to facilitate its administration of the assumed portion of the seller's defined benefit pension plan. Additionally, in connection with its acquisition of Bell Hospital ("Bell") in 2013, the Company assumed sponsorship of Bell's defined benefit pension plan, which provides benefits to certain non-union employees (the "Bell Pension Plan" and, collectively with the Marquette Pension Plan, the "Pension Plans"). Both Pension Plans are closed to new participants. Participants in the Marquette Pension Plan are required to make annual contributions totaling 6% of annual compensation to the Marquette Pension Plan to continue accruing benefits. Participants in the Bell Pension Plan stopped accruing benefits when the Bell Pension Plan was frozen by Bell, effective October 31, 2005, prior to its assumption by the Company. The Company makes contributions to the Pension Plans sufficient to meet its minimum funding requirements as prescribed by the Employee Retirement Income Security Act of 1974, as amended.

Status and Expense

The following table presents the changes in the benefit obligations and plan assets of the Pension Plans during the years ended December 31, 2016 and 2015 and the unfunded liability of the Pension Plans at December 31, 2016 and 2015 (in millions):

	2016	2015
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 55.2	$ 57.8
Service costs	0.6	0.8
Interest costs	2.3	2.2
Participant contributions	0.4	0.5
Actuarial loss (gain)	0.4	(5.0)
Benefits paid	(1.2)	(1.1)
Benefit obligation at end of year	57.7	55.2
Change in plan assets:		
Fair value of plan assets at beginning of year	29.5	29.0
Actual return (loss) on plan assets	1.8	(0.4)
Employer contributions	1.5	1.5
Participant contributions	0.4	0.5
Benefits and expenses paid	(1.2)	(1.1)
Fair value of plan assets at end of year	32.0	29.5
Unfunded liability included in other long-term liabilities in the Company’s accompanying consolidated balance sheets	$ 25.7	$ 25.7

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

The Company recognizes changes in the funded status of the Pension Plans as a direct increase or decrease to stockholders' equity through accumulated other comprehensive income (loss). For the year ended December 31, 2016, the Company recognized a pretax comprehensive loss of $0.2 million, or $0.1 million net of taxes, as a decrease in stockholders' equity through accumulated other comprehensive income (loss). For the year ended December 31, 2015, the Company recognized a pretax comprehensive gain of $2.6 million, or $1.7 million net of taxes, as an increase in stockholders' equity through accumulated other comprehensive income (loss). For the year ended December 31, 2014, the Company recognized pretax comprehensive loss of $12.0 million, or $7.8 million net of taxes, as a decrease in stockholders' equity through accumulated other comprehensive income (loss). These adjustments were primarily related to changes in the Company's unfunded pension liability due to changes in the discount rates and mortality assumptions used to measure the projected benefit obligation.

The following table summarizes the projected benefit obligation, accumulated benefit obligation and fair value of plan assets related to the Pension Plans as of December 31, 2016 and 2015 (in millions):

	2016	2015
Projected benefit obligation	$ 57.7	$ 55.2
Accumulated benefit obligation	$ 53.3	$ 50.4
Fair value of plan assets	$ 32.0	$ 29.5

The following table summarizes the weighted-average assumptions used by the Company to determine its benefit obligation as of December 31, 2016 and 2015 (in millions):

	2016	2015
Discount rate	4.0 %	4.2 %
Rate of compensation increases, when applicable	3.0 %	3.0 %

The following table summarizes the components of net periodic costs for the years ended December 31, 2016, 2015 and 2014 (in millions):

	2016	2015	2016

Service cost	$ 0.6	$ 0.8	$ 0.5
Interest cost	2.3	2.2	2.1
Expected return on plan assets	(1.8)	(2.0)	(1.9)
Amortization of net actuarial loss (gain)	0.1	0.1	(0.2)
Total net periodic benefit cost	$ 1.2	$ 1.1	$ 0.5

The following table summarizes the weighted-average assumptions used by the Company to determine its net periodic benefit costs during the years ended December 31, 2016, 2015 and 2014 (in millions):

	2016	2015	2014
Discount rate	4.2 %	3.9 %	4.9 %
Rate of compensation increases, when applicable	3.0 %	3.0 %	3.0 %
Expected long-term return on plan assets	6.0 %	7.0 %	7.0 %

Plan Assets

The investment policy for the Pension Plans has been formulated to achieve a risk adjusted return that balances the need for asset growth against the risk of significant fluctuations in asset prices and the need for significant contributions from the Company. On a quarterly basis, or more frequently as necessary, the current risk levels, asset performance and expected return on assets are reviewed and evaluated against goals and targets by a committee appointed to oversee investment of the Pension Plans' assets (the "Investment Committee"). The Investment Committee strives to maintain a balance between risk and return through the use of modern portfolio theory methods, in conjunction with Monte Carlo modeling to evaluate the behavior of the portfolio under different scenarios. At December 31, 2016, the Pension Plans' investments include a balance of mutual funds and money market funds in order to achieve an overall rate of return that minimizes the need for additional employer contributions.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

The Company measures the fair value of its Pension Plans' assets in accordance with ASC 820-10. ASC 820-10 establishes a framework for measuring fair value and establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. The tiers are as follows:

Level 1 - defined as observable inputs such as quoted prices in active markets;

Level 2 - defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and

Level 3 - defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

The Pension Plans' investments in mutual funds are valued at the net asset value ("NAV") of shares reported in the active market in which the funds are traded. Because quoted prices are available for mutual funds and the markets in which they are traded are generally considered active, the Company has classified each of them as a Level 1 investment. The Pension Plans' investments in money market funds are valued at quoted prices in markets that are not active by a combination of inputs, including but not limited to dealer quotes who are market makers in the underlying funds and other directly and indirectly observable inputs. Because the inputs used to value money market funds are either directly or indirectly observable, but are not quoted prices in active markets, the Company has classified these assets as Level 2 investments. Investments in corporate and U.S. government and municipal bonds and notes are generally valued at the closing price reported in the market in which the related instrument is traded. In certain limited circumstances, other corporate debt instruments are valued based on yields currently available on comparable securities of issuers with similar credit ratings. Investments in asset and mortgage-backed securities are valued based on external prices or on the basis of their future principal and interest payments that have been discounted to prevailing interest rates for similar investments, using market spread data and other current market assumptions on prepayments and defaults. Because all of the inputs used to value corporate and U.S. government and municipal bonds and notes, as well as asset and mortgage-backed securities are either directly or indirectly observable but other than quoted prices in active markets, the Company has classified these assets as Level 2 investments.

The following table summarizes the assets of the Pension Plans, measured at fair value as of December 31, 2016 and 2015, by major asset category and aggregated by level within the fair value hierarchy (in millions):

	Quoted Prices in Active Markets	Significant Other	Significant Unobservable

	Total	for Identical Assets (Level 1)	Observable Inputs (Level 2)	Inputs (Level 3)
December 31, 2016:				
Mutual funds	$ 30.8	$ 30.8	$ -	$ -
Money market funds	1.2	-	1.2	-
Total	$ 32.0	$ 30.8	$ 1.2	$ -
December 31, 2015:				
Mutual funds	$ 17.2	$ 17.2	$ -	$ -
Corporate bonds and notes	8.8	-	8.8	-
Asset and mortgage-backed securities	1.4	-	1.4	-
Cash and cash equivalents	1.3	1.3	-	-
U.S. government and municipal bonds and notes	0.8	-	0.8	-
Total	$ 29.5	$ 18.5	$ 11.0	$ -

The Company expects to contribute approximately $1.8 million to the Pension Plans during the year ended December 31, 2017. Additionally, the Company expects to make future benefit payments from the Pension Plans as follows for the years indicated (in millions):

2017	$ 1.6
2018	1.8
2019	2.0
2020	2.2
2021	2.5
Five years thereafter	15.3
	$ 25.4

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Multiemployer Pension Plan

As a result of the acquisition of Bell effective December 1, 2013, the Company became obligated to contribute to a multiemployer pension plan on behalf of certain employees covered by collective bargaining agreements, in accordance with the terms of such collective bargaining agreements. The Company's contributions to the multiemployer pension plan are determined based on the terms of the applicable collective bargaining agreements. Multiemployer plans are different from single-employer plans because assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers. Also, if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers. If the Company stops participating in the multiemployer plan, the Company may be required to pay a withdrawal liability based on its portion of the unfunded status of the plan. Currently, the Company does not anticipate ending its participation in this plan.

Note 11. Commitments and Contingencies

Legal Proceedings and General Liability Claims

Healthcare facilities are, from time to time, subject to claims and suits arising in the ordinary course of business, including claims for damages for personal injuries, medical malpractice, breach of contracts, wrongful restriction of or interference with physicians' staff privileges and employment related claims. In certain of these actions, plaintiffs request payment for damages, including punitive damages that may not be covered by insurance.

In addition, healthcare facilities are subject to the regulation and oversight of various state and federal governmental agencies. Further, under the federal False Claims Act, private parties have the right to bring qui tam, or "whistleblower," suits against healthcare facilities that submit false claims for payments to, or improperly retain overpayments from, governmental payors. Some states have adopted similar state whistleblower and false claims provisions. These qui tam or "whistleblower" actions initiated under the civil False Claims Act may be pending but placed under seal by the court to comply with the False Claims Act's requirements for filing such suits. As a result, they could be proceeding without the Company's knowledge. In addition, on June 30, 2016, in accordance with the requirements of the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, the Department of Justice ("DOJ") published an interim final rule that, effective as of August 1, 2016, increases the civil monetary penalties that may be imposed for violations of the False Claims Act from a minimum of $5,500 and a maximum of $11,000 to a minimum of $10,781 and a maximum of $21,563 for each false and fraudulent claim. The interim final rule also establishes a mechanism for increasing the amounts of those civil monetary penalties for inflation on an annual basis beginning in 2017 and continuing each year thereafter. These civil monetary penalties are in addition to violators' liability for three times the amount of damages which the government sustains as a result of the false or fraudulent claim.

Although the healthcare industry has seen numerous ongoing investigations related to compliance and billing practices, hospitals, in particular, continue to be a primary enforcement target for the Office of Inspector General ("OIG"), the DOJ and other governmental fraud and abuse programs. Certain of the Company's individual facilities have received, and from time to time, other facilities may receive, inquiries or subpoenas from fiscal intermediaries, and federal and state agencies. Any proceedings against the Company may involve potentially substantial amounts as well as the possibility of civil, criminal, or administrative fines, penalties, or other sanctions, which could be material. Settlements of suits involving Medicare and Medicaid issues routinely require both monetary payments as well as corporate integrity agreements. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material adverse effect on the Company's financial position, results of operations and liquidity.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 imposed an affirmative obligation on healthcare providers to report and refund any overpayments received. "Overpayments" in this context include any amount received from a government program by a provider to which it is not entitled, regardless of the cause. Such overpayments are deemed to be fraudulent and become violations of the False Claims Act if not reported and refunded within the later of 60 days of identification or the date any corresponding cost report is due (if applicable). Hospitals can meet the obligation to report and refund in three ways: (1) refunding overpayments directly to the program; (2) self-disclosing the overpayment to the OIG via its voluntary self-disclosure protocol (with respect to False Claims Act and other violations not related to the federal physician self-referral law (Stark law)); and (3) self-disclosing to the CMS via the self-referral disclosure protocol (with respect to overpayments caused by potential violations of the Stark law only) for which CMS has the authority to reduce the amounts otherwise owed.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

The Company does not control and cannot predict with certainty the progress or final outcome of discussions with government agencies, investigations and legal proceedings against the Company. Therefore, the final amounts paid to resolve such matters, claims and obligations could be material and could materially differ from amounts currently recorded, if any. Any such changes in the Company's estimates or any adverse judgments could materially adversely impact the Company's future results of operations and cash flows.

In connection with the Company's acquisitions of Marquette General and Conemaugh, the two sellers self-disclosed various potentially non-compliant physician arrangements under the CMS voluntary self-disclosure protocol. These self-disclosures are pending with CMS. With respect to Marquette General, to the extent that the seller's satisfaction of its retained liabilities, including those under its CMS voluntary self-disclosure, causes its net proceeds from the acquisition to be less than $15.0 million, the Company has agreed to pay additional purchase consideration to the seller. With respect to Conemaugh, to the extent that the potential settlement exceeds the seller's indemnification threshold in accordance with the asset purchase agreement, the Company will likely be responsible for funding any deficit. The Company's management believes it has made reasonable estimates of its potential exposure for these two matters and at December 31, 2016 has recorded a reserve for Marquette General of $18.0 million.

On September 16, 2013, the Company and two of its affiliated hospitals, Vaughan Regional Medical Center, located in Selma, Alabama, and Raleigh General Hospital, located in Raleigh, West Virginia, made a voluntary self-disclosure to the Civil Division of the Department of Justice. The voluntary self-disclosure related to concerns regarding the clinical appropriateness of certain interventional cardiology procedures conducted by one physician in each of these hospitals' cardiac catheterization laboratories. The Company cooperated with the government in its investigations of the voluntary self-disclosure and provided additional documentation, as requested. The Company believes that the government's investigations are now closed. Following reviews by independent interventional cardiologists, the Company notified patients of these two physicians who may have received an unnecessary procedure of such fact.

The Company and/or Vaughan Regional Medical Center and several of the Company's subsidiaries, as well as Dr. Seydi V. Aksut and certain parties unaffiliated with the Company, are named defendants in 26 individual lawsuits filed since December 2014, and two putative class action lawsuits, all filed in the Circuit Court of Dallas County, Alabama. These lawsuits allege that patients at Vaughan Regional Medical Center underwent improper interventional cardiology procedures. One of the putative class action lawsuits, filed on November 21, 2014, seeks certification of a class consisting of all Alabama citizens who underwent an invasive cardiology procedure at any Company-owned Alabama hospital and who received notice regarding the medical necessity of that procedure. The other putative class action lawsuit, filed on February 6, 2015 also in the Circuit Court for Dallas County, Alabama, seeks certification of a

class of individuals that underwent an interventional cardiology procedure that was not medically necessary and performed by Dr. Aksut. This action asserts, among other claims, claims under the Racketeer Influenced and Corrupt Organizations Act ("RICO"), which, if successful, would result in the awarding of treble damages for any injury resulting from the RICO violation and attorneys' fees. In March 2015, the Company removed this action to the U.S. District Court in Mobile, Alabama and filed a motion to dismiss and for summary judgment, as well as a stay of discovery pending resolution of these motions. On April 17, 2015 the court entered an order granting the requested stay of discovery. On November 17, 2015, the United States Magistrate Judge for the Southern District of Alabama filed a Report and Recommendation that the RICO claim be dismissed with prejudice, and that the court not exercise jurisdiction over the remaining state law claims, resulting in those claims being dismissed without prejudice. By Order dated March 28, 2016, the United States District Court Judge adopted in full the Report and Recommendation of the Magistrate, dismissing with prejudice the RICO claim and refusing to exercise jurisdiction over the remaining state law claims. In a filing made April 7, 2016 the plaintiffs appealed the District Court's Order to the United States Court of Appeals for the Eleventh Circuit.

In February 2017, the Company settled the claims against it, its subsidiaries and Vaughn Regional Medical Center with certain of the individual plaintiffs and claimants, and the Company is in discussions to settle the remaining individual lawsuits and claims. The Company is also in discussions to settle the putative class action lawsuits. As of the date of this filing, the Company believes that all such settlements will be accomplished within the amounts previously accrued for loss contingencies for cardiology-related lawsuits. However, there can be no assurance that the Company will complete any or all of these settlements, that definitive settlement documentation will be agreed upon by all parties, that the courts overseeing the putative class action lawsuits will approve those settlements, or that the final resolution will not materially exceed the amounts previously accrued.

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Additionally, the Company, and two of its subsidiaries, including Raleigh General Hospital, as well as Dr. Kenneth Glaser, were named in 82 individual lawsuits filed in the circuit court of Raleigh County, West Virginia. Additionally, three patients had notified Raleigh General of their claims and intent to file a lawsuit. These lawsuits and claims alleged that patients at Raleigh General Hospital underwent unnecessary interventional cardiology procedures. In January 2017, all parties to these lawsuits and claims entered into settlement agreements settling all claims against the Company, its subsidiaries, Raleigh General Hospital and Dr. Glaser. These settlements were accomplished within the amounts previously accrued for loss contingencies for cardiology-related lawsuits. Following these settlements, two additional lawsuits were filed against the same parties alleging the same claims. In addition, in February 2017, the Company received a notice of claim with respect to a putative class action lawsuit in the Circuit Court of Raleigh County, West Virginia against it, two of its subsidiaries, Raleigh General Hospital and Dr. Glaser, alleging that patients at Raleigh General Hospital underwent medically unnecessary interventional cardiology procedures and seeking to certify a class of such patients.

The lawsuits identified above variously seek compensatory and punitive damages, costs, attorneys' fees and other available damages. Additional claims, including claims involving patients to whom the Company did not send notice, have been threatened and may be asserted against the Company or the hospital. Any present or future claims that are ultimately successful could result in the Company and/or the hospitals being found liable. Such liability could be material.

The Company accrues an estimate for a contingent liability when losses are both probable and reasonably estimable. The Company reviews its accruals each quarter and adjusts them to reflect the impact of developments, advice of legal counsel and other information pertaining to a particular matter. During the year ended December 31, 2016, the Company recorded an accrual for loss contingencies for cardiology-related lawsuits, which resulted in a net expense of $24.7 million, $15.5 million net of income taxes, or $0.36 loss per diluted share.

Physician Commitments

The Company has committed to provide certain financial assistance pursuant to recruiting agreements with various physicians practicing in the communities it serves. In consideration for a physician's relocating to one of its communities and agreeing to engage in private practice for the benefit of the respective community, the Company may advance certain amounts of money to a physician, normally over a period of one year, to assist in establishing the physician's practice. The Company has committed to advance a maximum amount of approximately $16.2 million at December 31, 2016. The actual amount of such commitments to be subsequently advanced to physicians is estimated at $8.3 million and often depends upon the financial results of a physician's private practice during the guarantee period. Generally, amounts advanced under the recruiting agreements may be forgiven pro rata over a period of 36 to

48 months contingent upon the physician continuing to practice in the respective community. Pursuant to the Company’s standard physician recruiting agreement, any breach or non-fulfillment by a physician under the physician recruiting agreement gives the Company the right to recover any payments made to the physician under the agreement. Additionally, the Company is subject to annual commitments for certain physician recruiting activities, including the continuation of existing or initiation of new activities with several of its facilities.

Capital Expenditure Commitments

The Company is reconfiguring some of its facilities to more effectively accommodate patient services and to provide for a greater variety of services, as well as implementing various information system initiatives in its efforts to comply with the HITECH Act. The Company has incurred approximately $178.3 million in costs related to uncompleted projects as of December 31, 2016, which is included under the caption “Construction in progress” in the Company’s accompanying consolidated balance sheet. At December 31, 2016, these uncompleted projects had an estimated cost to complete and equip of approximately $521.8 million. Additionally, the Company is subject to annual capital expenditure commitments in connection with several of its facilities, including its recent acquisitions. At December 31, 2016, the Company estimated its total remaining unfulfilled capital expenditure commitments to be approximately $1,547.7 million.

Marquette Replacement Facility

In December 2015, the Company acquired a parcel of land in Marquette, Michigan, and in May 2016, began constructing a replacement hospital for the existing Marquette General hospital. The Company anticipates that it will continue to operate the existing hospital campus until such point that the replacement hospital is ready for its intended use. Management currently expects that the construction of the replacement hospital will take approximately two to three years.

In accordance with ASC 360-10, the Company performed an evaluation of the recoverability of the carrying values of certain of the assets of Marquette General which management anticipates disposing. Because the estimated future undiscounted cash flows of Marquette General exceed the carrying values of the assets being considered for disposal, the Company has determined that these long-lived assets are not impaired. However, the Company has begun accelerating its depreciation expense for the portion of the existing hospital management anticipates disposing of in the future in order to reduce its carrying value down to the estimated fair value at the end of the projected construction period of the replacement hospital. Accordingly, the Company incurred approximately $6.2 million, $3.9 million net of income taxes, or $0.09 loss per diluted share, of additional depreciation expense during the year ended December 31, 2016. The Company currently estimates this acceleration will result in approximately $6.0 million of additional depreciation expense per year during the construction of the replacement hospital. This estimate is subject to change as a result of possible modifications to the Company’s plans for the existing hospital, including, but not limited to, the finalization of the plans for the replacement hospital, changes in the estimated construction period for the replacement hospital, on-going discussions and negotiations with interested parties for the existing hospital, regulatory approvals and changing market conditions.

Acquisitions

The Company has historically acquired businesses with prior operating histories. Acquired companies may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations, medical and general professional liabilities, workers compensation liabilities, previous tax liabilities and unacceptable business practices. Although the Company institutes policies designed to conform practices to its standards following completion of acquisitions, there can be no assurance that the Company will not become liable for past activities that may later be asserted to be improper by private plaintiffs or government agencies. Although the Company generally seeks to obtain indemnification from prospective sellers covering such matters, there can be no assurance that any such matter will be covered by indemnification, or if covered, that such indemnification will be adequate to cover potential losses and fines.

Leases

The Company leases real estate properties, buildings, vehicles and equipment under cancelable and non-cancelable leases. The leases expire at various times and have various renewal options. Certain leases that meet the lease capitalization criteria in accordance with ASC 840-10, “Leases”, have been recorded as an asset and liability at the lower of the net present value of the minimum lease payments at the inception of the lease or the fair value of the asset at the inception date. Interest rates used in computing the net present value of the lease payments are based on the Company’s incremental borrowing rate at the inception of the lease. Rental expense of operating leases for the years ended December 31, 2016, 2015 and 2014 was $69.3 million, $52.9 million and $45.4 million, respectively.

Health Support Center Financing Lease

Under a financing lease arrangement which commenced on December 1, 2013, the Company is leasing from an unrelated third party a health support center for a period of just over 15 years (the “HSC Lease”). In accordance with ASC 840-40, “Leases – Sale-Leaseback Transactions”, upon commencement of the HSC Lease, the Company recorded an asset under the caption “Buildings and improvements” and a related financing obligation under the caption “Long-term debt” representing the cumulative costs incurred and funded by the unrelated third party to construct the new health support center. The Company is depreciating the associated asset and amortizing the related financing obligation over the expected lease agreement term of just over 15 years. At the end of the lease term, the Company expects there to be a residual net book value of the building which will equal the remaining unamortized obligation under the HSC Lease. The remaining unamortized obligation under the HSC Lease will not require the eventual settlement in cash but will rather be offset by the residual net book value of the building at the expiration of the original lease term.

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Future minimum lease payments at December 31, 2016, for those leases having an initial or remaining non-cancelable lease term in excess of one year are as follows for the years indicated (in millions):

	Operating Leases	Capital Leases and Financing Obligations	Total
2017	$ 37.8	$ 16.5	$ 54.3
2018	28.5	16.1	44.6
2019	21.1	16.3	37.4
2020	15.2	16.6	31.8
2021	11.8	17.0	28.8
Thereafter	46.7	118.3	165.0
	$ 161.1	$ 200.8	$ 361.9
Less: interest portion		(82.8)	
		$ 118.0	

Tax Matters

See Note 6 for a discussion of the Company’s contingent tax matters.

Note 12. Unaudited Quarterly Financial Information

The quarterly interim financial information shown below has been prepared by the Company’s management and is unaudited. It should be read in conjunction with the audited consolidated financial statements appearing herein (in millions, except per share amounts):

	2016			
	First	Second	Third	Fourth
Revenues	$ 1,580.7	$ 1,592.4	$ 1,585.7	$ 1,605.2
Net income	23.9	20.1	41.2	46.6
Less: Net income attributable to noncontrolling interests				
and redeemable noncontrolling interests	(2.3)	(3.2)	(1.7)	(2.7)
Net income attributable to LifePoint Health, Inc.	$ 21.6	$ 16.9	$ 39.5	$ 43.9
Earnings per share attributable to LifePoint Health, Inc. stockholders:				
Basic	$ 0.50	$ 0.39	$ 0.94	$ 1.10
Diluted	$ 0.48	$ 0.38	$ 0.92	$ 1.07

	2015			
	First	Second	Third	Fourth
Revenues	$ 1,263.7	$ 1,270.4	$ 1,309.5	$ 1,370.7
Net income	42.0	49.8	45.8	55.4
Less: Net income attributable to noncontrolling interests				
and redeemable noncontrolling interests	(3.1)	(3.4)	(2.2)	(2.4)
Net income attributable to LifePoint Health, Inc.	$ 38.9	$ 46.4	$ 43.6	$ 53.0
Earnings per share attributable to LifePoint Health, Inc. stockholders:				
Basic	$ 0.88	$ 1.05	$ 0.99	$ 1.22
Diluted	$ 0.84	$ 1.00	$ 0.94	$ 1.16

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Note 13. Guarantor and Non-Guarantor Supplementary Information

The 5.5% Senior Notes, 5.875% Senior Notes and 5.375% Senior Notes are jointly and severally guaranteed on an unsecured senior basis by substantially all of the Company’s existing subsidiaries that guarantee the Senior Credit Agreement. The guarantors are 100% owned by the Company. Additionally, the guarantees are full and unconditional and are subject to customary release provisions as set forth in the agreements for the 5.5% Senior Notes, 5.875% Senior Notes and 5.375% Senior Notes.

The condensed consolidating financial information for the parent issuer, 100% owned guarantor subsidiaries, non-guarantor subsidiaries, certain eliminations and the Company is presented below for the years ended December 31, 2016, 2015 and 2014 and as of December 31, 2016 and 2015.

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Operations
For the Year Ended December 31, 2016

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ -	$ 4,085.9	$ 3,187.7	$ -	$ 7,273.6
Provision for doubtful accounts	-	523.2	386.4	-	909.6
Revenues	-	3,562.7	2,801.3	-	6,364.0
Salaries and benefits	22.0	1,677.1	1,348.3	-	3,047.4
Supplies	-	570.4	496.2	-	1,066.6
Other operating expenses, net	(1.4)	902.7	656.8	-	1,558.1

Other income	-	(18.8)	(11.1)	-	(29.9)
Equity in earnings of affiliates	(256.9)	-	-	256.9	-
Depreciation and amortization	-	213.7	130.9	-	344.6
Interest expense, net	127.3	5.2	16.7	-	149.2
Debt transaction costs	22.0	-	-	-	22.0
Impairment charge	-	1.2	-	-	1.2
Management (income) fees	-	(76.9)	76.9	-	-
	(87.0)	3,274.6	2,714.7	256.9	6,159.2
Income before income taxes	87.0	288.1	86.6	(256.9)	204.8
(Benefit) provision for income taxes	(34.9)	107.9	-	-	73.0
Net income	121.9	180.2	86.6	(256.9)	131.8
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	-	(9.9)	-	(9.9)
Net income attributable to LifePoint Health, Inc.	$ 121.9	$ 180.2	$ 76.7	$ (256.9)	$ 121.9

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Operations
For the Year Ended December 31, 2015

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ -	$ 3,419.8	$ 2,594.6	$ -	$ 6,014.4
Provision for doubtful accounts	-	496.9	303.2	-	800.1
Revenues	-	2,922.9	2,291.4	-	5,214.3
Salaries and benefits	35.0	1,342.2	1,119.7	-	2,496.9
Supplies	-	422.2	392.8	-	815.0
Other operating expenses, net	(0.7)	729.6	517.5	-	1,246.4
Other income	-	(35.8)	(13.9)	-	(49.7)
Equity in earnings of affiliates	(260.7)	-	-	260.7	-
Depreciation and amortization	-	180.0	99.0	-	279.0
Interest expense, net	35.5	66.3	12.6	-	114.4
Impairment charges	-	13.8	-	-	13.8
Other non-operating gain	-	(4.0)	-	-	(4.0)
Management (income) fees	-	(59.7)	59.7	-	-
	(190.9)	2,654.6	2,187.4	260.7	4,911.8
Income before income taxes	190.9	268.3	104.0	(260.7)	302.5
Provision for income taxes	9.0	100.5	-	-	109.5
Net income	181.9	167.8	104.0	(260.7)	193.0
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(0.8)	(10.3)	-	(11.1)
Net income attributable to LifePoint					

Health, Inc.	$ 181.9	$ 167.0	$ 93.7	$ (260.7)	$ 181.9

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Operations
For the Year Ended December 31, 2014

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Revenues before provision for doubtful accounts	$ -	$ 3,482.6	$ 1,818.3	$ -	$ 5,300.9
Provision for doubtful accounts	-	576.5	241.3	-	817.8
Revenues	-	2,906.1	1,577.0	-	4,483.1
Salaries and benefits	29.7	1,331.5	773.3	-	2,134.5
Supplies	-	419.4	279.6	-	699.0
Other operating expenses, net	(0.6)	750.4	337.5	-	1,087.3
Other income	-	(56.8)	(15.1)	-	(71.9)
Equity in earnings of affiliates	(196.9)	-	-	196.9	-
Depreciation and amortization	-	180.0	70.5	-	250.5
Interest expense, net	43.4	68.9	10.7	-	123.0
Impairment charges	-	57.7	-	-	57.7
Management (income) fees	-	(45.1)	45.1	-	-
	(124.4)	2,706.0	1,501.6	196.9	4,280.1
Income before income taxes	124.4	200.1	75.4	(196.9)	203.0
(Benefit) provision for income taxes	(1.7)	69.8	-	-	68.1
Net income	126.1	130.3	75.4	(196.9)	134.9
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(1.0)	(7.8)	-	(8.8)
Net income attributable to LifePoint Health, Inc.	$ 126.1	$ 129.3	$ 67.6	$ (196.9)	$ 126.1

F-48

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Comprehensive Income
For the Year Ended December 31, 2016

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Net income	$ 121.9	$ 180.2	$ 86.6	$ (256.9)	$ 131.8
Other comprehensive (loss) gain, net of income taxes:					
Unrealized (loss) gain on changes in funded status of pension benefit obligations	(0.1)	0.1	(0.2)	0.1	(0.1)
Other comprehensive loss	(0.1)	0.1	(0.2)	0.1	(0.1)
Comprehensive income	121.8	180.3	86.4	(256.8)	131.7
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	-	(9.9)	-	(9.9)
Comprehensive income attributable to LifePoint Health, Inc.	$ 121.8	$ 180.3	$ 76.5	$ (256.8)	$ 121.8

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Comprehensive Income
For the Year Ended December 31, 2015

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Net income	$ 181.9	$ 167.8	$ 104.0	$ (260.7)	$ 193.0
Other comprehensive income, net of income taxes:					
Unrealized gain on changes in funded status of pension benefit obligations	1.7	0.2	2.4	(2.6)	1.7
Other comprehensive income	1.7	0.2	2.4	(2.6)	1.7
Comprehensive income	183.6	168.0	106.4	(263.3)	194.7
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(0.8)	(10.3)	-	(11.1)
Comprehensive income attributable to LifePoint Health, Inc.	$ 183.6	$ 167.2	$ 96.1	$ (263.3)	$ 183.6

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Comprehensive Income
For the Year Ended December 31, 2014

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Net income	$ 126.1	$ 130.3	$ 75.4	$ (196.9)	$ 134.9
Other comprehensive loss, net of income taxes:					
Unrealized loss on changes in funded status of pension benefit obligations	(7.8)	(2.6)	(9.4)	12.0	(7.8)
Other comprehensive loss	(7.8)	(2.6)	(9.4)	12.0	(7.8)
Comprehensive income	118.3	127.7	66.0	(184.9)	127.1
Less: Net income attributable to noncontrolling interests and redeemable noncontrolling interests	-	(1.0)	(7.8)	-	(8.8)
Comprehensive income attributable to LifePoint Health, Inc.	$ 118.3	$ 126.7	$ 58.2	$ (184.9)	$ 118.3

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

LIFEPOINT HEALTH, INC.
Condensed Consolidating Balance Sheets
December 31, 2016

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	$ -	$ 8.5	$ 87.6	$ -	$ 96.1
Accounts receivable, net	-	520.2	392.5	-	912.7
Inventories	-	91.3	63.0	-	154.3
Prepaid expenses	0.1	46.5	25.3	-	71.9
Other current assets	-	46.1	34.2	-	80.3
	0.1	712.6	602.6	-	1,315.3
Property and equipment:					
Land	-	98.6	93.0	-	191.6
Buildings and improvements	-	1,782.1	819.5	-	2,601.6
Equipment	-	1,632.8	604.9	-	2,237.7
Construction in progress	-	89.1	89.2	-	178.3
	-	3,602.6	1,606.6	-	5,209.2
Accumulated depreciation	-	(1,696.1)	(446.3)	-	(2,142.4)
	-	1,906.5	1,160.3	-	3,066.8
Intangible assets, net	-	38.9	41.4	-	80.3
Investments in subsidiaries	2,529.0	-	-	(2,529.0)	-
Due from subsidiaries	2,513.7	-	-	(2,513.7)	-
Other long-term assets	16.9	28.6	33.2	-	78.7
Goodwill	-	1,468.4	309.5	-	1,777.9
Total assets	$ 5,059.7	$ 4,155.0	$ 2,147.0	$ (5,042.7)	$ 6,319.0
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	$ -	$ 165.7	$ 95.5	$ -	$ 261.2
Accrued salaries	-	125.3	87.6	-	212.9
Income taxes payable	47.8	-	-	-	47.8
Other current liabilities	12.1	133.9	98.0	-	244.0

Current maturities of long-term debt		17.5		0.5		4.3		-		22.3
		77.4		425.4		285.4		-		788.2
Long-term debt, net		2,751.9		47.9		92.2		-		2,892.0
Due to Parent		-		1,635.2		878.5		(2,513.7)		-
Deferred income taxes		50.0		-		-		-		50.0
Long-term portion of reserves for self-insurance claims		-		115.4		46.1		-		161.5
Other long-term liabilities		-		36.0		49.2		-		85.2
Total liabilities		2,879.3		2,259.9		1,351.4		(2,513.7)		3,976.9
Redeemable noncontrolling interests		-		-		113.7		-		113.7
Total LifePoint Health, Inc. stockholders' equity		2,180.4		1,895.1		633.9		(2,529.0)		2,180.4
Noncontrolling interests		-		-		48.0		-		48.0
Total equity		2,180.4		1,895.1		681.9		(2,529.0)		2,228.4
Total liabilities and equity	$	5,059.7	$	4,155.0	$	2,147.0	$	(5,042.7)	$	6,319.0

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

LIFEPOINT HEALTH, INC.
Condensed Consolidating Balance Sheets
December 31, 2015

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
ASSETS					
Current assets:					
Cash and cash equivalents	$ -	$ 200.9	$ 83.1	$ -	$ 284.0
Accounts receivable, net	-	442.7	301.0	-	743.7
Inventories	-	75.1	52.6	-	127.7
Prepaid expenses	0.1	27.8	22.9	-	50.8
Other current assets	-	28.3	31.5	-	59.8
	0.1	774.8	491.1	-	1,266.0
Property and equipment:					
Land	-	74.0	88.8	-	162.8
Buildings and improvements	-	1,546.1	726.2	-	2,272.3
Equipment	-	1,344.0	423.8	-	1,767.8
Construction in progress	-	72.2	47.2	-	119.4
	-	3,036.3	1,286.0	-	4,322.3
Accumulated depreciation	-	(1,523.7)	(316.3)	-	(1,840.0)
	-	1,512.6	969.7	-	2,482.3
Intangible assets, net	-	30.2	40.4	-	70.6
Investments in subsidiaries	2,286.0	-	-	(2,286.0)	-
Due from subsidiaries	2,716.2	-	-	(2,716.2)	-
Other long-term assets	12.7	469.8	27.9	-	510.4
Goodwill	-	1,466.3	201.2	-	1,667.5
Total assets	$ 5,015.0	$ 4,253.7	$ 1,730.3	$ (5,002.2)	$ 5,996.8
LIABILITIES AND EQUITY					
Current liabilities:					
Accounts payable	$ -	$ 91.2	$ 73.1	$ -	$ 164.3
Accrued salaries	7.4	115.6	83.0	-	206.0
Income taxes payable	28.9	-	-	-	28.9
Other current liabilities	14.4	106.8	73.3	-	194.5

Current maturities of long-term debt	22.5	1.0	1.5	-	25.0
	73.2	314.6	230.9	-	618.7
Long-term debt, net	2,582.9	48.1	12.8	-	2,643.8
Due to Parent	-	2,044.4	671.8	(2,716.2)	-
Deferred income taxes	94.4	-	-	-	94.4
Long-term portion of reserves for self-insurance claims	-	104.5	50.2	-	154.7
Other long-term liabilities	0.6	25.4	46.8	-	72.8
Total liabilities	2,751.1	2,537.0	1,012.5	(2,716.2)	3,584.4
Redeemable noncontrolling interests	-	-	103.6	-	103.6
Total LifePoint Health, Inc. stockholders' equity	2,263.9	1,715.2	570.8	(2,286.0)	2,263.9
Noncontrolling interests	-	1.5	43.4	-	44.9
Total equity	2,263.9	1,716.7	614.2	(2,286.0)	2,308.8
Total liabilities and equity	$ 5,015.0	$ 4,253.7	$ 1,730.3	$ (5,002.2)	$ 5,996.8

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Cash Flows
For the Year Ended December 31, 2016

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 121.9	$ 180.2	86.6	(256.9)	$ 131.8
Adjustments to reconcile net income to net cash (used in) provided by operating activities:					
Equity in earnings of affiliates	(256.9)	-	-	256.9	-
Stock-based compensation	29.4	-	-	-	29.4
Depreciation and amortization	-	213.7	130.9	-	344.6
Amortization of physician minimum revenue guarantees	-	8.1	1.8	-	9.9
Amortization of debt issuance costs, discount and premium	5.4	-	-	-	5.4
Debt transaction costs	22.0	-	-	-	22.0
Impairment charge	-	1.2	-	-	1.2
Deferred income taxes	(44.7)	-	-	-	(44.7)
Reserve for self-insurance claims, net of payments	-	13.7	11.7	-	25.4
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	(27.7)	(96.0)	-	(123.7)
Inventories, prepaid expenses and other current assets	-	(19.4)	(5.4)	-	(24.8)
Accounts payable, accrued salaries and other current liabilities	(9.7)	22.9	32.5	-	45.7
Income taxes payable/receivable	18.9	-	-	-	18.9
Other	(1.4)	2.0	(6.5)	-	(5.9)
Net cash (used in) provided by operating activities	(115.1)	394.7	155.6	-	435.2

Cash flows from investing activities:					
Purchases of property and equipment	-	(221.1)	(178.4)	-	(399.5)
Acquisitions, net of cash acquired	-	(119.2)	(1.9)	-	(121.1)
Other	(0.1)	-	-	-	(0.1)
Net cash used in investing activities	(0.1)	(340.3)	(180.3)	-	(520.7)
Cash flows from financing activities:					
Proceeds from borrowings	1,350.0	-	-	-	1,350.0
Payments of borrowings	(1,186.3)	-	-	-	(1,186.3)
Repurchases of common stock	(233.1)	-	-	-	(233.1)
Payments of debt financing costs	(30.0)	-	-	-	(30.0)
Proceeds from exercise of stock options	12.1	-	-	-	12.1
Change in intercompany balances with affiliates, net	202.5	(248.0)	45.5	-	-
Other	-	1.2	(16.3)	-	(15.1)
Net cash provided by (used in) financing activities	115.2	(246.8)	29.2	-	(102.4)
Change in cash and cash equivalents	-	(192.4)	4.5	-	(187.9)
Cash and cash equivalents at beginning of period	-	200.9	83.1	-	284.0
Cash and cash equivalents at end of period	$ -	$ 8.5	$ 87.6	$ -	$ 96.1

TABLE OF CONTENTS

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Cash Flows
For the Year Ended December 31, 2015

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 181.9	$ 167.8	$ 104.0	$ (260.7)	$ 193.0
Adjustments to reconcile net income to net cash provided by operating activities:					
Equity in earnings of affiliates	(260.7)	-	-	260.7	-
Stock-based compensation	30.0	-	-	-	30.0
Depreciation and amortization	-	180.0	99.0	-	279.0
Amortization of physician minimum revenue guarantees	-	10.1	1.9	-	12.0
Amortization of debt issuance costs, discount and premium	5.1	-	-	-	5.1
Impairment charges	-	13.8	-	-	13.8
Other non-operating gain	-	(4.0)	-	-	(4.0)
Deferred income taxes	(14.4)	-	-	-	(14.4)
Reserve for self-insurance claims, net of payments	-	(7.3)	25.2	-	17.9
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	7.0	31.7	-	38.7
Inventories, prepaid expenses and other current assets	-	25.0	(5.1)	-	19.9
Accounts payable, accrued salaries and other current liabilities	7.3	(15.7)	(16.3)	-	(24.7)
Income taxes payable/receivable	61.9	-	-	-	61.9
Other	(0.9)	(0.5)	0.3	-	(1.1)

Net cash provided by operating activities	10.2	376.2	240.7	-	627.1
Cash flows from investing activities:					
Purchases of property and equipment	-	(156.8)	(117.9)	-	(274.7)
Acquisitions, net of cash acquired	-	(488.2)	(131.2)	-	(619.4)
Proceeds from sale of hospital	-	18.8	-	-	18.8
Other	(1.0)	-	-	-	(1.0)
Net cash used in investing activities	(1.0)	(626.2)	(249.1)	-	(876.3)
Cash flows from financing activities:					
Proceeds from borrowings	500.0	-	-	-	500.0
Payments of borrowings	(16.9)	-	-	-	(16.9)
Repurchases of common stock	(134.5)	-	-	-	(134.5)
Payments of debt financing costs	(7.2)	-	-	-	(7.2)
Proceeds from exercise of stock options	11.5	-	-	-	11.5
Change in intercompany balances with affiliates, net	(362.1)	388.0	(25.9)	-	-
Other	-	0.9	(12.1)	-	(11.2)
Net cash (used in) provided by financing activities	(9.2)	388.9	(38.0)	-	341.7
Change in cash and cash equivalents	-	138.9	(46.4)	-	92.5
Cash and cash equivalents at beginning of period	-	62.0	129.5	-	191.5
Cash and cash equivalents at end of period	$ -	$ 200.9	$ 83.1	$ -	$ 284.0

F-54

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

LIFEPOINT HEALTH, INC.
Condensed Consolidating Statements of Cash Flows
For the Year Ended December 31, 2014

(In millions)

	Parent Issuer	Guarantors	Non-Guarantors	Eliminations	Consolidated
Cash flows from operating activities:					
Net income	$ 126.1	$ 130.3	$ 75.4	$ (196.9)	$ 134.9
Adjustments to reconcile net income to net cash (used in) provided by operating activities:					
Equity in earnings of affiliates	(196.9)	-	-	196.9	-
Stock-based compensation	27.3	-	-	-	27.3
Depreciation and amortization	-	180.0	70.5	-	250.5
Amortization of physician minimum revenue guarantees	-	13.1	1.6	-	14.7
Amortization of debt issuance costs, discount and premium	14.0	-	-	-	14.0
Impairment charges	-	57.7	-	-	57.7
Deferred income taxes	22.8	-	-	-	22.8
Reserve for self-insurance claims, net of payments	-	7.9	3.8	-	11.7
Increase (decrease) in cash from operating assets and liabilities, net of effects of acquisitions and divestitures:					
Accounts receivable	-	(5.9)	(48.4)	-	(54.3)
Inventories, prepaid expenses and other current assets	-	(6.1)	(12.5)	-	(18.6)
Accounts payable, accrued salaries and other current liabilities	2.4	(38.6)	21.8	-	(14.4)
Income taxes payable/receivable	(35.5)	-	-	-	(35.5)

Other	(0.8)	1.8	0.5	-	1.5
Net cash (used in) provided by operating activities	(40.6)	340.2	112.7	-	412.3
Cash flows from investing activities:					
Purchases of property and equipment	-	(139.0)	(68.1)	-	(207.1)
Acquisitions, net of cash acquired	-	(11.4)	(254.2)	-	(265.6)
Other	(3.2)	3.3	(0.6)	-	(0.5)
Net cash used in investing activities	(3.2)	(147.1)	(322.9)	-	(473.2)
Cash flows from financing activities:					
Proceeds from borrowings	412.0	-	-	-	412.0
Payments of borrowings	(585.4)	-	-	-	(585.4)
Repurchases of common stock	(222.3)	-	-	-	(222.3)
Payments of debt financing costs	(7.2)	-	-	-	(7.2)
Proceeds from exercise of stock options	23.9	-	-	-	23.9
Change in intercompany balances with affiliates, net	423.0	(689.9)	266.9	-	-
Other	(0.2)	0.5	(6.8)	-	(6.5)
Net cash provided by (used in) financing activities	43.8	(689.4)	260.1	-	(385.5)
Change in cash and cash equivalents	-	(496.3)	49.9	-	(446.4)
Cash and cash equivalents at beginning of period	-	558.3	79.6	-	637.9
Cash and cash equivalents at end of period	$ -	$ 62.0	$ 129.5	$ -	$ 191.5

LIFEPOINT HEALTH, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2016

Note 14. Subsequent Events

Effective January 1, 2017, the Company entered into a joint venture agreement with a wholly-owned subsidiary of LHC Group, Inc. ("LHC") to form In-Home Healthcare Partnership ("IHHP"), the purpose of which is to own and operate the Company's home health agencies and hospices and certain of LHC's home health agencies and hospices located near the Company's hospitals, leveraging the combined expertise of the Company and LHC to enhance home health and hospice services in the communities the Company's hospitals serve. Effective January 1, 2017, ownership and management of 11 of the Company's home health agencies and 6 of the Company's hospices were transferred to IHHP. The Company contributed assets comprised of approximately $13.5 million in accounts receivable, $20.2 million in allocated goodwill, and a nominal amount of property and equipment pursuant to the formation of IHHP. Additional home health agencies and hospices owned by the Company and LHC are planned to be transitioned to IHHP during 2017 and later years, subject to regulatory approvals and customary closing conditions.

Additionally, during January 2017, the Company borrowed $80.0 million under the Revolving Facility for general corporate purposes.

TABLE OF CONTENTS

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized:

LIFEPOINT HEALTH, INC.

By: /s/ WILLIAM F. CARPENTER III
William F. Carpenter III
Chief Executive Officer and
Chairman of the Board of Directors

Date: February 17, 2017

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant in the capacities and on the date indicated.

3

Name	Title	Date
/s/ WILLIAM F. CARPENTER III William F. Carpenter III	Chief Executive Officer and Chairman of the Board of Directors (Principal Executive Officer)	February 17, 2017
/s/ MICHAEL S. COGGIN Michael S. Coggin	Executive Vice President and Chief Financial Officer (Principal Financial Officer and Principal Accounting Officer)	February 17, 2017
/s/ KERMIT R. CRAWFORD Kermit R. Crawford	Director	February 17, 2017

/s/ RICHARD H. EVANS Richard H. Evans	Lead Director	February 17, 2017
/s/ MICHAEL P. HALEY Michael P. Haley	Director	February 17, 2017
/s/ MARGUERITE W. KONDRACKE Marguerite W. Kondracke	Director	February 17, 2017
/s/ JOHN E. MAUPIN, JR. John E. Maupin, Jr.	Director	February 17, 2017
/s/ JANA R. SCHREUDER Jana R. Schreuder	Director	February 17, 2017
/s/ REED V. TUCKSON Reed V. Tuckson	Director	February 17, 2017

TABLE OF CONTENTS

Exhibit Number	Description of Exhibits
3.1	—Amended and Restated Certificate of Incorporation of LifePoint Health, Inc., as amended (incorporated by reference from exhibits to the LifePoint Health, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2015, File No. 000-51251).
3.2	—Seventh Amended and Restated By-Laws of LifePoint Health, Inc. (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed November 3, 2016, File No. 000-51251).
4.1	—Form of Specimen Stock Certificate (incorporated by reference from exhibits to the Registration Statement on Form S-4, as amended, filed by Historic LifePoint Hospitals, Inc. on October 25, 2004, File No. 333-119929).
4.2	—Indenture, dated as of December 6, 2013, by and among LifePoint Hospitals, Inc., the Guarantors (as defined therein) and Bank of New York Mellon Trust Company, N.A. as trustee (including the Form of 5.5% Senior Note due 2021) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed December 9, 2013, File No. 000-51251).
4.3	—Senior Debt Securities Indenture, dated as of December 4, 2015, by and between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed December 4, 2015, File No. 000-51251).
4.4	—Supplemental Indenture, dated as of December 4, 2015, by and among the Company, the Guarantors party thereto, and The Bank of New York Mellon Trust Company, N.A., as trustee (including the form of 5.875% Senior Notes due 2023) (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed December 4, 2015, File No. 000-51251).
4.5	—Indenture, dated as of May 26, 2016, by and among Lifepoint Health, Inc., the Guarantors (as defined therein) and Bank of New York Mellon Trust Company, N.A., as trustee (including the Form of 5.375% Senior Note due 2024) (incorporated by reference from exhibits to the Lifepoint Health, Inc. Current Report on Form 8-K filed May 26, 2016, File No. 000-51251).
4.6	—Registration Rights Agreement, dated as of May 26, 2016, by and among LifePoint Health, Inc., the Guarantors (as defined therein) and Goldman, Sachs & Co. as representative of the several initial purchasers (incorporated by reference from exhibits to the Lifepoint Health, Inc. Current Report on Form 8-K filed May 26, 2016, File No. 000-51251).
10.1	—Computer and Data Processing Services Agreement dated May 19, 2008, by and between HCA Information Technology Services, Inc. and LifePoint Hospitals, Inc. (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed May 21, 2008, File No. 000-51251).

10.2 — Amendment to the Computer and Data Processing Services Agreement, dated June 13, 2012, by and between HCA – Information Technology & Services, Inc. and LifePoint Corporate Services, General Partnership (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2012, File No. 000-51251).

10.3 — LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan, dated June 30, 2005, as amended by the Amendment dated May 13, 2008, the Amendment dated December 10, 2008, the Amendment dated April 27, 2010, and the Amendment dated June 8, 2010, the Amendment dated April 23, 2012 and the Amendment dated June 5, 2012 (incorporated by reference from Appendices A and B to the LifePoint Hospitals, Inc. Proxy Statement filed April 23, 2012, File No. 000-51251).*

10.4 — Form of LifePoint Hospitals, Inc. Restricted Stock Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*

10.5 — LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from Appendix C to the Historic LifePoint Hospitals, Inc. Proxy Statement dated April 28, 2004, File No. 000-29818).*

TABLE OF CONTENTS

10.6 – First Amendment, dated December 10, 2008, to the LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2008, File No. 000-51251).*

10.7 – Amendment No. 2 to the LifePoint Hospitals, Inc. Executive Performance Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed June 6, 2014, File No. 000-51251).*

10.8 – Form of LifePoint Hospitals, Inc. Performance Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*

10.9 – LifePoint Hospitals, Inc. Change in Control Severance Plan, as amended and restated (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed December 16, 2008, File No. 000-51251).*

10.10 – LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan, dated January 1, 2003, as amended by the Amendment dated May 22, 2003, the Amendment dated May 13, 2008, the Amendment dated December 10, 2008, the Amendment dated March 24, 2009, the Amendment dated April 27, 2010, and the Amendment dated June 8, 2010 (incorporated by reference from Appendix C and D to the LifePoint Hospitals, Inc. Proxy Statement filed April 29, 2010, File No. 000-51251).*

10.11 – Amendment, dated April 18, 2012 to the LifePoint Hospitals, Inc. Amended and Restated Management Stock Purchase Plan (incorporated by reference from exhibits to LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2012, File No. 000-51251).*

10.12 – Form of Outside Directors Restricted Stock Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2006, File No. 000-51251).*

10.13 – LifePoint Hospitals, Inc. Amended and Restated Outside Directors Stock and Incentive Compensation Plan, dated May 12, 2009, as amended by the Amendment dated April 27, 2010, the Amendment dated June 8, 2010 and the Amendment dated June 5, 2012 (incorporated by reference from Appendix C and D to the LifePoint Hospitals, Inc. Proxy Statement filed April 23, 2012, File No. 000-51251).*

10.14 – Form of LifePoint Hospitals, Inc. Deferred Restricted Stock Award (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2009, File No. 000-51251).*

10.15 — LifePoint Health Deferred Compensation Plan Amended and Restated Effective January 1, 2016 (filed herewith).*

10.16 — Credit Agreement, dated as of June 10, 2016, among LifePoint Health, Inc., as borrower, the lenders referred to therein, and Citibank, N.A. as administrative agent (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed June 13, 2016, File No. 000-51251).

10.17 — Executive Severance and Restrictive Covenant Agreement, dated December 11, 2008, by and between LifePoint CSGP, LLC and William F. Carpenter III (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2008, File No. 000-51251).*

10.18 — First Amendment to the Amended and Restated Executive Severance and Restrictive Covenant Agreement, dated December 11, 2012, by and between HSCGP, LLC and William F. Carpenter III (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed December 17, 2012, File No. 000-51251).*

10.19 — Recoupment Policy Relating to Unearned Incentive Compensation of Executive Officers (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Current Report on Form 8-K filed May 20, 2008, File No. 000-51251).*

10.20 — LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan (incorporated by reference from Appendix A to the LifePoint Hospitals, Inc. Proxy Statement filed April 24, 2013, File No. 000-51251).*

10.21 —Amendment to the LifePoint Health, Inc. 2013 Long-Term Incentive Plan, dated June 2, 2015 (incorporated by reference from exhibits to the LifePoint Health, Inc. Current Report on Form 8-K filed June 4, 2015, File No. 000-51251).*

10.22 —Amendment to the LifePoint Health, Inc. 2013 Long-Term Incentive Plan, dated January 23, 2017 (filed herewith).*

10.23 —Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement (Performance-Based Vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*

10.24 —Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*

10.25 —Form of LifePoint Hospitals, Inc. Nonqualified Stock Option Agreement for the LifePoint Hospitals, Inc. Amended and Restated 1998 Long-Term Incentive Plan (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, File No. 000-51251).*

10.26 —Form of LifePoint Hospitals, Inc. Restricted Stock Unit Award Agreement for non-employee directors (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2013, File No. 000-51251).*

10.27 —Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Outside Director Restricted Stock Unit Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*

10.28 —Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Restricted Stock Unit Award Agreement (time-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*

10.29 —Form of LifePoint Hospitals, Inc. 2013 Long-term Incentive Plan Restricted Stock Unit Award Agreement (performance-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2013, File No. 000-51251).*

10.30 —Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Restricted Stock Unit Agreement (performance-based vesting) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc.

Quarterly Report on Form 10-Q for the quarter ended June 30, 2014, File No. 000-51251).*

10.31 — Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Restricted Stock Unit Agreement (performance-based vesting; deferral provision) (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Annual Report on Form 10-K for the year ended December 31, 2014, File No. 000-51251).*

10.32 — Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Restricted Stock Unit Agreement (performance-based vesting; deferral provision) (incorporated by reference from exhibits to the LifePoint Health, Inc. Annual Report on Form 10-K for the year ended December 31, 2015, File No. 000-51251).*

10.33 — Form of LifePoint Hospitals, Inc. 2013 Long-Term Incentive Plan Non-Qualified Stock Option Award Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended June 30, 2014, File No. 000-51251).*

10.34 — Form of Indemnification Agreement (incorporated by reference from exhibits to the LifePoint Hospitals, Inc. Quarterly Report on Form 10-Q for the quarter ended September 30, 2012, File No. 000-51251).*

12.1 — Ratio of Earnings to Fixed Charges

21.1 — List of Subsidiaries

23.1 — Consent of Independent Registered Public Accounting Firm

TABLE OF CONTENTS

31.1	—Certification of the Chief Executive Officer of LifePoint Health, Inc. pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	—Certification of the Chief Financial Officer of LifePoint Health, Inc. pursuant to Section 302 of the Sarbanes Oxley Act of 2002
32.1	—Certification of the Chief Executive Officer of LifePoint Health, Inc. pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	—Certification of the Chief Financial Officer of LifePoint Health, Inc. pursuant to Section 906 of the Sarbanes Oxley Act of 2002
101.INS	—XBRL Instance Document**
101.SCH	—XBRL Taxonomy Extension Schema Document**
101.CAL	—XBRL Taxonomy Calculation Linkbase Document**
101.DEF	—XBRL Taxonomy Definition Linkbase Document**
101.LAB	—XBRL Taxonomy Label Linkbase Document**
101.PRE	—XBRL Taxonomy Presentation Linkbase Document**

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*- Management Compensation Plan or Arrangement

** - Furnished electronically herewith